VASCULAR IMAGE

Left Superior Gluteal Pelvic Escape Point Associated with Nonthrombotic Iliac Vein Compression Syndrome

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***Keywords*:** superior gluteal vein pelvic escape point, nonthrombotic iliac vein compression syndrome, atypical pelvic-origin varices, foam sclerotherapy

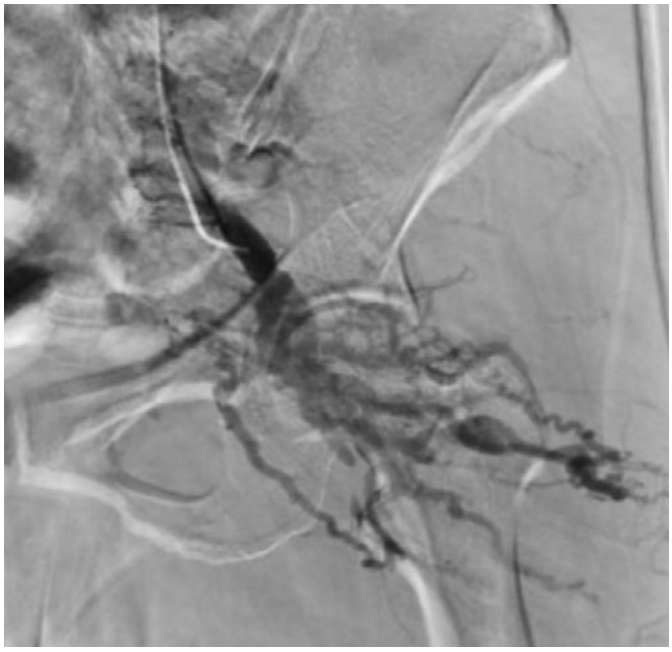

Figure 1: Descending venography of the left internal iliac vein demonstrating voluminous reflux arising from the left superior gluteal vein (SGV), feeding numerous varicosities of the ipsilateral buttock

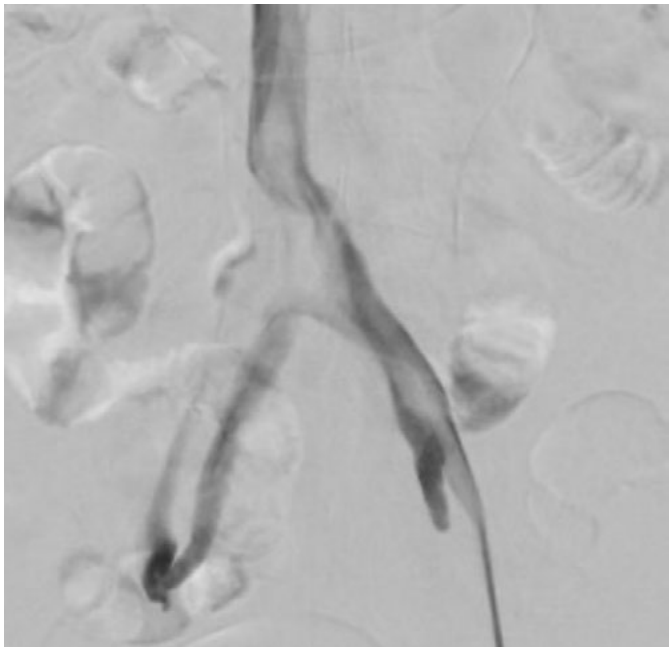

Figure 2: Nonthrombotic left iliac vein compression syndrome (NTIVC)

A 52-year-old female presented with pelvic vein disorders (PeVD**)** and symptomatic extensive atypical varicosities on the left buttock, posterior thigh, and lower leg. Duplex ultrasound (DUS) revealed reflux originating from a pelvic vein superior to the piriformis muscle. Descending venography of the left internal iliac vein demonstrated voluminous reflux arising from the left superior gluteal vein (SGV), feeding numerous varicosities of the ipsilateral buttock **(Figure 1)**. This was associated with a nonthrombotic left iliac vein compression syndrome (NTIVC) **(Figure 2)**. The patient was therefore classified as $\mathbf{S}_{2,3b}\mathbf{V}_{2,3b}\mathbf{P}_{LCIV,O,NT;\ LPELV,R,NT}$; $[_L]\mathbf{C}_{2s}\mathbf{E}_{sie}\mathbf{A}_{s,d}\mathbf{P}_{o(CIV),r(PELV,NSV)}$ according to the Symptoms-Varices-Pathophysiology and Clinical-Etiology-Anatomy-Pathophysiology classifications.

Venographic description of the superior gluteal pelvic escape point (SGP) has been rarely reported. The SGV typically enters the pelvis at an acute, superior angle, and is deeply encased by surrounding gluteal muscle. Consequently, blood outflow from high-pressure pelvic veins into the SGV is restricted compared to other internal iliac vein branches. The occurrence of the SGP was potentially triggered by anatomical variants and NTIVC.

A combination of foam sclerotherapy and coil embolization, along with recanalization of the left common iliac vein, has been performed. Follow-up visits extending up to eight years post-intervention have consistently demonstrated significant clinical improvements, a patent iliac stent, and the absence of pre-existing reflux from SGP on DUS. The Patient consented to the publication.

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