

39 years old male saudi admitted through ER to the medical ward on 11th of Jan 2019 complaining of bilateral lower limbs edam for 3 days ago, Patient is medically free and was well till since 3 days started to devolved that gradually .

The swelling noted after an upper respiratory tract infection which happened before 10 days ago and treated by (Amoxicillin + clavulanic acid for 7 days) associated with lower back pain mild to moderate with 5 of 10 feeling of pain ache dull not radiating starting one month back on and off relive by taking local analgesic cream and movement

The patient denied any History of:

Fever , shortness of breath cough, paroxysmal nocturnal dyspnea, orthopnea , dysuria , hematuria , frothy urine ,discoloration of urine, eye swelling, change in bowel habits, previous trauma, recent travel, no other medication or anti-inflammatory, no history of pelvic/abdominal neoplasm or radiation, a history of systemic disease like : heart-liver or kidney disease, allergies)

No nausea, vomiting, constipation, abdominal swelling .

Patient had one similar condition 7 months ago treated in another hospital as a case of acute kidney injury resolved within about five days with medication.

Patient had recurrent episodes of upper respiratory tract infection (3 times over the last 30 days)

Patient smoker and also has contact with animals.

On examination:

Patient awake oriented and alert to time, place, persons not distressed , not pale or jaundiced or cyanosed.

Vitals :

- Blood pressure: 120/69
- Heart rate: 101
- O2 sat. 96% in room air.
- Respiratory rate: 19.

Anthropometry

- Weight: 65kg.
- Height: 167cm.

His hydration status was good.

Examination of Face, upper limbs, Head & Neck: no abnormality detected

Examination of back :No spinal deformities such as scoliosis, lordosis and kyphosis ,No sacral edema, No .

Examination of lymph nodes : no abnormality detected.

Respiratory system :

The chest moves symmetrically with respiration on both sides. There was no chest deformity and it was not hyperinflated. .The trachea is centrally located and chest expansion was symmetrical on both sides. Normal vocal fremitus was noted resonance to percussion in both bases with No decreased excursion of the diaphragms.

Equal air entry bilaterally, NO crackles are heard or rhonchi .

Cardio-vascular system :

His chest moves symmetrically with respiration. There was no chest wall deformity, no dilated veins, no precordial bulge, and no visible pulsation noted. No jugular venous distension, no sign of respiratory distress or scars. Apex beat was felt at 5th intercostals space and at mid-clavicular line. There was no left parasternal heaves and no thrills at left sternal edge, pulmonary area and aortic area

S1 and S2 and no added sounds .

Nervous system: no abnormality detected .

Abdominal examination :

His abdomen was symmetrically not distended and moves with respiration. The umbilicus was centrally located and inverted. No scars , no dilated vein, no visible pulsation and peristalsis noted. Nothing notable hernia or phis .

On light palpitation, his abdomen was hard and not tender. On deep palpation, , no mass felt and no hepatosplenomegaly, kidneys were not ballotable no enlarged bladder

No tenderness over the the renal angles But mild tender over the right Lower quadrant of his abdomen.

On percussion, normal sounds no maximum or shifting dullness

On auscultation, normal bowel sound present with no renal bruit.

Lower limbs :

Generalized edema up to the level of the knee bilaterally not tender but tense like

Disappears in 10-15 seconds

4-6 mm indentation = 3+ edema Pit is noticeably deep and last > 1 minutes, extremity looks fuller & swollen.

Leg varicose veins are not present in patient.

Kaposi-Stemmer sign not present ,no hair loss, hyperkeratosis

or scratch marks

No Skin change

Decrease range of motion.

Diagnostic Studies

Labs :

complete blood count :

HG 129 mg/dl, PLT 455 , WBC 8300 cells/mcL

ESR: 57. CRP: 97. Urine analysis : Blood ++, Protein +

Electrolytes : Na139 K4.6 CL96 BCO3 23

creatinine: 75 μ mol/dl urea 5.7 mmol /L

D-dimer :

serum lipids :

Imaging Studies

Echocardiogram :

L leg pitting edema



R leg pitting edema

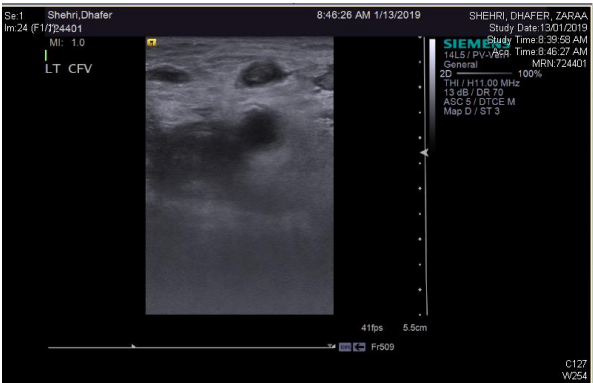


Both lower limbs .

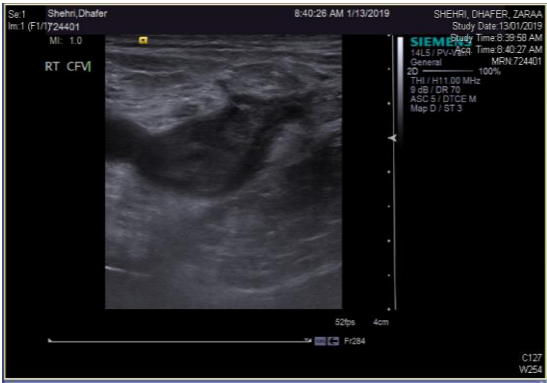


Ultrasound lower limbs shows following :

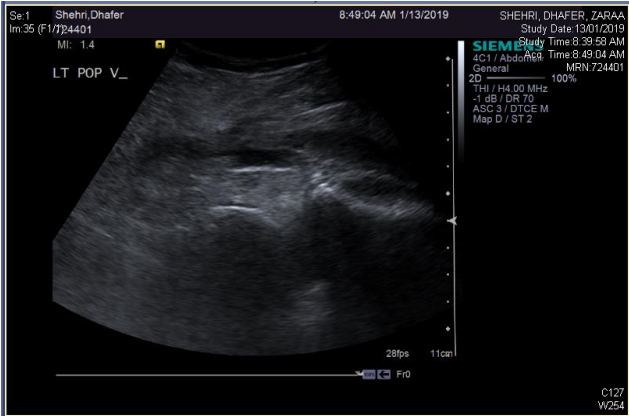
Left Femoral vein



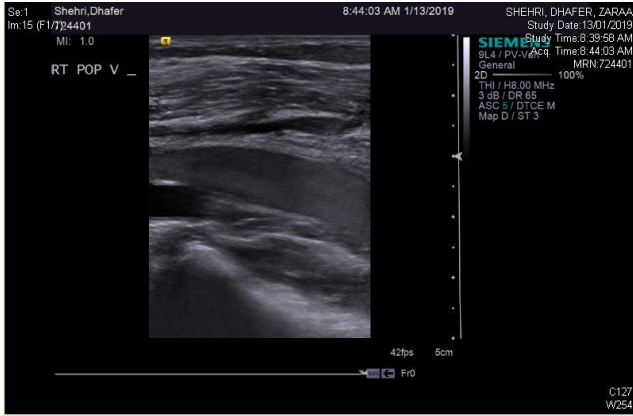
Right Femoral vein



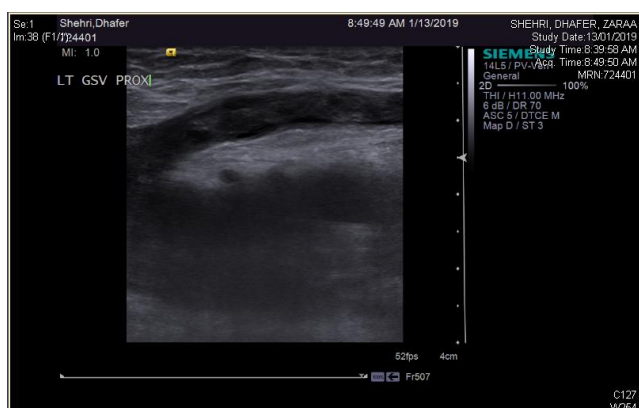
Left popliteal vein



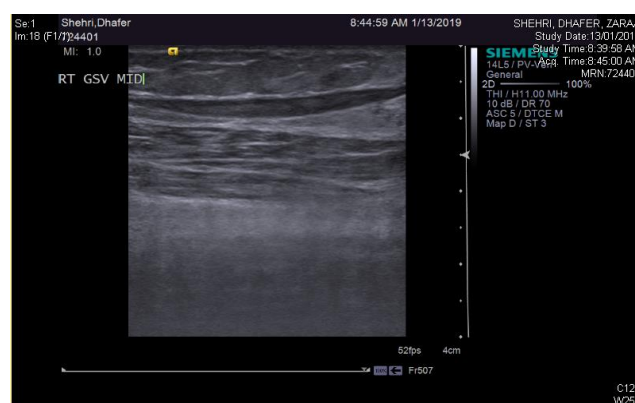
Right popliteal vein



Left great saphenous vein



Right great saphenous vein



The report of the procedures showing

Right common femoral and proximal superficial femoral veins appear bulky with internal echoes and are not compressible. No flow documented. No flow also seen in the great saphenous vein on the right side which appears bulky and echoic.

Sluggish flow documented from mid right superficial femoral and popliteal veins which are compressible.

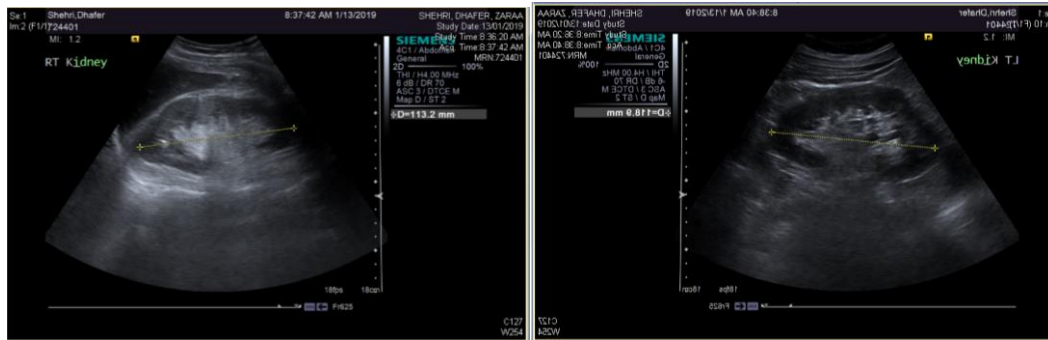
No flow documented from left common femoral, superficial femoral and popliteal veins which are bulky, echoic and non compressible with thrombosis seen also in the left great saphenous vein. Edema both legs noted.

IMPRESSION

Extensive Bilateral lower limbs DVT.

Approving Dr: Senior Registrar Radiology Shamila Mujtaba

Ultrasound kidneys and bladder showed:



Right kidney measures 11.3 cm.

Left kidney measures 11.9 cm.

Both kidneys are of normal size with mild increase in renal parenchymal echogenicity. Corticomedullary differentiation intact. No hydronephrosis seen. Urinary bladder appears unremarkable.

Approving Dr: Senior Registrar Radiology Shamila Mujtaba
Senior Registrar Radiology



CT ABDOMEN & PELVIS of 14-JAN-2019:

Clinical history:

Mid 80 years came with bilateral lower leg DVT.

Technique,:

trans axial CT images of the abdomen, pelvis post IV and oral contrast administration with 5 mm collimation, coronal and sagittal reformats were obtained.

No similar available prior studies for comparison.

Findings:

The IVC and its tributaries are nonenhancing and expanded by intraluminal hypodense thrombus down to the femoral veins bilaterally, there is abrupt change in IVC diameter in the subhepatic portion of the IVC reaching to 3 mm in luminal diameter, the intrahepatic IVC and right atrium are patent.

The thrombus also extends to the renal veins bilaterally. There is collateral flow and recanalization of the median umbilical vein with collateral flow in the anterior abdominal wall and retroperitoneum draining into the lumbar veins and azygos system.

The portal vein and hepatic veins are patent.

There is 2 cm enhancing lesion in segment five of the right liver lobe which could represent a hemangioma for further ultrasound correlation on a later date.

Spleen, pancreas, kidneys and adrenals are unremarkable.

No ascites or pneumoperitoneum.

Visualized lower cuts of the lungs are unremarkable.

Visualized bones show no acute or concerning bony lesions.

Impression:

Complete thrombosis of the IVC and its tributaries with collateral flow and drainage into the lumbar veins and azygos system as well as the anterior abdominal wall, significant narrowing of the subhepatic IVC concerning for underlying IVC membrane for further consultation with interventional radiology.

Approving Dr: Consultant Radiologist Majid Homiedan