VEITH SYMPOSIUM

Would Treatment Of The Whole Length Of The GSV Reduce Recurrence And Reinterventions?

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IMPERIAL

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For people with confirmed varicose veins and truncal reflux:

- *Offer endothermal ablation (radiofrequency ablation or endovenous laser ablation).*
- *If endothermal ablation is unsuitable, offer ultrasound-guided foam sclerotherapy.*
- *If ultrasound-guided foam sclerotherapy is unsuitable, offer surgery.*

esvs

For patients with great saphenous vein incompetence requiring treatment, endovenous thermal ablation is recommended as first choice treatment, in preference to high ligation/stripping and ultrasound guided foam sclerotherapy.

For the moment, RCT data looking at feasibility, safety, and long term results of fEVLA [flush EVLA] are still lacking

American Venous Forum
Promoting venous and lymphatic health

4.1.1. For patients with symptomatic varicose veins and axial reflux in the GSV, who are candidates for intervention, we recommend treatment with endovenous ablation over high ligation and stripping (HL&S) of the GSV.

5.2.5. In patients with reflux in the below-knee GSV, ablation to the lowest point of reflux resulted in better early outcome. Nonthermal techniques are preferred for ablation of refluxing distal calf saphenous veins to avoid thermal nerve injury.

MEETING REPORT

Recurrent varices after surgery (REVAS), a consensus document

Michel R. Perrin*, J. Jerome Guex, C. Vaughan Ruckley, Ralph G. dePalma, John P. Royle, Bo Eklof, Philippe Nicolini, Georges Jantet and the REVAS group
France

Factors predisposing to recurrence, recommendations for primary prevention

Factors of recurrence

1. Recurrence from inadequate or incomplete initial treatment
   (a) tactical error: failure to adequately identify initial pathology.
   (b) technical error: failure to carry out technically adequate primary treatment.
   (c) incomplete: failure to complete the primary plan of treatment.
2. Recurrence from evolution or progression of varicose disease.

Pathogenesis and etiology of recurrent varicose veins

Maresa Brake, MBBS, BSc, Chung S. Lim, MRCS, PhD, Amanda C. Shepherd, MRCS, MD, Joseph Shalhoub, MRCS, PhD, and Alun H. Davies, DM, FRCS, *London, United Kingdom*

Causes	*Explanation*
Tactical error	The persistence of venous reflux in a saphenous trunk resulting from erroneous or inadequate preoperative evaluation and inappropriate surgery
Technical error	The persistence of venous reflux due to inadequate or incomplete surgical technique
Disease progression	As a result of the natural history and evolution of the disease
Neovascularization	The presence of reflux in previously ligated saphenofemoral junctions cause by development of thin incompetent serpentine veins linked with a thigh varicosity

Conclusions: **Recurrence remains poorly understood following treatment of varicose veins. Neovascularization is an established and common cause of RVV, although other factors may contribute. (J Vasc Surg 2013;57:860-8.)**

Recurrence of varicose veins after endovenous ablation of the great saphenous vein in randomized trials

Thomas F. O'Donnell, MD,[1] Ethan M. Balk, MD, MPH,[2] Meghan Dermody, MD, MS,[1] Erica Tangney, BA,[1] and Mark D. Iafrati, MD,[1] *Boston, Mass*

Conclusions: **There is no difference in the incidence of REVAS for EVA vs L&S, but the causes of REVAS are different with L&S, which has important implications for treatment. (J Vasc Surg: Venous and Lym Dis 2016;4:97-105.)**

Original Article

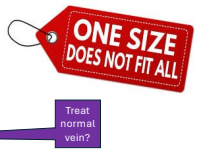
Phlebology

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[4], Suat Doganci[5] and Mark Meissner[6]

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.



Treat normal vein?

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[2], 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[3], Felizitas Pannier[10], Lorenz Uhlmann[11] 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?

Below the knee?

Extended EVA (both above and below knee):
- Improved patient reported symptoms
- Improved Aberdeen Varicose Vein Severity score
- Reduced rates of varicose vein recurrence

> J Vasc Interv Radiol. 2007 Dec;18(12):1495-9. doi: 10.1016/j.jvir.2007.07.029.

Endovenous laser treatment of incompetent below-knee great saphenous veins

Paul E Timperman [1]

Affiliations + expand

PMID: 18057283 DOI: 10.1016/j.jvir.2007.07.029

Randomized Controlled Trial > J Vasc Surg. 2008 Jul;48(1):173-8. doi: 10.1016/j.jvs.2008.01.062. Epub 2008 Apr 28.

Endovenous laser ablation: does standard above-knee great saphenous vein ablation provide optimum results in patients with both above- and below-knee reflux? A randomized controlled trial

Nadarajah S Theivacumar [1], Demos Dellagrammaticas, Andrew I D Mavor, Michael J Gough

> J Vasc Surg Venous Lymphat Disord. 2014 Oct;2(4):397-402. doi: 10.1016/j.jvsv.2014.04.004. Epub 2014 May 24.

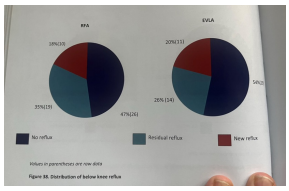
Reflux in the below-knee great saphenous vein can be safely treated with endovenous ablation

Shaun M Gifford [1], Manju Kalra [2], Peter Gloviczki [2], Audra A Duncan [2], Gustavo S Oderich [2], Mark D Fleming [2], Scott Harmsen [2], Thomas C Bower [2]

Randomized clinical trial

Randomized clinical trial of VNUS® ClosureFAST™ radiofrequency ablation *versus* laser for varicose veins

A. C. Shepherd, M. S. Gohel, L. C. Brown, M. J. Metcalfe, M. Hamish and A. H. Davies



At 6 months 19 % of BK new reflux

also

30% left with residual reflux.

The need for perforator treatment after VenaSeal and ClosureFast endovenous saphenous vein closure in CEAP 6 patients

Misaki M. Kiguchi, MD, MBA, FACS,[a] Kyle B. Reynolds, MD,[a] Bianca Cutler, MSN, FNP-C,[a] Eshetu Tefera, MS,[b] Mariya Kochubey, MD,[c] Rachel Dirks, PhD,[c] Steven D. Abramowitz, MD,[a] Edward Y. Woo, MD,[a] and Leigh Ann O'Banion, MD, RPVI.[c] *Washington, DC and Fresno, Calif*

Table II. Incidence of perforator reflux, perforator radiofrequency ablation (RFA), and sclerotherapy in CEAP 6 limbs

Limbs	Overall — 119	RFA — 68	VenaSeal — 51	*P* value
Perforator				
↑ reflux	54 (45)	39 (57)	15 (29)	.002
Requiring procedure	25 (19)	19 (28)	4 (8)	.009
Sclerotherapy	19 (16)	11 (16)	8 (16)	.942

Data represent number (%).

A comparison of cyanoacrylate glue and radiofrequency ablation techniques in the treatment of superficial venous reflux in CEAP 6 patients

Leigh Ann O'Banion, MD, FACS,[a] Kyle B. Reynolds, MD,[a] Mariya Kochubey, MD,[b] Bianca Cutler, MSN, FNP-C,[a] Eshetu A. Tefera, MS,[a] Rachel Dirks, PhD,[b] and Misaki M. Kiguchi, MD, MBA, FACS[a]
Fresno, Calif, and Washington, D.C.

Retrospective

Treatment of more distal vein led to less IPVs to treat

Research Article

Factors Associated with Recurrence of Varicose Veins after Thermal Ablation: Results of The Recurrent Veins after Thermal Ablation Study

R. G. Bush,[1] P. Bush,[1] J. Flanagan,[2] R. Fritz,[1] T. Gueldner,[1] J. Koziarski,[1] K. McMullen,[3] and G. Zumbro[1]

REVATA study n=2380

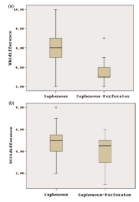
5. Conclusion

The majority of recurrences were in association with perforating veins. New AAGSV and SSV insufficiency was responsible for 40% of those patients who developed recurrent venous disease. The use of standard protocols and routine US examinations may reduce the frequency of saphenous vein recanalization after thermal ablation. New insufficiency in the unablated GSV can be reduced by beginning thermal ablations at midcalf. In the REVATA study, laser ablation of the GSV was statistically superior to RF, using first generation devices.

Treat lower down reduces distal insufficiency

Endovenous laser ablation and foam sclerotherapy for varicose veins: does the presence of perforating vein insufficiency affect the treatment outcome?

Mert Köroğlu[1], Hüseyin Naim Eriş[1], Aykut Recep Aktaş[1], Mustafa Kayan[1], Ahmet Yeşildağ[1], Meltem Çetin[1], Cem Parlak[2], Cemil Gürses[3] and Okan Akhan[4]



Better clinical outcome and lower recurrence if perforator treated

Up to the SFJ?

EVLA flush to SFJ:
- Technically feasible in most cases
- Low rates of endovenous heat-induced thrombosis
- Lower varicose vein recurrence rates

Observational Study · J Vasc Surg Venous Lymphat Disord. 2020 Nov;8(6):1006-1013. doi: 10.1016/j.jvsv.2020.01.017. Epub 2020 Apr 10.

Feasibility and safety of flush endovenous laser ablation of the great saphenous vein up to the saphenofemoral junction

Luca Spinedi [1], Hans Stricker [2], Hak Hong Kea [3], Daniel Staub [4], Heiko Uthoff [5]

Randomized Controlled Trial · Vasa. 2022 Jul;51(4):222-228. doi: 10.1024/0301-1526/a001007. Epub 2022 May 9.

Lower prevalence of stump reflux after endovenous laser flush ablation of the great saphenous vein

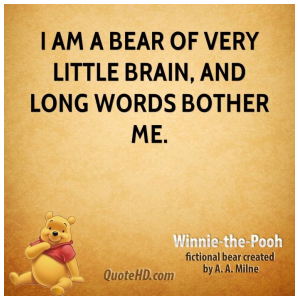
Juris Rits [1], Uldis Maurins [1], Eberhard Rabe [2], Arnolds Kadiss [1], Sandra Prave [1], Rets Vigants [1], Ints Brunenieks [1], Felicitas Pannier [2 3]

PLoS One. 2021 Jan 7;16(1):e0245275. doi: 10.1371/journal.pone.0245275. eCollection 2021.

Feasibility and potential significance of prophylactic ablation of the major ascending tributaries in endovenous laser ablation (EVLA) of the great saphenous vein: A case series

Lars Müller [1], Jens Alm [1]

In 2024 should we consider treating hemodynamically normal veins to reduce varicose vein recurrence/re-intervention?



Thank you

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