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The Case Deep Vein Thrombosis and Massive Pulmonary Embolism in Patient with Achondroplasia

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Introduction: Acute Pulmonary Embolism (PE) can be asymptomatic or cause a wide clinical course which can lead to death. Even though systemic thrombolysis is the recommended first-line treatment in massive PE, surgical embolectomy and percutaneous interventions are alternative treatment options when it is concerned high risk of bleeding. Vena cava inferior (VKİ) filter is recommended for mechanical treatment of recurrent embolism in the diagnosis of the acute proximal inferior extremity DVT.

Case Presentation: Out of hospital Physical Therapy Rehabilitation Outpatient Clinic While followed, with diagnosis massive pulmonary thromboembolism referred, 47-year-old female patient who was achondroplasia appearance Blood Pressure Arterial (BPA) was 85/50. The patient was performed pulmonary artery catheterization due to peptic ulcers recent medical history. Widespread thrombosis materials allowing to minimum flow in the bilateral main pulmonary artery and segmental branches were observed. The patient was given 20 mg of recombinant tissue plasminogen activator (rt-PA) with the catheter. Low molecular weight heparin (LMWH) was passed. The patient was followed up in chest intensive care. Inferior extremity venous doppler was observed the right popliteal vein, left femoral vein, and left popliteal lumen of the a thrombus consistent with the lumen. While the patient follow-up was continued with the diagnosis of massive PE and acute DVT, general deterioration and BPA were observed as 50/20. In the control thorax CT, left main pulmonary artery was completely occluded. The patient was performed with an ultrasonic catheter thrombolytic therapy (EKOS) and the pulmonary artery interventional treatment and Vena Cava inferior filter fitted in the same session. The patient's deep vein thrombosis was intervened with EKOS. 27mg rt-PA was given. Follow-up was continued with LMWH. The patient's follow - up was stable. Varicose Vein Compression Stocking was recommended. The patient was coumadinized. Clinical-laboratory and radiological improvement was observed. The patient was followed-up. Pt-INR was exoped at 2.45. Policlinic control continues.

Conclusion: Branch physicians should be consider DVT and Pulmonary embolism as preliminary diagnoses and who should refer to the relevant center as soon as possible.. The massive pulmonary is important BPA follow. During case management should be considered thrombolytics, Surgical-interventional interventions, Vena Cava filter.

Keywords: Achondroplasia, deep vein thrombosis, hypotension, pulmonary artery catheterization, pulmonary embolism