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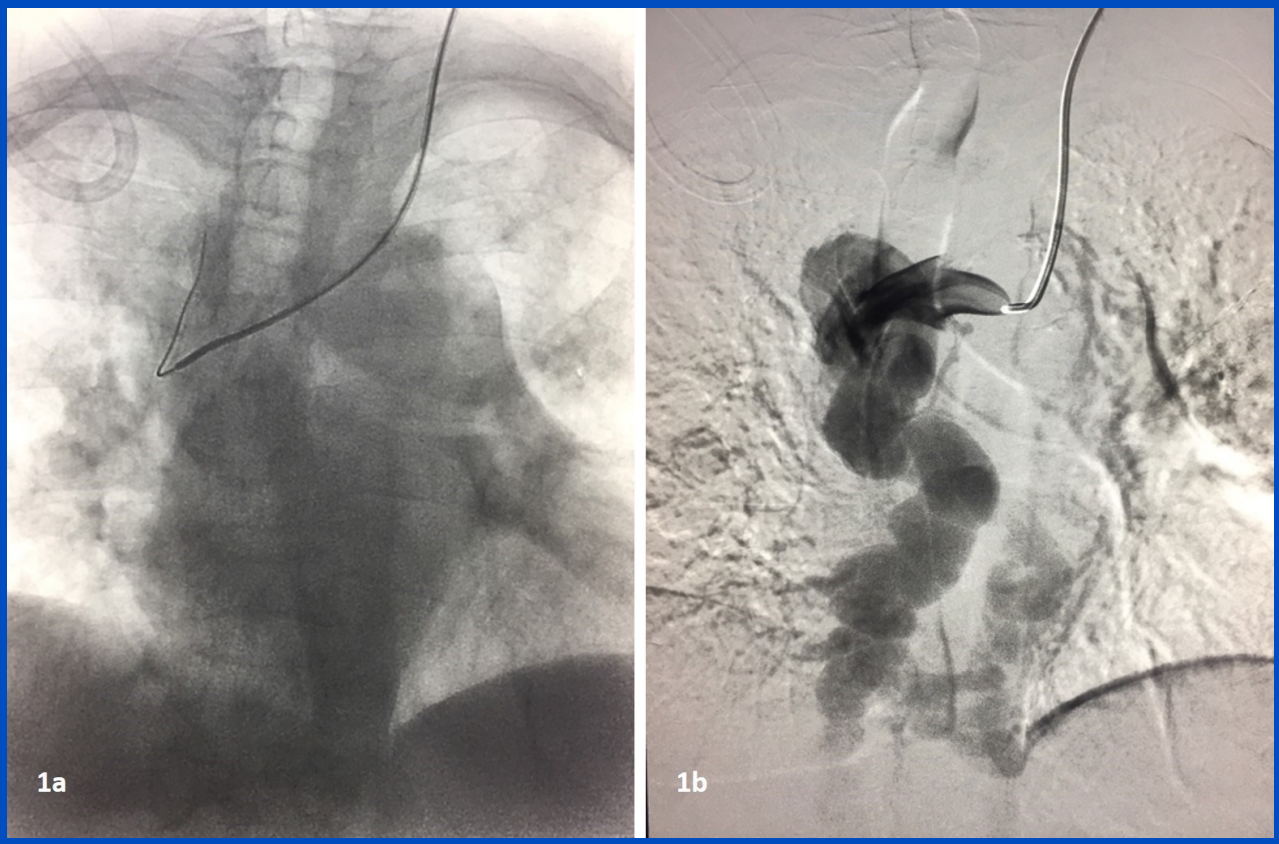

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The BIMJ publishes articles ranging from original research papers, review articles, medical practice papers, special reports, audits, case reports, images of interest, education and technical/innovation papers, editorials, commentaries and letters to the Editor. Topics of interest include all subjects that relate to clinical practice and research in all branches of medicine, basic and clinical including topics related to allied health care fields. The BIMJ welcomes manuscripts from contributors, but usually solicits reviews articles and special reports. Proposals for review papers can be sent to the Managing Editor directly. Please refer to the contact information of the Editorial Office.

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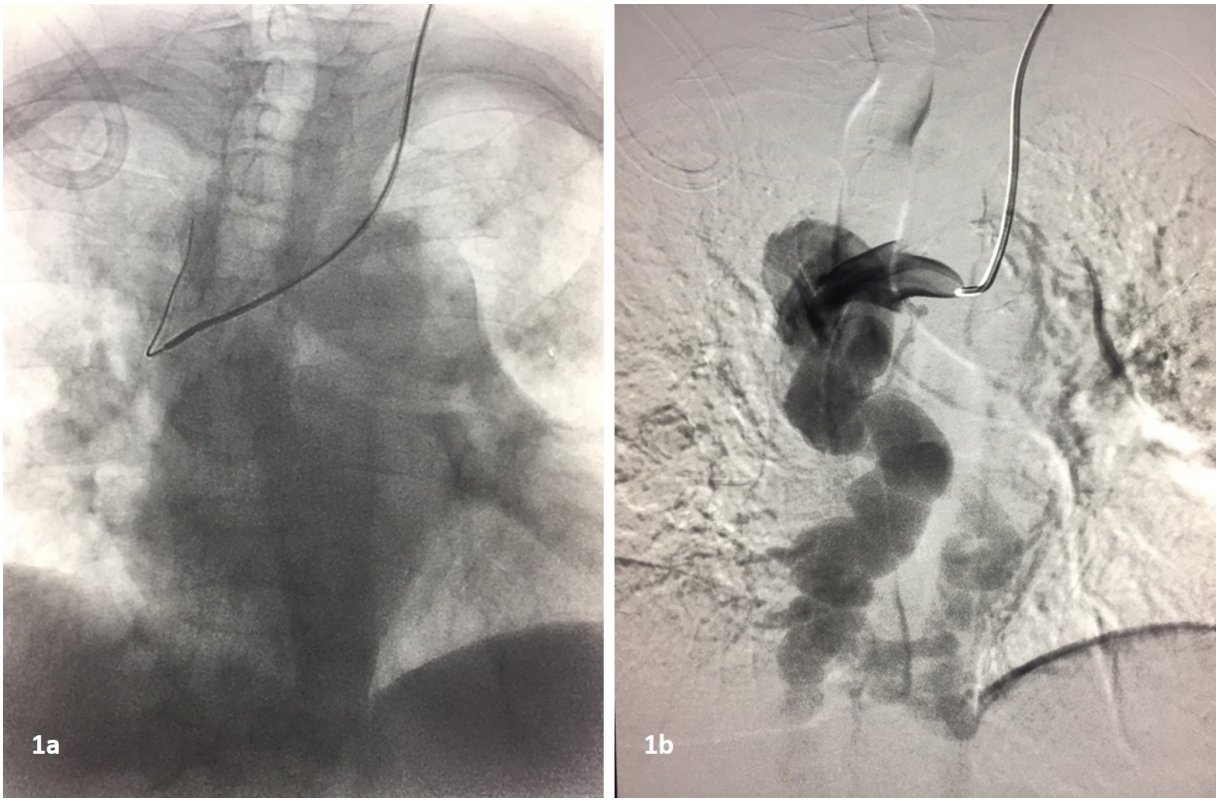

Figure 1

A 33 years old female Malaysian of Indian descendant, with end-stage renal failure on regular dialysis who had multiple failures of bilateral arteriovenous fistula, was referred to Interventional Radiology Unit for the insertion long term haemodialysis internal jugular catheter (permcath). The initial catheterization of the Superior Vena Cava (SVC) failed. Subsequent central venography was performed to assess the patency of the central vein. The fluoroscopy image and digital subtraction angiography of the failed procedure are shown above in Figure 1.

What is the diagnosis?

Answer*: refer to page 88*

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(***Refer to page 87***)

ANSWER: SUPERIOR VENA CAVA OBSTRUCTION (SVCO)

Lung cancer is the leading cause of SVCO worldwide. However, as many as 40% of SVCO are due to non-malignant causes, with thrombosis associated with indwelling intravascular catheters accounts for a substantial proportion of these cases. [1]

It is postulated that 1%–14% of the patients with indwelling central catheter may developed SVC syndrome. It is calculated that the rate of thrombosis formation is around 0.003%–0.2% daily. [1]

The SVCO may remain silent due to the slow gradual formation of endovascular web intraluminally which reduces the flow velocity, eventually leads to thrombosis and obstruction. The development of the efficient collateral pathways for venous return to the heart from the top half of the body, via the azygous, internal mammary and epigastric veins permits the patient to remain asymptomatic or with minimal symptoms until later severe stenotic stage. [2]

Based on the Standford classification system, our case can be classified as type III (complete SVCO with collateral flow, without mammary and epigastric veins). [3]

CT thorax is sometimes performed as a baseline diagnostic tool in cases of central vein obstruction. Central venography is a confirmatory investigation. The aims of central venography are to assess the collaterals , blood flow pattern, blood volume estimation and to provide a better understanding of the anatomy prior to the treatment.

Managment of patients with SVCO are dependent on the aetiology of the obstruction but in generally are supportive, which includes steroid and diuretics. Definitive therapy for the primary causes of SVCO include chemotherapy and radiotherapy for cancer, but for the narrowing or stenosis, balloon angioplasty to dilate the endovascular web with or without stenting, thrombolytic and anticoagulant for thrombosis can be tried. [4] Endovascular stents can be considered in obstruction caused by malignant lesion or when there is a potential life-threatening event caused by SVCO.

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