MORE THAN JUST VARICOSE VEINS!

By Dr. Joseph Magnant

When we here the diagnosis "Varicose veins", most folks dismiss it incorrectly as something that is better off left alone, uninvestigated.

Many patients have been advised to leave their varicose veins alone unless they have pain or complications suchas blood clots, inflammation or bleeding. Others may present with leg swelling and pain, without the classic external signs of varicose veins only to be told their swollen painful legs were a result of aging, their body habitus or their weight, with no further consideration of venous pathology entertained. Patients have been told their discolored and thickened skin around their ankles and lower legs was the result of diabetes, medication or some other obscure disease, and often have suffered for years unaware that a cure may have been within easy reach for their venous stasis dermatitis. Bleeding varicose veins may have been cauterized or ligated in the emergency room on multiple occasions without any thought of getting to the bottom of the problem responsible for the varicosities. Mothers of teenagers have been told their daughters painful, tight legs were the result of "growing pains" while the bulging varicose vein below the knee was dismissed as unrelated and cosmetic. I offer this partial list of real life scenarios I have heard from actual patients as food for thought for all who come across this article.

It has been said that the sign of a wise person is one who recognizes their limitations and keeps an open mind, calling on others more learned in other areas to assist in areas foreign to themselves. Venous insufficiency encompasses much more than just spider or minor varicose veins. It is time physicians and patients wake up to the reality that ignoring venous hypertension, which is the result of leaking leg vein valves (venous insufficiency) often leads to avoidable medical complications, infections, cellulitis, bacteremia, blood clots, external hemorrhage, stasis dermatitis the associated pain of thickened and inflamed skin at the ankle, and lastly, venous ulceration are often the direct result of unrecognized or untreated venous insufficiency. Patients should take an active interest in their health and wellbeing and develop a natural curiosity of what they observe happening to their bodies. Since when is bleeding from a varicose vein normal? How long should one wait for a leg wound to heal? Why is the eczema affecting only the swollen leg and ankle? If my swollen leg is part of aging then why is only the left leg aging (swollen)? Some things do not take a physician to tell you there is a problem. Sometimes we need to listen to our gut feeling. And if that doesn't work then listen to your wife! Education and empowerment are readily available; one need only have the interest in seeking out the answers through internet resources.

In the year 2000, the treatment of Venous Insufficiency changed dramatically, as if we had been in the dark and had a bright light turned on. Endovenous closure changed the evaluation and treatment paradigm for patients with all of the above noted presenting symptoms and signs as well as others noted below. This minimally invasive technique of sealing the incompetent (leaky) vein from within (rather than stripping the vein out) offers very effective and immediate remedy of the underlying problem of high venous pressure. Presenting symptoms other than varicose veins may include swollen achy legs, leg cramps, thickened and discolored skin, external bleeding from an eroded vein just under the skin to ulceration of the skin in the ankle area. Other, more obscure and less appreciated signs and symptoms include nigh-time leg cramps, restless legs syndrome, and frequent night-time urination. An estimated 35-40 million adults in the U.S.A. suffer from these more commonly appreciated and recognized presenting symptoms. Countless others may also be affected by this same disease and may be either undiagnosed or misdiagnosed.

The physical, emotional and functional impact of severe venous insufficiency is not quantifiable as the true prevalence of the disease is not known. Persistent misperceptions of the general public regarding the symptoms of the disease, the method of diagnosing the disease and most importantly the available treatment options remain hurdles for today's Vein Specialists. The natural history of untreated severe superficial venous insufficiency has been well documented in the wound care centers around the nation as unchecked venous hypertension progresses from benign appearing varicose veins to chronically swollen limbs years later, to skin changes which ensue in subsequent years resulting in one or more serious complications such as bleeding, infection and ulceration.

Endovenous closure can be safely performed in a completely outpatient setting under local anesthesia with very little time lost from work or normal activity. Venous insufficiency is accurately and reliably diagnosed with duplex ultrasound in the capable hands of an experienced registered vascular technologist. Duplex ultrasound allows for stratification of the severity of venous insufficiency which is critical to the decision phase and planning of subsequent treatments. Not all insufficient veins need to be sealed. Only those severely leaking veins in the distribution of the patient's symptoms and pathology should be considered for ablation after failure of conservative therapy.

Endovenous closure or ablation has allowed a more proactive approach to patients with this disease. Rather than reacting to the complications of the disease with compression wraps, wound care and submission, we now have a much more definitive, effective and noninvasive therapy to offer patients with appropriate indications for intervention. Minimally invasive endovenous ablation has opened the door to millions of adults who were once thought to be "too sick" for stripping, "too young" for stripping, "too obese" for stripping, "too old" for stripping, "too anti-coagulated" for stripping and now we should be encouraged to reconsider these and many other patients for a more definitive treatment. Our understanding of lower extremity venous pathophysiology has improved over the past 10 years due to the introduction of ultrasound guided, percutaneous endovenous techniques. Endovenous closure is not a license to seal veins at will. Rather, it is a minimally invasive, highly effective method which, in experienced hands and judiciously applied, has changed, for the better, the lives of many patients with symptomatic superficial venous insufficiency. Endovenous closure has indeed changed the treatment paradigm of venous insufficiency as much as any other modern minimally invasive technique in any other disease entity and we will not likely witness as significant a technologic advancement in the treatment of superficial venous insufficiency in the next 20 years.

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