COR-10150600

YWIU

ANL SS -- S 616.988072; TRO

Tropical and geographical medicine.

UNIVERSITY OF THE WEST INDIES
DEPARTMENT OF CLINICAL SURGICAL SCIENCE
Bldg 68 Eric Williams Medical Sciences Complex
Trinidad
TRINIDAD & TOBAGO

ATTN: Professor Vijay Naraynsingh
PHONE:
FAX:
E-MAIL:

SUBMITTED: 2009-10-14 13:53:00
PRINTED: 2009-10-15 11:37:39
REQUEST NO.: COR-10150600
SENT VIA: Manual
EXTERNAL NO.: NO 1

COR Core Copy Journal

TITLE: JOURNAL OF TROPICAL AND GEOGRAPHIC MEDICINE
VOLUME/ISSUE/PAGES: Vol 37 No 2 192-193
DATE: 1985
TITLE OF ARTICLE: MESENTERIC VENOUS THROMBOSIS AND ORAL CONTRACEPTIVE USE
COPYRIGHT COMP.: Fair Dealing - S50(1)

DELIVERY: E-mail Post to Web: bmyearwood@yahoo.com
REPLY: E-mail: bmyearwood@yahoo.com

This document contains 2 pages. You will be invoiced for $12.00. This is NOT an invoice.

WARNING. This material has been provided to you pursuant to section 49 of the Copyright Act 1968 for the purpose of research or study. The content may be subject to copyright protection under the Act.

National Library of Australia ABN 28346858075

MESENTERIC VENOUS THROMBOSIS AND ORAL CONTRACEPTIVE USE

VIJAY NARAYNSINGH, G.C. RAJU, G. BUSBY

Department of Surgery and Pathology, General Hospital, Port of Spain, Trinidad, West Indies

Received November 20, 1984
Accepted for publication November 22, 1984

Abstract. A case of mesenteric venous thrombosis in a young woman receiving oral contraceptives is reported. This is the first case encountered in the Caribbean region.

Key words: oral contraceptive; thrombosis; Trinidad

Introduction

Since the first record of primary mesenteric venous thrombosis in 1935 [1] there have been relatively few cases in the literature [2]. Even more rare is the occurrence of superior mesenteric venous thrombosis associated with oral contraceptive use. Reed and Coon [3] first documented this possibility in 1963 and a comprehensive review of the literature in 1977 [4] revealed a total of 17 cases; most of these occurred in Britain and the United States but it is expected that as oral contraceptive use becomes more widespread this condition will be seen in developing countries. Following is a case from Trinidad, the first to be reported from the Caribbean region.

Case report

A 37-year-old woman was admitted to hospital with a 6-day history of colicky upper abdominal pain. This pain was aggravated by eating any type of food and became progressively worse. She vomited twice daily prior to admission but had no haematemesis, diarrhoea, constipation or blood in the stool. She was taking the contraceptive pill Anovlar (norethisterone acetate 4 mg, ethinyl oestradiol 0.05 mg) regularly for the previous 5 years.

Though complaining of much pain, she looked quite well. She was not in shock; pulse 80/min, BP 130/80 and temperature 99°F. There was slight abdominal distension, mild central abdominal tenderness but no mass or rebound tenderness was appreciated. Haemoglobin was 13.1 g/dl, PCV 40, blood urea 79 mg%, SGOT 14 KA units, alk. phosfatase 7.0 KA units, blood sugar 169 mg% and sickle test negative. The elevated WBC 22.300/cumm showed a differential of polymorphs 93%, lymphocytes 5% and monocytes 2%. Because her abdominal signs were not remarkable, she was admitted, allowed oral fluids and observed. The next day, her abdominal pain worsened and the distension increased. She vomited 600 ml of blood stained fluid and went into shock. After resuscitation laparotomy was performed. There was blood-stained free fluid in the peritoneal cavity. 75 cm of gangrenous ileum was resected and end-to-end anastomosis performed. The remaining small intestine was oedematous and in dividing the superior mesenteric vessels it was noted that the arterial pulsations and lumen were normal while soft thrombus oozed from the cut mesenteric vein.

Post-operatively, her condition remained critical. She was toxic with a respiratory rate of 36/min, a thready pulse of 132/min and unstable blood pressure with frequent hypotension. She was heparinised, given intravenous antibiotics and appeared to improve over the next 48 hours. However, the abdominal distension persisted and on the fourth post-operative day she passed black tarry stool. She developed bilateral pneumonia, remained toxic with unstable pulse and blood pressure and died on the sixth post-operative day. Permission for post-mortem was not granted.

Discussion

Vascular complications of oral contraceptive use include hepatic vein thrombosis, cerebrovascular accidents, venous thrombosis in the lower limb and mesenteric vascular occlusion. In spite of what appears to be abundant epidemiologic evidence relating contraceptive use to thromboembolic phenomena [5], the precise pathogenesis remains unclear and is almost certainly multifactorial. Ruoff and Ranson [6] demonstrated a persistent hypercoagulable state in a patient with venous mesenteric infarction, 19 months after she discontinued contraceptive medication. Irey and Norris [7] showed intimal proliferation associated with hormonal contraceptives and suggest that this may be an important factor in thrombotic events.

Whatever the pathogenesis, mesenteric venous thrombosis associated with oral contraceptive use carries a case fatality rate of over 30% and, in patients who have survived, major sequelae such as burst abdomen, intra-abdominal abscesses, progressive gut infarction and septicaemia are quite common [8]. Thus, although rare, mesenteric thrombosis due to oral contraceptive use is extremely important because of this high morbidity and mortality.

Early diagnosis is valuable since reversible mesenteric ischaemia has been demonstrated before gangrene is established and these cases can be managed conservatively successfully [9]. In spite of some successful reports of conservative therapy, the surgeon must be prepared to operate on any suspicion of gut infarction since conservative treatment in established gut gangrene is invariably fatal. In addition, more than one operation may be needed since thrombosis can be progressive and result in infarction of previously viable bowel [10].

Perhaps the most dangerous aspect of this disorder is the relatively slow and unremarkable onset of signs and symptoms; consequently, the diagnosis is often missed initially and recognised only when advanced gut gangrene is established. Increased awareness of mesenteric vascular thrombosis due to contraceptive use should lead to earlier diagnosis and prompt treatment, with improved results. The condition should be considered especially in young women, (average age 34 years) on hormonal contraceptives, who present with vague abdominal pain of gradual onset and unexplained aetiology.

Correspondence to: Mr. V. Naraynsingh, University of the West Indies, General Hospital, Port of Spain, Trinidad, W.I.

References

1. Warrem S, Eberhard TP. Mesenteric venous thrombosis. Surg Gynecol Obstet 1935; 61: 102–3.
2. Naitove A, Weismann RE. Primary mesenteric venous thrombosis. Ann Surg 1965; 161: 516–23.
3. Reed DL, Coon WW. Thrombo-embolism in patients receiving progestational drugs. New Engl J Med 1963; 269: 622–4.
4. Nesbit RR Jr., Weisman RE. Primary mesenteric thrombosis and oral contraceptives. Southern Med J 1977; 70: 360–2.
5. Vessey MP, Doll R. Investigation of relation between use of oral contraceptives and thromboembolic disease. Brit Med J 1968; 2: 199.
6. Ruoff M, Panson JH. Persistent hypercoagulability after venous mesenteric infarction and oral contraceptives. NY State J Med 1973; 791–3.
7. Irey NS, Norris HJ. Intimal vascular lesions associated with female reproductive steriods. Arch Pathol 1973; 96: 227–34.
8. Bose MB. Superior mesenteric vein thrombosis and oral contraceptives. Postgraduate Med J 1972; 48: 430–3.
9. Cotton PB, Thomas ML. Ischaemic colitis and the contraceptive pill. Brit Med J 1971; 3: 27–8.
10. Hurwitz RL, Martin AJ, Grossman BE, Waddell WR. Oral contraceptives and gastro-intestinal disorders. Ann Surg 1970; 172: 892–6.