INTRODUCTION

Protein C is a glycoprotein that is dependent on vitamin K synthesized by the liver and acts as a physiological anticoagulant that hydrolyzes factors Va and VIIIa. It probably increases fibrinolytic activity by neutralizing the inhibition of plasminogen; consequently, protein C deficiency induces hypercoagulability. The genetic defect is a simple mutation in exon 7 of the protein C gene located on chromosome 2q13-q14. Protein C deficiency is usually manifested as thrombosis of the venous system, with a prevalence of arterial thrombosis reaching 7.1% in a study of 337 heterozygotes. In general, additional vascular risk factors must be present for arterial involvement to occur. Although aortic thrombosis at different levels has been frequently reported, its association with protein C deficiency has not often been reported in the literature. In the case presented here, the diagnosis and follow-up of aortic arch thrombosis was made using a window in the jugular fossa, a technique used more often in radiology than in routine echocardiography practice.

CLINICAL CASE

The case presented was a 63-year-old man with no known cardiovascular risk factors who was referred from another hospital with the diagnosis of abdominal pain to be studied and repeated cerebrovascular accidents over a 13-day period. The Doppler study of the carotid was normal, cerebral CT performed at admission disclosed right temporal infarction, and trans-thoracic echocardiography revealed severe dilated cardiomyopathy with diffuse hypokinesia, ejection fraction 30%, and absence of cardiac valve disease or other possible sources of emboli. Since transesophageal echocardiography was not available, anticoagulation was begun with sodium heparin, which had to be discontinued 5 days later in view of CT evidence of a mild hemorrhagic transformation of the temporal infarction. The patient continued to present transient is-
chemic events. His digestive semiology remained latent in the context of turbulent cerebrovascular instability. Thirteen days after admission, the patient was transferred to our center at the request of his family.

Upon admission to the intensive care unit, the patient, who had been breathing spontaneously without hypoxemia, had a Glasgow scale score of 12, dysarthria, left palpebral ptosis, and homolateral hemiparesis. The patient had no signs of heart failure, sinus rhythm 110 beats/min with LBBB, and no murmurs in cardiac auscultation. Aside from the neurological findings, the patient had abdominal distension and pain in the right iliac fossa. Cerebral CT demonstrated the presence of ischemic, low-density areas in the right temporal lobe and confirmed the disappearance of the residual hemorrhagic component. Abdominal CT revealed low-density images in both kidneys compatible with embolic ischemic infarctions and a thickened intestinal loop responsible for the occlusive condition. In view of these findings and suspecting mesenteric ischemia, emergency laparotomy was performed. It disclosed segmental ileal necrosis that did not affect the rest of the intestinal tract. The ileum was resected and side-to-side anastomosis was performed. In the postoperative period of abdominal surgery, which was free of complications, transthoracic echocardiography did not reveal any new findings with respect to the previous study. Before making the transesophageal study, the aortic arch and descendent thoracic aorta were evaluated. When the brachiocephalic trunk was aligned with the right jugular fossa, a thrombus 30 mm long by 20 mm wide was visible that was fringed, movable, and had a broad base of implantation on the aortic wall (10 mm) that threatened the ostium of the brachiocephalic trunk. Two minutes after admission of the patient, transesophageal echography demonstrated an atheroma approximately 2-cm long located in the anterior wall of the aorta, which was concluded to be the probable cause for nesting of the aortic thrombus. The thrombus had disappeared, but the plaque had not been visualized in the study made in the acute phase of thrombosis (Figure 2B).

Due to the accessibility of the jugular fossa, in this patient, for visualizing the brachiocephalic trunk and the initial part of the aortic arch, the remission of the thrombus could be controlled (Figure 3A) until it had completely disappeared, which occurred 40 days after oral anticoagulant treatment began (Figure 3B).

After 5 months of treatment with acenocoumarol, it was replaced by subcutaneous enoxaparin at a dose of 75 mg/12 h for one week for the purpose of controlling protein C values. Functional protein C values of 29% (in normal conditions, from 70% to 130%) and of antigenic protein C of 1.60 mg/dL (in normal conditions, from 1.70 to 3.20 mg/dL) confirmed the previous finding of a severe and predominantly functional protein C deficiency in our patient.

Familial coagulation studies did not reveal thrombophilia.

DISCUSSION

Arteriosclerotic disease of the thoracic aorta is recognized as a potential source of cerebral and peripheral embolisms. Transesophageal echography is the technique of choice in these patients as a noninvasive intervention for both diagnosis and therapeutic follow-up. Although thrombotic pathology of the aorta is habitually related to the classic cardiovascular risk
factors, our growing familiarity with thrombophilic situations is making it possible to identify an appreciable number of patients with pathology of the coagulation factors, generally of genetic origin.

In the case presented here, several points merit comment, beginning with the thrombophilic etiology of the case. In the acute phase, while sodium heparin treatment was still being given, coagulation studies disclosed a primary protein C deficiency that was confirmed 5 months later, after discontinuing the oral anticoagulants that are known to interfere with protein C. Heterozygotic protein C deficiency is present in 2%-5% of patients with thrombosis and in up to 0.3%-0.5% of healthy subjects, suggesting the association of an increment in risk, which increases the incidence of venous thrombosis by up to 10-fold. Our patient had a type II deficiency because it affected mainly the functional activity of protein C, but not its antigenic activity (the parallel reduction of both activities corresponds to type I). As reported in the literature, additional vascular risk factors generally must be present in order for the arterial system to become involved in patients with protein C deficiency, as reflected by the finding of an atheroma plaque on the aortic arch of our patient (Figure 2B). In contrast with other congenital risk factors, protein C deficiency can be effectively treated. Whereas inhibitors of platelet aggregation, such as aspirin and ticlopidine, are ineffective, anticoagulation with coumarins prevents future thrombotic accidents. The conservative therapeutic attitude in this case, consisting of the administration of anticoagulants in the presence of a threatening thrombus with high embolic potential, was taken in light of the high risk of surgery of the aortic arch in a patient with recent cerebral infarction.

Another interesting aspect of this case was the echographic window used for the diagnosis of aortic arch thrombosis and the therapeutic follow-up of anticoagulant treatment. In the field of transthoracic echocardiography, particularly pediatric, the accessibility by
2-D echo to the origin of the supra-aortic trunks from the aortic arch using the suprasternal and high left parasternal windows is well-known. Nevertheless, the visualization of the trunks through the neck usually requires the intervention of radiologists using conventional echography. The region of the jugular fossa is located inside the suprclavicular fossa, delimited externally by the clavicular fascicle of the sternocleidomastoid and internally by the sternal fascicle of this muscle. Direct bidimensional examination of the brachiocephalic trunk from this window is not easy for radiologists and sometimes is fruitless, especially in obese patients. In contrast, the behavior of blood flow can be hemodynamically assessed by pulsed and continuous Doppler. In our case, probably the smaller size of the transducers used in cardiology and the fact that our patient was not obese and had a long neck allowed us to achieve a perfect alignment of the longitudinal axis of the brachiocephalic trunk from its origin on the proximal portion of the aortic arch. In this position it was possible to observe a thrombus of large size adhered to the lower aortic wall with a broad base of implantation. Transesophageal echography was used in this case to confirm the morphology of the thrombus, after the diagnosis had been reached using the window of the jugular fossa, and, later, to assess the aortic wall after resolution. However, the response to treatment was followed-up completely by echography of the jugular fossa, which made studies quicker and more comfortable for the patient.

In summary, we report an uncommon case of «spontaneous» thrombosis of the aortic arch in a patient with multiple central and peripheral embolic accidents and functional protein C deficiency. After 3 years of follow-up, conservative treatment with acenocoumarol has been shown to be fully satisfactory. The diagnosis and follow-up of response to anticoagulant treatment was carried out noninvasively by bidimensional echography using the window of the jugular fossa.

REFERENCES