INTRODUCTION:
Polysplenia syndrome is a rare congenital anomaly frequently associated with various visceral anomalies including multiple spleens, impaired visceral lateralization, congenital heart diseases, gastrointestinal abnormalities and azygos continuation of the inferior vena cava (IVC). It appears to have increased with the advent of noninvasive imaging techniques such as CT and MRI.
Radiologists need to be aware of the various congenital variants of this syndrome in order to recognize clinically important anomalies and to avoid mistaking less significant ones for an abnormality.
We report the case of an accidental scannographic discovery of this syndrome in a male patient aged of 50 years, explored in the radiology department of Farhat Hached in Sousse.
In this pictorial review, the appearance on CT is described and diagnostic pitfalls are identified.
DISCUSSION:

Polysplenia is a complex congenital syndrome characterized by partial visceral heterotaxia (situs ambiguous) and concomitant levoisomerism (bilateral left-sidedness). It is associated with multiple, highly variable cardiovascular and visceral anomalies. The role of genetic factors in polysplenia remains undefined. It is more likely that this condition result from the interaction of both genetic and environmental factors.

The splenic mass is usually divided into fairly equally sized masses, varying in number from two to six and ranging from 1 cm to 6 cm in diameter, which together equal the mass of a normal spleen. Less often there may be several small spleens adjacent to either one or two large spleens, as in our case. The location of the spleens is in either the left or right upper quadrant, along the greater curvature of the stomach.

Azygos continuation of the IVC is a well-known vascular anomaly in association with polysplenia syndrome.
It is a venous system anomaly touching the systemic veins with an azygous return of the inferior vena cava. This azygous vein is coursing on either the right or the left side. This anatomical variant has no clinical significance, although it needs to be recognized as anatomical variant by the radiologist to interpret the imaging findings correctly and to avoid mistaking them for an abnormality. Useful signs on chest X-ray film of this IVC anomaly are convexity in the right tracheobronchial angle on the posteroanterior view and an absence of the IVC shadow on the lateral view. On CT examination, the enlarged azygous vein may resemble retroperitoneal lymphadenopathy or paravertebral mass. However, the azygous vein is easily identified when the tubular structure, the intense contrast enhancement to the same degree as the aorta and the continuity with the SVC through the azygous arch are seen.

**CONCLUSION:**

Most patients with inferior cava venal anomaly through polysplenia syndrome may be overlooked because they are asymptomatic, and thus polysplenia syndrome may be more frequent than is generally considered. Unawareness of this syndrome entails extensive investigations including angiography and even unnecessary thoracotomy because of its associated unusual anomalies. Radiologists should be familiar with the spectrum of anomalies that occurs in patients with polysplenia syndrome to recognize them as part of a syndrome to avoid misinterpreting them as pathological processes.