

Deep Vein Thrombosis Develop Chronic Post Thrombotic Complications are Severe

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Description

Conventional treatment of Acute Deep vein thrombosis is with Antithrombotic therapy starting with intravenous unfractionated heparin or subcutaneous low molecular weight heparin followed by oral anticoagulation with vitamin K antagonists. The conventional anticoagulation prevents the expansion and progression of thrombus, pulmonary thromboembolism and death from venous thromboembolism. Approximately half of the patients with proximal Deep vein thrombosis develop symptoms of Post Thrombotic Syndrome (PTS) and one fourth with proximal deep vein thrombosis develop chronic post thrombotic complications are severe. Trials have demonstrated that proper use of graduated Compression stockings reduces the risk of PTS morbidity by 50%.

Cardiothoracic and Vascular Surgery

Mean dose of Thrombolytic used was 36 mg and the mean duration of infusion was 38 hours. 68 patients of acute DVT of lower limb achieved lysis of more than 50% with Villalta Score of them was an average of 4, whereas in 14 patients of acute DVT of lower limb achieved lysis of less than 50% and of them the average villalta score was 9. Non-major bleeding was present in 4 patients in our study a population study conducted by Mayo Clinic in which the mean age was 61.7 years which suggests that DVT occurs in much younger age groups in Indians compared to Western. In this study we have retrospectively analysed data of about 100 patient of acute deep vein thrombosis. This study looked primarily at symptomatic DVT with lower and upper limb pain and swelling presenting with pulmonary thromboembolism as main presenting feature and not the isolated pulmonary thromboembolism. Males in our study contributed to 68% while in Indian Subgroup of Endorse and the Arrive study they contributed to 69% and 70% of the patient load.

On-going Acute deep vein thrombosis is a common disease and is associated with complication of Post thrombotic syndrome (PTS) and Pulmonary thromboembolism (PTE). Catheter directed thrombolytic therapy of acute deep vein thrombosis is associated with decreased thrombus burden and maintenance of the vein valve patency which prevents

progression into Post thrombotic Syndrome. Randomized control trial-Dutch Cava Trial comparing the catheter directed thrombolytic therapy group vs. anticoagulation alone for the proximal deep vein thrombosis may provide more clinical evidence for the benefit of catheter directed thrombolytic therapy. Catheter directed thrombolytic therapy in the setting of acute deep vein thrombosis was safe and tolerated by most of our patients, in a way to decrease in complications of Post thrombotic syndrome, improving the quality of life of the patients. This study evaluates only one modality of treatment, additional comparative studies with other modalities of treatment to clarify the potential risks and benefits of this treatment approach. This was a retrospective cross-sectional study carried out in the department of Cardiothoracic and vascular Surgery from September 2018 to February 2022. All the patients included in this study were taken from the Medical records of the hospital considering International Classification of Diseases code. Catheter directed thrombolytic therapy is loco-regional delivery of thrombolytic dose directly to the venous thrombus, resulting in significant reduction of the thrombus burden with minimal systemic thrombolytic effect.

Myocardial Symptoms

The patients' clinical characteristics, interval between MRI surgery and new symptoms of angina, type of myocardial symptoms, and technical aspects of the revascularization procedure were registered in a dedicated database. Stenosis was categorized as ostial or located in the middle segment of the subclavian vessel proximal to the ITA. Clinical characteristics included: Age, sex, hypertension, dyslipidemia, diabetes, current smoking habits, and chronic renal failure. All procedures were performed with patients under local anesthesia and systemic heparinization. Access site varied according to the location and type of occlusive disease (stenosis versus occlusion). In vascular surgery service, the approach of choice was through the brachial artery. When necessary, predilation was performed to cross the stenosis with the stent. Balloon expandable stents were used for ostial lesions and selfexpanding stents for non-ostial lesions. Perioperative results included "technical success", defined as a treatment resulting in < 30% residual stenosis. Her peripheral

pulses were full and symmetrical in the lower extremities, and no peripheral edema was observed. Admission ECG was not found in the patient's medical record. Echocardiogram showed no significant changes. She underwent a stress test to verify a possible coronary distribution for the cause of the chest pain. Afterwards, a cardiac catheterization showed 95% non-ostial

stenosis in the left subclavian artery. The patient underwent successful balloon angioplasty for pre-dilation, followed by the release of an 8.0 x 25mm self-expanding stent in the subclavian artery. After the procedure, the patient remained asymptomatic during an eight-month follow-up.