Massive Legs and a Massive Thrombus

Steven D. Hajdu MD[1], Roni B. Idan MD[1], Victor Belsky MD[2] and Nancy Agmon-Levin MD[1]

[1]Department of Medicine B & Center for Autoimmune Diseases and [2]Department of Diagnostic Imaging, Sheba Medical Center, Tel Hashomer, Israel

KEY WORDS: massive thrombus, elephantiasis

IMAJ 2010; 12: 190

A 71 year old woman with bilateral elephantiasis of the lower extremities was admitted to our internal medicine department with dyspnea and chest pain. On physical examination, we observed a sedentary woman with severely edematous lower limbs and signs of stasis dermatitis, petechiae and several small ulcers [Figure 1]. Her complete blood count and blood chemistry results, including absolute eosinophil count, were unremarkable. A chest computed tomography scan revealed a massive thromboembolus to the pulmonary artery and segmental branches [Figure 2, arrow], which was treated with anticoagulants.

Elephantiasis, as observed in our patient, has multiple primary and secondary etiologies. Primary causes include Meig's disease, Milroy's disease, and lymphedema tarda – all of which are autosomal dominant genetic lymphatic dysplasias presenting at birth, puberty and adolescence respectively [1]. In the absence of a family history, secondary causes are investigated, of which the most common is lymphatic filariasis. This tropical parasitic disease is found in Sub-Saharan Africa and is associated with eosinophilia and elevation of inflammatory markers. Other secondary causes of lymphatic outflow obstruction are neoplastic diseases such as prostate carcinoma or lymphoma; iatrogenic causes such as surgery or radiation; trauma; and previous deep vein thrombosis [2]. Our patient had severe venous stasis, congestive heart failure and immobilization, all of which are major risk factors for deep vein thrombosis, and pulmonary emboli. To the best of our knowledge an association between elephantiasis and pulmonary emboli, although very likely, has not been documented previously [3].

Correspondence:
Dr. N. Agmon-Levin
Dept. of Medicine B & Center for Autoimmune Diseases, Sheba Medical Center,Tel Hashomer 52621, Israel
Phone: (972-3) 530-2652
Fax: (972-3) 535-2855,
email: Nancy.Agmon-Levin@sheba.health.gov.il

References

1. Andersson HC, Parry DM, Mulvihill JJ. Lymphangiosarcoma in late-onset hereditary lymphedema: case report and nosological implications. *Am J Med Genet* 1995; 56(1): 72-5.
2. Kurz W, Wittlinger G, Litmanovitch YI, et al. Effect of manual lymph drainage massage on urinary excretion of neurohormones and minerals in chronic lymphedema. *Angiology* 1978; 29(10): 764-72.
3. Brenner B. Travel-related thrombosis: is this a problem? *IMAJ Isr Med Assoc J* 2006; 8(12): 859-61.

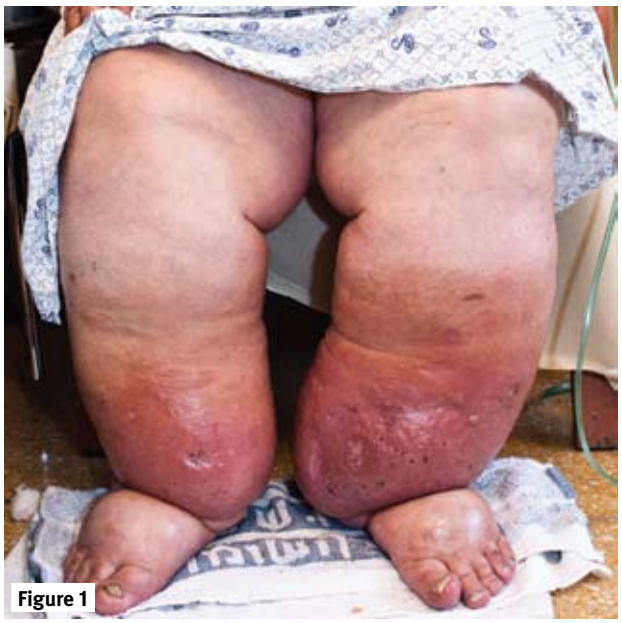

Figure 1

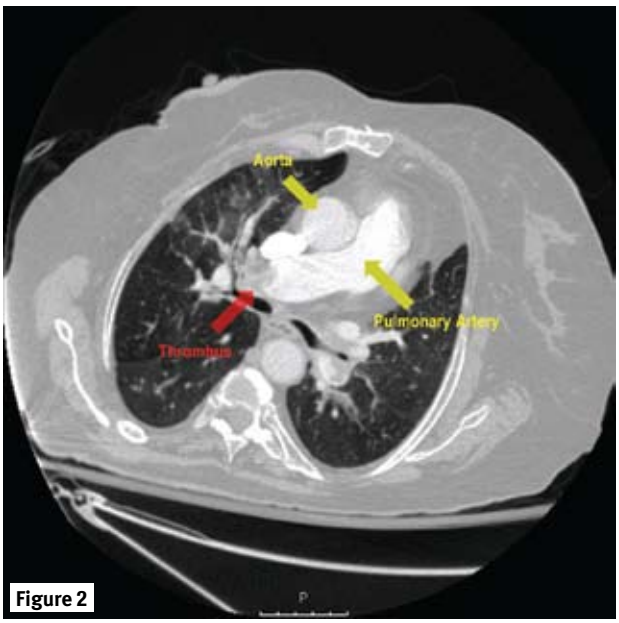

Figure 2