Efficiacy of iliac venous stenting for proximal venous occlusive disease

We read with interest the article by Xu et al.[1]

There are some questions we would like to ask to the authors. In this study, authors performed popliteal or femoral vein access for all patients. Using the small saphenous vein for venous access may provide ease of access and prevent residual thrombus in the popliteal vein after the procedure.

In the article, it is mentioned that a temporary vena cava inferior filter was used for all patients with deep venous thrombosis to avoid pulmonary embolism. Today, there is a downward trend in the use of inferior vena cava filters all over the world.[2] Inferior vena cava filtration is most likely to benefit patients at high risk (presence of caval thrombus or free-floating thrombus image during venography) of iatrogenic pulmonary embolism during endovenous intervention.[3,4]

Finally, it is mentioned that five patients have current cancer diagnosis. Have the life expectancy of these patients been taken into consideration while planning the intervention? Stent patency rates may be good, but quality of life after post-thrombotic syndrome is generally poor in patients with cancer.[5]

We congratulate Xu et al for their important study about the endovascular treatment of proximal occlusive venous disease. We would like to hear the authors' thoughts on these points.

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Reply

Thank you for the comments and questions from Bademci et al[1] for the article "Clinical outcomes of venous self-expanding stent placement for ilio-femoral venous outflow obstruction." It is our pleasure to address the questions as follows.

First, the reasons that we did not routinely choose the small saphenous vein for venous access include the high chances of phlebitis, saphenous nerve injury, and bleeding related to the small saphenous access,[2] but the key issue is that until now we could not find any piece of solid evidence to support that the small saphenous vein as the access for venous intervention would not potentiate venous thrombus formation.

Secondly, although routine use of retrievable inferior vena cava filters has been found to have some disadvantages, according to our current guideline,[3] the placement of filters was justified on the basis of preventing the patients from pulmonary embolism when they underwent pharmacomechanical thrombolysis or catheter-directed thrombolysis.

Thirdly, there is no definitive guideline or solid evidence to either support or undermine the stent use in patients with malignancy. However, it is important to balance between life expectancy and stent patency when stenting patients with cancer. In our practice, we usually recommend that stent implantation be considered for patients with more than 1 year of survival.

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