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Thus, stratification of the severity of insufficiency or reflux times, rather than using the arbitrary cutoff of 0.5 seconds is critical to determining which of the superficial veins would benefit from endovenous ablation and, in cases of mixed insufficiency, the reflux times (in seconds) as well as the reflux velocities are absolutely necessary to selecting patients likely to realize significant benefit. If one suspects they may have venous insufficiency, it is our recommendation to obtain a referral if needed or make an appointment with a qualified Vein Specialist for a full evaluation including a comprehensive venous insufficiency ultrasound.

Vein Specialist's goal is not to simply find patients with leaky veins and seal them. We focus on cultivating interest in and awareness of venous insufficiency in the general public as well as reaching out to, and offering educational materials to physicians of all backgrounds and specialties. Venous insufficiency is a broad diagnosis which encompasses a diverse patient population including more than those with only the most obvious clinical findings

of bulging varicose veins. Our website offers video lectures and discussions about the historical treatments of venous insufficiency and more importantly up to date information on the modern evaluation and treatment techniques which we have been employing for the last 10 years. We are dedicated to defining venous insufficiency in as specific and individual terms as possible so that patients and physicians will be able to fully appreciate the full spectrum of this disease. Our extensive gallery of pre and post procedure photographs illustrates this full spectrum and is just a small sample of our actual patients. Vein Specialists is 100% focused on evaluating patients with ultrasound, stratifying the disease we find, correlating these findings with the patient's clinical findings, and determining whether endovenous ablation or other procedures have a significant chance of improving patients' clinical conditions. These conditions may be a bit more obscure than the garden variety varicose or spider veins and we encourage the public to consider venous insufficiency in the differential diagnosis of their swollen legs, non-healing ulcers, restless legs syndrome, nocturnal leg cramps, nocturnal urination, neuropathy, tarsal tunnel syndrome, volume overload, and other symptoms affecting their lower extremities.

In the past few months I have seen a few dozen patients who have had urologic evaluations for nocturnal urination (all with swollen legs) in whom venous ultrasound evaluation confirmed severe superficial venous insufficiency. Following successful endovenous ablation (sealing leaky veins), their nocturnal diuresis resolved and they were able to sleep through the night without having to make frequent trips to the bathroom. Other patients have presented with the diagnosis of idiopathic lymphedema of one or both legs without any identifiable

surgical, infectious or familial cause, yet had not been studied for venous insufficiency. These patients also had severe superficial venous insufficiency and the only way to determine the venous contribution to their "lymphedema" was to seal the severely abnormal veins. Other musculoskeletal and orthopedic conditions we have encountered and achieved success with endovenous treatment include tarsal tunnel syndrome in a 40 year old male who failed surgical tarsal tunnel releases. He was noted on the op note to have extensive varices in the tunnel and second opinion podiatry evaluation led to referral for further venous evaluation and the diagnosis of severe bilateral great saphenous vein insufficiency was identified by our exam. Staged endovenous ablation after trial of compression hose resulted in near complete resolution of his preop symptoms. Tendonitis around the distal leg, ankle or foot in a patient with severe leg swelling or other more obvious signs of venous insufficiency such as skin discoloration, thickening or large varicose veins in the same extremity, should prompt one to consider venous insufficiency as a potential contributing factor and referral for formal venous evaluation would be logical.

We appreciate the confidence many physicians and patients have placed in us in referring their patients, friends and families and hope that they will continue to recognize the wide range of clinical presentations of significant venous insufficiency, some of which are often somewhat obscure, and allow us the opportunity to offer them a thorough, scientific venous examination and ultrasound evaluation. We will treat them according to the Golden rule, when severe correlative disease is identified, conservative therapy has proven ineffective and the likelihood for significant clinical improvement is near certain.

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