Chronic deep venous occlusive disease: what is the true extent of the problem; Do we know; Optimal anticoagulation after deep venous stenting

Manj Gohel
Cambridge University Hospitals & Imperial College London

Disclosures
I have the following potential conflicts of interest:
- Consulting / Conferences:
  - WL Gore
  - Covidien / Medtronic
  - Cook medical
- Research funding:
  - Laboratoires Urgo

Introduction
Major interest in deep venous occlusive disease
Assumption that this is a major healthcare issue

Defining the problem
Deep vein thrombosis (and post-thrombotic syndrome) is common

Incidental iliac vein compression
Evaluation of 250 abdo-pelvis contrast CT scans (non-venous indications)
Overall, 161/250 (64%) patients had stenosis >50%

Typical May-Thurner point Distal left CIV

Pathophysiology
The same anatomical occlusive disease, may have dramatically varying significance in different patients
The need for a classification

Ideally should incorporate:

- Anatomy
- Clinical status
- Aetiology
- Pathophysiology
- Haemodynamics (inflow)

Post-thrombotic iliac vein occlusion

Anticoagulation

Literature search and systematic review
Sixteen studies included
Total of 4959 patients
(2373 post-thrombotic, 2586 non-thrombotic)

Conclusions

The true extent of the problem of deep venous disease is poorly understood

There is urgent need for a reliable classification

Policies vary, but anticoagulants and antiplatelet medications may have a role

VIT K antagonists, LMWH, DOACs and antiplatelet medication have all been used

High risk patients probably need lifelong anticoagulation

Role of antiplatelet therapy is controversial