

Evidence Discussion (PVI.204.A.2)

Treatment of Iliocaval vein stenosis, occlusion and compression (Including May-Thurner Syndrome)

Following treatment of acute DVT via mechanical thrombectomy or thrombolysis, treatment of a residual stenosis of more than 50% via angioplasty and/or stenting is medically necessary to decrease the risk of re-thrombosis, thromboembolic events and post-phlebitic syndrome.

For patients with chronic limb edema, chronic venous stasis skin changes and imaging findings of chronic iliofemoral venous occlusion or stenosis of >50% diameter in the iliac vein or IVC, venous angioplasty and/or stenting is medically necessary to improve venous outflow, and decrease the risk of leg edema, and venous ulceration.

Venous claudication may occur due to impaired outflow due to deep vein stenosis or occlusion. Evaluation is initially directed at identifying non-vascular causes of leg pain and a trial of compression therapy should be undertaken. If imaging identifies a stenosis of more than 50% on the iliac vein or IVC, and symptoms persist or worsen despite compression therapy, angioplasty and or/stenting may be medically indicated.

References

1. Mahnken AH, Thomson K, de Haan M, O'Sullivan GJ. CIRSE Standards of Practice Guidelines on Iliocaval Stenting. Cardiovasc Intervent Radiol (2014) 37:889–897.
2. Taha MAH, et al. A clinical guide to deep venous stenting for chronic iliofemoral venous obstruction. J Vasc Surg Venous Lymphat Disord 2022. PMID: 34020107 Review.
3. Jayaraj A, Buck W, Knight A, Johns B and Raju S. Impact of degree of stenosis in May-Thurner syndrome on iliac vein stenting. JVLS. 2019 . 7(2):195-202