Spontaneous subcutaneous tissue haematoma associated with warfarin

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DESCRIPTION

A 75-year-old man with a history of non-valvular atrial fibrillation anticoagulated on warfarin for the past 5 years without any prior complications presented to the emergency department with a cutaneous haemorrhagic lesion on his right lower limb, developed within the previous 24 h. There was no history of local skin lesion or trauma, and no infection or erroneous warfarin overdose.

Physical examination highlighted voluminous haematic phlyctena in the anterior, lateral surface of the right leg, surrounded by a large haematoma (figure 1A, B). Laboratory results revealed a supra therapeutic international normalised ratio (INR) (5.9), with no evidence of anaemia, nor of hepatic or renal abnormalities, and no signs of infection. A soft tissue ultrasound was performed revealing a large and heterogeneous haematoma of the local subcutaneous tissue, without muscular involvement, measuring 15×5 cm, compatible with the diagnosis of acute/subacute haematoma.

Drainage of the haematic phlyctena was then performed, as well as correction of INR with fitomenadione and human prothrombin complex. Self reabsorption of the haematoma was achieved in the following days, without further evidence of haemorrhagic complications. The patient was discharged on day 5 of admission and placed on dabigatran.

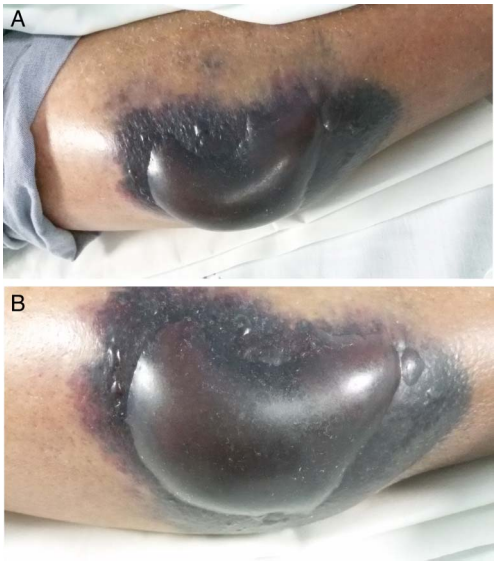

Figure 1 (A) Subcutaneous haematoma of the right leg with large haematic phlyctena; (B) detailed view of the lesion.

Despite decades of experience, warfarin still continues to be associated with haemorrhagic events.[1–3] It is estimated that in 1 year, up to 6.5% of patients on anticoagulant therapy will experience a major bleeding event affecting their soft tissue, gastrointestinal tract or urinary tract.[3] Approximately 1% of patients will develop a fatal bleed, often an intracranial haemorrhage.[3] As far as the authors are concerned, this is the first warfarin-related spontaneous subcutaneous tissue haematoma of the lower limb reported in the literature. Clinicians should be aware of sporadic fluctuations of INR, even if the warfarin scheme is accomplished and regular INR control performed. Large haematomas such as that being reported can be life threatening, thus correction of the underlying coagulation abnormalities and close monitoring of the patient should be assured.[1–3]

Learning points

- Despite prescription compliance and regular INR control, warfarin can be associated with spontaneous haemorrhagic events, even with moderately supratherapeutic INR.
- Correction of the coagulation disorder should be performed using fitomenadione, fresh frozen plasma or human prothrombin complex, with an individualised approach.
- Maintaining oral anticoagulation after a significant bleeding event is not consensual. However, novel oral anticoagulants could be a valid option after major bleeding, because of their shorter duration of action and new targeted antidotes.

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