Venous Thoracic Outlet Syndrome
Infraclavicular Approach is Sufficient

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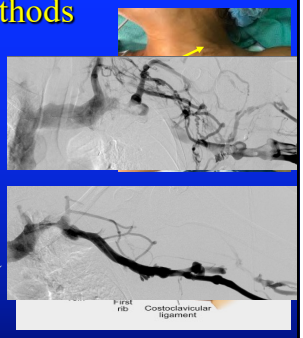
51stAnnual VEITH Symposium.
New York, NY. November 22, 2024.

NO DISCLOSURES

Methods

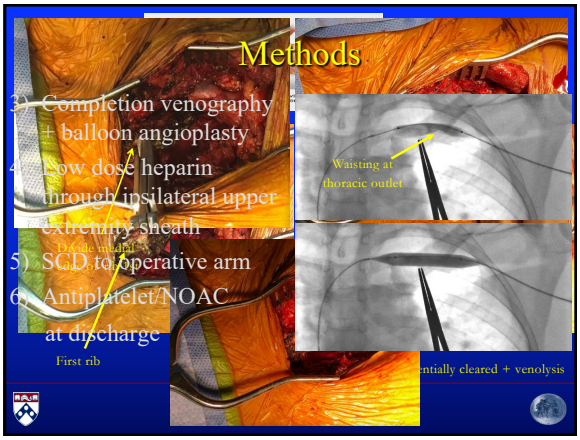
- PAH experience from 1993 – 2022
- All patients undergoing 1st rib resection for acute Infraclavicular rib resection during same admission
- Since 2006 all done via infraclavicular (IC) approach (PC prior)

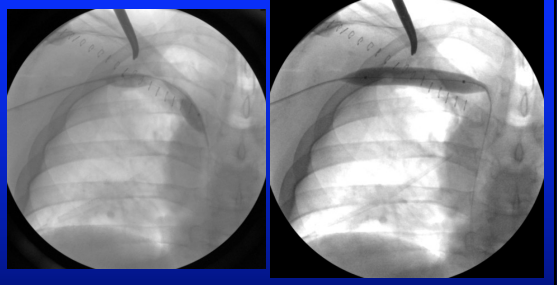
1) Pre-operative catheter directed thrombolysis
   - Angiojet + overnight infusion catheter
2) VTOS included



Methods

3) Completion venography + balloon angioplasty
4) Low dose heparin through ipsilateral upper extremity sheath
5) SCD to operative arm
6) Antiplatelet/NOAC at discharge





Results

- 59 patients (11 PC, 48 IC)
- All underwent pre-op lysis with mechanical thrombectomy
- 97% (n=57) post-resection balloon angioplasty
- Operative time: 2.5 hrs for IC vs. 3.5 for PC ($p < 0.0001$)
- Complications:
  - 2 hematomas, 2 PTX
  - No difference between PC and IC ($p = .44$)

Results

- Post-op DU: 1wk, 3mo, 6mo, then yearly
- Average follow-up: 3 years (3 months – 20 years)
- Re-Interventions during f.u.: 7 patients (12%)
  - All treated endo
  - No significant difference between PC & IC (p = 0.22)

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Conclusions

IC approach offers equal results with shorter OR time vs. paraclavicular technique

Evolving strategy:

pre-operative mechanical thrombectomy/lysis,
same admission rib-resection,
intraop balloon angioplasty,
low-dose heparin via sheath + compression pump on arm,
antiplatelet + Xarelto at discharge,
postop DU surveillance

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