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Acute Upper Limb Ischemia as the First Manifestation in a Patient with COVID-19

Authors:

Tony Shao¹, MD; Christina In-Bok Lee², BS; Sinan Jabori³, BS; Jorge Rey⁴, MD; Elizabeth Ramos Duran⁵, MD; Naixin Kang⁶, MD.

Affiliations

¹-⁶ Division of Vascular & Endovascular Surgery, University of Miami, Miami, Florida, United States.

Corresponding Author:

Tony Shao¹, MD.

1321 NW 14th St, Suite 600. Miami, Fl. 33125

Email: tony.shao@jhsmiami.org

Post-publication Corresponding Author:

Naixin Kang⁶, MD.

1321 NW 14th St, Suite 600. Miami, Fl. 33125

Email: nxk315@med.miami.edu

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Conflict of Interest:

¹-⁶ No conflict of interest.
Abstract:
Coronavirus disease 19 (COVID-19) first emerged in December 2019 in China and rapidly spread worldwide. While various studies have reported that COVID-19 is associated with a hypercoagulable state and thrombotic complications in critically ill patients, there are scant case reports on thrombotic events as one of the presenting symptoms. We report a case of acute upper extremity ischemia as the initial clinical presentation of a COVID-19 patient.
Introduction:
The novel coronavirus first emerged in December 2019 in China and is now classified as a pandemic. According to a report from the Chinese Center for Disease Control and Prevention, up to 19% of the confirmed cases in China were classified as severe or critical.\(^1\) In spite of COVID-19 being initially a respiratory infection, multiple case reports globally have demonstrated various complications, including cardiovascular complications, liver failure, and renal insufficiency.\(^2\)–\(^7\) Studies have revealed markedly elevated D-dimer and fibrinogen degradation product (FDP) in this group of patients, which suggest this infection can lead to procoagulant states and thrombotic events.\(^8\)–\(^9\) In appraising the current body of literature, a number of studies have described the link between critically ill COVID-19 patients and hypercoagulable states. However, there are scant reports that highlight acute thrombotic events at initial presentation. We believe that clinicians should be aware of the possibility of acute thrombotic events being one of the initial symptoms of this infection. In this report, we describe an unusual case of a patient who presented with acute unilateral upper extremity ischemia who was diagnosed with COVID-19. Consent was obtained from the patient for publication.

Case Report:
The patient is a 67-year-old male with no significant medical history that presented to the emergency room with a chief complaint of worsening right hand and forearm pain. He also reported mild shortness of breath and cough for three days. His distal forearm and hand were cold and mottled with motor and sensory loss on physical examination (Figure 1). His axillary pulse was palpable however his brachial, radial and ulnar pulses were absent. His laboratory tests
were only remarkable for leukocytosis and elevated D-dimer. A computed tomography
angiogram (CTA) of the chest and right arm showed extensive patchy ground-glass opacities
throughout bilateral lungs and an occlusion of the brachial artery at the level of the mid-humerus
with no reconstitution of any vessels distally (Figure 2). A rapid PCR test for COVID-19
confirmed active infection. Anticoagulation was initiated and he was taken to the operation room
for emergent revascularization. Upon exploration, the brachial, radial and ulnar arteries were
completely thrombosed. Embolectomies were performed via incisions at the antecubital fossa
and the wrist. The arteries were noted to be healthy with no appreciable atherosclerotic disease.
A significant amount of dark, acute appearing thrombus was retrieved. Palpable pulses were
achieved; however the digits still appeared ischemic. Therefore, thrombolysis was performed by
injecting alteplase directly into the radial and ulnar arteries. Palpable brachial, radial and ulnar
pulses as well as doppler signal of the palmar arch were present at completion. Forearm and hand
fasciotomies were performed and the muscles were all viable. The patient remained intubated
and recovered in the intensive care unit (ICU). Postoperatively, the patient maintained palpable
radial and ulnar pulses on full anticoagulation; however three digits remained non-viable. The
remaining digits were viable along with the palm and forearm (Figure 3). A work-up for
hypercoagulability and source of embolism was performed (Table 1). The only positive test was
the lupus anticoagulant panel. However, the patient was on a direct thrombin inhibitor when the
test was sent, which can affect the reliability of the results. During the course of hospitalization,
he was diagnosed with subsegmental pulmonary embolism. This may have occurred during a
three day period when anticoagulation was held due to concerns of gastrointestinal bleeding.
Two months after surgery, the patient had well demarcated dry gangrene of his 1st, 4th and 5th
digits with preserved motor and sensory function of his hand. At the time of publication, the
patient remained on full anticoagulation with the plan to discontinue it after 3 months to allow further work-up for hypercoagulability.

Discussion
The current body of literature has been focused on the severe to critical cases of COVID-19 and their association with hypercoagulability and risk of thrombotic events. Chuen et al. found that the critically ill cases had substantially elevated clot waveform analysis (CWA) parameters, which indicates hypercoagulability. Klok et al. presented a 31% incidence of thrombotic complications in (ICU) patients with COVID-19 demonstrating that the infection may predispose patients to both venous and arterial thrombosis. Zhang et al. reported seven ICU cases of COVID-19 patients who subsequently developed marked cyanosis and gangrene of the digits. Our case is unique as the patient presented with acute limb ischemia as an initial symptom of COVID-19, unlike those who were already admitted to the ICU and subsequently developed thrombotic events. There was no discernible cause of in-situ thrombosis in this case other than COVID-19 infection. Our patient demonstrates that thrombotic events can be one of the early presenting symptoms. Li et al. postulated that around 7-14 days after onset of symptoms, the virus starts a second attack which leads to developing a hypercoagulable state. However, our case speculates that regardless of the severity or duration of symptoms, COVID-19 can lead to a hypercoagulable state.

The pathophysiology of thrombotic events in the context of COVID-19 is not completely understood. Recent studies have focused on outlining the mechanism of microthrombotic lesions. Currently, there are no studies on the pathogenesis of thrombosis in medium sized vessels as
seen in our patient. One potential contributing factor found in our patient is the presence of antiphospholipid antibodies versus a cytokine storm. Our patient had elevated levels of anticardiolipin IgM antibodies and a positive lupus anticoagulant panel, along with elevated levels of fibrinogen and D-dimer. Previous studies have reported the possibility of developing antiphospholipid antibodies following viral infections. A recent case report by Zhang et al. also observed the presence of anticardiolipin antibodies along with elevated levels of fibrinogen and D-dimer in three ICU patients with limb ischemia.\textsuperscript{14}

Due to the acuity and severity of ischemia, our patient required emergent surgery. The post-operative anticoagulant treatment the patient received was therapeutic intravenous unfractionated heparin (UFH) infusion which was then switched to argatroban due to concerns of developing heparin induced thrombocytopenia. There is currently no consensus on anticoagulating COVID-19 patients prophylactically to prevent arterial thrombotic events. The current pharmacological anticoagulant therapy recommendations for COVID-19 cases are focused on venous thromboembolism (VTE) prophylaxis, but it is recommended that these guidelines should be considered and applied to arterial thrombotic prophylaxis.\textsuperscript{15} The World Health Organization (WHO) recommends only prophylactic doses of low molecular weight heparin (LMWH) daily or subcutaneous UFH twice daily for VTE prophylaxis in critically ill COVID-19 patients.\textsuperscript{15-16} Tang et al. showed that anticoagulant treatment with LMWH is associated with better prognosis in severe COVID-19 cases with elevated D-dimer and a sepsis-induced coagulopathy (SIC) score \textsuperscript{\geq 4}.\textsuperscript{17} Given the potential benefit of antithrombotic therapy, some hospital systems have implemented protocols that treat critically ill COVID-19 patients with empiric full anticoagulation.
Data regarding the role of pharmacologic prophylaxis for asymptomatic or mild COVID-19 cases in quarantine is limited. One may consider prescribing prophylactic dosage of anticoagulation for COVID-19 patients who are not hospitalized; in effort to prevent thrombotic events.

Conclusion

In conclusion, acute thrombotic events are a serious and potentially life-threatening complication associated with COVID-19 patients. Providers must be vigilant in identifying these events and initiate appropriate treatment. Further studies on the use of empiric anticoagulation on select COVID-19 patients are warranted.
References


Legends

**Figure 1.** Clinical presentation of the upper extremity acute limb ischemia.
Palmar view with discoloration of the hand and digits.

**Figure 2.** Diagnostic Images.
Computed tomography of the chest demonstrating extensive peripheral patchy ground-glass opacities throughout bilateral lungs.

**Figure 3.** Postoperative examination.
Palmar view of the hand showing three non-viable digits.

**Table 1.** Hypercoagulable and embolic work-up.
Various tests performed to identify the cause of this patient’s acute limb ischemia.
<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lupus anticoagulant panel</td>
<td>Positive</td>
</tr>
<tr>
<td>Homocysteine level</td>
<td>Normal</td>
</tr>
<tr>
<td>Anticardiolipin antibodies</td>
<td>Negative</td>
</tr>
<tr>
<td>Factor 5 Leiden mutation</td>
<td>Negative</td>
</tr>
<tr>
<td>Serotonin assay</td>
<td>Negative</td>
</tr>
<tr>
<td>Antithrombin 3 activity</td>
<td>Normal</td>
</tr>
<tr>
<td>Protein C activity</td>
<td>Normal</td>
</tr>
<tr>
<td>Protein S activity</td>
<td>Normal</td>
</tr>
<tr>
<td>Echocardiogram</td>
<td>Negative for patent foramen ovale</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>Negative for arrhythmia</td>
</tr>
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