A 28-year-old previously healthy man presented with a 5-year history of recurrent painful subcutaneous nodules in varying locations, including both legs, left foot, hand, and groin. He initially spontaneously developed a 1-cm nodule in his right calf that progressed over 2 days to 4 cm in length and then resolved, with the entire episode lasting 5 days. The patient reported >10 similar events occurring once every few weeks in different locations. He denied tobacco use. There was no family history of venous thromboembolism. Examination revealed a mildly erythematous and tender nodular cord in the patient’s right upper leg (Figure 1).

An extensive workup for thrombophilia, malignancy, and rheumatologic disease was unrevealing. Biopsy of the affected vein showed thrombotic occlusion with microabscesses and multinucleated giant cells and an extensive inflammatory cell infiltration into the intima and thrombus (Figure 2). The patient’s biopsy results were consistent with the clinical suspicion of thromboangiitis obliterans or Buerger disease, a segmental inflammatory disease with formation of thrombi that most commonly affects small to medium blood vessels. Although arteries are most commonly involved, veins also can be affected. The cause and pathogenesis of Buerger disease are not fully understood, but tobacco exposure is often considered essential for the diagnosis and progression of the disease. A few cases associated with cannabis use have been reported.1

Further questioning of our patient revealed that he smokes cannabis. Episodes of superficial thrombophlebitis were particularly frequent and pronounced when he smoked cannabis as blunts (made from shells of cigars in which the tobacco fillers are replaced with cannabis) and mixed cannabis with tobacco. A switch to smoking pure cannabis with a water pipe reduced the frequency and severity of episodes. Cannabis cessation was recommended. The patient stopped smoking for 1 year and remained asymptomatic during that period. On follow-up, he reports experiencing recurrent episodes of superficial thrombophlebitis after having resumed water-pipe smoking of pure cannabis. He now consumes ≈0.25 g cannabis per session, smoking between 4 to 10 times per day; that is, consuming 1 to 2.5 g daily.

The main routes of administration of cannabis include smoking blunts or joints (with or without tobacco), smoking or inhaling with a water pipe (with or without tobacco), and swallowing.2 Smoking cannabis and tobacco in combination is common worldwide, and this practice may also be growing in popularity in the United States.2,3 Unlike our case, the majority of reports on cannabis use and Buerger disease describe patients with concomitant tobacco use. Another unusual aspect of our patient’s presentation is his venous involvement; the current literature primarily offers evidence of “cannabis arteritis.” In conclusion, the case illustrates a cause of superficial thrombophlebitis that clinicians may not normally take into account but, given the prevalence of cannabis use, is worth considering.

Disclosures

None.

References

Figure 1. The patient’s right upper leg revealing an erythematous and tender nodular cord.

Figure 2. A, Low-power view (hematoxylin and eosin stain, ×10 magnification) revealing an intraluminal thrombus and an extensive inflammatory cell infiltration into the intima and thrombus. B, High-power view (hematoxylin and eosin stain, ×60 magnification) of the vessel lumen showing microabscesses and a multinucleated giant cell within the thrombus. C, High-power view (hematoxylin and eosin stain, ×60 magnification) showing that the vessel wall is essentially intact. Findings are consistent with thromboangiitis obliterans.
Migratory Superficial Thrombophlebitis in a Cannabis Smoker
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