Early results of venous stenting when there are no healthy landing zones in thrombophilic patient.

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Introduction
The endovenous treatment of iliocaval obstruction includes traversing the obstruction with a guide wire, balloon angioplasty followed by placement of a stent to cover the obstructed vein segment. Stenting should be performed from healthy to healthy venous segments, but in real life this is not always available.

Patient and methods
Our patient is a 38-year old female with edema of both lower limbs and recurrent active venous ulcer (C6) of the right side for 2 years with failure of 3-month compression therapy. She had previous attack of iliofemoral DVT 15 years ago that was managed by anticoagulation. Her laboratory investigations showed thrombophilia in the form of hyperhomocysteinemia and elevated anti-cardiolipin antibodies. Direct MSCT-venogram showed occlusion of the IVC and the iliac systems on both sides with engorged pelvic veins. Endovascular treatment was performed with venous stenting from the suprarenal IVC to the EIV on both sides by extended double barrel configuration. The patient is on dual antiplatelet, DOAC and folic acid 5mg/day.

Results
At 1-month follow-up; direct MSCT-venogram showed patent stents, 1 of 3 of the venous ulcers healed. She had no residual edema of both legs. At 4-month follow-up; patent stents by DUS, 2 of the 3 venous ulcers healed and the last one is regressing. No postoperative complications were seen.

Conclusions
- Venous stenting still performing good even when there are no healthy landing zones.
- Intermittent pneumatic compression during and after the procedure is crucial.
- Graduated compression elastic stocking is mandatory thereafter.
- Hypercoagulability should always be tackled.