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## Abdominal Mondor disease mimicking acute appendicitis

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## ABSTRACT

**INTRODUCTION:** Mondor disease (MD), a superficial thrombophlebitis of the thoraco-epigastric veins and their confluents is rarely reported in the literature. The superior epigastric vein is the most affected vessel but involvement of the inferior epigastric vessels or their branches have also been described. There is no universal consensus on treatment in the literature but most authors suggest symptomatic treatment with non-steroid anti-inflammatory drugs (NSAIDs).

**CASE REPORT:** We report the case of a marathon runner who presented with right iliac fossa pain mimicking the clinical symptomatology of an acute appendicitis. The history and the calculated Alvarado score were not in favor of an acute appendicitis. This situation motivated multiple investigations and we finally arrived at the diagnosis of MD.

**DISCUSSION:** Acute appendicitis (AA) is the most common cause of surgical emergencies and one of the most frequent indications for an urgent abdominal surgical procedure around the world. In some cases, right lower quadrant pain remains unclear in spite of US, CT scan, and exclusion of urological and gynecological causes, thus we need to think of some rare pathologies like MD.

**CONCLUSION:** MD is often mentioned in the differential diagnosis of breast pathologies but rarely in abdominal pain assessment. It should be mentioned in the differential diagnosis of the right lower quadrant pain when the clinical presentation is unclear and when acute appendicitis has been excluded. Awareness of MD can avoid misdiagnosis and decrease extra costs by sparing unnecessary imaging.

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## 1. Introduction

Mondor disease (MD) was first described by Henri Mondor in 1939 [1]. It is an uncommon condition which occurs mostly in the middle aged population and is three times more common in women than men [2,3]. It is characterized by superficial thrombophlebitis of the thoraco-epigastric veins and/or their confluents and mainly presents in the vessels of the anterolateral thoraco-abdominal wall which involves the superior epigastric vessels. There are cases of thrombophlebitis of the inferior epigastric vessels and veins of the

upper limbs [2]. This pathology can also rarely arise in the groin, arm, and axilla [4].

There are three classifications of MD. Type 1, involves the chest wall, Type 2 involves other venous districts, mainly the dorsal vein of the penis and Type 3 occurs after breast surgery [5].

It is a very rare condition where less than 500 cases have been reported in the literature [5]. It is underreported and underdiagnosed mainly because many patients do not seek medical attention as it is a benign and self-limited disorder [1]. There is no typical clinical presentation of this disease, however most of the reported cases present with a subcutaneous, tender, cord-like induration, where the overlying skin is freely mobile lacking inflammatory signs [1,3]. Some of these lesions are asymptomatic while others are extremely painful and cause severe discomfort [1]. Symptoms typically last from 6 to 8 weeks before complete resolution [2], but in some reported cases it can last up to 6 months [5]. There has been no evidence report of any long term sequelae as it is a benign self-limiting condition [2].

Diagnosis of Mondor disease is clinical, based on history and physical examination [2]. However ultrasound and Doppler ultrasonography may be necessary not only to confirm MD, but also to

**Abbreviations:** MD, Mondor disease; AA, acute appendicitis; CT, computed tomography; US, ultrasound; MRI, Magnetic Resonance Imaging; RLO, right lower quadrant; NSAIDs, non-steroid anti-inflammatory drugs.

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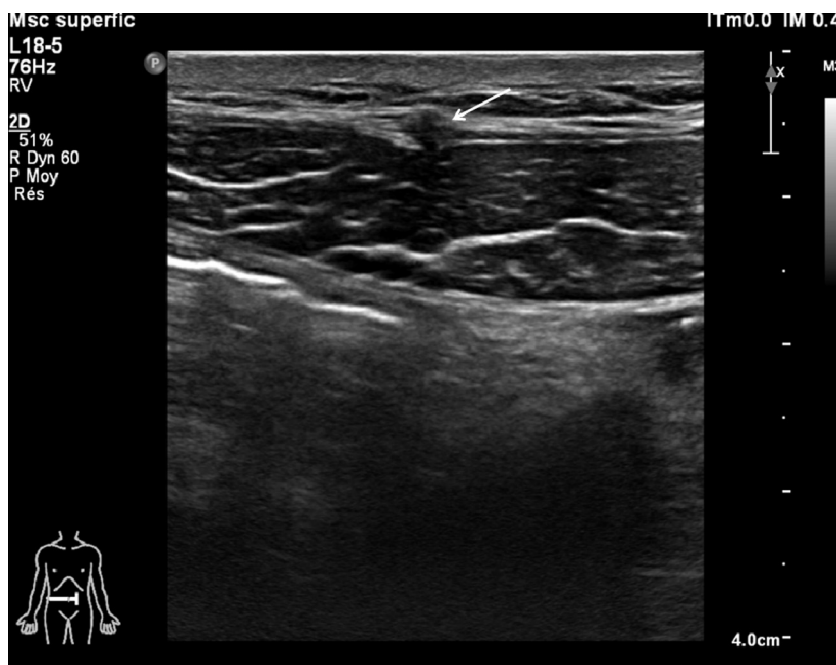


Fig. 1. Doppler US showing thrombophlebitis of the inferior epigastric veins superficial to the rectus abdominis muscle on the right.

exclude other differential diagnoses such as presence of an underlying compressing mass [1].

We discuss a case of an abdominal MD who presented right lower quadrant pain and clinical manifestation that mimicked an acute appendicitis. This case report highlights the difficulty to diagnose such a condition due to its rare entity.

## 2. Case report

A 46 year old male patient, marathon runner, presented to our Emergency Department with localized right lower quadrant pain (RLQ) of one week duration. The only past surgical intervention was an orchidopexy during childhood for right undescended testis.

The main complaints of the patient were excruciating RLQ pain mainly when seated and in upright positions. The symptoms were exacerbated with body movements but relieved only in supine position. The other associated symptoms were nausea.

Clinical examination revealed guarding and rigidity at the Mc Burney point. There was rebound tenderness and a positive psoas sign. The Rovsing sign was negative. There were neither palpable masses nor any cutaneous lesions. The patient felt pain on active and passive flexion above 90° on examination of the right hip; however no pain was reproduced on internal and external rotation. Neurological exam was normal.

Laboratory findings were within the normal range except for a mild isolated elevation of the CRP of 12.5 mg/l. The calculated Alvarado score was 4 [6,7]. Due to uncertainty of the diagnosis, a standard intravenously enhanced CT scan was performed without any abnormality detected. It also ruled out the classic differential diagnoses of right lower quadrant pain.

The patient was hospitalized for monitoring and pain management with non-steroid anti-inflammatory agents (NSAIDs). There was no improvement even when the daily laboratory investigations showed no inflammatory or infectious processes. Due to the exacerbating, movement dependent right lower quadrant pain (RLQ), a Magnetic Resonance Imaging (MRI) of the lumbar spine was performed and a specialized opinion of the neurologist was obtained.

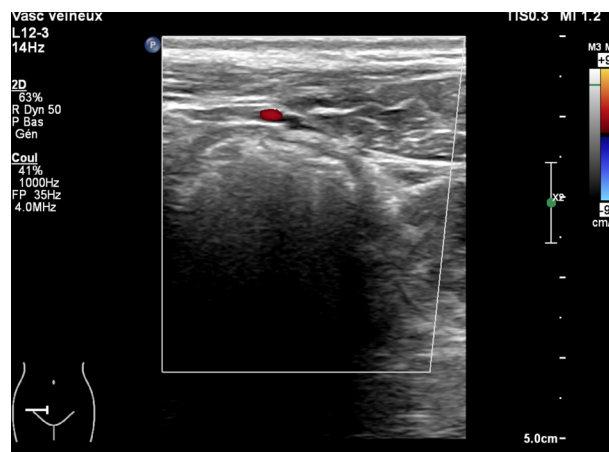


Fig. 2. Follow up US was performed 11 weeks later and showed a complete resolution of the thrombophlebitis.

The imaging and neurological assessment revealed no neurological pathologies.

Finally an abdominal Doppler US showed a thrombophlebitis of the inferior epigastric veins superficial to the rectus abdominis muscle on the right (Fig. 1). The patient was hospitalized for a total of 10 days and was discharged home after he regained near-normal mobility.

A follow up US was performed 11 weeks later and showed a complete resolution of the thrombophlebitis (Fig. 2). The patient's symptoms, however, persisted for 5 months after initial presentation. There was no recurrence during one year follow up and the patient resumed his marathon runs without any handicap.

## 3. Discussion

Right lower quadrant pain is a frequent complaint observed in the emergency department with appendicitis as the most featured

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