RIGHT OVARIAN VEIN THROMBOSIS

New York Hilton Midtown | Manhattan, New York
Clinical Presentation

Female 43 years old
Presented with abdominal pain in the last 3 days
Pain is sharp, moderate to severe
  - No specific modifying factors
  - Unrelated to eating
No GI tract symptoms
No fever or chills
No urinary symptoms
No bleeding
Normal vital signs
Height 152cm (5 feet),
Weight 77.6Kg (171lb)
BMI 33.6
Medical and Surgical History

Dyspnea from Asthma
  Albuterol 90mcg/inh
Never smoked
Drinking only socially beer and wine
No substance abuse

Tonsillectomy
Umbilical hernia repair
She had 6 children from 5 pregnancies
In the last pregnancy she had twins
Last two pregnancies with cesarean section
Tubal ligation prior to the last pregnancy
Family History

Mother
  Multiple sclerosis

Father
  Heart attack

Sister
  High blood pressure

Grandmother
  Heart attack
Findings
The upper abdominal aorta and IVC are unremarkable.

Liver is normal size without focal lesions. No intrahepatic ductal dilatation. The liver is echogenic probable fatty infiltration. Pancreas, where seen is unremarkable in appearance. Gallbladder wall is not thickened. No pericholecystic fluid. Negative sonographic Murphy's sign. No evidence of gallbladder stones. Common bile duct is non-dilated at 4 mm. Right kidney measures approximate 10 cm in length; no stones or hydronephrosis. No ascites.

Unremarkable exam, no findings to explain the patient’s abdominal pain
Diagnostic evaluation

Blood and urine analysis were normal

What needs to be done next?

a. Send the patient away and re-evaluate in a week
b. General abdominal ultrasound
c. Pelvic ultrasound
d. Abdominal and pelvic CT
Diagnostic evaluation

A three view abdominal X-ray to rule out free air
Normal

She had a CT and a pelvic ultrasound
Rt ovary larger
With much higher flow.
PSV and EDV >4x higher on the right ovary
Dilated ROV measuring 13mm
ROV was normal on the previous CT on 2007
ROV thrombus into IVC
ROV thrombus into IVC

Absence of color flow in the ROV and filling defect in the IVC

Lack of compressibility in the ROV. The IVC is partially compressible.
Treatment

a. Leave patient as is and re-evaluate in one week
b. Place patient on antiplatelet medication
c. Give anticoagulation
d. Perform thrombolysis
Treatment

She was admitted and placed on Heparin

She was discharged on Rivaroxaban
15mg x2 daily for 3 weeks
followed by 20mg per day for 3 months

Scheduled to see a vascular surgeon in a week
Follow-up

The patient was seen at 1 week, 3 months and 12 months

She is free of pain without any recurrent VTE
Clinical presentation

Pelvic or lower abdominal pain
Fever of unknown origin
This is most common in pregnant patients

Asymptomatic
- Postpartum
- Cancer
- Trauma
Symptomatic OVT is rare and most often associated with identifiable venous thromboembolism risk factors. Patients fare well with anticoagulation; complete recanalization occurs in about two thirds of veins involved.

Recurrent DVT is found in lower extremity veins after the interruption of anticoagulation in 17% of patients.

Postpartum patients were more likely to experience a recurrent DVT than were patients with other causes of OVT.

Nonfatal PE occurred in 9% of the patients. There were four mortalities, found only in cancer patients, and they were unrelated to OVT.