Superficial thrombophlebitis of the inferior epigastrica vein
U Yetkin, M Bademci, T Taktakolu, Y Yurekli, A Gurbuz

Citation

Abstract
Dear Editor:

Our case was a 29-year-old female who suffered a tender and progressing swelling in the left hypochondriac region which was located vertically and spindle-shaped. This lesion developed 10 days before she was referred to our clinic after a tight hug given by her relative. She was first admitted to another institution and given oral antibiotherapy since this swelling was told to show inflammatory signs. She didn't recognize any improvement after this initial therapy by means of tenderness and dimension of this swelling. Our physical examination confirmed this prominent swelling (Figure 1).

Figure 1

After this physical examination, color Doppler ultrasonography was carried out revealing a subacute thrombus material within tract of left inferior epigastric vein (Figure 2). Biochemical screenings showed no signs of systemic coagulopathy.

Consequently, topical and oral non-steroidal anti-inflammatory (NSAID) drug treatment (heparinoid luitpold gel, etofenamate spray and acemetacine 90 mg/day retard capsule) and enteric coated acetylsalicylic acid (ASA) 300 mg/day combined therapy were started. At the first week follow-up visit as an outpatient she demonstrated complete recovery from her complaints and physical examination confirmed that this swelling showed near-total regression (Figure 3).
A repeat ultrasonographic examination showed obliteration of the superficial subcutaneous venous structure extending from left hypochondriac region to the umbilicus with incompletely recanalized chronic thrombus material. Longitudinal and axial images of this structure were demonstrated in Figures 4 and 5.

**Figure 3**

**Figure 4**

Regarding the manifest regression of these signs, NSAID therapy was continued for 1 more week and ASA therapy was completed to 3 months. Monthly follow-up controls were carried out.

**COMMENTS**

Superficial thrombophlebitis of vena epigastrica inferior is an uncommon disease. Superficial vein thrombophlebitis (SVTP or ST) appears in two distinct forms: varicose vein thrombophlebitis (TP) represents the principal cause. It is characterized by a large thrombus in a varicose vein and a modest inflammatory process localized in the vessel surrounding but not in its wall. Rarely, SVTP affects a non-varicose vein (NVV)\(^1\). ST occurring in NVV, although representing 5 to 10% of all ST\(^2\). Although SVTP is perceived as trivial and benign coexistence of (mostly distal) deep venous thrombosis (DVT) in the legs\(^1\). SVTP can be diagnosed in a clinical setting but ultrasonography is useful to check correctly it.

The optimal treatment of superficial thrombophlebitis (ST) of the legs remains poorly defined\(^1\). While improving or relieving the local painful symptoms, treatment should aim at preventing SVTP recurrence. Anticoagulant treatment is mandatory if DVT is present and thrombectomy should be considered in cases of thrombus propagation into the deep veins\(^1\). Historical therapy of uncomplicated SVTP except in the legs consists of local or systemic anti-inflammatory agents. Non-steroidal-anti-inflammatory drugs (NSAIDS) appear as the current best therapeutic options for ST. Non-steroidal-anti-inflammatory drugs or local treatment with heparinoid may reduce the pain\(^4\). Prophylactic vein ligation alone was found less effective than conservative therapy\(^1\). The optimal doses and duration of treatment, and whether a
combination therapy may be more effective than single
treatment(3).

CORRESPONDENCE TO
Doç. Dr. Ufuk YETKIN, 1379 Sok. No: 9,Burç Apt. D: 13 -
35220, Alsancak - İZMIR / TURKEY Tel: +90 505 3124906
Fax: +90 232 2434848 e-mail: ufuk_yetkin@yahoo.fr

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Author Information

Ufuk Yetkin, M.D.
Deputy Chief, Department of Cardiovascular Surgery, İzmir Atatürk Training and Research Hospital

Mehmet Bademci, M.D.
Resident, Department of Cardiovascular Surgery, İzmir Atatürk Training and Research Hospital

Tahir Taktako?lu
Specialist Radiologist in Barış Imaging Center, Department of Cardiovascular Surgery, İzmir Atatürk Training and Research Hospital

?smail Yürekli, M.D.
Specialist, Department of Cardiovascular Surgery, İzmir Atatürk Training and Research Hospital

Ali Gürbüz, M.D.
Clinic Chief, Department of Cardiovascular Surgery, İzmir Atatürk Training and Research Hospital