CORRESPONDENCE

Complete Caval Thrombosis Secondary to an Implanted Venous Port – a Case Study

by Dr. med. Jens Hasskarl, Diplom-Pflegepädagoge (FH) Stefan Köberich, Dr. med. Alex Frydrychowicz, Dr. med. Gerald Illerhaus, Prof. Dr. med. Cornelius F. Waller in volume 1–2/2008

Overly Extensive Treatment Recommendations

From a practical point of view, and in consideration of the associated costs, the authors' treatment recommendations are far too extensive and fail to reflect current practice. The frequency of clinically relevant pulmonary embolism or post-thrombotic syndrome in patients with subclavian or arm vein thrombosis is extremely low, and there is thus no indication for six months of oral anticoagulation, in view of the at least relative contraindication to this form of therapy in these patients, most of whom are in an advanced stage of neoplastic disease. There is no evidence in the literature to support this practice, and data derived from patients with leg vein thromboses cannot be applied to this situation.

Furthermore, the recommendation that a non-infected, still functioning port catheter should be surgically removed is wrong, or at least cannot be adequately justified. There is insufficient evidence to support a benefit for explantation that would outweigh the risk of dislodging a pulmonary embolus, or of worsening a thrombosis, through a further surgical procedure in the thrombosed area. For modern port-catheter systems, the routine flushing of unused ports is not indicated, because the theoretical possibility of infection is not outweighed by any clear-cut evidence that flushing and heparinizing an unused port is beneficial. The references provided to support this contention are based on data that are more than 10 years old and therefore inapplicable to the systems currently in use. In my more than 25 years of professional experience in a hematology/oncology service providing maximal care and in a private oncological practice, there has not been any increased frequency of port complications due to non-adherence to the recommendations given in this article.

I have never encountered a case of pulmonary embolism or a clinically significant post-thrombotic syndrome that was due to a port, not even in a patient who was not orally anticoagulated. The high incidence of pulmonary embolism in tumor patients is independent of venous ports. We have never yet chosen to remove a non-infected and still functional port system, and we have had excellent results with this approach. Treatment with low-molecular-weight heparins for about three to four weeks seems to be adequate.

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Dr. med. Manfred Reeb
Onkologische Schwerpunktgemeinschaftspraxis
Kaiserslautern
Schneiderstr. 12, 67655 Kaiserslautern, Germany
manfred.reeb@t-online.de

In Reply:

There is indeed no scientific evidence to support the practice of regularly flushing a port system every four weeks to keep it open. Kuo et al. (1) recommend critical reconsideration of this practice in view of the findings of their retrospective study. These authors point out the high cost of flushing a catheter every four weeks, as well as the considerable additional effort that this demands from the patient. There was no statistically significant change in the complication rate when the interval was prolonged. In view of the sparse data on the subject, the manufacturer's recommendations were also taken into account in the decision whether to flush, and how often.

There have not yet been any reports about the extent to which regular flushing might cause infection. In view of the absence of evidence from scientific studies on this topic, the expert opinion expressed here ought to be taken into account alongside the data that are currently available.

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REFERENCES

1. Kuo YS et al.: How often should a Port-A-Cath be flushed? Cancer Investigation 2005; 23: 582–5.

Prof. Dr. med. F. Cornelius Waller
Medizinische Universitätsklinik Freiburg I, Hämatologie/Onkologie
Hugstetter Str. 55
79106 Freiburg, Germany
cornelius.waller@uniklinik-freiburg.de

Conflict of interest statement

The authors of the above letter and of the reply to it state that they have no conflict of interest as defined by the International Committee of Medical Journal Editors.