



An impenetrable venous cto

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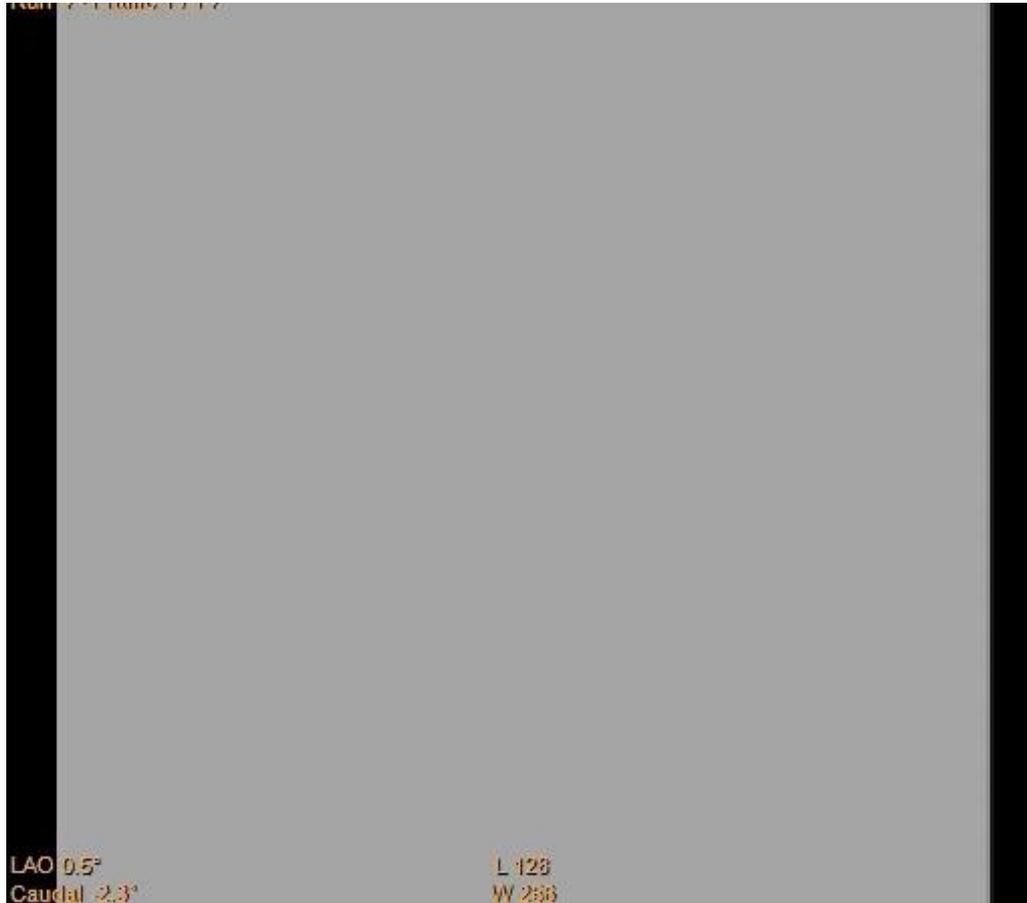
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- 55 Year old, no co-morbidities
- Long standing bilateral pedal oedema with pigmentation and varicosities
- Dilated tortuous superficial veins on anterior abdominal wall flowing from below upwards
- CT Venogram: Chronic total occlusion of supra-hepatic IVC
- Planned for venoplasty plus stenting

Venograms



Cavograms showing complete occlusion of IVC at IVC-RA junction

Venoplasty



Repeated attempts at crossing with straight and angled 0.035 glidewire over JR and multi-purpose from below and above unsuccessful, Hard end of glidewire too didn't cross from any side

Venoplasty

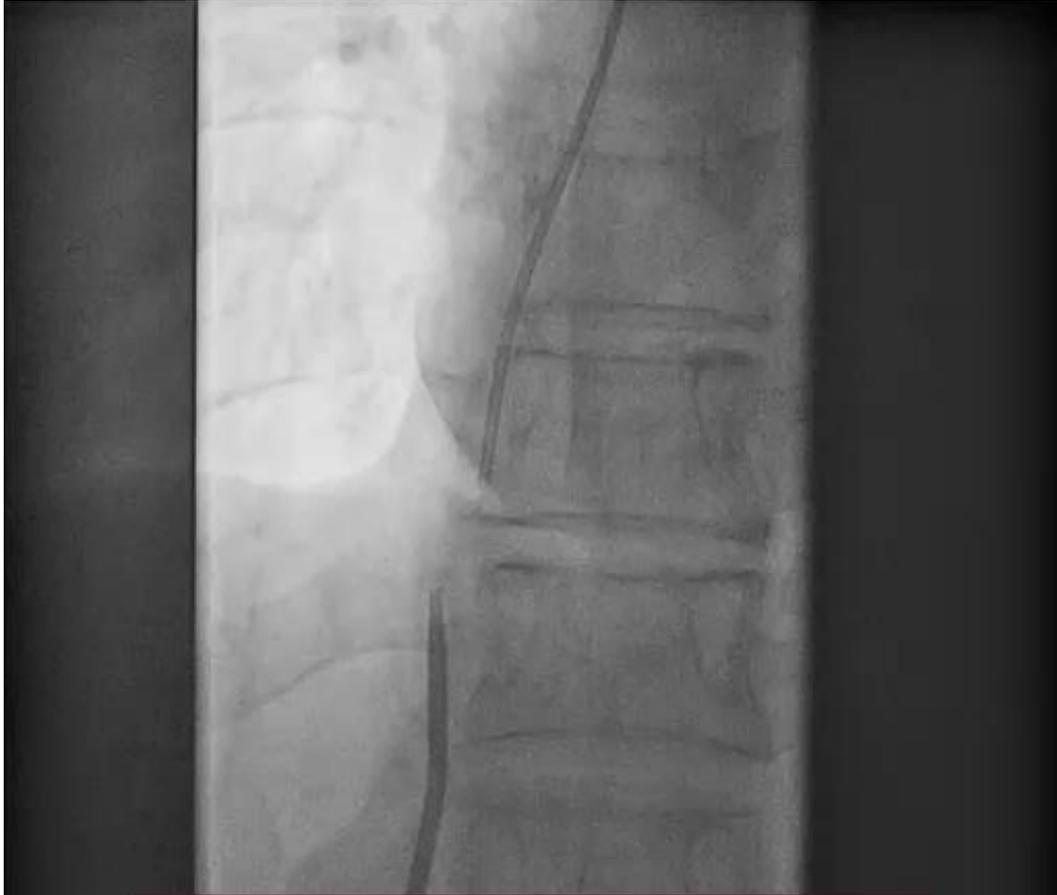


Lesion crossed with Brockenbrough needle over 8f mullins dilator



Needle position confirmed with contrast injection through needle and catheter in right atrium

Venoplasty

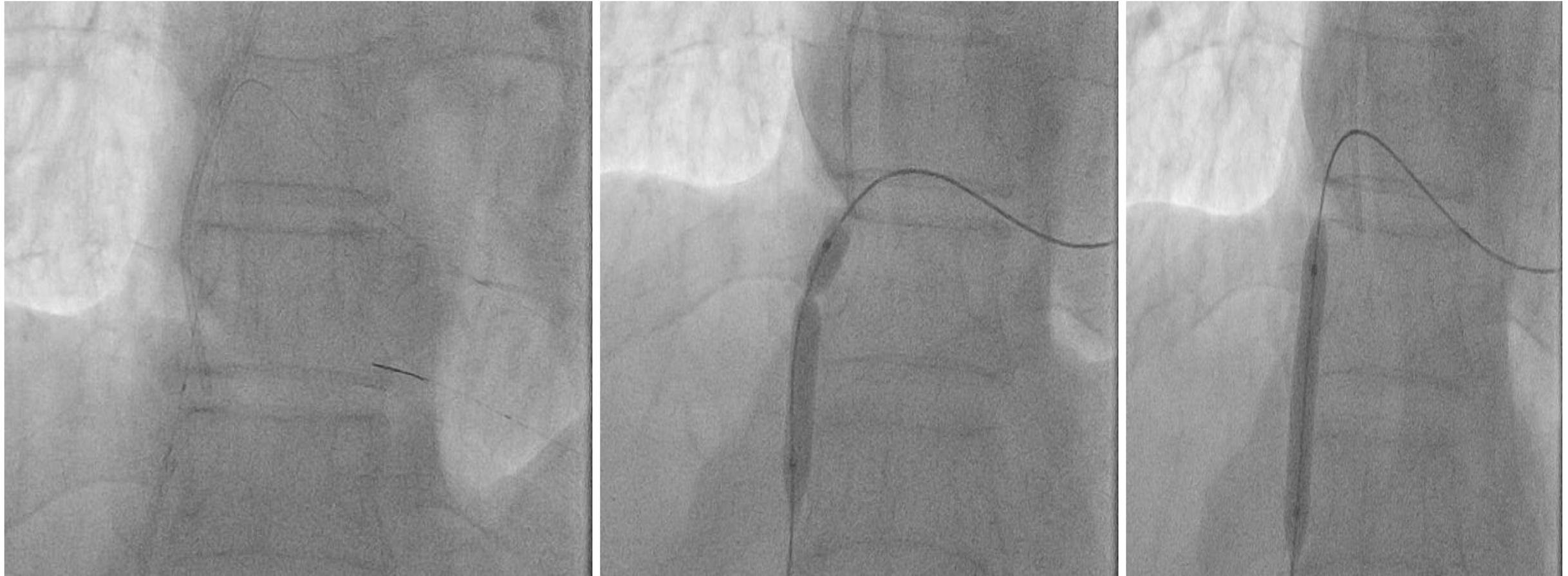


Mullins dilator not crossing after penetration with needle



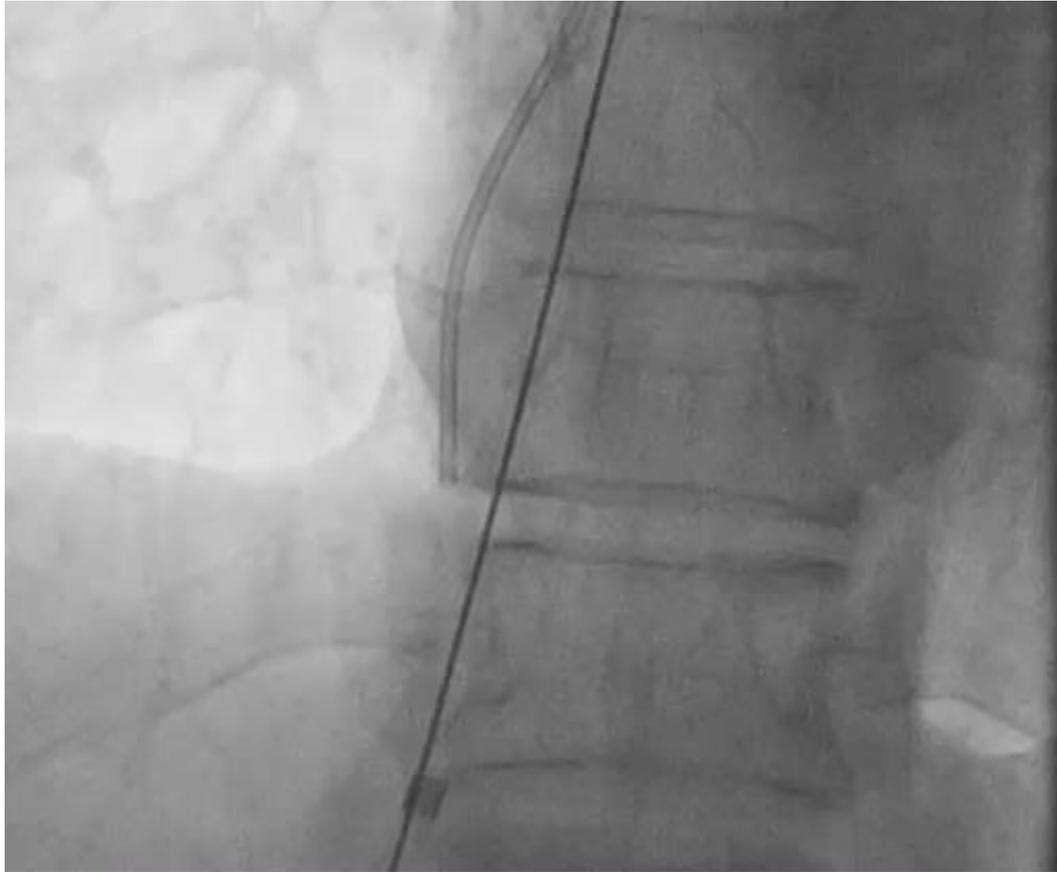
Finally, a 0.014 coronary wire passed through the needle into right atrium

Venoplasty



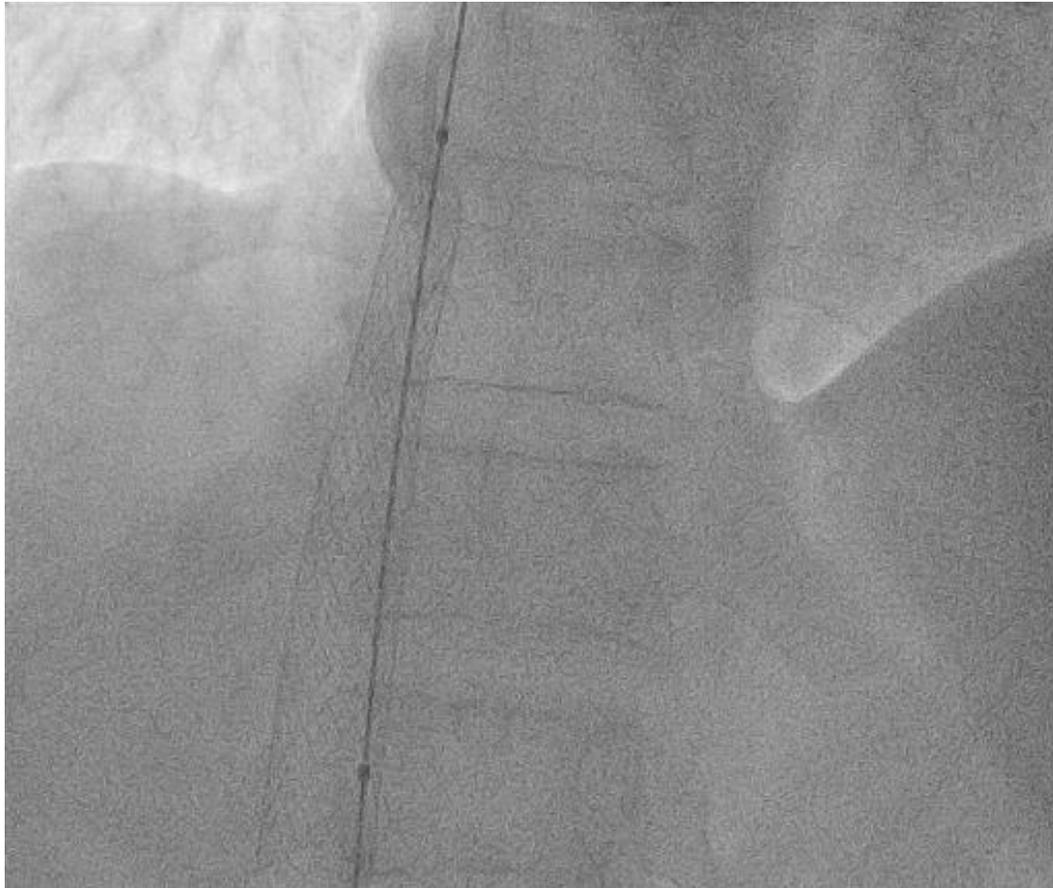
Serial balloon dilatations with coronary and peripheral balloons

Venoplasty

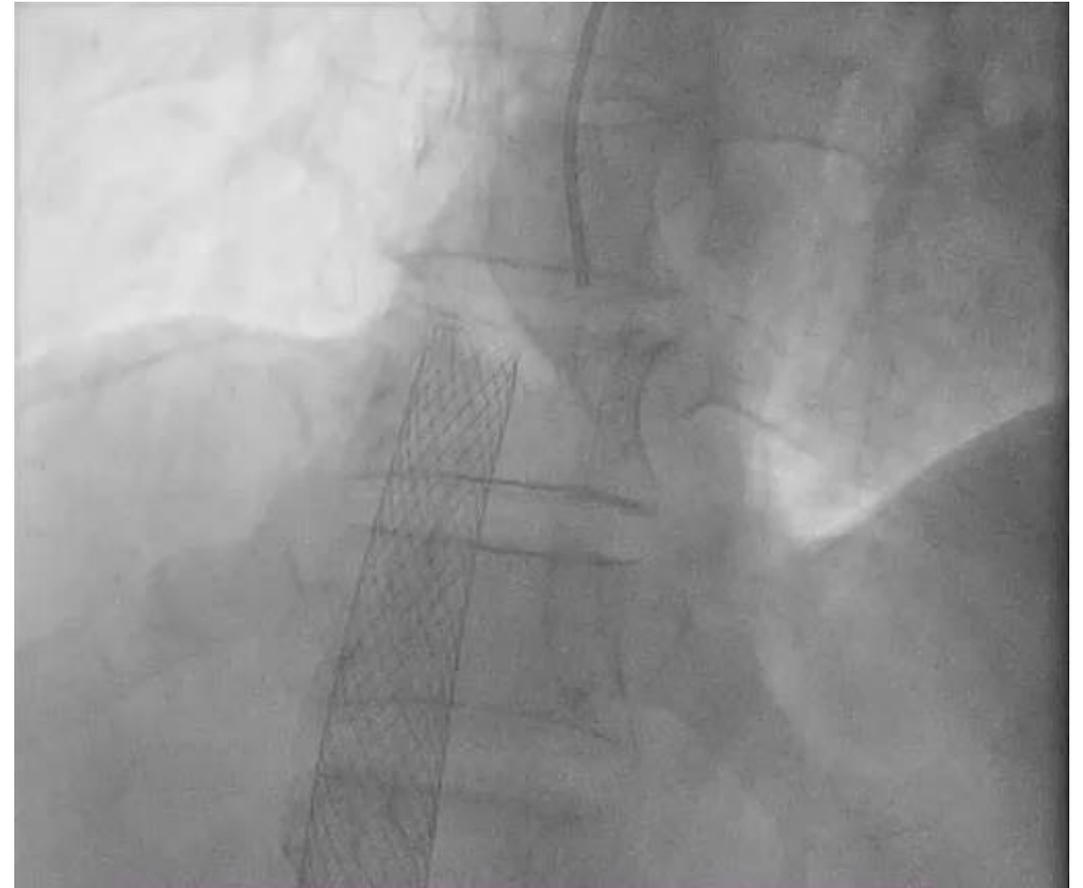


Venograms post balloon dilatation

Venoplasty



24*45 Wallstent implanted across the diseased segment



Final venogram after post dilatation with 24 mm balloon

- Post procedure course uneventful
- Discharged on NOAC and aspirin
- Asymptomatic at 9 months follow up, patent stent on ultrasound
- Venous diseases are underdiagnosed and frequently untreated
- Venous cto at times turn out to be extremely hard, BB needle, RF ablation can be tried with caution