Reminder of important clinical lesson

A large and massive abdominal venous thrombosis associated with the presence of a big axillary mass, lupus-like syndrome and antiphospholipid antibodies

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Summary

This case report concerns a 40-year-old patient with an unspecific abdominal pain, diarrhoea, a big axillary mass and a previous pulmonary infection. After biopsy of the axillary mass the diagnosis of lymphoma was excluded based on the presence of cells expressing polyclonal antibodies. Abdominal CT scans and angionuclear magnetic resonance showed an extensive intestinal venous thrombosis. The patient also presented positive results for C and S proteins, lupic anticoagulant factor and antiphospholipid antibodies (anticardiolipin antibodies – IgM and IgG). Treatment started with administration of recombinant tissue plasminogen activator and heparin which decreased the degree of thrombosis. Antibiotics were also administrated to treat pulmonary and abdominal infections. After 25 days, he was discharged with no signs of infection, no abdominal pain and reduction of the thrombosis. He was medicated with warfarin, hydroxichloroquine and clopidogrel. Forty-five days after discharge, abdominal CT scan showed a significant regression of thrombosis.

BACKGROUND

The patient presented with an undefined clinical picture for severe diseases that included infection, thrombophilia, lupus-like syndrome and antiphospholipid antibodies. This

case reminds us that sometimes we have to investigate a clinical situation deeper than usual to reach a diagnosis and subsequently an appropriate treatment.

Figure 1 Right axillary mass – lymph node of 3.5 cm of diameter – with blood flow slightly increased when seen in colour-Doppler.

Figure 2 CT scans. (A) Right axillary mass – lymph node of 3.3 cm of diameter. Normal fat density and no collections. (B) Heart and lungs – no heart disease seen. The lungs showed micronodules calcified (lungs granuloma).

Figure 3 Thrombosis of abdominal veins: splenic, superior mesenteric, right hepatic portal branch and ileal.

CASE PRESENTATION

A 40-years-old man in a bad clinical condition was received at the emergency room in a Hospital in São Paulo, Brazil. He presented with abdominal pain, diarrhoea and a history of previous pulmonary infection and weight loss (8 kg). His body temperature was 37°C. The examination verified the presence of a big right axillary mass, left inguinal-umbilical

and left iliac pain, suggesting pulmonary and intestinal infections.

INVESTIGATIONS

Ultrasound of the axillary mass showed a diffuse inflammatory response (figure 1) and in the abdomen suggested a diverticulitis.

Figure 4 Reduction in high sensitivity C reactive protein during treatment.

Figure 5 (A) B&W – Caecum ischaemic ulcer. (B) Colour – Caecum ischaemic ulcer.

Since the patient had abdominal pain and a history of pulmonary infection, thoracic and abdominal CT scans were done to evaluate the axillary mass, the lungs and the abdomen. The mass showed no abscess and confirmed an inflammatory reaction. The lungs showed a mild to moderate infection and the heart did not show any structural pathology (figure 2). In addition, in the abdomen, we verified the presence of a massive venous thrombosis in the following veins: splenic, right hepatic portal branch, superior mesenteric and ileal (figure 3). Caecum thickening and inflammatory exudate were also seen.

Laboratory tests showed a small increase in the number of leucocytes that decreased during treatment. High sensitivity C reactive protein was elevated: day 1 – 13.3 mg/l and day 20 – 1.1 mg/l (figure 4). C and S proteins showed reduction of more than 50% of the normal range. Anticardiolipin IgM, IgG and lupic anticoagulant factor were positive. Antinuclear factor was 1/640. Factor V Leiden was negative.

The microscopic aspect of the biopsy of the axillary mass showed neutrophils and total lymphocytes in the same proportion. However, the flow cytometry showed reduced CD4 (18%) and increased CD8 (61%).

The immunohistochemical analysis showed cell-associated polyclonal antibodies and the morphological study showed no evidence of neoplasm. Colonoscopy showed only a caecum ischaemic ulcer (figure 5).

Abdominal CT scan and angionuclear magnetic resonance were done during the treatment and before discharge and showed a very important regression of intestinal venous thrombosis (figure 6). Forty-five days after discharge CT scan showed only a partial thrombosis of the ileal veins (figure 7).

DIFFERENTIAL DIAGNOSIS

- Lymphoma
- Other blood diseases which could cause venous thrombosis

Figure 6 (A) CT scan – important regression of intestinal venous thrombosis. (B) Nuclear magnetic resonance confirmed thrombosis regression.

- Diverticulitis
- Colitis
- Recurrent pneumonia.

TREATMENT

Initially the patient was treated with ceftriaxone (Rocefin – Roche, Berlin, Germany) 1 g every 12 h, amikacin (Lab. Neo Quím. Com. e Ind. Ltda, São Paulo, Brazil) 500 mg twice daily (12/12 h) and metronidazole (Flagyl – Sanofi Aventis, Paris, France) 500 mg twice daily for the treatment of the axillary mass and intestinal infection. We associated

tenoxicam (Tilatil – Roche, Hamburg, Germany) 20 mg intravenously twice daily.

After the diagnosis of abdominal thrombosis and as it was referred to as a recent event, the patient received rTPA-100 mg intravenous plus enoxaparin (Clexane – Sanofi Aventis, Paris, France) 60 mg twice daily, subcutaneously.

Later, the patient started to receive Coumadin (Bristol-Myers Squibb, Los Angeles, USA) 5 mg/day, hydroxychloroquine (Plaquinol – Sanofi Aventis, Paris, France) 400 mg/day, clopidogrel (PLAVIX – Sanofi Aventis, Paris, France) 75 mg/day and Pentoxiphillin (Trental – Sanofi

Figure 7 CT scan – 6 weeks after discharge showed only ileal venous thrombosis.

Aventis, Paris, France) 400 mg intravenously twice daily for the treatment of the colonic ischaemic ulcer.

OUTCOME AND FOLLOW-UP

Patient was discharged 21-days after entering the hospital with warfarin, clopidogrel and hydroxychloroquine with a good clinical condition.

Forty-five days after discharge, the patient came for an appointment with a new abdominal CT scan that showed a very high regression of intestinal venous thrombosis and no caecum inflammatory disease.

DISCUSSION

This is a very interesting case of a patient with an axillary mass, pulmonary and intestinal infectious disease and massive venous thrombosis in the same region, with an undefined clinical picture. The case showed that the patient had anticardiolipin antibodies^{1–8} that could contribute to the pathology. The reduction of C and S proteins suggesting thrombophilia^{9–10} could partly explain venous thrombosis. Lupic anticoagulant factor positive suggests that in this case there is a ‘lupus-like syndrome’ involved in the diagnosis and also collaborates with the inflammatory picture. The axillary mass could remind us about a kind of lymphoma, but the immunohistochemical tests showed the presence of cells which expresses polyclonal

antibodies¹¹ and nullified the possibility of viral infections like HIV and/or neoplasms.

Learning points

- ▶ Undefined clinical picture can hide very complex diseases.
- ▶ Adult with family history of thrombosis has to be very well investigated for thrombophilia.
- ▶ Antiphospholipid syndrome has to be considered as diagnosis in many patients with venous or arterial thrombosis.
- ▶ Look for immune-related diseases/diagnosis.

Competing interests None.

Patient consent Obtained.

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