Anticoagulant therapy induced haematoma presenting as acute dysphagia

Angshuman Dutta · S. K. Awasthi · Vishal Singh

Abstract

Oropharyngeal haematoma secondary to bleeding from anticoagulant therapy is uncommon and difficult to manage. We report a case of Oropharyngeal haematoma secondary to anticoagulant Acitrom (Nicoumalone) which was treated successfully with Inj Vit K.

Keywords Oropharyngeal Haematoma · Acitrom · Internationalized ratio (INR)

Introduction

Acute dysphagia and airway obstruction due to oropharyngeal haematoma secondary to bleeding from anticoagulant (Acitrom) therapy is rare. Management involves early suspicion and diagnosis with close observation, prompt airway control and reversal of coagulopathy by use of Vit K and fresh frozen plasma.

Case report

65-year-old lady was referred to the ENT Dept with complaints of dysphagia to solids and liquids for 2 days and swelling below the chin and hoarseness of voice for 1 day. She had been seen by a GP who had prescribed her oral Amoxycillin. There was no history of fever, respiratory distress or trauma. There was no history of epistaxis, haematuria or malena. Past medical history showed her as a case of Rheumatic heart disease and had undergone Coronary Artery Bypass Grafting with Mitral valve replacement. Her medications included Acitrom 2mg OD, Enalapril 5 mg BD, Lasilactone 1 OD, Atorvastatin 10 mg Hs, Digoxin 250 µg OD (5 days a week), Dispirin 150 mg OD and Folic acid 5 mg OD. Her recent investigation done 2 weeks prior to presentation showed her prothrombin time as 45.2 (Control 13.4) with internationalized ratio (INR) as 3.67. Examination revealed patient to be febrile with temperature 103°F, pulse 106/min, respiratory rate 26/min and BP 168/80 mmHg. General examination showed bruises over Right elbow and Left knee and anterior aspect of neck. ENT examination showed a soft red submucosal swelling involving floor of mouth and the undersurface of tongue (Fig. 1). The tongue was raised and pushed backwards. There was marked bruising around the neck and visible swelling over the submental region (Fig. 2). A flexible fiberoptic laryngoscopy was carried out under local anaesthesia which showed haematoma of both vallecula and edematous epiglottis. Both vocal cords were mobile. There was pooling of secretions in both pyriform fossa. A provisional

A. Dutta¹ (✉) · S. K. Awasthi² · V. Singh³

¹Graded Specialist ENT Command Hospital (Air Force), Bangalore

²Classified Specialist ENT; Institute of Aerospace Medicine, Bangalore

³Graded Specialist Medicine 7 Air Force Hospital, Kanpur

Graded Specialist ENT Command Hospital (Air Force), Bangalore -560 007
Mobile: +91 / 9343217611

diagnosis of oropharyngeal haematoma with supraglottitis possibly secondary to anticoagulant therapy was made and patient was urgently shifted to ICU where blood was taken for coagulation studies, blood grouping, full blood count and biochemical studies. Blood was kept standby for transfusion if required. 10mg VitK was administered and her condition closely observed for onset of any respiratory distress. She was started on Oxygen, Inj Cefotaxime, Inj Gentamicin, Inj Flagyl, Inj Hydrocortisone, Steam inhalation and Tab Chymoral forte. In consultation with the physician Tab Acitrom was discontinued and Tab Dispirin

Fig. 1 Figure showing haematoma involving the floor of the mouth

Fig. 2 Figure showing bruises on the neck of the patient

replaced by Clopidogrel 75mg OD. The remaining medications were continued. Laboratory investigations revealed an INR of 17.5 (control 1.5) and Prothrombin time of 199.6sec (control 14sec). Post Vit K administration INR reduced to 5 and Prothrombin time reduced to 60 sec within 6 hours. Other investigations showed Hemoglobin of 9.9gm/dl, TLC 7600/mm, DLC N74L23E2M1 and Platelet count of 2.4lakh. Remaining biochemical parameters were normal. The condition of the patient improved dramatically following VitK administration and edema of the epiglottis reduced and both sublingual and vallecular haematomas started resolving within 12 hours. She could be started on semisolids on the 1st day itself. Followup investigations showed an INR of 2.57 on day 2 of admission with Prothrombin time 25sec which reduced to 15sec and INR of 1.5 on day 3 of admission and subsequently to INR of 1.1 on day 4 of admission. From day 4 she was started on Low molecular weight Heparin 3200units intravenously 12 hourly which was changed to tab Sintrom 1 mg OD from day 6. Steroids were tapered over 3 days and antibiotics stopped after 5 days. Her sublingual and vallecular haematomas completely resolved by day 7 following which she was discharged.

Discussion

Sublingual and pharyngeal haematoma causing upper airway obstruction secondary to warfarin therapy are uncommon. It is well documented that whenever anticoagulant therapy is employed haemorrhage is a possible complication. Numerous sites have been described including genitourinary, gastrointestinal tract, skin, central nervous system & nose. Upper airway obstruction secondary to anticoagulants can occur from acute laryngeal haematomas [1] or from spontaneous bleeding into retropharyngeal and submandibular (sublingual and submaxillary) spaces [2, 3]. The diagnosis is elusive and absence of infectious features makes the severity of the process less obvious. The diagnosis becomes easy to establish once suspected and prompt intervention can be life saving. There is generally no history of trauma although previous reports [4] have implicated atypical trauma such as violent cough or sneeze as a possible precipitating factor.

Spontaneous bleeding into the sublingual space secondary to anticoagulant therapy has been referred to by Lepore [5] as a pseudoLudwig's phenomenon with initial involvement of only the sublingual space and subsequent spread below the mylohyoid muscle into the submaxillary space leading to displacement of tongue upward and backwards leading to dysphagia and progressive respiratory distress.

Management of these cases involves correction of the underlying coagulopathy as early as possible to limit further extension of haemorrhage so as to prevent the need of an artificial airway by tracheostomy or intubation [2]. Rapid correction of coagulopathy includes discontinuation of anticoagulant therapy followed by administration of fresh

frozen plasma/prothrombin complex concentrate or parenteral Vit K [6]. Prophylactic intubation or tracheostomy in these patients is hazardous and difficult due to additional bleeding occurring during airway manipulation and also altered anatomy resulting from a large haematoma [2]. Correction of the underlying coagulopathy will limit further extension of haemorrhage and prevent need for intubation or tracheostomy. Surgical drainage of the haematoma is not indicated and resolution usually occurs within a few days once the coagulation patterns are normalized [6].

Aim of highlighting this case was to present a life threatening complication of anticoagulant therapy. The peculiar feature in this case was the vague and sudden clinical presentation without any history of trauma. A careful drug history gave an explanation of the presentation. Initial signs of haematoma are vague and hence diagnosis needs a high index of suspicion. Immediate correction of the coagulopathy and monitoring of the airway was useful in successfully managing the case without requiring the need for a surgical airway.

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