Setting up a deep venous service in your hospital

Gerry O’Sullivan
Galway, Ireland
gerard.osullivan2@hse.ie
Iliac venous obstruction - who cares?

- Landmark study by O’Donnell/Browse 1977
- Purely Ilio-femoral DVT
- At 5 years most could not walk properly
- At 10 years
  - 50% had ulcers
  - 11 of 12 men were disabled and unable to maintain a steady job because of their leg symptoms
  - “”7 of 9 women were unable to perform household duties””

What about venous disease

- It is on the increase
- Obesity
- Aging population
- Better recognition/publicity
- Increasing patient awareness from the web..
- Recognition of PE/PERT teams
How to:

• Become the go-to person for deep venous problems
  – Diagnosis
  – Imaging: US; CTV; MRV; IVUS
  – Intervention
  – Clinical review of patients

• Ultimately become the target for deep venous referrals for your region
First of all:

• Show an interest
  – You will probably be the first doctor who has shown any interest in the patient’s DVT/swollen leg since they first started attending clinics

• If you haven’t already you MUST set up your own clinic

• See patients in ED/Wards/On Consults

• Write letters to all GPs/Clinicians
  – In the letter stress:
    • who you are
    • what you offer
    • consultant-led and DELIVERED service
To be an “expert” you have to know what you don’t know
How do you do learn a topic that well?

– Attend conferences- ask awkward questions (watch that “EXPERT” squirm)

– Read the literature- ask yourself what does this paper bring to the table?

– Start with general books and work into the nitty gritty

– YOU MUST be able to offer a reasonable opinion on all imaging- often to RULE OUT any intervention

– If you don’t know go and look it up or email someone whose opinion you trust- your referrers will be impressed when you come back..
Next:

• Investigate patients appropriately
  – US/CTV/MRV/IVUS
• See the patients back in clinic
• If you aren’t comfortable then refer elsewhere
• Give grand rounds
• Give GP talks
• Ask device companies for help...
• Direct CTV provides much better images
• Direct CTV’s difficult if limb swollen
• Indirect CTV more generally applicable, can be done as a follow on to standard CTPA; 150cc at 150s
• More idiot proof
• No matter how inept your colleagues are *indirect CTV* is hard to screw this up...
• Most MRVs sent to me are poor quality
• Read Carsten Arnuldussens chapter in that book- he makes it bullet proof!!

• Therefore:
  DIRECT CTV for chronic
  INDIRECT for acute
  MRV for either IF you are expert

Direct CTV v Indirect CTV v MRV
CTPA followed by Indirect CTV
DIRECT CTV
Perfect delineation of iliac vein compression
And scarring/synechiae in L EIV CFV PFV
MRV- tends to overcall stenosis, but is Radiation free and getting much faster

Easier to miss calcification on MR
OK

• Imaging: sorted!
• Haematology: I get haematology to see patients AFTER I perform intervention
• Intervention itself:
  – Acute- identify “winners” from “losers”
  – Chronic: sort out the inflow to the stent site
  – If unsure whether acute or chronic- anticoagulate and review at 6 months (unless phlegmasia)
Learn to choose patients who are likely to benefit from an endovascular intervention for acute DVT

“Winners”
- Young, fit, active
- Definite onset of s/s; <2/52
- Able to hold still/prone
- Able to use comp. stockings
- Able to take meds
- Can take anticoagulation
- Ilio-femoral

“Losers”
- Very old/immobile/stroke
- Not a definite time of onset
- Can’t hold still or prone
- Can’t tolerate stockings
- Refuses to take meds
- Unable/unwilling to take anticoagulation
- Fem-pop
In Galway every DVT patient gets:

- Initial US to diagnose
- CTPA + CTV
- Focussed US
- Hx/Physical/Consultation/Consent
  – then actual DVT treatment
Treatment

• We aim for single session in all cases
  • Fully anticoagulated
  • Prone/Popliteal puncture
  • DVT thrombectomy or thrombolysis
    – Straub Aspirex does not require tPa
  • Aspiration using any 8F catheter
  • Angioplasty- large diameter and high pressure
  • Stent- large diameter
  • Repeat Angioplasty
  • Pneumatic boots
  • Stockings
The vast majority of patients post IF DVT need a stent
If you miss the 4 week window (or are unsure of timing) for DVTs what do you do?

• See the patient in clinic
• Examine; do your own US
• Review anticoagulation- are they reliable?
• DO NOT INTERVENE until at least 6/12
• Ask haematology to see them (if you have a good relationship that is!!)
• At 6/12 get a CTV/MRV
• See the patient again; reassess- maybe stent
Setting up a new service isn’t hard-it’s just HARD WORK

- The clinical component of your job will increase
- Will your partners tolerate you doing this?
- How about private practice- you WILL get private referrals- how will you handle that?
- Do you need a secretary?
- Do you need rooms?
In time you will become known as the “vein guy/girl”

• You won’t lose all the rest of your work
• You will still get all the cold legs, abscesses, PICCs, central venous access etc etc you need or ?? want
• And THEN you can pick and choose which deep venous cases you want to take on.....
NEW HORIZONS IN DEEP VENOUS DISEASE MANAGEMENT
DVT is an orphan disease

- Why don’t you take ownership?

- Beware:
  - Venous disease is a big area and you will become much busier much more quickly than you might think!!!
Thank you
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