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EJVES Extra Abstracts☆

Failure of Sweat Gland Curettage to Relieve Axillary Hyperhidrosis: A Salutary Lesson

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Introduction: Several treatment options are available for primary hyperhidrosis. Selection for individual patients is influenced by symptom severity, success rates and the relative risk of compensatory hyperhidrosis.

Case report: A 24-year-old female presented with a 10-year history of palmar, pedal and axillary hyperhidrosis. Following recurrent relapse after botulinum toxin (BOTOX®) injections for axillary hyperhidrosis bilateral axillary sweat gland curettage was performed with immediate procedural success. At 6 month follow-up recurrent hyperhidrosis was reported affecting both axillae. A starch-iodine test showed a rim of persisting sweating at the periphery of both axillae.

Discussion: Curettage is generally performed without specific identification of sweat gland distribution, perhaps explaining the recurrence in this patient. In contrast, a starch–iodine test is used to guide administration of BOTOX® for hyperhidrosis. We propose pre-operative use of this technique before axillary curettage.

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A Case of Iatrogenic Ilio-iliac Arteriovenous Fistula Initially Mistaken for Deep Venous Thrombosis

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Deep venous thrombosis (DVT) and associated complications cause significant morbidity and mortality in orthopedic surgery. Typical DVT symptoms, such as swelling, pain and discoloration in the affected extremities are often unreliable for diagnosis. Here we report a rare case of iatrogenic ilio-iliac arteriovenous fistula (AVF) due to lumbar discectomy, which was initially misdiagnosed as DVT, resulting in unnecessary implantation of a permanent inferior vena cava filter. Endovascular treatment is an attractive treatment option for such an AVF. We recommend a thorough physical and ultrasonography for patients presenting with DVT-like symptoms, especially following lumbar spinal surgery, to prevent overlooking underlying AVF.

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