The postthrombotic syndrome
Recanalizing treatment strategies

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Indication

- Symptomatic obstruction in femoroiliac and caval level
- 10-12 months after DVT and conservative therapy
Contraindication

- Severly impaired inflow due to extensive involvement of FV and DFV (trabeculation in FV and DFV)
- DVT in the past 10 months
- Contraindication for therapeutic anticoagulation
Diagnostic

- **Com. fem. V.**
- **Fem. V.**
- **Deep. fem. v.**
- **Impaired inflow from fem. v.**
- **Sup. fem. a.**
- **Good inflow from deep fem. v.**
Diagnostic

• Duplex
Classification based on anatomical expansion of the postthrombotic trabeculation (> 50% lumen reduction)

1. Endovascular + Endophlebectomy
2. Endovascular + Stenting into the DFV

1. Endovascular + Endophlebectomy
2. Endovascular + Stenting into the FV

1. Contraindication (conservative)
2. Garcia method (Access PTS study)

Extensive chronic venous obstruction (they cannot be managed in a routine endovascular manner)
Patients preping and draping
Visualization of the confluence

- Cross over pull back technique
- IVUS
- Bilateral Injection (only if bilateral pathology)
Endophlebectomy of CFV

- Involvement of the CFV covering the ostium of DFV

CFV involved but good inflow from DFV
Hybrid

IV a

16 x 120 mm Stent

14 x 100 mm Stent

Patchplastic

6 mm PTFE
Endophlebectomy

- Use 12-14 mm dedicated venous stent
- The stent should be implanted down to the ostium of DFV
- Use negative pressure wound dressing
- Immobilization for 2 days + pneumatic compression
- Aggressive and long-term anticoagulation
Preventing the endophlebectomy of CFV (hostile groin)

- use this technique to prevent blocking the DFV with postthrombotic trabeculation
Anticoagulation

• sufficient anticoagulation is very important ! ! !

  • Do not stop anticoagulation before the procedure

  • If the patient has no anticoagulation start 1 d before the procedure with NOAC

  • Start with 5000 IE Hep. and keep the ACT > 200 sec. during the procedure

  • Administer the rivaroxaban at night to have a sufficient effect during the resting period (half-life ca. 10 h)
Follow Up

• First follow up evaluation after 2 weeks (not later than 4 weeks)
  • Better possibility of thrombus removal

• Proper ultrasound evaluation to detect
  • Geometry and hemodynamic changes
  • Thrombus formation
Thank you for your attention

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