Abstract Title: History repeats itself, unless you take a full history: A May-Thurner Syndrome case study

Abstract Text:
May-Thurner syndrome (MTS) is a rarely diagnosed condition in which the patient's left iliac vein is compressed by the right iliac artery against bony structures in the iliocaval territory. Although most patients with MTS are asymptomatic, the syndrome increases the risk of having deep vein thrombosis (DVT). A 22-year-old woman with a medical history of MTS, type 1 diabetes, left lower extremity (LLE) venous stent placement, and thrombectomy presented to the emergency department with severe left leg pain and swelling, chest pain, and shortness of breath (SOB). She was previously admitted with a similar presentation and found to have a pulmonary embolism (PE) in a distal pulmonary artery and DVT of the left common and external iliac vein stent/graft for which she underwent LLE venogram, angiojet thrombectomy, balloon angioplasty, lytic therapy and discharged on Eliquis which she claims to be compliant with. Computed tomography angiography (CTA) of the chest was done which showed similar PE bilaterally as seen on previous CTA. CT venogram of LLE showed occlusions in the left lower extremity venous structures from the left common iliac vein to the left foot, the left iliac femoral region stent, and a central prominent thrombus in the mid-popliteal vein and in the IVC towards the left side at the iliac bifurcation. Arterial studies done did not show any arterial occlusive disease. This time around, she also presented with diabetic ketoacidosis (DKA) and was placed on an insulin drip. Once her DKA was resolved, she was immediately started on heparin drip and vascular surgery service was consulted. When gathering history, it was found that the patient still had a Nexplanon birth control device that was implanted in 2016 and that she was still oddly amenorrheic. She underwent LLE venous catheter placement with instillation of thrombolytics with simultaneous removal of her birth control device from her left arm, given her inherent risk and recurrence of thrombosis. The following day, she underwent a subsequent venogram with thrombectomy, angioplasty, and subsequent catheter removal. Pain control was managed with PRN opioids initially, however, after the procedure, she no longer had significant pain. Her LLE was also placed on compression bandage. She was then transitioned to therapeutic Lovenox dosing and started on warfarin therapy given the possibility of Eliquis failure. She was advised to follow-up closely with her primary care provider (PCP) to setup INR monitoring and Lovenox bridging. This case illustrates the importance of thorough history taking. Due to this patient being diagnosed with MTS, her recurring thrombosis was attributed to that; however, a patient with a prothrombotic syndrome requires complete history to identify and minimize other prothrombotic factors. Despite having multiple visits to her PCP and hospital admissions, her expired Nexplanon was never discussed for removal and was possibly contributing to the formation of her DVTs. The menstrual and sexual history of patients is very personal and can be uncomfortable to discuss, but it is necessary for a complete history. In cases like this, that information could be vital for a patient's life.