KSN SEOUL, KOREA 2023
April 27(Thu) - 30(Sun), 2023
Coex, Seoul, Korea

Abstract Type : Poster
Abstract Submission No. : 1546

Lower Extremity Arterial Thromboembolism in a Patient with Membranous Nephropathy

Eujin Lee, Moo Jun Kim, Ho Joon Ko, Su Yeon Han, Young Rok Ham, Dae Eun Choi, Ki Ryang Na, Kang Wook Lee
Department of Internal Medicine-Nephrology, Chungnam National University Hospital, Korea, Republic of

Case Study: Thromboembolism due to increased hypercoagulability is one of the most serious complications among patients with nephrotic syndrome. Usually, venous thromboembolism (VTE) is known to be more frequent than arterial thromboembolism (ATE). Here, we report a case of suspicious ATE presented with claudication and Raynaud's phenomenon in a patient with membranous nephropathy (MN).

A 40-year-old male, without previous comorbidities, visited local secondary hospital due to sustained edema for two months. His initial serum creatinine and albumin levels were 0.6mg/dL and 1.7g/dL, respectively. Kidney biopsy result was consistent with MN. Conservative treatment was initiated, and later, prednisolone and tacrolimus were added due to progression of proteinuria. However, his adherence to medication was very low. At two months after diagnosis, he newly developed severe claudication in both lower leg with color change in both feet and toes, and Raynaud's phenomenon at right second and third finger. CT angiography reported diffuse chronic total occlusion (CTO) in both tibiofibular trunks and right posterior tibial artery; multifocal significant stenoses or near total occlusions in left anterior tibial artery and dorsalis pedis artery; and chronic total occlusion in the right deep femoral artery. (Figure 1).

At one month after CT exam, he was transferred to our hospital for multidisciplinary management. His ankle-brachial index was 0.84 at right side and 0.7 at left side. Being highly suspicious of thromboembolic occlusion, aspirin was switched to rivaroxaban. Because peripheral CTOs carry anatomic risks such as dissection and perforation during angioplasty, medical treatment was preceded. Additionally, nailfold capillary microscopy and laboratory tests for systemic rheumatic disease were all negative. Laboratory results and medications from our hospital are shown in Table 1.

The patient's claudication is partially improving, and proteinuria is decreasing after three weeks of treatment of tacrolimus, prednisolone and rivaroxaban at our hospital.

Figure 1. CT angiography of lower extremities