1.0 Background

By 4–5 months of age, splenomegaly develops in some infants with sickle cell disease, and by 12 months of age a palpable spleen is noted in nearly half. Although enlarged, the spleen does not properly perform its filtration function. However, its reservoir function is overactive: sequestration of large quantities of blood (often half or more of a child’s blood volume) can occur rapidly. This complication, termed acute splenic sequestration, is characterized by pooling of large quantities of sickled RBCs in the splenic red pulp, sudden enlargement of the spleen (within hours), and a precipitous decline in haemoglobin (Hb) and platelets, and an increase in reticulocytes.

Presentation is often (60%) associated with episodes of fever, suggesting an underlying viral etiology. Most commonly occurs in infants and young children between 6 months and 5 years of age with sickle cell anaemia. It may also occur in older patients with any sickle cell phenotype with or without chronic splenomegaly. Often there is no obvious triggering event.

2.0 Clinical/Laboratory Features

A child with an acute splenic sequestration presents with symptoms of:
- acute anaemia (pallor, tachycardia, frank cardiovascular collapse);
- splenomegaly/abdominal pain (pain in the left upper quadrant); and
- evidence of an active bone marrow response (increased reticulocytes) plus or minus thrombocytopenia.

Retrospective reviews have shown a first-episode mortality of as high as 14%. On physical examination, patients show signs of anaemia, hypovolemia, and an enlarged spleen (larger than baseline), sometimes massively so. Mild cases may be asymptomatic.

Haemoglobin concentration is at least 20g/L below the baseline steady state. In severe cases, haemoglobin may decline to life-threatening levels. Reticulocyte counts are usually elevated, which distinguishes this condition from aplastic crisis. The platelet count often declines to <50 X 10⁹/L.

The mainstay of management is transfusion to provide circulating erythrocytes and volume. Risk of recurrence is approximately 40–50%, usually within 3 years. Because it is not possible to predict which children will have recurrent attacks, most experts recommend splenectomy after the first major attack (for patients >2 years old), or chronic transfusion to maintain a haemoglobin S level under 50% until the patient can get to surgery once all relevant immunizations have been completed.
### 3.0 Clinical Practice Guideline

**Acute Splenic Sequestration: Guidelines for Management in Children with Sickle Cell Disease**

**Symptoms of Acute Splenic Sequestration:**
- Acute onset of pain in the left upper quadrant.
- Evidence of an acute bone marrow response (increased reticulocyte level or increased thrombocytosis).
- Enlarged spleen palpable in the left lower quadrant.
- Evidence of increased reticulocytes.
- Hematocrit falls to less than 20%.
- Evidence of hypovolemia.
- Pulmonary edema, shock, and frank cardiovascular collapse.

**Inpatient Management:**
- Child is on cardiac or O2 monitor.
- Monitor vital signs as per BedsidePEWs.
- Repeat physical assessment.
- Spleen size q4h (measure with tape and record).
- Ls q4h.
- If splenomegalia is > 2x normal, obtain baseline transvaginal ultrasound or computed tomography (CT).
- If unstable, give IV fluid bolus followed by PRBC and follow BedsidePEWs recommendations.
- Child on cardiac or O2 monitor.
- Monitor vital signs as per BedsidePEWs.
- Continue regularly scheduled medications.
- Administer O2 to keep SpO2 > 95%.
- Child discharged home from inpatient unit with appropriate follow-up:
  - Evidence of rising hemoglobin and diminishing spleen size.
  - Refer to discharge planning process document.
  - Child has stable vital signs (i.e., stable unless clear viral source).
  - Tenderness and palpation of bone.
  - Pain is controlled by oral analgesics.
  - Hemoglobin and platelet count should be monitored due to persistent splenomegaly and hypersplenism.
  - Headache.
  - Transfusion volume.

**ED Management:**
- Complete history.
- Establish IV access.
- Ensure child is on cardiopulmonary monitoring and O2.
- Hematocrit is > 20%. If below baseline, transfuse as soon as possible with cross-matched PRBC not exceeding 10U, and notify hematologist/oncologist.
- Transfusion volume S. Height, determined in consultation with Hematology Team. Use phenotypically mismatched blood. If unstable, give IV fluid bolus followed by PRBC.
- Initiate Sickle Cell Fever order set in Epic as indicated.

**4.0 References**


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Attachments:

- [Revision History.docx](#)
- [SC_Clinic Follow Up Revised 2021_FINAL.pdf](#)
- [Splenic Sequestration Care Pathway 2021 Final.pdf](#)