VEITH SYMPOSIUM

Phlebology 2024

Professor Alun H Davies, FMedSci.
Editor in Chief

Original Article — Phlebology

The anterior saphenous vein. Part 1. A position statement endorsed by the American Vein and Lymphatic Society, the American Venous Forum, and the International Union of Phlebology

Mark Meissner[1], Edward M Boyle[2], Nicos Labropoulos[3], Alberto Caggiati[4], Rachel Drgastin[1], Suat Doganci[5] and Antonios Gasparis[1]

Abstract

Background: There is a lack of clarity regarding the terminology of the anterior accessory saphenous vein (AASV) that can impact treatment outcomes. Although use of the word "accessory" implies that the vein is a superficial tributary, evidence supports its role as a truncal vein, similar to the great and small saphenous veins, and warranting a change in terminology.
Methods: A multisocietal panel was convened by the American Vein and Lymphatic Society (AVLS), the Union International of Phlebology (UIP), and the American Venous Forum (AVF). The group was charged with reviewing the existing anatomic and clinical literature pertaining to the term "anterior accessory saphenous vein" and to consider the need for alternative terminology.
Conclusion: Based on the insights gathered from the literature review and extensive discussions, the panel recommends changing the terminology such that the "anterior accessory saphenous vein" (AASV) now be designated the anterior saphenous vein (ASV).

Anterior saphenous vein

Original Article — Phlebology

The Anterior Saphenous Vein. Part 2. Anatomic considerations in normal and refluxing patients. Endorsed by the American Vein and Lymphatic Society, the American Venous Forum and the International Union of Phlebology

Alberto Caggiati[1], Nicos Labropoulos[2], Edward M Boyle[3], Rachel Drgastin[3], Antonios Gasparis[3], Suat Doganci[4] and Mark Meissner[5]

Abstract

Background: The term Anterior Accessory of the Great Saphenous Vein suggest this is a branch tributary vein despite this vessel's anatomic features of a truncal vein. A multisocietal group suggested to designate this the Anterior Saphenous Vein (ASV). This study was aimed to evaluate its ultrasound anatomy in normal and varicose limbs.
Methods: The clinical anatomy of the ASV was evaluated by narrative review of the literature. Additionally, the course of the ASV was evaluated in 62 limbs with no evidence of venous disease and 62 limbs with varicosities.
Results: The ASV length, patterns of origin and termination are reported in both normal and patients with varicose veins. Discussion of the patterns is supported by the narrative review of the literature.
Conclusions: The ASV must be considered a truncal vein and its treatment modalities should be the same that for the great and small saphenous veins rather than a tributary vein.

Same treatment as all members of the team

Original Article — Phlebology

The anterior saphenous vein. Part 3. Systematic review of the literature and payor coverage policies. Endorsed by the American Vein and Lymphatic Society, the American Venous Forum and the International Union of Phlebology

Rachel Drgastin[1], Edward M Boyle[1], Nicos Labropoulos[2], Alberto Caggiati[3], Antonios Gasparis[2], Suat Doganci[4] and Mark Meissner[5]

Abstract

Objective: The objective of this study is to systemically review the literature on Anterior Saphenous Vein (ASV) reflux treatment and insurance impediments to treatment coverage.
Methods: A literature search was performed using a PRISMA framework. In addition, a cross-sectional analysis of insurance policies for ASV treatment was evaluated.
Results: Published evidence and treatment considerations in the literature for ASV treatment are discussed. In 155 of 226 (68.6%) insurance policies reviewed coverage of ASV ablation was allowed while 62/226 (27.4%) did not specify coverage and 9/226 (4.0%) specified ASV treatment was not covered. Of the 155 that provide ASV coverage, 98 (62.2%) provide coverage with criteria such as requiring prior treatment of the great saphenous vein.
Conclusions: Vein treatment experts should continue to advocate to insurance carriers to update their varicose vein treatment policies to reflect the substantial clinical evidence so that patients with ASV reflux can be appropriately treated.

Original Article — Phlebology

The anterior saphenous vein. Part 4. Clinical and technical considerations in treatment. Endorsed by the American Vein and Lymphatic Society, the American Venous Forum, and the International Union of Phlebology

Edward M Boyle[1], Rachel Drgastin[1], Nicos Labropoulos[2], Alberto Caggiati[3], Antonios Gasparis[2], Suat Doganci[4] and Mark Meissner[5]

Abstract

Background: The decision to treat a refluxing anterior saphenous vein (ASV) should be a clinical decision based on the assessment on the ASV's contribution to patient's signs and symptoms. Once the decision to treat has been made, there are anatomic, clinical, and technical considerations in treatment planning.
Methods: Clinical scenarios were discussed by a panel of experts and common anatomic, clinical, and technical considerations were identified.
Results: There are unique clinical considerations such as whether both the great saphenous vein (GSV) and ASV should be concomitantly treated, if a normal ASV should be treated when treating a refluxing GSV and when and how to treat the associated tributary varicose tributaries. Being aware of the anatomic, clinical, and technical considerations allows development of a treatment plan that optimizes long-term outcomes in patients with ASV reflux.
Conclusion: Ultimately the treatment plan should be tailored to address these types of variables in a patient-centered discussion.

Original Article — Phlebology

Safety of synchronous prophylactic ablation of the anterior saphenous vein in patients undergoing great saphenous vein thermal ablation– 6 months follow-up data of the SYNCHRONOUS study

Carmen K Dietrich[1], Tobias Hirsch[2], Karsten Hartmann[3], Thomas Mattausch[4], Hans-Christian Wenzel[4], Philipp Zollmann[5], Jürgen Veltman[5], Thomas K Weiler[4], Guido Lengfellner[2], Lars Müller[2], Markus Stücker[2], Felizitas Pannier[1,2], Lorenz Uhlmann[1,] and Christine Müller-Christmann[1]

Abstract

Background: The SYNCHRONOUS-study investigates simultaneous ASV-ablation with great saphenous vein (GSV) treatment in endovenous laser ablation (EVLA) for preventing varicose vein recurrence. This sub-study examines complication rates associated with prophylactic ASV-ablation.
Methods: Among 1173 patients with refluxing GSV, 604 underwent GSV-ablation only, and 569 received additional ASV-ablation. Complication rates were compared over 6 months.
Results: Approximately 80% of patients were complication-free with minor bruising and dysesthesia being most common complications. After 6 months, additional prophylactic ASV-ablation did not increase the rate of complications compared to GSV-only treatment.
Conclusion: The 6-months follow-up data suggests that prophylactic ASV-closure, alongside GSV-treatment, is safe, with similar complication rates to GSV-only EVLA.

Watch this space?

Original Article

Phlebology

Diagnosis of post-thrombotic syndrome: International union of phlebology (UIP) survey of medical specialists

Nuo Xu[1,2], Manisha Siriwardene[1,2,3], Nikita Naidu[1,2,3], David E Connor[1,2], Alun H Davies[4], Peter Glovicki[5], Mark H Meissner[6] and Kurosh Parsi[1,2,3]

Abstract

Objective: To review the current approaches to the diagnosis of Post-Thrombotic Syndrome (PTS) and to evaluate the potential need for a diagnostic tool.

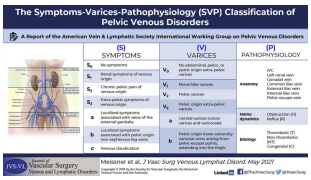
Method: Medical specialists were invited to participate in an online survey of their current approaches to the diagnosis and management of PTS, including the use of scoring systems, diagnostic imaging techniques and the extent the practitioner reviews the patient's venous history.

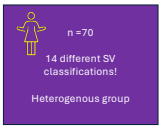
Results: 502 participants completed the survey. Over 80% obtained imaging reports to confirm a history of deep vein thrombosis (DVT). 72% of participants always obtained an up-to-date duplex ultrasound for PTS diagnosis. Over 50% did not use a scoring system for either PTS diagnosis or management. 63% of the participants agreed that a new system for PTS diagnosis should be devised.

Conclusion: Heterogeneity was observed in methods of diagnosing PTS by medical practitioners with frequent use of medical imaging studies and moderate use of scoring systems. Development of a new diagnostic tool for PTS should be considered for future studies.

Application of the Symptoms-Varices-Pathophysiology classification system in patients with pelvic venous disorders

Neel Gadhoke[1], Shreeya Bahethi[1], Gaurav Lakhanpal[1], Levan Sulakvelidze[1], Richard Kennedy[1], Sanjiv Lakhanpal[1,2] and Peter J Pappas[1,2]





Original Article

Phlebology

High intensity focused ultrasound in treating great saphenous vein incompetence: Perioperative and 1-year outcomes

Paolo Casoni[1], Daniele Bissacco[2], Matteo Pizzarniglio[1] and Emanuele Nanni[1]

Abstract

Background: To investigate the use of high intensity focused ultrasound (HIFU) for great saphenous vein (GSV) incompetence.

Material and methods: Patients with GSV incompetence underwent HIFU. The primary endpoint was the rate of GSV target segment shrinkage or closure after 1 year.

Results: Out of 188 limbs treated, the GSV treated segment shrinkage/closure rate at 1 week, 3 months, 6 months, and 12 months was 92.3%, 98.2%, 97.6%, and 98.3%, respectively.

Conclusion: These preliminary results suggest that HIFU holds promise for the treatment of GSV incompetence. Further trials are needed to compare it with other techniques and assess long-term outcomes.

n=188
Excellent closure

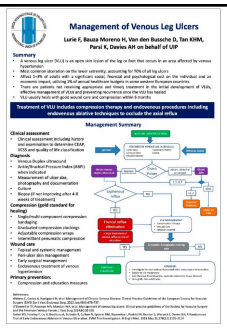
Figure 4. Summary of follow-up findings in 188 patients treated with great saphenous vein HIFU.

Short Report

Phlebology

Management of venous leg ulcers

Matthew Tan[1], Fedor Lurie[2], Hernan Bazca Moreno[3], Daphne Van den Bussche[4], Kurosh Parsi[5], Alun H Davies[6] and on behalf of UIP



Original Article

Phlebology

Current practice of cyanoacrylate endovenous ablation: American vein and lymphatic society position statement

Michael A Vasquez[1], Michael Di Iorio[2], Robert L Worthington-Kirsch[3], Elias Fakhoury[4] and John Blebea[5]

Abstract

Background: Cyanoacrylate endovenous ablation and closure of incompetent saphenous veins have become increasingly utilized since its approval for use in the United States in 2015. This increase in usage necessitates a societal update to guide treatment and ensure optimal and consistent patient outcomes.

Method: The American Vein and Lymphatic Society convened an expert panel to write an updated Position Statement with explanations and recommendations for the appropriate use of cyanoacrylate endovenous ablation for patients with venous insufficiency.

Result: A Position Statement was produced by the expert panel with recommendations for appropriate use, treatment technique, outcomes review, and potential adverse events. Their recommendations were reviewed, edited, and approved by the Guidelines Committee of the Society.

Conclusion: This societal Position Statement provides a useful document for reference for physicians and venous specialists to assist in the appropriate use of cyanoacrylate endovenous ablation in the treatment of patients with venous insufficiency.

Appropriate usage

Original Article

Phlebology

Implementation of a varicose vein module added to Swedvasc, the Swedish National Registry for vascular surgery

Lena Blomgren

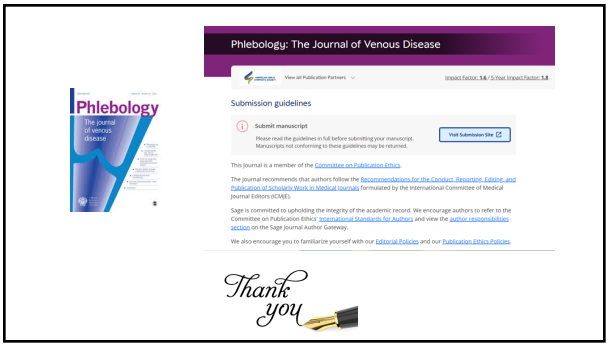
Abstract

Objectives: The addition of a varicose veins (VV) module to the existing Swedish National Registry for Vascular Surgery (Swedvasc) and its impact on quality of care were evaluated.

Methods: Vascular departments and private VV clinics were invited to enter data from 2016.

Results: Registrations were approximately 10,000 yearly but dropped to 5390 in 2022 when a fee was introduced for private clinics due to reduced funding. 88% more interventions were reported to Swedvasc 2020 than to the National Board of Health and Welfare. Regions differed in interventions per 100,000 inhabitants/year from 21 to 233 and in preoperative CEAP C4–6 from 30.8%–90.4%. Follow-up was 9.4%. These data contributed to the decision to prioritize the patient group for national guidelines and pathways of care, which will be monitored by Swedvasc.

Conclusions: A national VV registry with high coverage is possible and can contribute to national quality of care. The main challenge is funding.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