Patients with a postthrombotic syndrome, chronic venous insufficiency, or accelerated recurrent varicosities may suffer from a persistent central venous outflow obstruction. Therefore, it is important to recognize the clinical signs for central venous obstruction. Unfortunately, most physicians are not inclined to expose the groin and lower abdominal wall to search for these signs. Additionally, patients themselves rarely voluntarily invite inspection of the pubic region. These images illustrate the fact that by examining the lower abdominal wall and pubic region, one can easily recognize subtle ipsilateral left suprapubic crossover collaterals often indicative of left iliac vein obstruction such as May-Thurner syndrome (Figure, A through E) or right ipsilateral ascending subcutaneous venous collaterals (Figure, F through I), which are natural escape routes in patients with an iliac venous outflow obstruction. Extensive bilateral collaterals are indicative of more than isolated iliac vein pathology, implying a central inferior vena cava lesion (Figure, J and K). Patients with central venous obstruction should be analyzed and treated in dedicated centers because endovenous recanaliza-

Figure. A through E, Suprapubic crossover collaterals as clinical signs for a left iliac vein obstruction. F through I, Right ipsilateral ascending subcutaneous venous collaterals as natural escape routes in patients with an iliac venous outflow obstruction. J and K, Extensive bilateral venous collaterals indicative of a central inferior vena cava lesion.

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(Circulation. 2010;122:2089-2090.)

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Circulation is available at http://circ.ahajournals.org

DOI: 10.1161/CIRCULATIONAHA.110.979534
tion and stent placement result in a relief of clinical symptoms with an acceptable long-term secondary patency rate of approximately 90% at 24 months\(^1\) and 80% at 54 months.\(^2\)

**Disclosures**

None.

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**References**


Abdominal Wall Venous Collaterals: The Latent Clinical Sign for Central Chronic Venous Obstruction
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_Circulation_. 2010;122:2089-2090
doi: 10.1161/CIRCULATIONAHA.110.979534
_Circulation_ is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
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