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LETTERS TO THE EDITOR
EDİTÖRE MEKTUP
The location of hepatic outflow obstruction in Turkish patients with Budd-Chiari syndrome

Türkiye'de Budd-Chiari sendromunda hepatik akım obstrüksiyonunun lokalizasyonu

To the Editor,

Budd-Chiari syndrome comprises a variety of disorders resulting from obstruction of hepatic venous outflow. The clinical presentation is diverse and ranges from an asymptomatic state to either fulminant hepatic failure or end stage liver disease with its associated liver complications (1).

Patients with Budd-Chiari syndrome present with occlusion of terminal hepatic venules (veno-occlusive disease), major hepatic veins, or inferior vena cava (2).

Hepatic veno-occlusive disease is non-thrombotic, fibrous, obliterative endophlebitis of the central or sublobular hepatic veins. Bone marrow and renal allograft recipients are at risk for the developments of hepatic veno-occlusive lesions (3).

In the West, hematologic disorders, paricularly myeloproliferative diseases (sometimes latent myeloproliferative states) are the most frequent causes of venous obstruction. The use of oral contraceptives and pregnancy may exacerbate hypercoagulability. Paroxysmal nocturnal hemoglobinuria and deficiencies of antithrombin III, protein C and protein S are precipitants of Budd-Chiari syndrome (4, 5).

As compared with pure hepatic vein thrombosis, inferior vena cava thrombosis, membranes and webs account for most cases of suprahepatic vena caval occlusion and Budd-Chiari syndrome in the Far East, South Africa and India. The pathogenesis of membranous occlusion is not clear (6, 7).

We analyzed 39 patients with Budd-Chiari syndrome to obtain the localization of hepatic outflow obstruction in our hospital.

Between 1989 and 2005, we performed interventional therapeutic techniques on 39 patients (19 female, 20 male, mean age 28.8, range 9-44 yrs) with Budd-Chiari syndrome at the Radiology Department of Turkiye Yuksek Ihtisas Hospital.

The localization of hepatic outflow obstruction was vena cava inferior in 25 (64%) patients and hepatic veins in 14 (36%) patients. As a result, inferior vena cava obstruction is more common in our country as compared with pure hepatic venous thrombosis.

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