**TABLE 2** Risk factors associated with VTE

| Patient's Risk Factors | | Thrombosis Risk Factor | |
|---|---|---|---|
| Cancer | 4 (19.0%) | Immobilization | 9 (42.8%) |
| Gastrointestinal | 2 (9.5%) | Infection | 14 (66.7%) |
| Congenital Heart Disease | 2 (9.5%) | Surgery or Intravascular procedure | |
| Kidney Disease | 2 (9.5%) | ICU | 8 (38.1%) |
| Neurological Disease | 1 (4.8%) | CVC | 13 (61.9%) |
| Others | 3 (14.3%) | | 10 (47.6%) |

**Conclusions**: Preliminary data from the first Brazilian VTE pediatric registry indicate it is prevalent among hospitalized children, and largely associated to CVC.

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## PB0806 | A Prospective Data Collection Utilizing the International Pediatric Thrombosis Network (IPTN) to Understand the Epidemiology for the Development of Neonatal Renal Vein Thrombosis

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**Background**: Renal vein thrombosis is the most prevalent non-catheter associated neonatal thrombosis. Macroscopic hematuria, palpable abdominal mass, and thrombocytopenia are cardinal symptoms with prematurity, perinatal asphyxia, and inherited thrombophilia identified as common risk factors. Despite this knowledge, the epidemiology of neonatal renal vein thrombosis (nRVT) is still not completely understood and optimal management strategies are unclear.

**Aims**: We aimed to collect prospective international data to clarify the epidemiology and risk factors associated with nRVT and to describe appropriate management strategies, understand long term renal sequelae and identify risk factors for recurrent nRVT.

**Methods**: The International Pediatric Thrombosis Network (IPTN) registry was used to collect prospective data on nRVT including thrombosis characteristics, presenting symptoms, risk factors, and management.

**Results**: Three patients (two females) have been described in the registry. All were born prematurely, with gestational ages of 27, 33, and 35 weeks, had macroscopic hematuria as their only symptom, and were diagnosed by doppler ultrasound. Two patients had right nRVT with one having inferior vena cava extension, and one had a left nRVT. Two were treated with therapeutic anticoagulation for at least 3 months. The right nRVT without IVC extension had a history of a previous venous thromboembolism, recurrence in the contralateral renal vein and was treated with therapeutic anticoagulation for 8 months. Thrombophilia testing for this patient was unremarkable. The two right nRVT had renal atrophy at one year follow up.

**Conclusions**: Neonatal RVT are rare events with variable clinical characteristics and management strategies. An international registry to collect data could optimize the ability to understand nRVT risk factors and appropriate management approaches. Encouraging the international pediatric thrombosis community to utilize the IPTN (https://redcap.isth.org/surveys/?s=FPEDLXEF9A) to collect patient data would aid in the development of much needed international guidelines for nRVT management.

## PB0807 | A Case of a Pediatric Patient with Protein S Heerlen Polymorphism and Deep Venous Thrombosis

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**Background**: Hereditary Protein S (PS) deficiency is an autosomal dominant disorder with increased risk of venous thromboembolism (VTE), prevalent in 0.5% of the general population. The PS Heerlen polymorphism is a rare mutation at codon 501 of the PS gene that was initially considered a variant of uncertain significance but has since been shown to have a reduced levels of free PS.

**Aims**: Description of PS Heerlen polymorphism in an adolescent with deep venous thrombosis.

**Methods**: Collection of clinical data from Hamilton Health Sciences Medical record.

**Results**: A female patient, 14-year-old, presented with history of left lower leg fullness was diagnosed with deep vein thrombosis. The patient recently had prolonged airline travel and was using combined oral contraceptives. Anticoagulation with low molecular weight heparin was initiated. MRI venogram showed a narrowed left common iliac vein with mild compression of the proximal left common iliac vein by right common iliac artery, consistent with May Thurner syndrome. After 9 months of anticoagulation, a pro-thrombotic work up was initiated, including antithrombin III, protein C, Factor V Leiden, anticardiolipin antibodies, prothrombin gene mutation, which were normal. Free PS was decreased, 0.60 U/mL (some pediatric ranges reported, but not established). Peripheral blood was sent for DNA