



6th ANNUAL Venous Symposium New York

RIGHT OVARIAN VEIN THROMBOSIS

New York Hilton Midtown | Manhattan, New York

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THE MOST INTERACTIVE VENOUS MEETING IN THE WORLD





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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



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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



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Family History

Mother

Multiple sclerosis

Father

Heart attack

Sister

High blood pressure

Grandmother

Heart attack



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Abdominal and pelvic CT 2007 - for abdominal pain

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 nondilated 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



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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**



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Diagnostic evaluation

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

Normal

She had a CT and a pelvic ultrasound

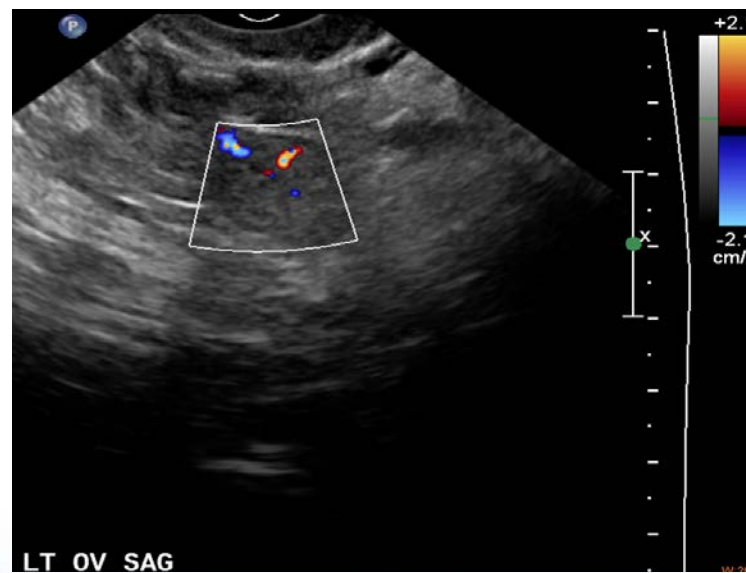
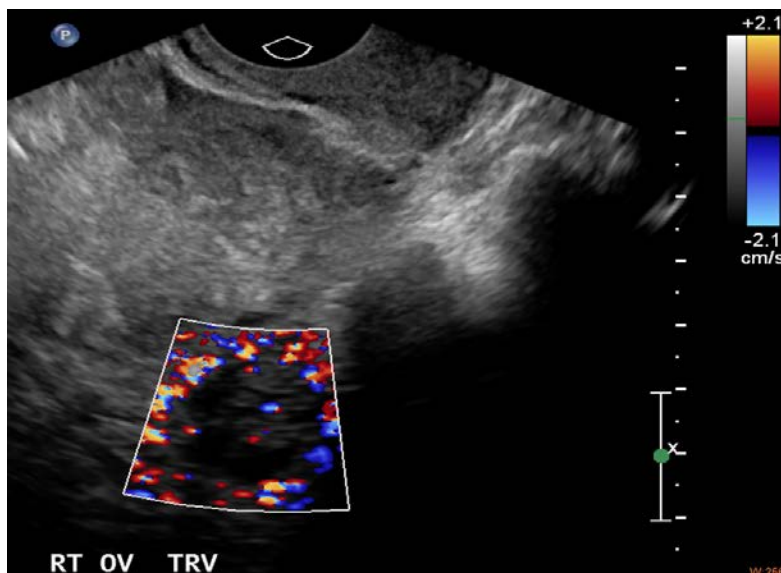


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Rt ovary larger
With much
higher flow.

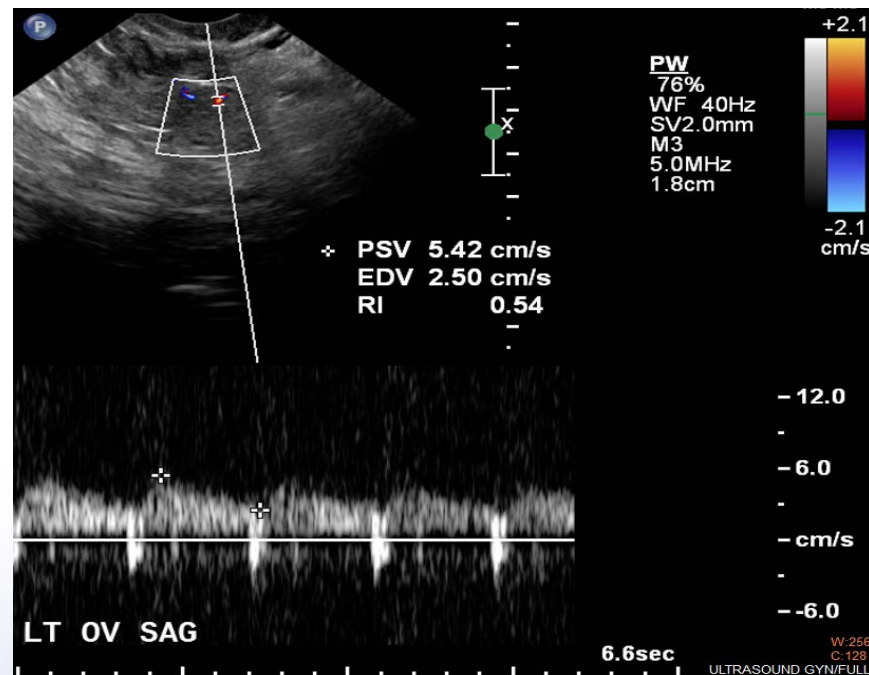
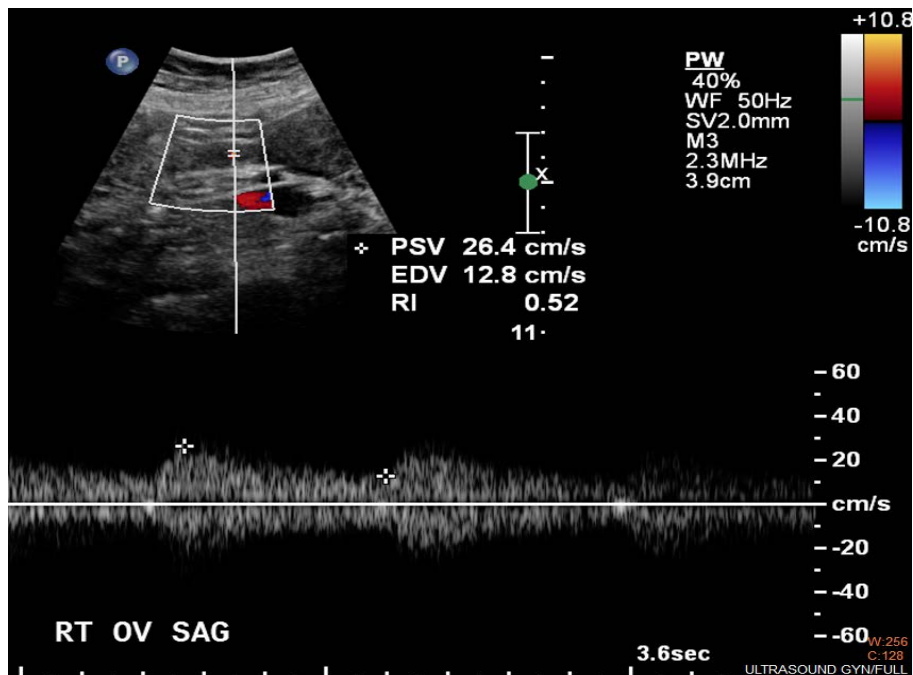




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PSV and EDV >4x higher on the right ovary

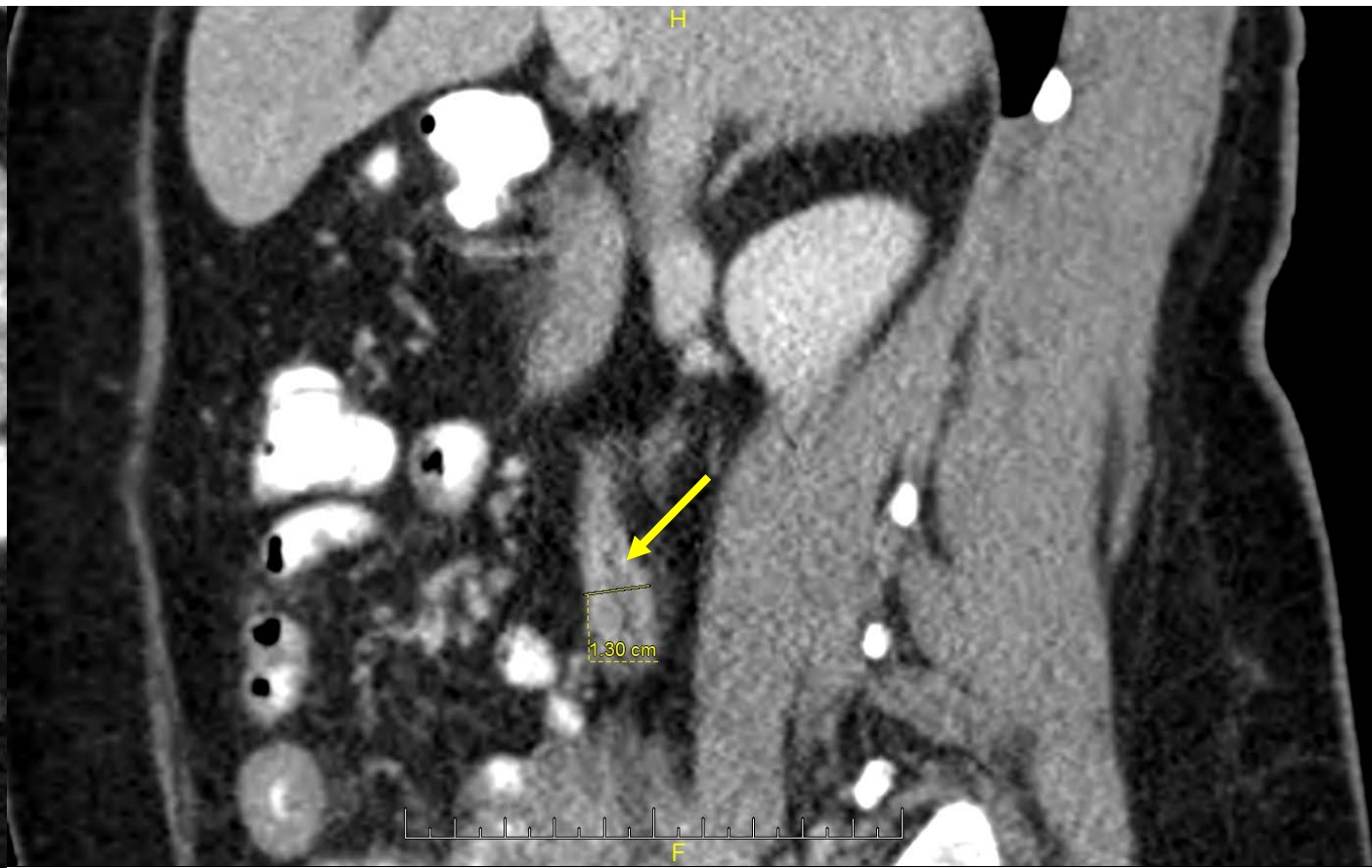
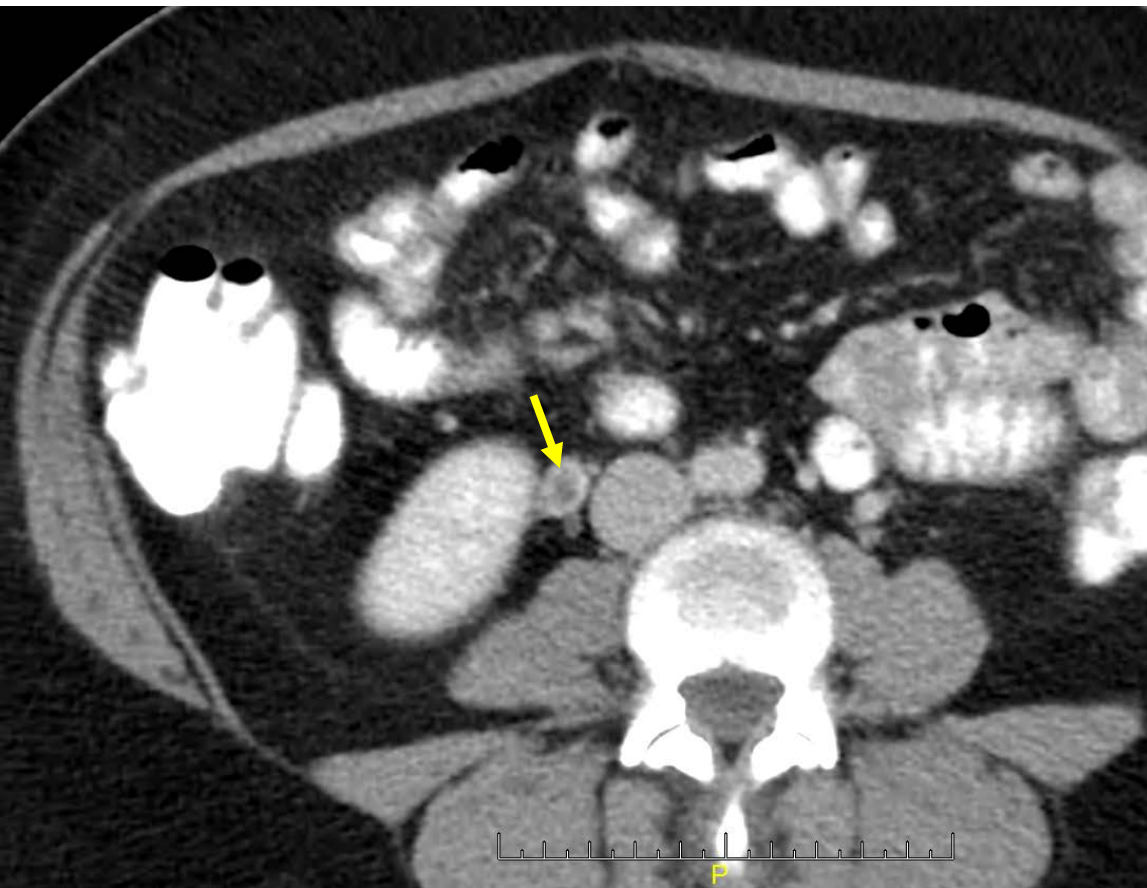


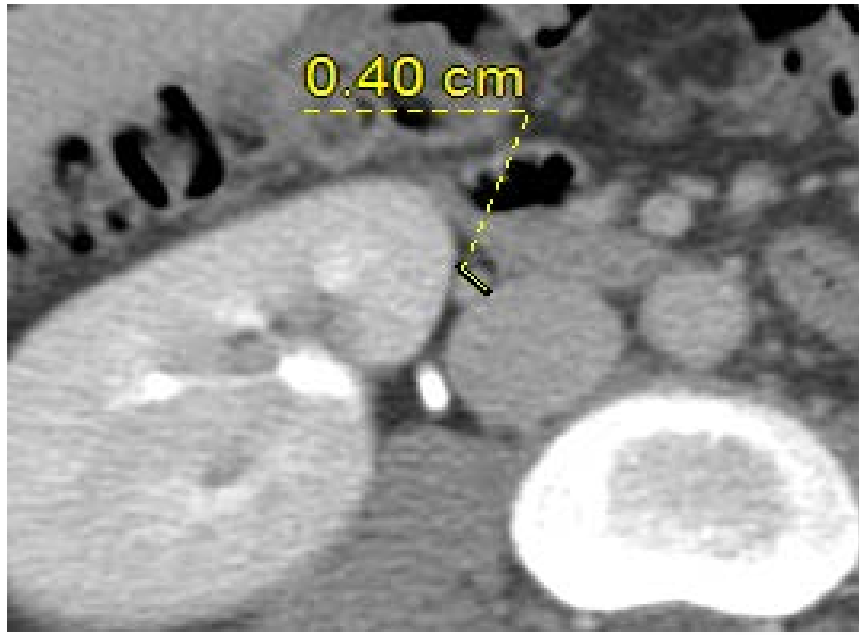
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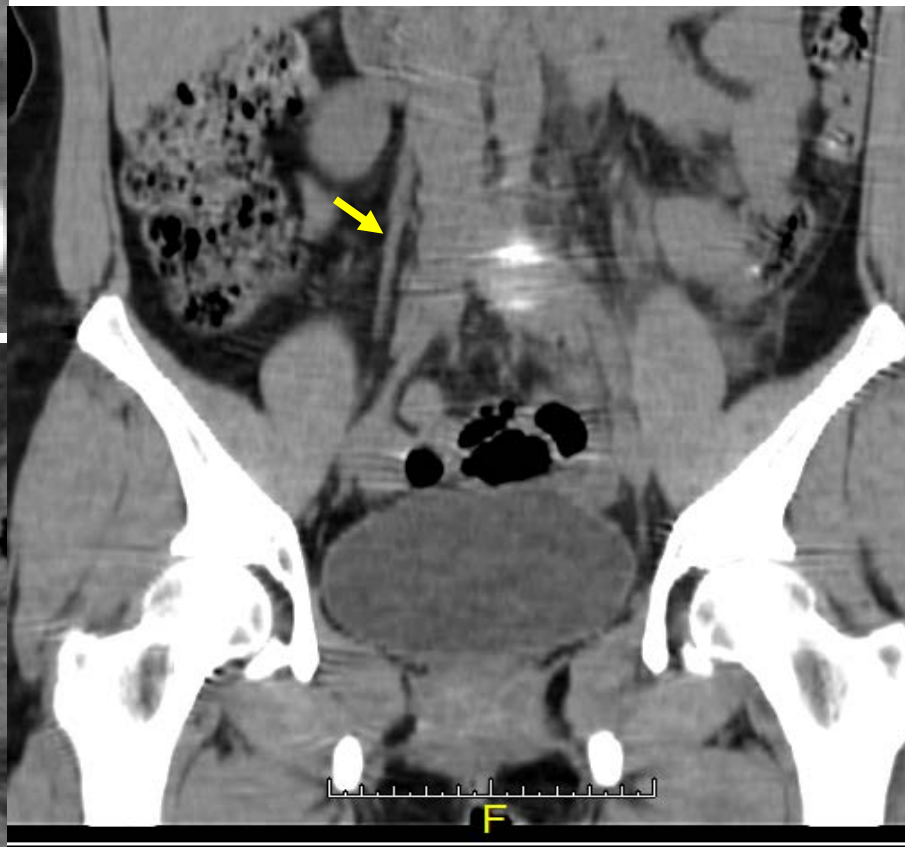
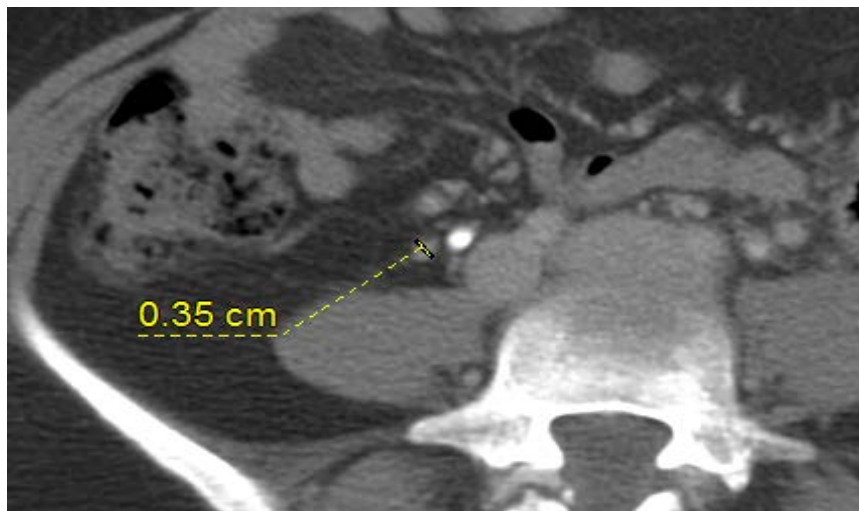
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Dilated ROV measuring 13mm





**ROV was normal on the
previous CT on 2007**

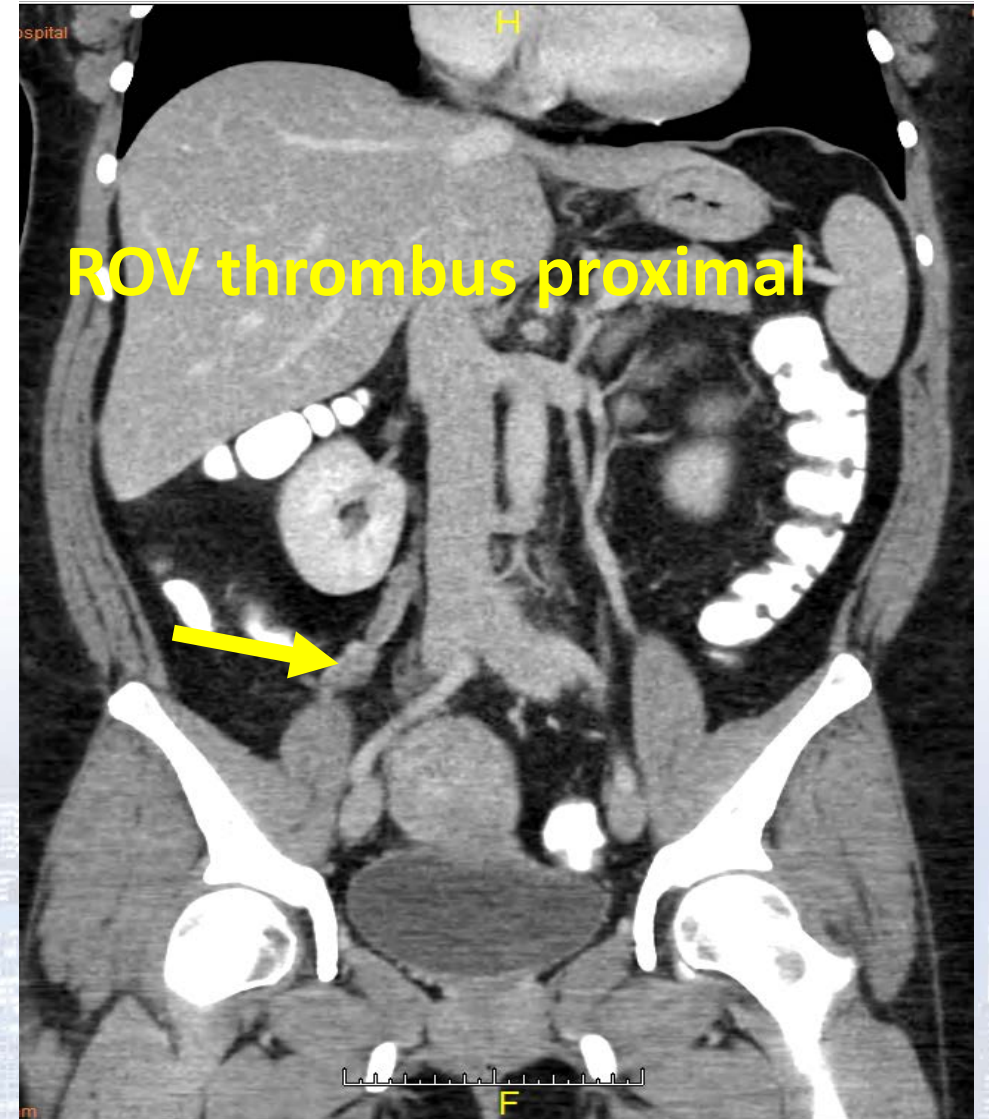
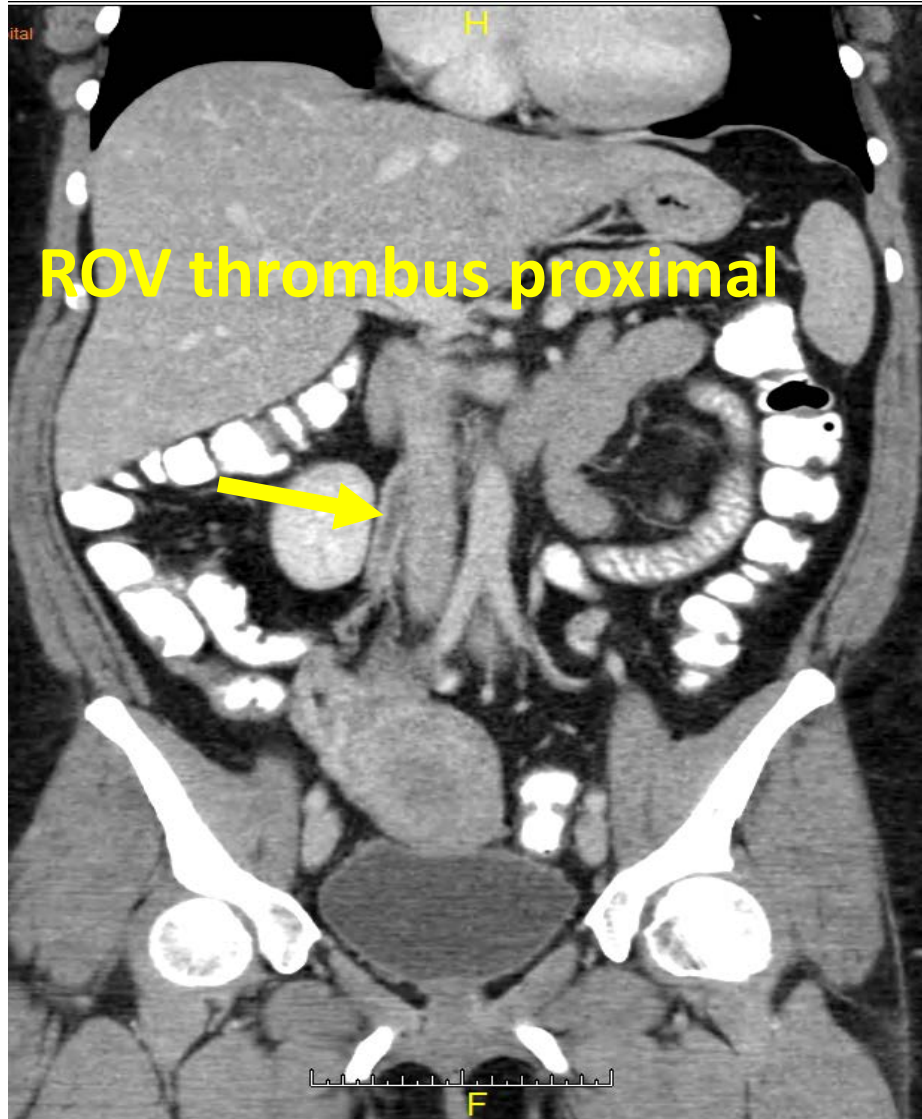


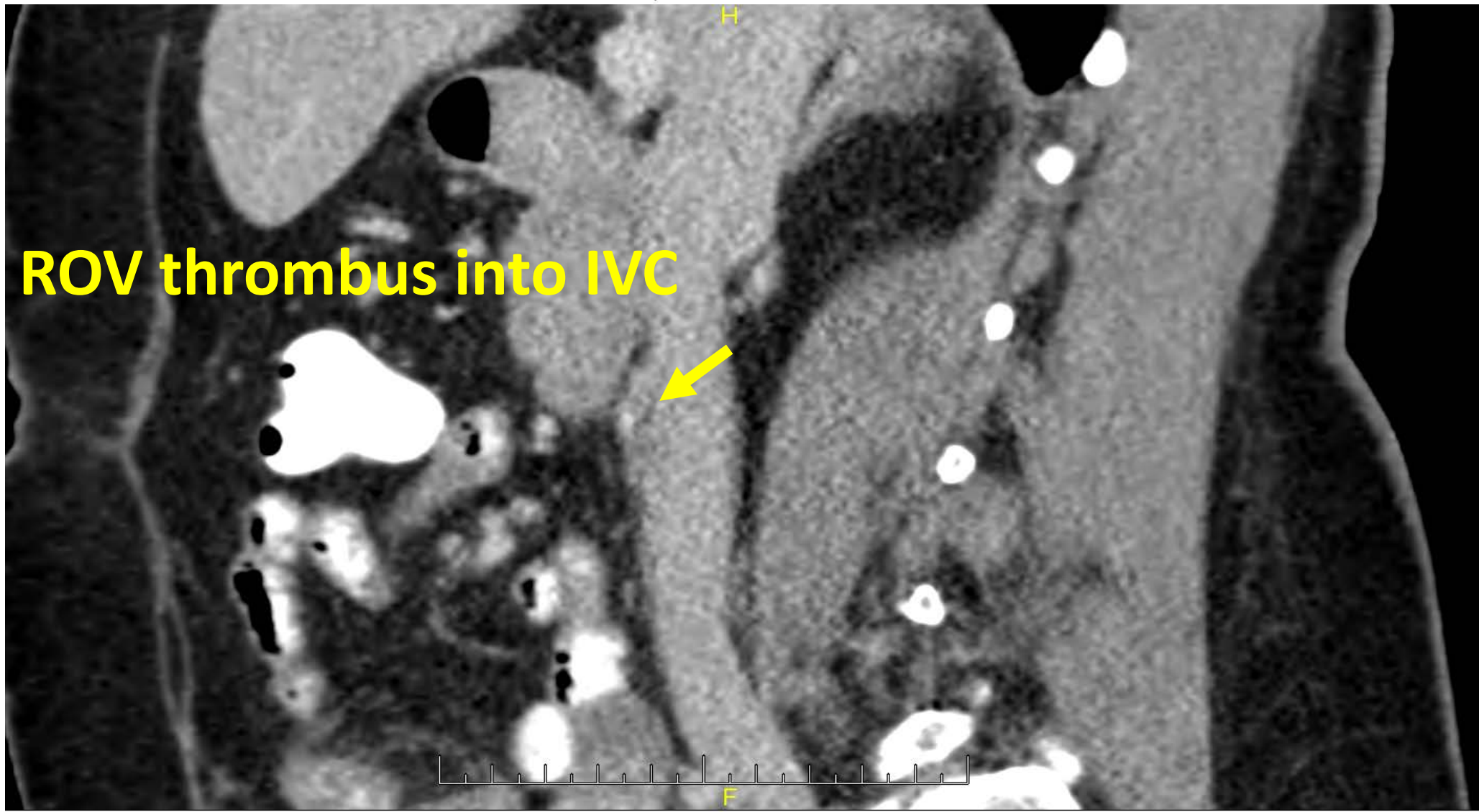


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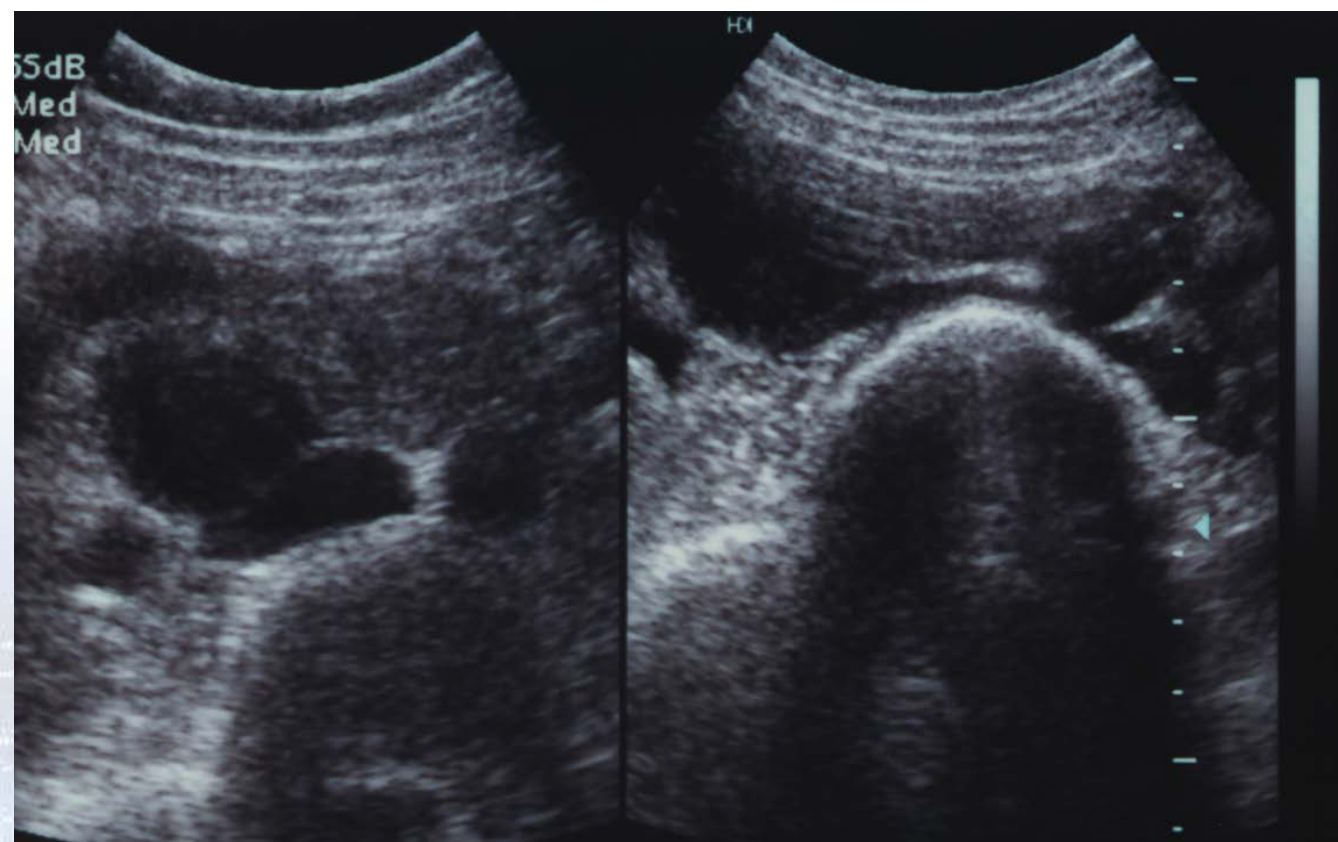
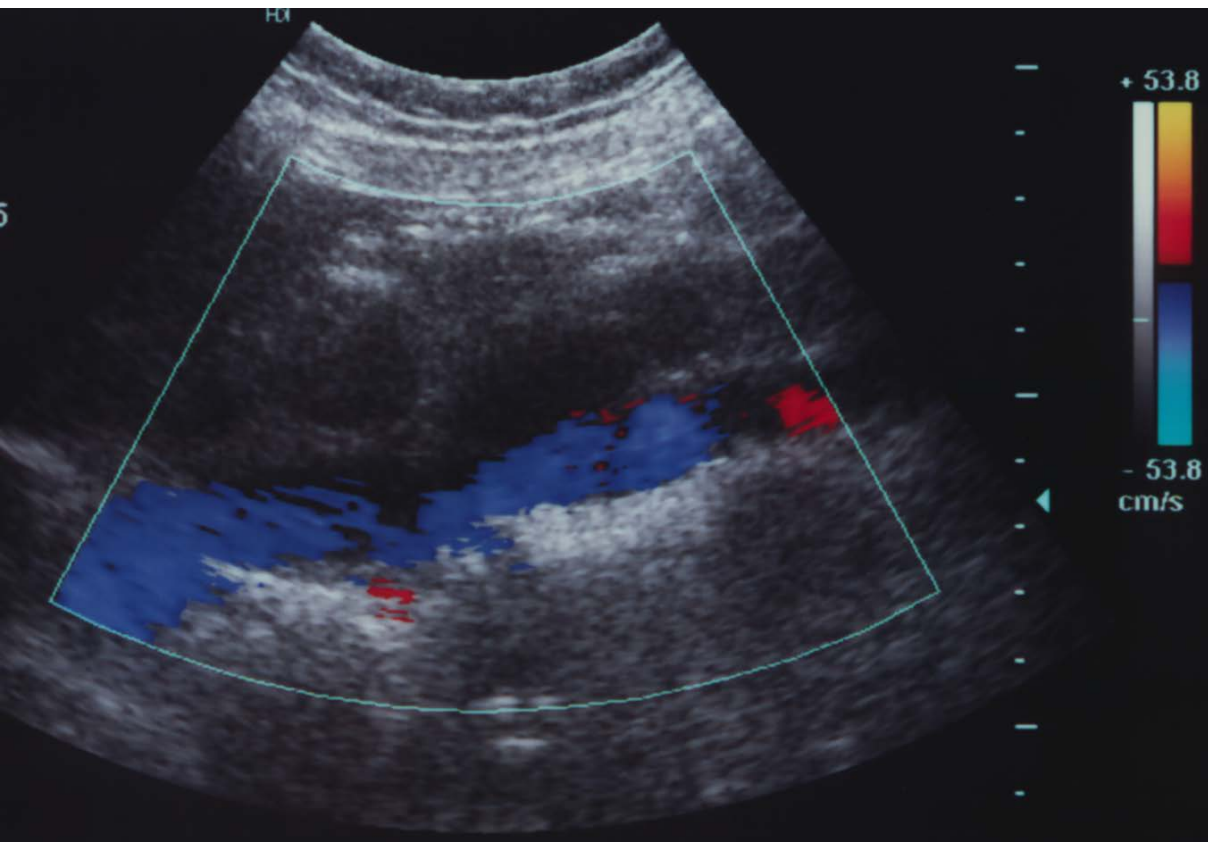
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ROV thrombus into IVC

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

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





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Treatment

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



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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



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Follow-up

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

She is free of pain without any recurrent VTE



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Clinical presentation

Pelvic or lower abdominal pain

Fever of unknown origin

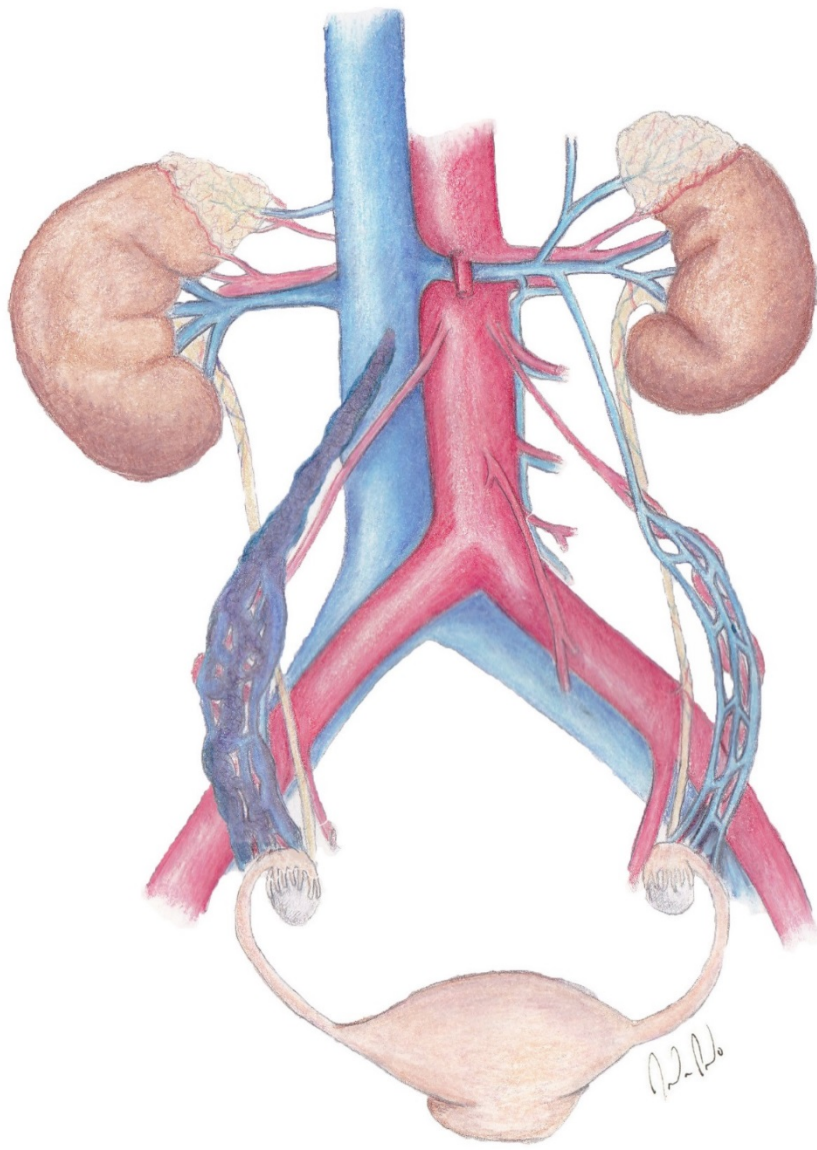
This is most common in pregnant patients

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.