

INTERVIEW

Managing IVC Filters With Chronic Iliocaval Venous Obstruction

An Interview With Vivian Bishay, MD

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Mount Sinai Medical Center, New York, New York

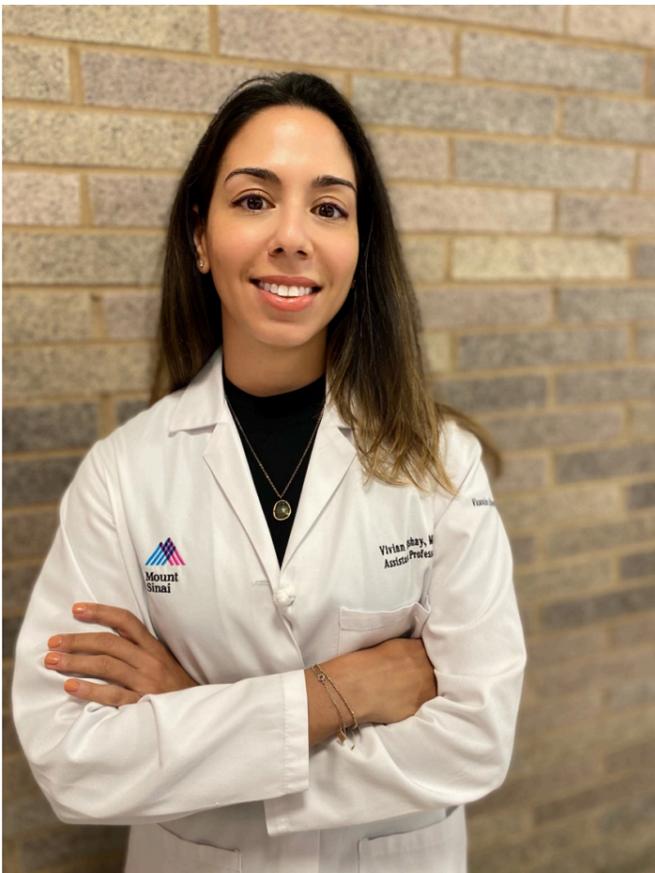
Keywords [IVC Filters](#)
[Venous Occlusion](#)

April 2024
ISSN 2152-4343

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VASCULAR DISEASE MANAGEMENT 2024;21(4):E26-E27



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At the 2024 SIR Meeting in Salt Lake City, Utah, Vivian Bishay, MD, an interventional radiologist from the Mount Sinai Medical Center in New York, presented several sessions, including “Managing IVC Filters With Chronic Iliocaval Venous Obstruction.” *Vascular Disease Management* spoke with Dr. Bishay about treating patients with inferior vena cava (IVC) filters who present with chronic venous occlusion.

Dr. Bishay, why are patients with chronic iliocaval venous obstruction challenging to treat?

Iliocaval venous obstruction is a challenging disease process to take care of because these patients are very often quite debilitated. They can come in with ulceration on their legs or are very decompensated because of leg swelling, and it becomes a complex situation that’s not just from central occlusion and resulting venous hypertension but also from dependent edema on top of that because they’re not moving, they’re not using their calf pump. A lot of these patients are very miserable.

It is very important to work these patients up correctly. Often, they’re not sent to their vascular specialist necessarily knowing that they even have a filter. The filter may have been in for a long time; placement may have occurred in the setting of a trauma or surgery, and the patient is not even aware of it. It definitely adds a level of complexity when you have a filter, either a permanent

one or one that’s retrievable with associated chronic venous occlusion. What type of filter is it? Is there strut migration or other damage? Can this filter safely be retrieved? A lot of this falls on the operator to know about the filter and how to retrieve it safely.

A complicating factor is that the filter can create situations where you develop subsequent thrombosis, so even though they’re put in to prevent, we know that if these filters are left in for a long time, they can promote caval thrombosis. A lot of the time these patients come in way after the fact—the clot is no longer fresh but they have extreme swelling and venous hypertension from the chronic occlusion that’s associated with an IVC filter. They’ve been trialed on stockings and a vasodilator and may have improvement but have persistent debilitating symptoms.

The treatment for patients who are symptomatic with a filter and chronic venous occlusion is filter retrieval and stenting. The issue with putting stents in these patients, which is what we need to do in order to improve flow, unfortunately, is we know that those stents, in terms of patency in this scenario, are fine, but it could be better. It’s in the 70% to 80% range. These patients need to be compliant with their anticoagulation or whatever regimen they’re on; sometimes it’s anticoagulation plus antiplatelet therapy. If there isn’t good adherence, you’re going to run into a situation where you have stents that then thrombose, and it’s a vicious cycle. So you need to really have an in-depth discussion with the patient, that they understand this is a long-term problem and they’re going to

have to be on medications. They need to be very vigilant; if there's any change in their leg swelling once they've undergone stenting and filter retrieval, they need to let you know so you can catch any clot that forms very quickly during the acute phase when it is much easier to deal with. The positive side of things is that these patients can experience profound improvement in their symptoms.

The intervention needs to be done at an experienced center. We say that, for the most part, all filters can be retrieved if the procedure is performed by expert hands, but do you need to retrieve it? Not all filters need to be retrieved. So in this situation, where it's associated with chronic occlusion, typically we take the filter out at the same time; they're done with general anesthesia, and we can successfully remove it and then re-line that area with stents. The patients usually feel significantly better afterwards, but again it's important that they have very good long-term follow-up just because the rethrombosis rate is not insignificant.

Why was this an important subject to present at SIR?

I think it's important because there's a lot of new knowledge around it that's developing. Better stent technology to improve patency and a lot of research around the pro-inflammatory state that exists in these patients even in the chronic occlusive phase of the disease. We have expert consensus guidelines that have been recently published by SIR for this disease state, so it's a way to draw attention to that. The goal is to pool all the knowledge we have so far and come up with recommendations that can be put into practice across the community and different practice spaces.

What is the one takeaway that you wanted the audience to get from your presentation?

That it's a complex disease. It's multifactorial—making sure that the patient selection for intervention is thorough, that the patient is worked up appropriately and you know that they have a high chance to benefit from an intervention. These patients need to be followed for a long time and you need to make sure that they can adhere to therapy and imaging follow-up. ■