

Varicose Veins and Venous Hypertension



Dr Mayo Theivendran

Up to 50% of the population can present on the spectrum of venous hypertension. This can result in functional, medical and cosmetic concern.

Main aetiological components are

- Inadequate calf pump function
- Valvular incompetence
- Venous obstruction

Symptoms

- Visual – cosmetic concern, oedema, inflammatory skin change, ulcers
- Superficial thrombophlebitis (STP) progressing to DVT without anticoagulation
- Bleeding

Non specific symptoms

- Fatigue
- Heaviness
- Discomfort
- Restless legs
- Pruritus

CEAP Classification of chronic venous disease

CEAP classification of chronic venous disease	Clinical classification
C0	No visible or palpable signs of venous disease
C1	Telangiectasies or reticular veins
C2	Varicose veins
C3	Edema
C4a	Pigmentation or eczema
C4b	Lipodermatosclerosis or atrophie blanche
C5	Healed venous ulcer
C6	Active venous ulcer

Public wait list NSW if greater than C3 (skin change and or STP/bleeding) – wait time approx. 6-9 months

Insured patients – C1 and above meet indication.

Diagnosis

Clinical assessment

- Assess for signs of venous hypertension
- Assess distribution and size of varicosities

Venous duplex assessment

- Venous insufficiency scan of lower limb
- Abdominal and pelvic venous insufficiency if atypical pattern (fed by ovarian vein reflux and pelvic congestion in most circumstances leading to early recurrence)
- Determine arterial inflow status

Duplex scanning can demonstrate the competency and patency of the deep and superficial venous system. It will also allow for anatomical characteristics of the insufficiency which will impact the surgical method of ablation.

First line treatment

- Encourage mobilisation with regular walking to improve calf pump function
- Compression therapy (25-35mmHg) below knee stocking in absence of arterial insufficiency. Not required in bed
- Elevating limb when at rest
- Weight loss

When to consider vascular surgical assessment

- Arterial insufficiency inhibiting compression
- STP, bleeding, Skin changes
- Symptoms of venous hypertension (oedema, pain, restless legs, pruritus) not manageable with compression
- Cosmetic concern

Urgent referrals accommodated for when STP, bleeding, chronic ulcers.

Surgical options for Superficial Venous Insufficiency

Open Surgery

- Stripping, ligation of perforators, stab avulsion
- Has 97% success rate but has prolonged recovery time and more painful
- DVT risk is 3-5%
- Reserved for when contemporary endovenous option is not anatomically suitable (large vein diameter, extreme tortuosity and complex recurrent sapheno-femoral junction)

EndoVenous:

- 97% technical success, rapid recovery and minimal pain
- The DVT risk is 1%

Sclerotherapy:

- Reserved for spider and reticular veins due to 60% primary success rate. May need 2 or 3 cycles.
- Good option for cosmetic result when major axial vein insufficiency ablated

Hybrid approach (open and endovenous +/- sclerotherapy):

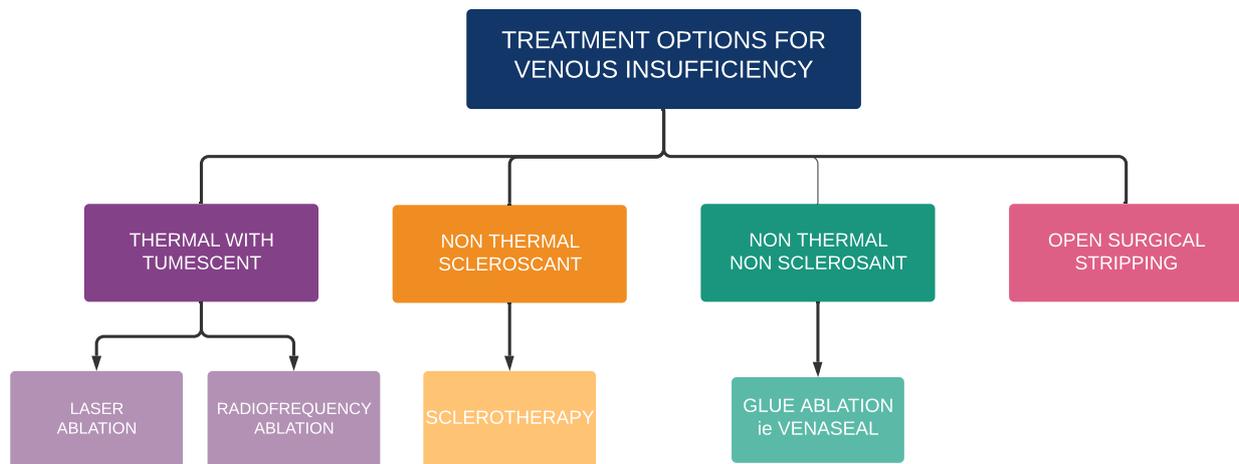
- May need to be employed in complex recurrence and to treat primary varicose veins effectively to mitigate risk of DVT and recurrence

Post procedure instructions:

- Compression stockings 4 weeks (First 2 weeks 24 hours, following 2 weeks 12 hours)
- No gym work, running, swimming for 4 weeks
- No long haul flights for 4 weeks
- Review with Dr Theivendran in week 1 week post procedure with ultrasound to exclude DVT
- Final review at 6 weeks
- Ultrasound follow up bulk billed for all patients

Risks of Venous surgery

- DVT 1-3%, neuroprexia/numbness at avulsion sites 3%, haematoma/bruising which will resolve within 3 months



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This snapshot has been developed by Dr Mayo Theivendran for GPs.