Incidence of Deep Venous Thrombosis in Patients with Erysipelas of the Leg: Prospective Study of 30 Cases in an Emergency Department

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\section*{Introduction}

Erysipelas is a non-necrotizing dermo-hypodermatitis mainly caused by \textit{Streptococcus pyogenes}. It occurs in 10–100 cases per 100,000 people per year \cite{1}. This incidence is increasing despite the control of streptococcal infections \cite{2}: 2 French studies \cite{3, 4} described a progressive increase in the yearly number of hospitalizations for erysipelas between 1978 and 1991 and between 1959 and 1995. A recent study \cite{5} showed that the yearly age-standardized incidence of erysipelas increased from 1.88 per 1,000 patients in the years 1994–1995 to 2.49 in 2003–2004 in primary care in Flanders and the northern part of Belgium. The diagnosis of erysipelas is made clinically in the presence of an acute inflammatory plaque characterized by 2 features: the lesions are raised above the level of the surrounding skin, and there is a clear line of demarcation between involved and uninvolved tissue \cite{6}. Other local signs such as lymphangitis or adenopathy and general signs like fever and hyperleucocytosis can be associated. Bacteriologic examinations are not helpful because of the low sensitivity of blood culture and stan-
is given orally. For in-house patients, penicillin G is prescribed by intravenous route (oral Pyostacine in the case of allergy), and a prophylactic anticoagulation by low-molecular-weight heparin is also administered. In case of a confirmation of DVT, low-molecular-weight heparin with a curative dose is given in combination with vitamin K antagonist (VKA): acenocoumarol (Sintrom®).

Results

Thirty patients were enrolled (12 males/18 females), with a mean age of 61.7 ± 15.3 years. Nineteen patients were hospitalized and 11 treated as ambulatory patients. Three DVT cases, homolateral to erysipelas, were diagnosed among hospitalized patients (2 males/1 female), affecting the posterior tibial vein in 2 patients and extending from the inferior third of the superficial femoral vein to the popliteal vein in 1 patient. The Wells score [11] was high in 6 patients, moderate in 10 patients and low in 14 patients (table 1).

The mean age and inflammation markers (C-reactive protein, D-dimers and leucocytes) did not differ significantly in hospitalized patients with or without DVT.

Two asymptomatic bilateral subsegmental pulmonary embolisms (PEs) were diagnosed among the 3 patients with DVT: CT arteriography was normal, but the ventilation-perfusion scanning revealed bilateral subsegmental defects of perfusion with normal ventilation.

The patient without PE underwent oral anticoagulation during 3 months with VKA, then stopped after a DVCUS control showing a total permeability of the posterior tibial vein. For the 2 other patients, VKA was continued during 8 and 12 months, respectively, and then stopped after the ventilation-perfusion scanning control showed improvement.

Discussion

Erysipelas brings about a favourable environment to thrombosis because of the initial bedridden state, disturbance of coagulation with superficial micro-thrombosis and local fibrin deposition mentioned by Hammar et al. [12] and also because of the underlying disease (congestive heart failure, venous insufficiency). In an open study, these authors showed that fibrinolysis is decreased; fibrinogen and activities of several plasma serine proteinases involved in coagulation were increased during the initial course of erysipelas and even at follow-up.

The incidence of DVT in patients with lower limb erysipelas in our study was 10%. There are few studies where
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DVT was systematically looked for (table 2): Mahe et al. [13], in a series of 40 patients admitted to the internal medicine department with the diagnosis of erysipelas and explored by systematic DVCUS within the first 48 h, found 6 DVT homolateral to erysipelas, which is an incidence of 15%. Lindblad et al. [14] performed a $^{125}$I-fibrinogen uptake test for the diagnosis of DVT in 43 patients with erysipelas of the leg. The test was positive in 16 patients, and only 11 patients had confirmation by phlebography. Three DVT cases were diagnosed, but the authors admit the low specificity of the $^{125}$I-fibrinogen uptake test for the diagnosis of DVT in the setting of erysipelas. Jeune [15] explored 10 patients with systematic phlebography, and no DVT was found. Finally, Perrot et al. [16] reported a larger series of 155 patients explored by a systematic DVCUS at admission and at discharge from the hospital: 1 DVT is diagnosed at admission and 3 at discharge, 2/3 contralateral to erysipelas. Two asymptomatic PEs were diagnosed by ventilation-perfusion scanning.

The Wells score [11] allowed the identification of patients at high risk of thromboembolism. Indeed, no DVT was diagnosed in moderate- or low-risk patients.

Plasma dosage of D-dimers (ELISA method) shows positive values in all our patients (>500 ng/ml) regardless of the presence of DVT, acting rather as a marker of the inflammation and the infection process. Mazzolai et al. [17] also concluded that D-dimer testing is not recommended for the exclusion of DVT in out-patients with lower limb erysipelas.

The confirmation of DVT in our patients (2 distal and 1 proximal DVT) was made by colour Doppler vein exploration with a study of the compressibility with ultrasonics (US). In fact, the diagnostic accuracy of US for DVT varies according to the technique used [18]. In the United States, Canada and the Netherlands, the examination is limited to proximal veins and often limited to US compression only. In France, Italy and Spain, the exploration is complete and includes distal and proximal veins, and US compression is often associated with colour Doppler exploration. A recent meta-analysis [19] identified 100 cohorts comparing US with venography in patients with suspected DVT and established its diagnostic performance with regard of the technique used and the localization of DVT (table 3).

The specificity of the technique employed for our patients is satisfactory; however, the sensitivity, especially in the sub-popliteal veins, is less optimal. This fact could lead us to under-estimate the incidence of DVT in our patients, but clinical follow-up during hospitalization and after discharge did not confirm this hypothesis.

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**Table 2.** Incidence of DVT in patients with lower limb erysipelas

<table>
<thead>
<tr>
<th>Reference</th>
<th>Year</th>
<th>Patients</th>
<th>DVT</th>
<th>DVT, %</th>
<th>Exploration method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lindblad et al.</td>
<td>1988</td>
<td>43</td>
<td>3</td>
<td>6.9 (1.5–19.1)</td>
<td>$^{125}$I-fibrinogen uptake test ± phlebography</td>
</tr>
<tr>
<td>Mahe et al. [13]</td>
<td>1992</td>
<td>40</td>
<td>6</td>
<td>15 (5.7–29.8)</td>
<td>DVCUS</td>
</tr>
<tr>
<td>Jeune [15]</td>
<td>1991</td>
<td>10</td>
<td>0</td>
<td>0 (0.0–30.9)</td>
<td>phlebography</td>
</tr>
<tr>
<td>Perrot et al. [16]</td>
<td>2001</td>
<td>155</td>
<td>4</td>
<td>2.6 (0.7–6.5)</td>
<td>DVCUS</td>
</tr>
<tr>
<td>Our study</td>
<td>2008</td>
<td>30</td>
<td>3</td>
<td>10 (2.1–26.5)</td>
<td>DVCUS</td>
</tr>
</tbody>
</table>

Figures in parentheses are 95% confidence intervals. Ponderated incidence with 95% confidence interval: 5.8% (3.3–9.2).

**Table 3.** Sensitivity and specificity stratified by US technique [19]

<table>
<thead>
<tr>
<th></th>
<th>Sensitivity, %</th>
<th>Specificity, %</th>
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<tbody>
<tr>
<td></td>
<td>all DVT</td>
<td>proximal DVT</td>
</tr>
<tr>
<td>Compression only</td>
<td>90.3 (88.4–92.0)</td>
<td>93.8 (92.0–95.3)</td>
</tr>
<tr>
<td>Colour Doppler</td>
<td>81.7 (77.4–85.5)</td>
<td>95.8 (85.7–99.5)</td>
</tr>
<tr>
<td>Compression plus colour Doppler</td>
<td>91.1 (89.0–93.0)</td>
<td>96.4 (94.4–97.9)</td>
</tr>
</tbody>
</table>

Figures in parentheses are 95% confidence intervals.
Conclusion

The incidence of DVT in patients with lower limb erysipelas is 10% in our study. The combination of clinical evaluation of DVT probability and the exploration by DVCUS refines the diagnosis and the management. As a matter of fact, DVT should be considered in patients with erysipelas of the lower limb having a high pretest clinical probability, but larger studies are needed to confirm this result.

References