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Case Report

Deep venous thrombosis associated with fibroid uterus in a woman complicated by diabetes, hypertension and hemiparesis

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Introduction

Pelvic deep vein thrombosis (DVT) is a rarely reported complication of leiomyomatous uterus[1-6]. Performance of hysterectomy is more risky in these cases due to the possibility of development of postoperative venous thrombosis and pulmonary thromboembolism. Careful multidisciplinary approach in a diagnosed case is the key to achieve success.

Case report

A 47-year-old female was admitted on 17.10.2003, with chief complaints of severe menorrhagia for the last 3 years, weakness of the left upper and lower limbs for 3 months and painful swelling of the left lower limbs for 1 month. The patient was a known hypertensive for the last 8 months, which was inadequately controlled. There was development of sudden weakness of the left upper and lower limbs 3 months ago prior to admission, which was more pronounced in the proximal muscles. There was no impairment of sensation, no facial or visual involvement, but slurring of speech and occasional urinary incontinence were present. This was followed by the development of painful swelling of the left lower limb. She had three full term normal deliveries, the last one 25 years back. She had tubal ligation 22 years back. She had never used any oral contraceptive pills.

There was no family history of hypertension, diabetes mellitus, thromboembolic episodes or tuberculosis. Her bowel function was normal. She attained menarche at 12 years. Her cycle was of 28-30 days with the bleeding averaging 4-5 days without any dysmenorrhea. She had mild pallor; her pulse was 84/minute with B.P. 152/90 mm/Hg. She had swelling over the left lower limb with shiny tense skin with red appearance (left calf diameter: 17 cm; right calf diameter: 11 cm) with presence of non-pitting edema. Homan's sign was present on the left side. The thyroid was normal and no lymph node was palpable. No hepato splenomegaly was observed. On abdomino-pelvic examination, a firm mass of 24 weeks gravid uterus size was palpable in the suprapubic area, surface was smooth with restricted mobility. Vaginal examination corroborated the above findings and cervix was normal. The neurological examination revealed that the higher function was normal and slurring of the

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speech was present. The pupils were equal with normal reflexes. There was hemiparesis on the left side with more involvement in the proximal group of muscles with the power being 3/6. The sensory system was normal

The investigations revealed mild anemia with hemoglobin 10 g/dL; total leukocyte count was 6,000/ µL with neutrophils 60%, lymphocytes 30% and eosinophils and monocytes 5% each. The ESR was 46 mm. The prothrombin time was 14 seconds with the control being 12 seconds. APTT was normal. The fasting blood sugar was 104 mg/dL and the post prandial 231 mg/dL. The lipid profile, TSH, chest x-ray and ECG were normal. The urea, serum creatinine and electrolytes were within normal limits. CT scan of the brain showed the presence of infarct in the right middle carotid artery territory along with hypodense lesion in the frontal, temporal and parietal region. The lumbosacral spine x-ray showed early spondylosis. The anticardiolipin antibody, protein C, protein S and antithrombin III activity were within normal limits. Ultrasonogram of the whole abdomen revealed that the uterus was enlarged with a single hypoechoic space occupying lesion of size 14.4x10.8x7.4 cm; the endometrium and adnexa were normal. The color Doppler study of the lower limbs showed the evidence of deep venous thrombosis. The noted thrombus extended from the popliteal vein to the left common iliac vein. The thrombosed vein had minimal canalization upto the level of femoral vein and the upper end of the thrombosis was not seen due to the presence of a large fibroid of 24 weeks gestational size.

The patient was admitted with severe menorrhagia, with left sided hemiparesis. The physician was consulted and she was treated with low molecular weight heparin (Enoxaprin 60 mg) twice a day through subcutaneous injection along with aspirin 75 mg and medroxyprogesterone orally for menorrhagia. The patient was put on oral anticoagulant, nicoumalone later on. She was planned for surgery. Aspirin was stopped 7 days prior to the operation and restarted 48 hours after the procedure. Subcutaneous heparin was stopped 48 hours before the operation. After thorough preoperative preparation the operation was performed by low transverse incision on 17-2-04. On opening the peritoneum the huge fibroid containing uterus was found to be deeply impacted mainly in the left side of the pelvis. Hysterectomy was performed without any postoperative complication. The patient attended for follow up upto 2 years with no recurrence of thromboembolic episode. Color doppler study was done twice showing gradual recanalisation and restoration of patency from the popliteal to the femoral veins.

Discussion

The coincidental findings of pelvic vein thrombosis in cases of fibroid uterus are rare. We found only a few recent case reports in a Medline Search [1-6]. Large uterine myomata are a potential cause of lower extremity venous stasis [4], resulting thrombosis being more on the left side [1], and this can be treated successfully with hysterectomy [1-4]. Based on earlier reports, a decision of hysterectomy is rational in this case. Furthermore, it is logical to assume that leiomyoma was the precipitating factor of pelvic DVT in our case because of the fact that the preoperative thrombosis had full resolution after the surgical intervention along with medication.

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