Venski stent u kroničnoj kompresiji zajedničke ilijačne vene: prikaz slučaja

Venous stenting in chronic iliac vein compression: a case report

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Uvod: Simptomatska kronična kompresija ilijačne vene zbog May-Thurner sindroma (MTS) može se pojaviti u starijoj dobi. MTS nastaje kao posljedica česte anatomske varijante kada je lijeva zajednička ilijačna vena (VIC) komprimirana desnom zajedničkom ilijačnom arterijom. Obično se MTS prikazuje akutnom iliofemoralnom trombozom, no klinički tijek se može razvijati i postupno.[1-3]

Prikaz slučaja: 78-godišnja žena je hospitalizirana zbog kroničnog, opsežnog edema lijeve noge. Tegobe su se razvijale postupno kroz dvije godine. Isprva je liječena kao limfedem nepoznate etiologije, obzirom da je opetovani ultrazvuk vena isključivao duboku vensku trombozu (DVT), a nativni CT abdomena i zdjelice nije pokazao abnormalnosti. Kod prijema, bolesnica opisuje tegobe sukladne venskim klaudikacijama. Opseg lijeve natkoljenice je bio 66 cm, a desne 54 cm. Osim antihipertenzivne terapije, bolesnica je uzimala rivaroksaban zbog permanentne fibrilacije atrija (AF). Ultrazvukom vena lijeve noge nađu se jasni znakovi kompresije zdjeličnih vena (reducirane respiratorne varijacije protoka, otežana kompresibilnost i dilatirane duboke vene), bez znakova DVT. CT venografija je pokazala tipičnu anatomiju MTS s filiformnim lumenom VIC. Napravljena je venografija uz angioplastiku i implantaciju venskog stenta. Kontrolna venografija pokazala je urednu hemodinamiku duž ilijačne vene. Značajna regresija edema lijeve noge je zamijećena nakon intervencije uz smanjenje razlike u opsegu natkoljenica s 12 cm na 3 cm. Bolesnica je otpuštena kući nakon tri dana, liječena je enoksaparinom u terapijskoj dozi kroz dva tjedna, a potom je enoksaparin zamijenjen s rivaroksabanom. U kontrolama (1 i 3 mjeseca nakon intervencije) bolesnica je bez tegoba, a ultrazvuk vena pokazuje normalan venski protok. Za sada nema jasnih smjernica o dužini trajanja antikoagulantne terapije nakon postavljanja venskog stenta, no budući da bolesnica ima AF, u ovom je slučaju antikoagulantna terapija trajna.

Zaključak: U bolesnika s kroničnom ilijačnom venskom kompresijom i značajnim simptomima, endovaskularna intervencija s implantacijom venskog stenta može dovesti do potpune regresije simptoma. Potrebna su dodatna istraživanja koja bi razjasnila optimalno trajanje antikoagulantne terapije nakon postavljanja venskog stenta u MTS.

Introduction: Symptomatic chronic iliac venous compression caused by May-Thurner syndrome (MTS) can occur at advanced age. May-Thurner syndrome results from a frequent anatomic variant in which left common iliac vein (VIC) is compressed by right common iliac artery. MTS usually presents with acute iliofemoral deep venous thrombosis (DVT), but clinical course can also develop gradually. Endovascular intervention with venous stenting can provide resolution of the symptoms.[1-3]

Case report: 78-year-old woman presented with chronic, painful, sever edema of the left leg. Two years before, she noticed gradual swelling of her left leg and progression of her symptoms with time. In that period several Duplex ultrasound (DUS) excluded DVT, native CT of abdomen and pelvis did not reveal abnormalities and she was treated as lymphedema of unknown origin. At presentation, she complained of venous claudication, her proximal thigh volume was 66 cm on the left side and 54 cm on the right side. Besides antihypertensive drugs, she was taking rivaroxaban due to permanent atrial fibrillation (AF). DUS of the left leg showed clear signs of pelvic veins compression (attenuated respiratory flow variation, dilated deep veins, limitation of full compression), but without DVT. CT venography revealed MTS with filiform lumen of VIC. A venography was performed, followed by angioplasty and stent implantation. Control venography showed unlimited blood flow through stented vein. Significant regression of left leg edema was evident shortly after the procedure. Volume difference between left and right tight changed from 12 cm to 3 cm postprocedural. The patient was discharged from the hospital after 3 days, therapeutic dosage of enoxaparin was continued for the next 2 weeks, and after that switched to rivaroxaban. In control interval (1 and 3 months), the patient was without complaints and DUS showed normal venous flow. Duration of anticoagulant therapy after venous stent is questionable, but since our patient has AF, anticoagulation is, in this case, permanent.

Conclusion: For patient with chronic iliac vein compression and severe leg problems, endovascular intervention and venous stenting can provide complete resolution of symptoms. Further studies are necessary to identify optimal anticoagulant regimen after venous stenting in MTS.

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