

Femoral port implantation as a first choice in superior vena cava syndrome (SVCS)

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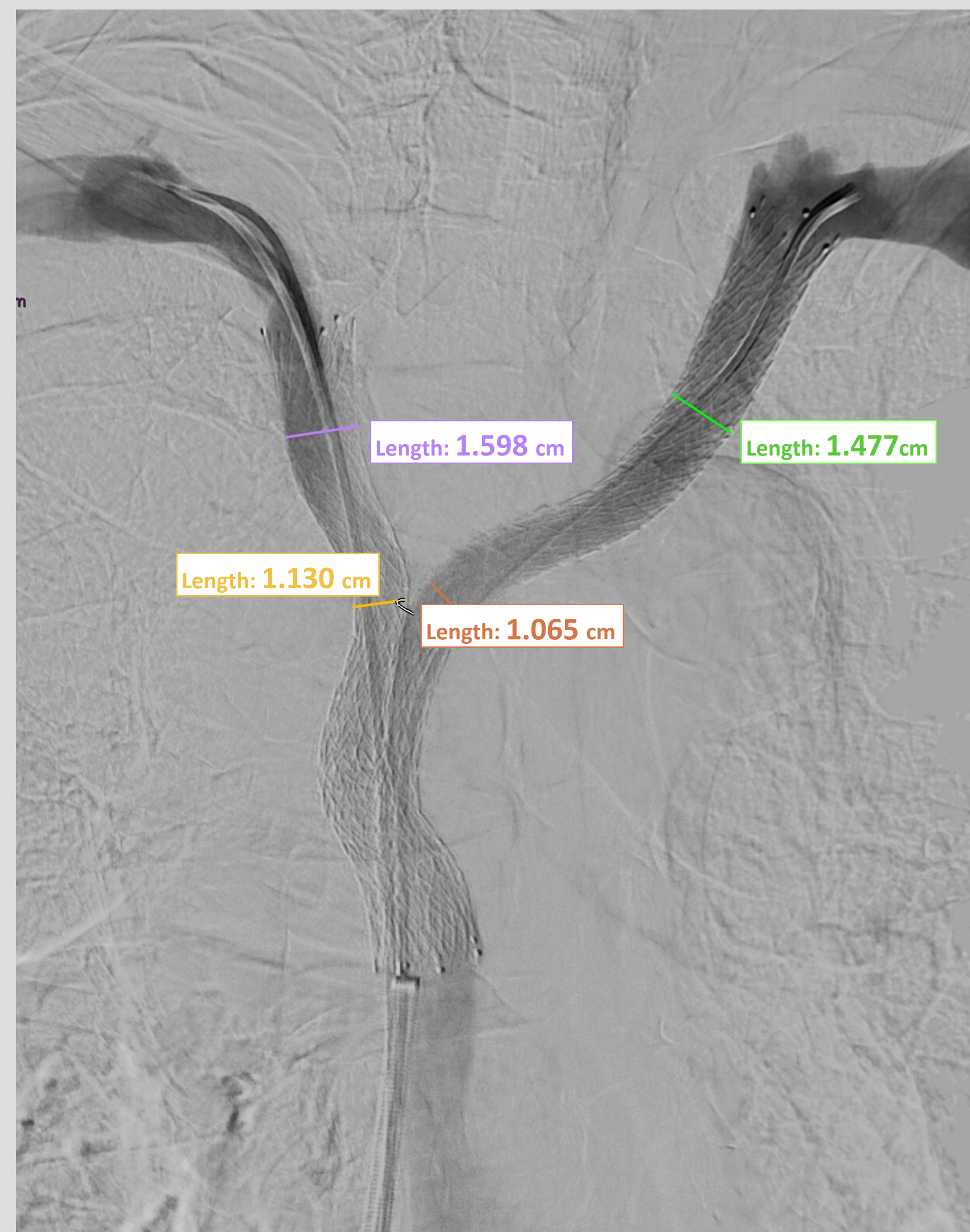
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Clinical Background

- SVCS - a common complication of mediastinal malignancies
- Limited options for central venous access
- Endovascular stenting restores venous flow but may preclude standard implantation of TIVAD
- Alternative access strategies required in selected patients

Case Presentation



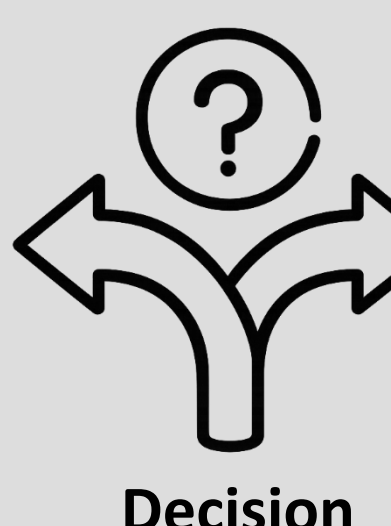
- 71-year-old male
- Mediastinal mass (MCL)
- SVCS due to tumour compression



- Percutaneous venous angioplasty
- Double-barrel stenting of both BCV and SVC



- Extensive mediastinal lymphadenopathy
- Venous stents
- High risk of thrombosis and obstruction
- No feasible upper-body central venous access



FICC port as a primary access

Procedure

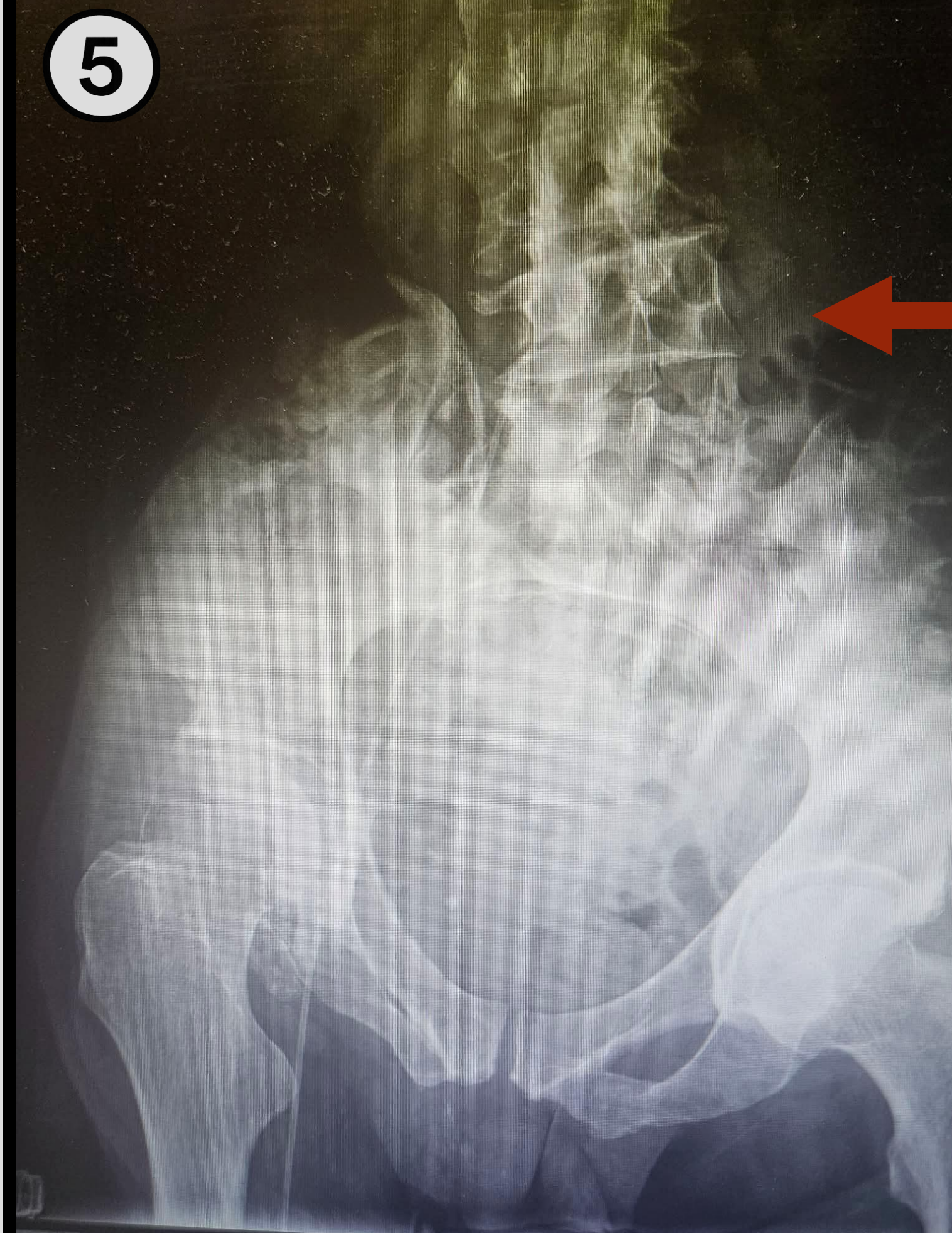
- ① Ultrasound-guided cannulation of the right femoral vein (in-plane technique)

- ③ Subcutaneous port chamber placement in the subtrochanteric region



- ② 7 Fr, 47 cm catheter advancement into the IVC (modified Seldinger technique)

- ④ Tip position confirmed by ultrasound bubble test (IVC, hepatic margin)



Technical challenge

- Catheter tortuosity in subcutaneous tunnel
- Difficulty with catheter repositioning using guidewire
- Catheter length optimisation
- Final tip position adjustment to L4–L5

Results & Follow-up

- Procedure completed without early complications
- Catheter function confirmed (aspiration and saline infusion)
- Persistent withdrawal occlusion at 30 days



Take-home message:

**No SVC access?
Consider femoral implanted port**