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Ulcerative colitis leading to repeated portal vein thrombosis despite anticoagulation

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Patient is a 33-year-old Puerto Rican female with past medical history significant for pulmonary embolism, portal vein thrombosis on Coumadin, untreated ulcerative colitis, peptic ulcer disease, who presented with one episode of syncope and dark red stools with duration of one day. On review of systems, the patient also complained of nausea, dizziness, and non-radiating "squeezing" upper abdominal pain. Patient had fatigue and when she arose from bed the day of admission, she found herself lying on the floor with residual pain on the back of her head and left side of her body. Patient was unsure how she fell or how long she lost consciousness. Patient had one prior episode of severe bleeding in the past four-five years ago after banding procedure. Patient denies pain or straining with bowel movements, NSAID use, fevers, chills, weight loss, and pruritus, use of supplements or herbal remedies, recent travel, sick contacts, history of right upper quadrant abdominal pain, emesis or rashes. Vitals on admission were pulse 89, respiratory rate 20, and blood pressure: 109/59, PO2 99%. Physical exam was notable for minor orthostatic hypotension and a soft non-distended abdomen with mild tenderness to deep palpation in the epigastric area with no rigidity, guarding, or masses. Patient was admitted to the ICU when systolic blood pressure dropped to the 70's with tachycardia in the 100-110s. Hemoglobin was found to be 5.3, prothrombin of 25.5, international normalized ratio of 2.39, and partial thomboplastin time of 26.4. Patient was then given three liters normal saline and six units total of packed red blood cells with improvement of symptoms. Patient was started on Protonix drip. Endoscopy was performed which showed grade II esophageal varices, gastritis and gastric erosion with no active bleeding. Patient was then started on an octreotide drip. Patient's ulcerative colitis was diagnosed twelve years ago, but patient admits to non-compliance after many attempted trials of therapy without alleviation of symptoms. Patient continued to have persistent symptoms including intermittent diarrhea, cramping abdominal pain. Patient also had a negative coagulopathic work up including Factor V Leiden deficiency, prothrombin gene mutation, and Protein C and S deficiency. Last colonoscopy was in August 2016, which showed diffuse inflammation and polyps. Cirrhosis workup was obtained to search for cause of increased portal venous pressure and therefor varices. Magnetic resonance imaging of the abdomen findings unexpectedly revealed thrombosis of the portal vein with cavernous transformation. Patient was then restarted on Coumadin which had been stopped due to bleeding and was patient was bridged with heparin until patient achieved therapeutic internationalized ratio levels. After discussing at length with patient's hematologist and gastroenterologist the conclusion was reached that her suspected herpcoagulability was due to uncontrolled ulcerative colitis. This case illustrates the importance of always considering portal vein thrombosis as part of initial differential in someone with even minimal abdominal pain who is hyercoagulable. Most notably it helps signify the importance of treating uncontrolled inflammatory bowel disease as it can cause hypercoagulability.

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