TROMBOFLEBITIS SUPERFICIAL MIGRATORIA: REVISIÓN CLÍNICA E HISTOLÓGICA DE 8 CASOS

Resumen. Introducción. La tromboflebitis superficial migratoria (TSM) o tromboflebitis migrans se caracteriza por episodios recurrentes de trombosis segmentaria de las venas superficiales de los miembros y el tronco. La TSM se ha asociado con diversas enfermedades sistémicas que deben tenerse en cuenta a la hora de evaluar al paciente.

Material y métodos. Desde 1997 hasta 2007, 8 pacientes con TSM fueron estudiados en el Hospital General Universitario de Valencia. Se revisaron las características clínicas e histopatológicas, así como las enfermedades asociadas.

Resultados. La presentación clínica más frecuente fue en forma de nódulos dolorosos recurrentes en las extremidades inferiores, similar a un eritema nodoso. Otras localizaciones fueron el abdomen y el tronco. Sólo en un caso el diagnóstico clínico fue de TSM. Otros diagnósticos clínicos fueron celulitis, linfangitis, vasculitis nodular o panarteritis nodosa. Las características histológicas fueron compatibles con tromboflebitis superficial, y...
la tinción con orceína mostró ausencia de la lámina elástica interna en todos los casos. En ninguno se demostró asociación con una neoplasia oculta. En 2 casos existían antecedentes de enfermedad de Buerger y otro apareció en el contexto de una fiebre de origen desconocido.

Conclusion. El reconocimiento de la TSM es importante por su posible asociación con enfermedades sistémicas, incluyendo el cáncer. En nuestra serie fuimos incapaces de encontrar una enfermedad asociada en la mayoría de los casos. Sin embargo, y dado que el cáncer se puede manifestar entre meses e incluso años después de la aparición de la TSM, es necesario el seguimiento de los pacientes.

**Palabras clave:** tromboflebitis superficial migratoria, tromboflebitis migrans, enfermedad de Mondor, signo de Trousseau.

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**Introduction**

Superficial migratory thrombophlebitis (SMT) or thrombophlebitis migrans is characterized by recurrent episodes of localized thrombosis of the superficial veins in the limbs and trunk. It has been associated with various systemic diseases that should be considered when examining the patient.

Here we describe a series of 8 patients seen by the Dermatology Department of Hospital General Universitario de Valencia, in Valencia, Spain, between 1997 and 2007.

**Materials and Methods**

A search was undertaken to identify patients diagnosed with SMT in the Dermatology Department of Hospital General Universitario de Valencia between January 1997 and April 2007.

The following data were routinely collected from the patient’s medical history: age, sex, clinical presentation, clinical diagnosis, additional tests, and associated diseases. All biopsies were reassessed to analyze the characteristics of the epidermis, papillary dermis, type of infiltrate in the vascular wall, existence of organized thrombus, hemorrhage, and conditions of surrounding fat. Orcein staining was performed in all cases.

**Results**

Tables 1 and 2 describe the results obtained from the search. Eight patients (5 men, 3 women) with a mean age of 52 years (range, 39–60) were identified. The most common clinical presentation was painful erythematous plaques on the legs. Other clinical presentations included recurrent infraumbilical erythematous nodules with a linear distribution, hot erythematous plaques on the right foot, linear erythematous lesion on the chest wall, painful recurrent nodules on the legs, painful pretibial plaque, painful erythematous nodules with a linear distribution on the right leg, and painful erythematous plaques with a linear distribution on the right leg.

**Table 1. Epidemiological Data, Clinical Presentation, and Associated Diseases**

<table>
<thead>
<tr>
<th>Case</th>
<th>Sex/Age, y</th>
<th>Clinical Presentation</th>
<th>Clinical Diagnosis</th>
<th>Associated Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M/60</td>
<td>Painful erythematous plaques on the legs</td>
<td>Periarteritis nodosa</td>
<td>Thromboangitis obliterans</td>
</tr>
<tr>
<td>2</td>
<td>F/45</td>
<td>Recurrent infraumbilical erythematous nodules with a linear distribution</td>
<td>Superficial migratory thrombophlebitis</td>
<td>None</td>
</tr>
<tr>
<td>3</td>
<td>M/57</td>
<td>Hot erythematous plaques on right foot</td>
<td>Cellulitis</td>
<td>Peripheral venous insufficiency</td>
</tr>
<tr>
<td>4</td>
<td>M/47</td>
<td>Linear erythematous lesion on the chest wall</td>
<td>Lymphangitis</td>
<td>None</td>
</tr>
<tr>
<td>5</td>
<td>M/52</td>
<td>Painful recurrent nodules on the legs</td>
<td>Nodular vasculitis</td>
<td>Peripheral venous insufficiency</td>
</tr>
<tr>
<td>6</td>
<td>F/60</td>
<td>Painful pretibial plaque</td>
<td>Erythema nodosum</td>
<td>Fever of unknown origin Viral hepatitis C treated with interferon and ribavirin</td>
</tr>
<tr>
<td>7</td>
<td>F/39</td>
<td>Painful erythematous nodules with a linear distribution on the right leg</td>
<td>Erythema nodosum</td>
<td>No associated diseases</td>
</tr>
<tr>
<td>8</td>
<td>M/58</td>
<td>Painful erythematous nodules with a linear distribution on the right leg</td>
<td>Erythema nodosum</td>
<td>Thromboangitis obliterans</td>
</tr>
</tbody>
</table>

Abbreviations: F, female; M, male.
presentation was painful nodules in the legs (n = 6). Other sites were the abdominal region (n = 1) and trunk (n = 1). The various clinical diagnoses (Figures 1 and 2) were erythema nodosum (n = 3), nodular vasculitis (n = 1), periarteritis nodosa (n = 1), lymphangitis (n = 1), and cellulitis (n = 1). SMT was diagnosed clinically in only 1 case.

A total of 9 biopsies were carried out. In most, pathology showed epidermal atrophy (n = 7) and proliferation of the capillary vessels along with a thickened basement membrane that stained positive with periodic acid Schiff stain in the papillary dermis (n = 6). Ulceration was not observed in any patient.
All cases showed involvement of a large vein in the superficial subcutaneous tissue with occlusion of the vascular lumen (Figures 3 and 4). The inflammatory infiltrates in the vessel wall were composed of neutrophils (n = 4), eosinophils (n = 4), histiocytes (n = 9), lymphocytes (n = 3), and giant cells (n = 2). In addition, 5 biopsies showed an organized thrombus and 1 case had minimal recanalization of the vascular lumen. Hemorrhaging was observed in 2 patients. The surrounding fatty tissue showed lipophagy (n = 1), proliferation of the capillary vessels and
endarteritis obliterans ($n = 6$), septal fibrosis ($n = 5$), and mucin ($n = 2$). In all cases, orcein staining confirmed the absence of the internal elastic lamina.

The mean time from the onset of symptoms until SMT diagnosis was 10 months (range, 1–24 months).

The extended study for each patient included a complete laboratory workup consisting of blood counts, biochemistry, autoimmunity, tumor markers, and a coagulation and thrombosis study, along with chest x-ray, and abdominal ultrasound. The patients were also assessed by a vascular surgeon. No evidence of an occult tumor (Trousseau sign) was seen in any patient. Patients 1 and 8 had a history of Buerger disease (thromboangiitis obliterans). Another case presented with a fever of unknown origin in a patient with viral hepatitis C treated with interferon and ribavirin. In patient 5, the initial thrombosis study showed a partial deficiency of protein C that was not confirmed in subsequent tests. Case 7 was initially associated with lupus anticoagulant, although the patient did not report a history of spontaneous abortions or other thrombotic phenomena. A repeat laboratory workup at 6 weeks showed no abnormalities and, therefore, the patient was referred to the hematology department where repeated studies ruled out this initial association.

Patient 3 developed a depressive syndrome, leading to suspicion of a possible associated pancreatic tumor. Computed tomography scans of the chest and abdomen were therefore performed, showing thickening of the gastric wall; however, malignancy was ruled out by gastroscopy.

Deep vein thrombosis was not observed in any patient. Two patients showed signs of chronic venous insufficiency in the legs. No patient was found to have inflammatory bowel disease or Behçet disease.

All patients (except patient 4) had recurrences. The therapeutic options employed included conservative measures such as rest and elastic compression stockings, as well as systemic treatment with nonsteroidal anti-inflammatory drugs, pentoxyphylline, corticosteroids, and anticoagulants in the 2 cases associated with Buerger disease.

The mean follow-up time of patients was 3 years (range, 6 months to 5 years).

Discussion

SMT presents as painful erythematous nodules, usually located on the legs. It can also affect the epigastric, thoracoepigastric, or lateral thoracic veins, resulting in visible or indurated cords in the chest wall, a condition known as Mondor disease. This has also been occasionally reported in the axilla, inguinal region, and penis. After several days, cord-like induration can be palpated. Clinically, the lesions can be confused with conditions such as nodular vasculitis, erythema nodosum, polyarteritis nodosa, cellulitis, or lymphangitis. In our series, lower limb involvement in the form of subcutaneous nodules similar to erythema nodosum was the most common clinical presentation. Patient 7 had a linear erythematous lesion on the chest wall that resembled lymphangitis. SMT was initially diagnosed only in patient 2, who presented infraumbilical subcutaneous nodules.

SMT usually affects the veins located in the superficial subcutaneous tissue. Recent lesions are characterized by predominantly polymorphonuclear inflammatory infiltrates in the vein wall. The polymorphonuclear cells are progressively replaced by lymphocytes and histiocytes, as well as by giant cells on occasion. The thrombus initially occluding the vascular lumen is later replaced by recanalization and fibrosis. The differential histologic diagnosis is performed with polyarteritis nodosa; in this condition, the vessels are arteries that can be recognized by the diameter of the lumen, the thickness of the wall, and the presence of an internal elastic lamina.

The possible association of SMT with various systemic diseases, including occult tumors, makes its diagnosis important. Trousseau was the first to describe the potential association between venous thrombosis and cancer. Various vascular phenomena have preceded the diagnosis of cancer, such as arterial thrombosis, arterial embolism, nonbacterial thrombotic endocarditis, and SMT. The Trousseau sign appears particularly in mucinous adenocarcinomas and is apparently triggered once the circulating mucin secreted by carcinoma cells interacts with platelet and leukocyte selectin (P-selectin and L-selectin). These data may explain why heparin, which is able to inhibit mucin interaction with L-selectin and P-selectin, can improve Trousseau syndrome whereas oral anticoagulants that are vitamin K antagonists are often ineffective.

However, SMT can be diagnosed months or even years before the occult tumor is diagnosed.

Other diseases that have been related to SMT include Buerger disease, Behçet syndrome, inflammatory bowel disease, deep vein thrombosis, coagulation defects potentially leading to a hypercoagulable state, such as protein C or S deficiencies, lupus anticoagulant, or factor XII (Hageman factor) deficiency.

The onset of Mondor disease has been related to direct injuries, strenuous exercise, breast infections, or surgical procedures on the breast. The condition is related to breast cancer in up to 12% of patients.

SMT treatment may yield disappointing results, with frequent recurrences. Measures such as rest and elastic compression stockings may improve the symptoms. In the case of Mondor disease, the lesions tend to resolve within a few days, with a low frequency of recurrence. Most clinicians use anticoagulants only for patients with deep vein disease. In cases of associated tumors, adjuvant anticoagulants (particularly heparin) are used in addition to treatment of the tumor.
Conclusion

The possible association of SMT with various systemic diseases, including occult tumors, makes its diagnosis important. Our case series shows, however, that the condition is not always easily recognized because it can be confused with other, more common, entities such as cellulitis or erythema nodosum. In fact, the mean time to definitive diagnosis was 10 months. SMT was diagnosed clinically in only 1 patient. Therefore, SMT should be included in the differential diagnosis whenever the patient has recurrent cutaneous nodules with a linear distribution. In our case series, we were unable to find an associated disease in most cases. However, because cancer can present months or years after SMT is diagnosed, follow-up is necessary in these patients.

Conflicts of Interest

The authors declare no conflicts of interest.

References