DVT: When outpatient anticoagulation is not enough: 
* A Case of May-Thurner-Syndrome

N.M. Farrell¹, O.O. Haastrop², A. Jan¹
³Ipswich Hospital NHS Trust, ²Nottingham University Hospitals NHS trust

Introduction

Following the introduction of Low Molecular Weight Heparins, the management of Deep Vein Thrombosis (DVT) with anticoagulation is typically outpatient-clinic based, plus or minus an initial same-day discharge from Accident & Emergency.

This case outlines an atypical management of Deep-Vein Thrombosis (DVT) with an unexpected underlying diagnosis.

We aim to increase acute physicians’ awareness of:
- propriety of admission and/or access to the vascular team in select cases of DVT
- their role as secondary preventers of recurrent DVT and post-thrombotic syndrome morbidity.

Case Vignette

A 67 year old female presented to our Acute medicine team via A&E of a District General hospital.

She had a three day history of buttock and thigh pain and one day of an increasingly swollen left leg; recent long-haul flight to the USA. No significant medical history.

Physical examination revealed a tender left thigh and calf; circumference of 52cm and 42cm respectively, her right leg: 45cm and 37cm. Blood tests showed a D-Dimer 17020ng/ml and Ultrasound, a *popliteal-femoral-ilial vein thrombosis*.

Acute medical team decision to admit but tumour markers were found to be normal. A further Ultrasound revealed no pelvic mass or lymphadenopathy.

Vascular assessment confirmed extension of the thrombus to the left common iliac and a decision for *catheter-directed thrombolysis* was made. Post-procedure venous angiogram showed appearances typical of *May-Thurner-Syndrome*. The dilated segment of the left common iliac vein was promptly pre-dilated and stented with ensuing angioplasty within the stent.

Discussion

In *May-Thurner syndrome* (or Iliac vein Compression Syndrome), the left iliac vein is compressed by the Right common iliac artery, causing a stenosis and intraluminal changes which pre-disposed to left leg DVT formation.¹² It is the cause of 2-5% of DVTs³⁴.

Converse to the typical management, this patient is at lower risk of DVT recurrence associated with ilio-femoral thrombi³ and May-Thurner-Syndrome. She is less likely to suffer the morbidity of the secondary vascular pathology (pain, swelling, ulceration and venous claudication) known as *post thrombotic syndrome*⁶.

We highlight this case to flag the value of admission for special cases of DVT, not necessarily increase the consideration of thrombolyis per se since this has its own pitfalls.

Conclusion

- The acute medicine team should consider admitting or creating alternative care pathways where patients with large ilio-femoral DVTs may be assessed by the vascular team.

References