



## Image of the Month

## Percutaneous recanalization of a segmental inferior vena cava occlusion in a patient with situs viscerum inversus and symptomatic Budd-Chiari syndrome



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67 y/o female patient with onset of dyspnea and abdominal pain. Past medical history of primary biliary cholangitis and systemic lupus erythematosus. Coronal contrast-enhanced CT reconstruction (a) showed situs viscerum inversus, hepatomegaly, ascites, patent hepatic veins (HV) (\*) and a suspected segmental inferior vena cava (IVC) occlusion with a small thrombus below the occlusion (→). A cavography (b–c) confirmed the complete segmental occlusion (→) of the IVC above the HV outflow with multiple collateral vessels draining in the azygos and emiazygos system (>). Cavo-atrial pressure gradient was 16 mmHg. Percutaneous recanalization of the occlusion (d–e) was performed advancing a Colapinto needle from a left jugular approach under fluoroscopic and trans-abdominal US guidance. After progressive balloons dilatation (f), a 14 mm diameter non-covered stent was deployed with good flow at the cavography (g). Final cavo-atrial pressure gradient was 1 mmHg. The patient was still in good clinical condition and the stent was patent at 6 months follow-up. Budd-Chiari syndrome results from hepatic venous outflow obstruction at any level from the hepatic veins to the junction of the IVC and the right atrium [1]. Percutaneous recanalization can be a safe and effective alternative procedure to surgery in patients with complete segmental IVC occlusion (Fig. 1).

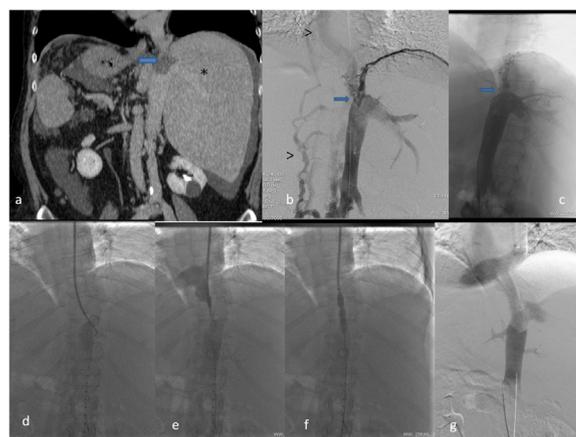


Fig. 1. xxx.

### Conflict of interests

None declared.

### Reference

- [1] Menon KV, Shah V, Kamath PS. The Budd-Chiari syndrome. *N Engl J Med* 2004;350(Febuary (6)):578–85.

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