



Scientific letter

Mondor disease in male: An infrequent clinical entity[☆]



Enfermedad de Mondor en el varón: una entidad clínica poco frecuente

Thrombophlebitis of the superficial epigastric vein, or Mondor's disease, is a rare clinical entity¹. It is characterized by the presence of a fibrous cord in the veins of the anterolateral chest wall. It was defined by the French surgeon Henri Mondor in 1939, although similar cases had already been documented in the 1850s². It characteristically occurs in women of around 35 years of age, and documented cases in males are between 3 and 14 times less frequent.

We present the case of a 40-year-old man with no relevant medical history, who presented pain and bruising after mild trauma to the chest (impact with the stair handrail) in the area of said contusion after two days. Seven days later, the patient began to notice a fibrous cord in the anterolateral area of the left hemithorax, which became more evident upon exertion or when raising his arms. At that time, he consulted with his Primary Care physician, who referred him to the Emergency Department, where we assessed the patient for the first time. On physical examination, this fibrous cord was notable, painful to the touch, and showed minimal accompanying ecchymosis (Figs. 1 and 2). The remainder of the physical examination was within normal limits. Routine lab work-up was ordered, and all parameters were within reference values. Given the clear recent trauma injury, other initial tests were ruled out, anti-inflammatory treatment was initiated, and relative rest was prescribed. The patient's symptoms improved progressively until their complete resolution 12 weeks later.

Mondor's disease is a rare entity that has an approximate incidence of 0.5%–1%, although the actual percentage could be higher since the documented cases are symptomatic^{1,2}.

Superficial vein thrombophlebitis could be grouped into three groups: thoracoepigastric, axillary and penile^{2,4}. Although there are idiopathic forms of presentation, there are also several factors that can cause this disease^{5,6}, including: tumors, strenuous exercise, trauma, surgical manipulation and infections, etc.⁷.

The diagnosis is clinical in most cases, and its course is self-limiting. When there is a clear history that justifies the condition,

symptomatic treatment can be performed; if this does not improve or resolve the symptoms in a short period of time, diagnostic tests should be started. The most commonly used studies for the diagnosis of Mondor's disease are ultrasound, magnetic resonance or even biopsy of the lesion³. In the case of women, a mammogram is recommended to rule out tumor pathology. Depending on the location of the fibrous cord (thoracic, axillary or penile), the most important differential diagnoses should be considered, and specific tests for each should be conducted when there is a high index of suspicion.

The treatment of Mondor's disease is symptomatic and based on the administration of NSAIDs, usually resulting in spontaneous resolution of the condition between 4 and 12 weeks later^{2,3}. There is controversy regarding the use of



Fig. 1 – Photo of the patient within a few days of presentation, with slight visualization of the lesion.

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Fig. 2 – Photo of the patient with arms raised, in which the lesion is more evident and a minimal hematoma is observed in the contusion area.

thromboprophylaxis in these cases, although in general it is only indicated if the patient has underlying disease that justifies it³. Different specific approaches may be advisable depending on the etiology and location of the clinical symptoms, such as physiotherapy in the case of axillary thrombophlebitis after surgery^{8,9}. When the presentation is secondary, the baseline disease should also be treated.

In short, we could say that Mondor's disease is a rare, self-limiting clinical entity, with a varied spectrum of presentation. Its course is usually benign and requires only symptomatic treatment. It is vitally important to consider the multiple forms of presentation of this disease, as it will be included in the differential diagnosis of very varied pathologies.

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Virginia Ramos Pérez*, Miguel Lamas López, Rubén Darío Arias Pacheco, Germán Mínguez Ruiz, Berta Martín Rivas

Hospital Universitario San Agustín, Avilés, Spain

*Corresponding author: virginiaramosperez@gmail.com (V. Ramos Pérez).

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Unusual technical resource in an urgent abdominal panniculectomy in a super-obese patient[☆]



Recurso técnico inusual en una panniculectomía abdominal urgente en paciente superobeso

Any surgery in morbidly obese patients is associated with a higher incidence of complications, such as deep vein

thrombosis, pulmonary thromboembolism, pneumonia, fat necrosis, and wound dehiscence¹. For these reasons, these

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