Debate: Renal vein transposition (with patch) is the ideal treatment for NCS, not stenting

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Disclosure
- Consultant for
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  - Cook
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NCS + MTS
- MTS
  - Reverse flow in the LIIV
  - Reduces outflow to LGV
  - 50% of patients with NCS

NCS + MTS
- MTS treatment:
  - Left CIV stent: simple + efficient
  - 50% improved => no TRT of NCS

=> Treat MTS first

Stenting for NCS
- Looks easy and simple

Complications
- Restenosis
- Stent migration

=> Need for a specific stent
**Surgery**

- Different techniques
  - LRV transposition +/- patch
  - LRV-IVC bypass
  - LGV transposition
  - SMA transposition
  - Autotransplantation
  - Nephrectomy

- Invasive but
  - Minilaparotomy
  - Laparoscopy
  - Robotic

**Results**

<table>
<thead>
<tr>
<th>Technique</th>
<th>N</th>
<th>Complications</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRV transposition</td>
<td>36</td>
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<td>34</td>
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<tr>
<td>Autotransplantation</td>
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<td>LRV bypass</td>
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<td>External stenting</td>
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<td>Gonadocaval bypass</td>
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<td>SMA transposition</td>
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<tr>
<td>Kidney resection</td>
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<tr>
<td>Nephrectomy</td>
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<tr>
<td>Total</td>
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<td>65</td>
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</tbody>
</table>

**Restenosis**

- Erben 37p (JVS VL 2015)
  - Patency 74%, 97%, 100% at 24M
  - 1/3 reinterventions = stenting

- Hartung 26p
  - 4 transpositions, 22 bypass
  - 10 p reoperated (8 stenting)
Conclusion

- LRV transposition and bypass: frequent secondary stenting
- Stenting needs a dedicated stent
- LGV transposition:
  - Only in case of large incompetent LGV
  - Fragile, multiple trunks in the lower part

=> Improve the technique