



## ABSTRACT CASE

Klinische casus voor de sessie '*moeilijke gevallen en complicaties met een panel van experts*'  
Cas difficiles et complications: *avis d'un panel d'experts*

Titel/Titre:

**Treatment of venous insufficiency in a patient with systemic mastocytosis**

Auteur(s) & Affiliation:

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Specialist in/Assistent en  
Dermatology

Abstract: (max. 150 woorden; max. 150 mots)

**Case:** A 37-year-old woman presented with heaviness and restlessness in the right leg. Personal history revealed thrombophlebitis of the right greater saphenous vein, an anaphylactic reaction following general anesthesia and an indolent systemic mastocytosis. Her medication consisted of a H1- and H2-blocker. At examination, besides varicose veins and edema of the right leg, multiple red to brownish papules were noted on her trunk and extremities. Venous ultrasound examination showed insufficiency of the right greater saphenous vein with a diameter of 10 mm at mid-thigh.

**Discussion:** Lidocaine and general anesthesia can provoke a mast cell release, which in case of a patient with systemic mastocytosis may result in an anaphylactic reaction. Three major issues arise, i.e. (1) which treatment mode is preferable in this patient, (2) is it safe to treat her as an outpatient, (3) which precautions need to be taken to prevent an anaphylactic shock reaction.



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## **ABSTRACT**

*Sessie vrije mededelingen assistenten in opleiding*  
*Séance communications libres assistants en formation*

Titel/Titre:

**Klippel Trenaunay: a case presentation**

Auteur(s) & Affiliation:

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Assistent in / Assistant en  
Chirurgie

Abstract: (max. 300 woorden; max. 300 mots)

The Klippel-Trenaunay syndrome is a combination of venous and capillary malformations associated with soft tissue and/or bony limb hypertrophy of the affected limb. The venous abnormalities of the deep venous system that occur in KTS include aneurysmal dilatation, duplication, aplasia, agenesis, hypoplasia and valvular incompetence. We present the case of a 16year old boy diagnosed with the Klippel Trenaunay syndrome, affecting his left leg. He consults for a chronic ulcer on medial malleolus of this leg. The patient underwent epiphysiodeses of distal femur and proximal tibia epiphyses 2 years previously. Actually there is an important difference in perimeter of both calves. On echo Doppler no deep venous system was shown in the thigh of the left leg. The venous sequences of an arteriography of his left leg showed a very wide v. saphena magna connected to a great number of muscular veins and a hypoplastic left iliofemoral axis. The left vena saphena magna drains in the right iliofemoral axis through spontaneous "Palma bypass" collateral. Although all deep veins of the lower extremities can be affected, it has been reported that the popliteal vein (51%) is most commonly involved, the femoral vein (16%) is second most commonly affected and abnormalities of the iliac vein (3, 3%) are rare. The Palma bypass could explain why the patient doesn't have the typical hypertrophy off his left leg, since this bypass gives an extra burden of his right leg. The vena saphena magna is the only venous drainage of the patients left leg. It is imperative to preserve it. The patient was treated with local wound therapy and compression. In a first time zero extension bandages and afterwards AD compression socks were used. Wound healing was successful. The possible alternatives for treatment are discussed.

## ABSTRACT

Sessie vrije mededelingen assistenten in opleiding  
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Titel/Titre:

### CHARACTERIZATION OF THROMBUS EXTENT IN PATIENTS WITH ACUTE LOWER LIMB DEEP VEIN THROMBOSIS

Auteur(s) & Affiliation:

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**Andere/autre discipline:** 4<sup>de</sup> jaar Master student Geneeskunde Universiteit Antwerpen.

Abstract: (max. 300 woorden; max. 300 mots)

**Background:** In patients with acute lower limb deep vein thrombosis (DVT), localisation and extent of the thrombus remains ill-defined. Usually report of DVT extension is limited to a subdivision between distal DVT (in the calf veins) and proximal DVT (above the calf vein level).

**Aim:** The purpose of the present study was to identify more precise localisation and extent of thrombosis in a large cohort of DVT patients.

**Materials and methods:** 1338 patients with unilateral acute DVT on duplex ultrasound investigation and aged > 18 yrs were registered at our vascular department. Exact localisation, concomitant superficial vein thrombosis (SVT) and extent of the thrombus was drawn on a diagram. This included a subdivision in 5 segments.

**Results:** Patients' age was  $59.6 \pm 16.6$  years and 49.8% were male. In 24.3% of cases DVT was localized above the inguinal ligament (segment 1). Duplex ultrasound data of DVT extension are summarized in the table.

	left	right	p
<b>total</b>	760	578	< 0.001
<b>segment 1</b> (iliac veins) (+/- inferior caval vein)	199	126	< 0.001
<b>segment 2</b> (common femoral vein)	297	215	< 0.001
<b>segment 3</b> (femoral vein)	450	332	< 0.001
<b>segment 4</b> (popliteal vein)	428	322	< 0.001
<b>segment 5</b> (calf veins)	614	472	< 0.001



DVT was limited to one segment in 443 patients (33.1%), of which 370 had isolated calf thrombosis. DVT involved 2 adjacent segments in 208 patients (15.5%), 3 segments in 345 (25.8 %), 4 segments in 149 (11.1%) and all 5 segments in 193 patients (14.4%). Concomitant SVT was present in 179 patients (13.4%).

**Conclusion:** The present data indicate that proximal lower limb DVT can be subdivided according to different levels of extension. Taking into account that patients with DVT extension above the inguinal ligament may be considered for catheter directed thrombolysis, we would suggest to better characterize localisation and extent of proximal DVT.

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In te sturen via email / à envoyer par e-mail: [secretariaat@vmec.nl](mailto:secretariaat@vmec.nl)

Uiterste datum/date limite: 22/04/2013

## **The effect of phlebectomies of tributaries on great saphenous vein reflux**

**Mw. A.A.M. Biemans**

Background: Phlebectomy of tributaries is usually seen as a secondary treatment and is often performed during or after truncal ablation. As it affects the hemodynamic of the venous system, it can be effective as a primary treatment in selected cases.

Objective: In this prospective multicenter study we analyzed short-term outcomes after phlebectomy. As well as assessing effectiveness, patients' health reports and the need for additional treatment of the great saphenous vein (GSV), we also determined the predictors for success or failure.

Methods: We included 100 patients with a symptomatic GSV and tributary incompetence of the upper leg; incompetence was defined as reflux  $> 0.5$  s in both veins. We used ultrasound duplex to assess saphenous and tributary characteristics, and performed a reflux elimination test. Three and twelve months after phlebectomy of the tributary, the anatomical result was evaluated with ultrasound duplex. If the great saphenous vein was still incompetent, additional ablation followed. Clinical outcome was measured using the CEAP classification and Venous Clinical Severity Score; patients' reported outcome was assessed with the Aberdeen Varicose Vein Questionnaire.

Patients: We analyzed 94 patients (65 women and 29 men). Most had C2 or C3 varicose veins; mean age was 53 years (range 21 – 83).

Results: Three months after treatment, reflux of the GSV had disappeared in 50% of the patients ( $P > .01$ ), and GSV diameter had decreased significantly ( $p > 0.01$ ). Clinical outcome and patients' health reports improved significantly ( $p > 0.01$ ). Symptoms had disappeared in 66%. Only 32 patients (34%) received an additional treatment because of persisting GSV incompetence. We found different predictors for success and failure of this approach.

Conclusions: After short term follow up, treatment with phlebectomy is effective as primary treatment in 50% of patients with GSV incompetence. Because symptoms disappear, 66% percent of the patients do not need additional treatment. We believe that the predictors will give physicians criteria for deciding when phlebectomy can be used in the treatment process.



## ABSTRACT

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Titel/Titre:

### **Innominate vein compression syndrome caused by right-sided aortic arch.**

Auteur(s) & Affiliation:

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Assistent in Chirurgie: Resident Vaatheelkunde

Abstract: (max. 300 woorden; max. 300 mots)

We present the case of a 38 -year-old woman who presented at the emergency department with an acute painful swelling of the left arm.

She reported no trauma and had no other complaints. Medical history showed breastreduction and urolithiasis. She smoked and did not take any medication.

Blood tests showed D dimers of 1,44 ug fib.eq./ml and duplex ultrasound demonstrated a thrombosis of the axillar and subclavian vein. The proximal end of the thrombus could not be visualized, so CT scan was ordered for further evaluation and revealed full thrombosis of the innominate vein, right-sided aortic arch with anterior movement of the esophagus and thrachea and no pulmonary embolism.

The patient was admitted to the ICU and catheter-directed thrombolysis (Actosolv 100.000 IU/h) was started. Clear clinical progression was noted after one day and venous patency was restored on day 4. Besides hematoma at the puncture place of the central line, there were no complications.

Since the innominate vein compression syndrome was described by Wurtz in 1981 as a thoracic equivalent of May-Turner syndrome, we opted for an analogue treatment and placed a self-expandable stent (Wallstent 12-40) at the level of compression. She left the hospital on day 5. An elastic armstocking and LMWH were prescribed for six months.

Clinical examination at month 3 showed discrete swelling of the arm and visible collaterals. Venography showed retraction of the stent with restenosis of the distal innominate vein which was treated with a self-expandable stent (Sinus Superflex 10-40) with normalisation of the vessel diameter. Anticoagulation therapy is continued and control venography is planned in 3 months.