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ERRATUM

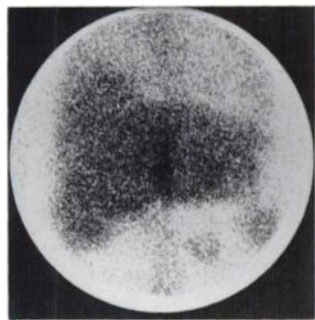


FIGURE 1. Initial anterior ¹¹¹In-WBC image of the upper abdomen performed 1 mo ago. It demonstrates a wound abscess, a colostomy site, and no evidence of splenic activity.

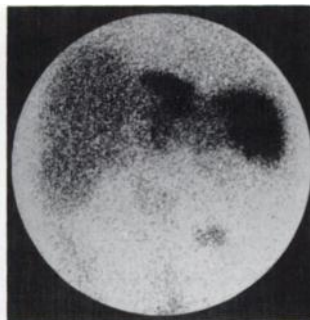


FIGURE 2. Anterior ¹¹¹In-WBC image of the upper abdomen from the second study. It shows a wound abscess, a splenic bed abscess, and the colostomy site.

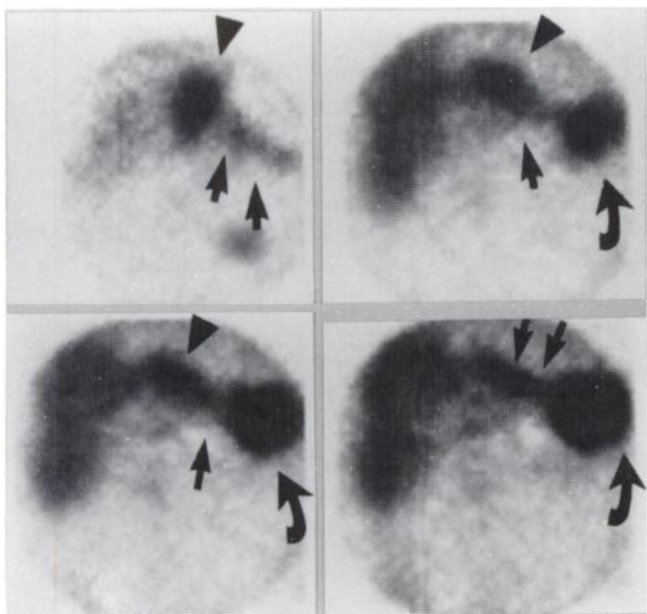


FIGURE 3. Coronal ¹¹¹In-WBC SPECT images of the upper abdomen from the second study. It demonstrates a wound abscess (arrow heads), a communicating tract (straight black arrows) and a splenic bed abscess (curved arrows).

Due to a production error, Figures 1 and 2 in the First Impression by Desai et al. in the September issue of the *Journal (J Nucl Med 1993;34:5A, 1493)* were printed incorrectly. The corrected text and figures are printed below.

PURPOSE

The patient is a 66-yr-old man who had an abdominal aortic aneurysm repair about 2 mo before this examination. The post-operative period was complicated by retroperitoneal bleeding, hypotension, ischemic bowel, for which a left hemicolectomy was performed, and persistent fever. Ten days later, the patient underwent a splenectomy for splenic infarcts. The fever continued to persist.

The patient underwent two white blood cell (WBC) scans to evaluate the persistent fever. The first scan (Fig. 1), done 1 mo prior to the current examination, showed increased WBC activity in the abdominal wound consistent with a wound abscess. A colostomy stoma was also seen. Normal splenic WBC activity was not seen because of the splenectomy.

The current WBC scan (Fig. 2) shows a large spleen-shaped collection of intense WBC activity in the splenic bed, which on first impression could easily pass for normal splenic activity. The history of a splenectomy and correlation with the earlier WBC scan makes the diagnosis of an abscess in the splenic bed quite apparent. The abscess was drained on the same day under CT guidance, and 180 cc of pus was removed. A moderately intense collection of WBC activity in the upper end of the midline abdominal wound was again seen and is consistent with a persistent wound abscess. The colostomy stoma was again noticed. A SPECT scan of the abdomen revealed a communication between the wound abscess and splenic bed abscess just beneath the diaphragm (Fig. 3).

Without the history of a splenectomy, how many of you made the diagnosis of a splenic bed abscess, in addition to a wound abscess? We did not! The purpose of this study is to illustrate the critical importance of appropriate history and correlation with prior or other imaging studies in making the proper diagnosis in complex clinical circumstances.

TRACER

Indium-111-WBCs.

ROUTE OF ADMINISTRATION

Intravenous.

TIME AFTER INJECTION

24 hours.

INSTRUMENTATION

ROTA dual-head gamma camera.

CONTRIBUTORS

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INSTITUTION

St. Luke's Medical Center, Milwaukee, Wisconsin.