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RESEARCH ARTICLE

RARE CASE PRESENTATION OF ANTERIOR ABDOMINAL WALL VARICOSE VEIN IN POST THROMBOTIC LEG IN DVT PATIENT WITH SECONDARY VARICOSE VEIN WITH VENOUS ULCER

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ABSTRACT

Background: Post thrombotic syndrome an important chronic consequence of deep vein thrombosis. Severe post thrombotic syndrome including venous ulcer, which develop in 5% to 10 %, the principal risk factors of post thrombotic syndrome are anatomically extensive DVT, recurrent ipsilateral DVT. Recurrent DVT that may occur years later after the initial event is a known risk factor for the development of PTS. [1] Post thrombosis of big vein in abdomen (vena cava) or pelvic (iliac vein) leads to development of collaterals in anterior abdominal wall. **Case report:** A 28 year male chronic smoker known case of DVT presented with non healing venous ulcer with dilated anterior abdominal wall and left leg vein. On evaluation, he was diagnosed with anterior abdominal wall varicose vein in post thrombotic syndrome post DVT with secondary varicose vein and venous ulcer in left leg for which anticoagulant was prescribed with advice of stenting. **Discussion:** Post thrombotic syndrome of the legs, characterized by chronic venous insufficiency, occurs in up to half of patients who experience DVT or Pulmonary embolism. After DVT, Post thrombotic syndrome will develop in 20% to 50% of patient and post thrombotic syndrome complication are stasis ulcer, skin changes and varicose vein of leg commonly. Post DVT of major vessel of leg, resulting varicosity of the veins of abdominal wall which is a rare complication. Large, prominent normal veins are seen often in the abdominal wall, particularity in thin individual is and in conjunction with prominent veins elsewhere in the body.

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INTRODUCTION

Post thrombotic syndrome an important chronic consequence of deep vein thrombosis. Awareness of this long-term complication is low among treating physicians whose main focus is the acute embolic complications of DVT. Severe post thrombotic syndrome including venous ulcer, which develop in 5% to 10 %, the principal risk factors of post thrombotic syndrome are anatomically extensive DVT, recurrent ipsilateral DVT, persistent leg symptom 1 month after acute DVT, obesity and older age, poor compliance with treatment. The known risk factor for the development of PTS is due to recurrent DVT that may occur years later after the initial event (Kahn *et al*., 2014). Post thrombosis of big vein in abdomen (vena cava) or pelvic (iliac vein) leads to development of collaterals in anterior abdominal wall. The direct and indirect costs of this disease that affects all adult age groups is estimated to be enormous, arousing the interest of public health planners.

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CASE REPORT

A 28 years male chronic smoker follow up case of deep vein thrombosis for 3 year with irregular medication, now presented with anterior abdominal wall varicose vein with secondary varicose vein with venous ulcer over left leg was evaluated. Vital sign shows oxygen saturation of 98% on room air, RR-18/mint, BP-130/80 mm of Hg, pulse 72 /mint. Physical examination revealed grossly dilated vein of lower abdomen, left inguinal region as well as dilated vein in the patient's left leg with multiple ulcers over. Colour Doppler showed thrombosis involving the external iliac, common femoral, popliteal, anterior tibial and posterior tibial vein of lower limb and saphenous femoral junction with greater and lesser saphenous vein partially thrombosed. The patient was started on anticoagulant with low molecular weight heparin, oral rivaroxaban (factor Xa inhibitor) and elastic compression bandage and daily dressing of wound. After discharge he was advised to be consulted with vascular surgeon for stenting.

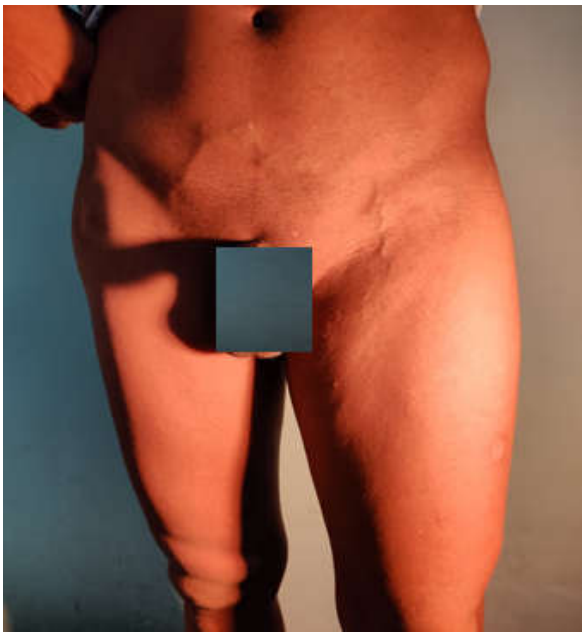

Figure 1. Anterior abdominal wall varicose vein following external iliac, common femoral, popliteal anterior tibial and posterior tibial vein of lower limb and saphenofemoral junction.

Figure 2. Varicose vein

DISCUSSION

Post thrombotic syndrome of the legs, characterized by chronic venous insufficiency, occurs in up to half of patients who experience DVT or Pulmonary embolism. Manifestations vary from mild clinical symptoms or signs to more severe chronic leg pain that limits activity and ability to work. After DVT, Post thrombotic syndrome will develop in 20% to 50% of patient and post thrombotic syndrome complication are stasis ulcer, skin changes and varicose vein of leg commonly.[1] Post DVT of major vessel of leg, resulting varicosity of the veins of abdominal wall which is a rare complication. Large, prominent normal veins are seen often in the abdominal wall, particularly in thin individuals and in conjunction with prominent veins elsewhere in the body.

Figure 3. Venous Ulcer

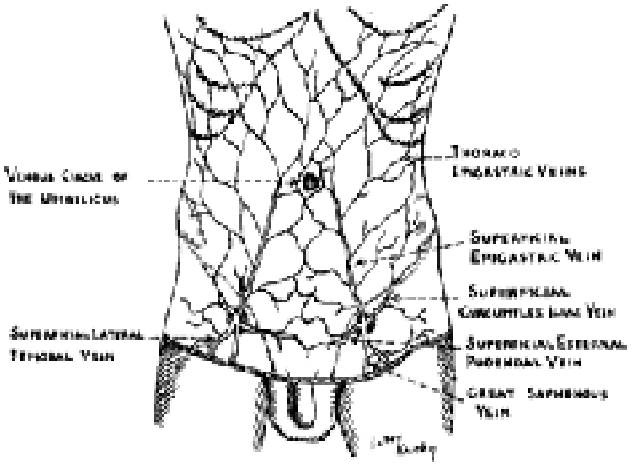

Figure 4. Superficial veins of abdomen and groin

Enlarged or engorged abdominal veins are seen not uncommonly where there is portal obstruction or in iliac vein obstruction especially secondary to deep phlebo- thrombosis in the lower extremities. But these should not be designated as varicose veins in spite of the usual definition of a varicose vein as simply an "emargement or dilatation of a vein (Froehlich, 1933)." Evidence offered by the present knowledge of the causation of varicose veins is not conclusive. The theory that varicose veins of the legs are contributed to by man's erect posture has many proponents. This is the popmar explanation of Delbet who says that back pressure from the iliac veins causes the valves at the sapheno- femoral junction to give way. Loss of valve function is the first step; dilatation of the vein is next. Almost exclusive occurrence of varicose veins in adult life is consistent with the fact that fewer valves are present in adult life than at birth. The same theory may hold in explaining simultaneous abdominal wall varices (if increased intra- venous pressure is the important factor) since the superficial veins of the abdomen are tributaries of the great saphenous vein.

Anatomy of the superficial veins of the abdomen: The veins which may be involved in varicosities are the superficial epigastric, the superficial circumflex iliac, and the superficial external pudendal (Fig. 4). The flow in these veins is downward into the femoral vein via the great saphenous vein. They may enter the saphenous vein individually or by a variable combination of trunks very close to the saphenofemoral junction. These veins possess extensive anastomoses. There is anastomosis between the superficial circumflex iliac and the superficial lateral femoral, between the superficial epigastric and the deep epigastric vein which in turn anastomoses with the para-umbilical veins which empty into the portal system (Mclaughlin, 1938).

Conclusion

There has been a rare presentation of anterior abdominal wall varices post thrombosis of big vein in abdomen (vena cava) or pelvic (iliac vein).

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