Controversies :

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Should we still offer surgical intervention for varicose veins ?

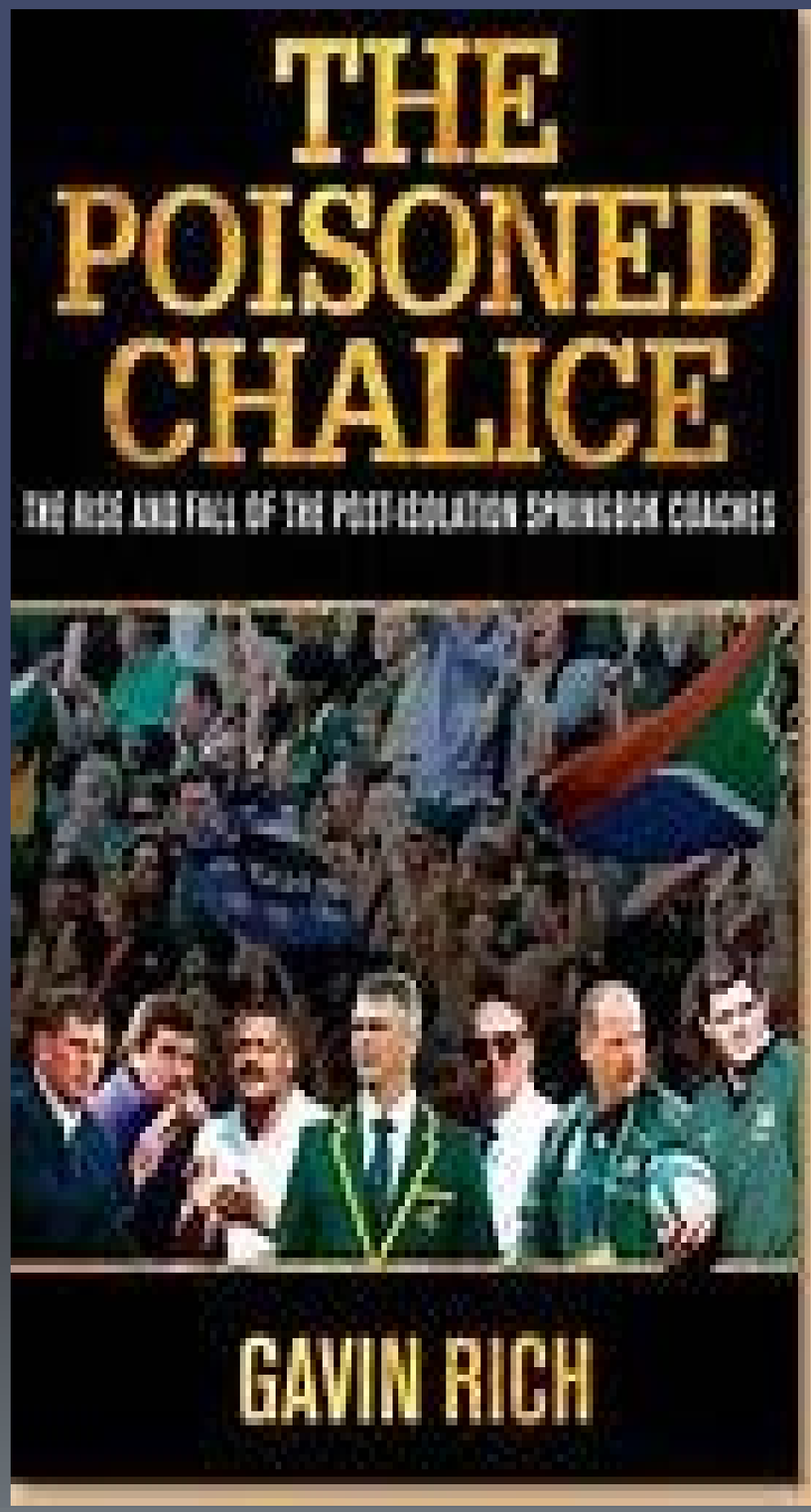
Against the motion

NJ Cloete

Vascular Unit

Sefako Makgatho Health Sciences University

Dr. George Mukhari Academic Hospital


THE
POISONED
CHALICE
THE RISE AND FALL OF THE POST-EXPULSION SPRINGBOK COACHES
GAVIN RICH


SHOWER HEAD
GOLDEN SHOWER HEAD

Table 55-5 Treatment of Venous Disorders Based on Pathophysiology

Venous Pathophysiology	Primary Treatment	Secondary Treatment*
REFLUX		
Superficial saphenous tributaries	For varicose veins saphenous vein ablation (1B), compression (2C). For venous ulcer compression (1B), for recurrent venous ulcer ablation of superficial vein in addition to compression (1A)	Sclerotherapy (1B), foam (1B), ligation and stripping (2B), phlebectomy, or pharmacologic (2B); phlebectomy or sclerotherapy (1B)
Deep	Compression	Valve reconstruction
Perforator	Compression (C5-C6)	Ablation, foam, ligation, or SEPS (2B)
OBSTRUCTION (NONACUTE)		
Central	Compression, venous stenting	Venous stenting
Peripheral	Compression	Valve reconstruction
Muscle pump dysfunction	Compression	Structured exercise

SEPS, Subfascial endoscopic perforator surgery.

*Ablation indicates endovenous radiofrequency and laser ablation. Pharmacologic includes the micronized purified flavonoid fraction (Daflon), horse chestnut seed extract. Central obstruction indicates vein segments involving the femoroiliocaval segments, and peripheral vein segments involve the femoropopliteal segments. Grade recommendations where applicable from Clinical Practice Guidelines are in parenthesis.[59]

INDICATIONS FOR VV SURGERY

Symptomatic vv

Complicated vv

-thrombophlebitis
- variceal bleeding
- leg ulceration

-

Trends in Patient Reported Outcomes of Conservative and Surgical Treatment of Primary Chronic Venous Disease Contradict Current Practices

Fedor Lurie, MD, PhD and Robert L. Kistner, MD

Objective: To analyze patient-reported quality of life (QOL) and symptoms in a prospective cohort of CVD patients who was managed within the framework of existing policies.

Study Design: Prospective cohort study of 150 patients with C2–C4 clinical class of primary chronic venous disease (CVD). Management consisted of initial conservative measures, following which patients were given a choice of continuing conservative therapy, or surgical treatment. Patients completed Specific Quality of Life and Outcome Response–Venous (SQOR-V) tool before initial visit, after completion of conservative treatment, and at 1 and 12 month follow up visits after surgical treatment. Management consisted of initial conservative measures. QOL score and symptom score (SS) part of this instrument was analyzed separately.

Results: Conservative treatment resulted in improvement of symptom score in 85(57%) patients, and the QOL in 111(74%) patients. Despite this improvement, the majority of patients (121) chose surgical option. At the 1-month follow up after surgical treatment 97 (80%) patients reported significant improvement of their symptoms and 114 (94%) in the QOL compare to their status after conservative therapy. The QOL improvement was due mainly to improvement in symptom score. Patients who improved after conservative therapy were more than 15 times more likely to have symptoms relief at 1 month (RR = 15.6, 95% CI 4.3–56.5), and 21 times higher at 1 year after surgery (RR = 21.3, 95% CI 4.7–96.9) compared with those who did not change the SS.

Conclusions: Surgical treatment resulted in a better relief of symptoms compare to conservative therapy. The relief of symptoms after conservative therapy predicts better outcomes of surgical treatment. These findings suggest that success of conservative measures should be considered as an indication, and the failure of conservative therapy should not be an indication to surgical treatment.

(*Ann Surg* 2011;254:363–367)

Primary chronic venous disease (CVD) is widespread in the population. It is a progressive chronic condition with manifestations ranging from varicose veins to leg ulcers. This condition can be asymptomatic, but many patients have various leg symptoms.[1,2] The Medicare and Medical Insurance policies consider interventional treatment of varicose veins medically necessary if the patient remains

Justification of such policies has not been validated. There is no high level evidence that conservative therapy can obviate the need for invasive treatment, and the proportion of patients in whom this occurs has never been directly measured. The symptoms of CVD and their change in response to different treatments have been specifically addressed in just a few studies.[8–12] The patient-reported outcome (PRO) instruments were rarely used in studies of CVD in the past causing clinical trials to become subject to interpreter bias and questionable validity.

The transition from paternalistic to patient-centered medicine requires examination of the practice guidelines and policies from the patients' perspective of disease severity and treatment outcomes.[13] Addressing this need, this study analyzed patient-reported QOL and symptoms in a prospective cohort of CVD patients who were managed within the framework of existing policies.

METHODS

The study population comprised of 150 consecutive patients with primary CVD who met the inclusion criteria. Patients were included if they had confirmed primary etiology, unilateral involvement, axial reflux in the Great Saphenous Vein (GSV) defined as reflux in thigh and calf segments ($A_{2,3}$),[1] C2–C4 clinical classes, and did not use compression stockings for at least a year. The CEAP classification[2] of the included patients was C2–C4 E_P $A_{2,3}$ P_r. They were selected from 341 primary CVD patients that were treated at Kistner Vein Clinic during 12 month period. Reasons for excluding patients from the study were C6–C5 class in 28 patients, bilateral GSV involvement in 56 patients, involvement of the Small Saphenous Vein in 27 patients, current or recent use of compression stockings in 36 patients, noncompliance with compression therapy in 10 patients. Thirty-four patients who expressed difficulties in completing the QOL form, or who were judged to have English language comprehension problems were not included in the study.

As a part of their initial documentation before their first visit, all patients received by mail the SQOR-V form, which is a disease-specific quality of life assessment tool (DSQOL). All patients returned completed forms before their initial consultation. At the first visit, all patients were examined clinically and by duplex ultrasound. As initial treatment, all patients were prescribed class 1 (20–30

SYMPTOMATIC VV

- A good clinical response to compression predicts response to surgical intervention

THROMBOPHLEBITIS

- Systemic review

- 6 studies

- Surgery vs anticoagulation - similar outcomes

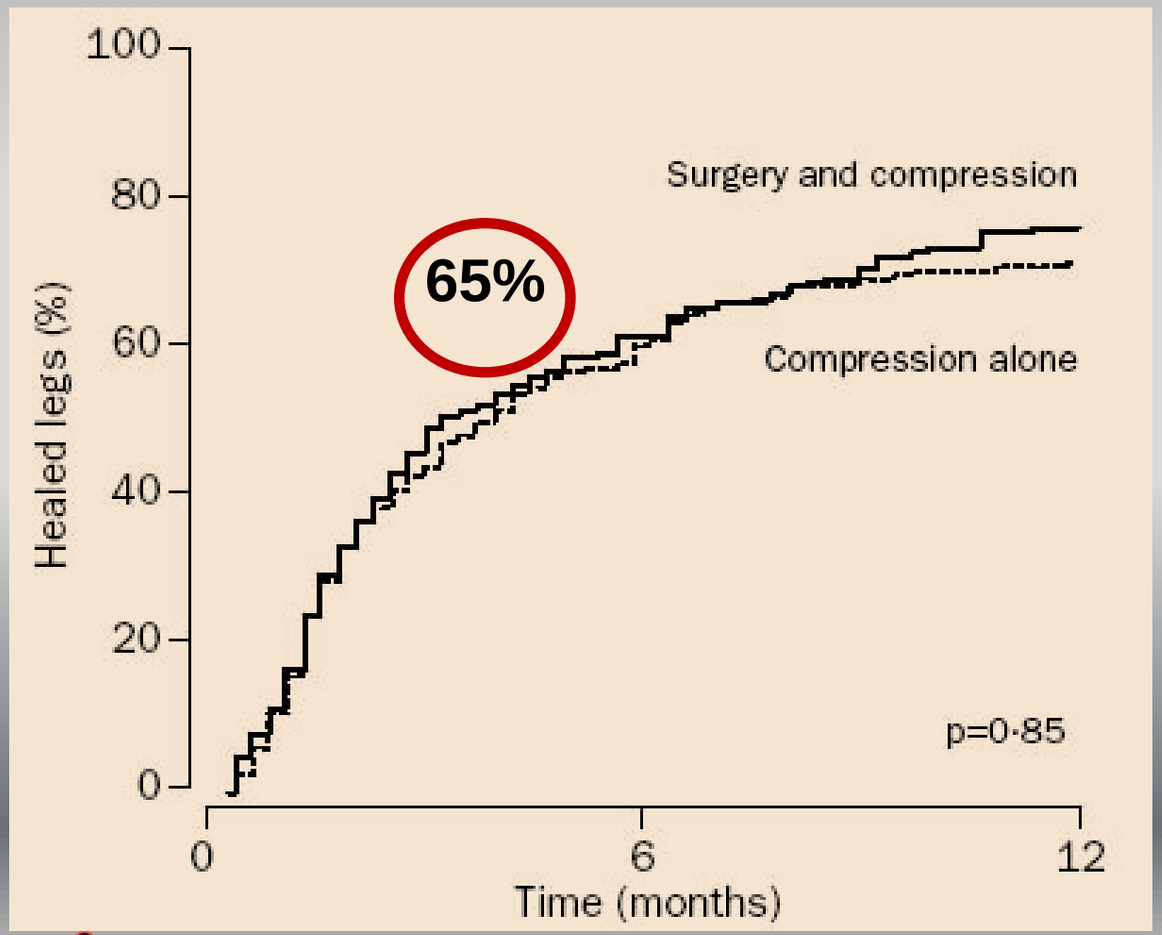
- 7,7 % complication rate surgery

Comparison of surgery and compression with compression alone in chronic venous ulceration (ESCHAR study): randomised controlled trial

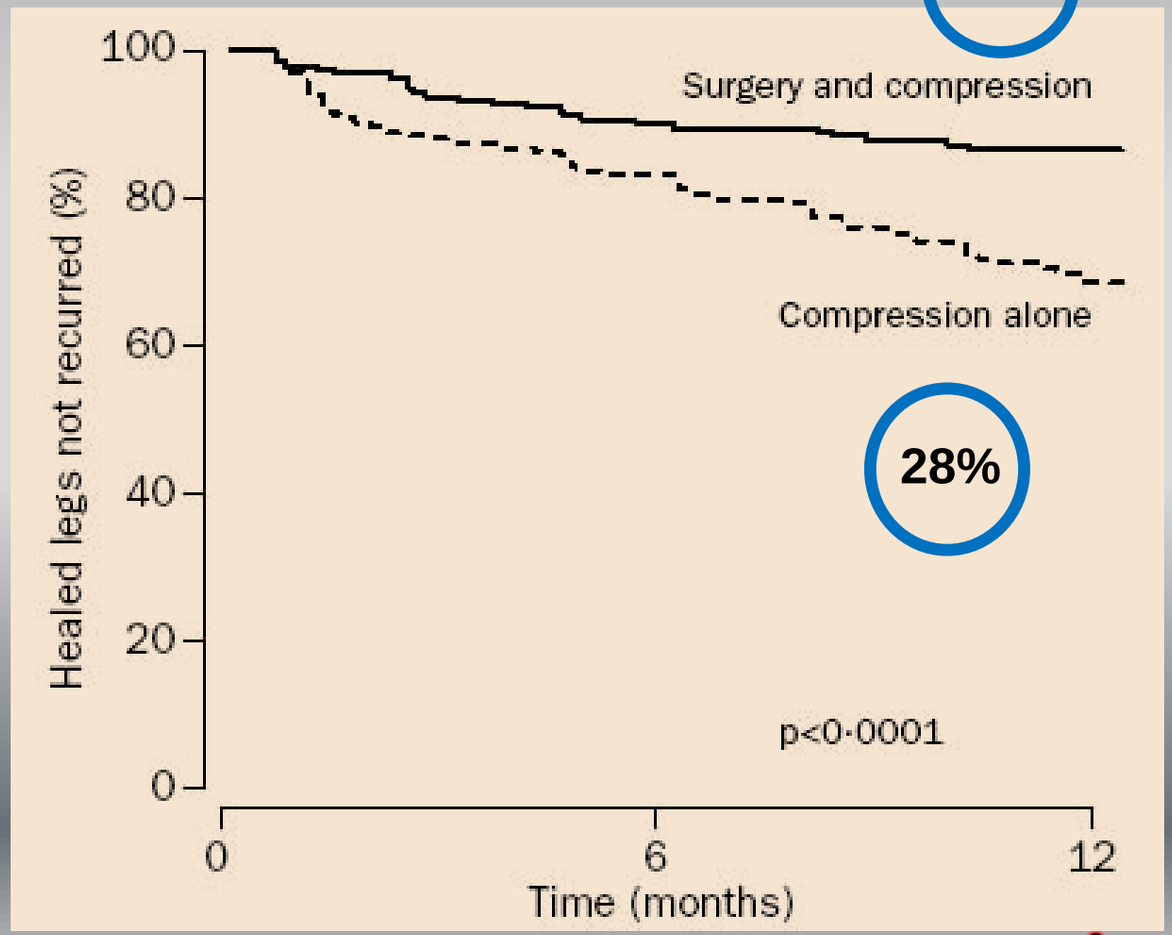
Jamie R Barwell, Colin E Davies, Jane Deacon, Kate Harvey, Julia Minor, Antonio Sassano, Maxine Taylor, Jenny Usher, Clare Wakely, Jonathan J Earnshaw, Brian P Heather, David C Mitchell, Mark R Whyman, Keith R Poskitt

Lancet 2004; **363:** 1854–59

HEALING



RECURRENCE



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

A Randomized Trial of Early Endovenous Ablation in Venous Ulceration

Manjit S. Gohel, M.D., Francine Heatley, B.Sc., Xinxue Liu, Ph.D., Andrew Bradbury, M.D., Richard Bulbulia, M.D., Nicky Cullum, Ph.D., David M. Epstein, Ph.D., Isaac Nyamekye, M.D., Keith R. Poskitt, M.D., Sophie Renton, M.S., Jane Warwick, Ph.D., and Alun H. Davies, D.Sc., for the EVRA Trial Investigators*

ABSTRACT

BACKGROUND

Venous disease is the most common cause of leg ulceration. Although compression therapy improves venous ulcer healing, it does not treat the underlying causes of venous hypertension. Treatment of superficial venous reflux has been shown to reduce the rate of ulcer recurrence, but the effect of early endovenous ablation of superficial venous reflux on ulcer healing remains unclear.

METHODS

In a trial conducted at 20 centers in the United Kingdom, we randomly assigned 450 patients with venous leg ulcers to receive compression therapy and undergo early endovenous ablation of superficial venous reflux within 2 weeks after randomization (early-intervention group) or to receive compression therapy alone, with consideration of endovenous ablation deferred until after the ulcer was healed or until 6 months after randomization if the ulcer was unhealed (deferred-intervention group). The primary outcome was the time to ulcer healing. Secondary outcomes were the rate of ulcer healing at 24 weeks, the rate of ulcer recurrence, the length of time free from ulcers (ulcer-free time) during the first year after randomization, and patient-reported health-related quality of life.

RESULTS

Patient and clinical characteristics at baseline were similar in the two treatment groups. The time to ulcer healing was shorter in the early-intervention group than in the deferred-intervention group; more patients had healed ulcers with early intervention (hazard ratio for ulcer healing, 1.38; 95% confidence interval [CI], 1.13 to 1.68; P=0.001). The median time to ulcer healing was 56 days (95% CI, 49 to 66) in the early-intervention group and 82 days (95% CI, 69 to 92) in the deferred-intervention group. The rate of ulcer healing at 24 weeks was 85.6% in the early-intervention group

From Cambridge University Hospitals NHS Foundation Trust, Cambridge (M.S.G.), the Department of Surgery and Cancer (M.S.G., F.H., A.H.D.) and Imperial Clinical Trials Unit (X.L., J.W.), Imperial College London, London, University of Birmingham, Birmingham (A.B.), Gloucestershire Hospitals NHS Foundation Trust, Gloucester (R.B., K.R.P.), the Medical Research Council Population Health Research Unit and the Clinical Trial Service Unit and Epidemiological Studies Unit, Nuffield Department of Population Health, University of Oxford, Oxford (R.B.), University of Manchester, Manchester (N.C.), Worcestershire Acute Hospitals NHS Trust, Worcester (I.N.), North West London Hospitals NHS Trust, Harrow (S.R.), and University of Warwick, Coventry (J.W.) — all in the United Kingdom; and the University of Granada, Granada, Spain (D.M.E.). Address reprint requests to Dr. Davies at the Section of Vascular Surgery, Department of Surgery and Cancer, Imperial College London, Charing Cross Hospital, London W6 8RF, United Kingdom, or at a.h.davies@imperial.ac.uk.

*A complete list of the Early Venous Reflux Ablation (EVRA) trial investigators is provided in the Supplementary Appendix, available at NEJM.org.

COMPLICATED VV

- The dogma of mandatory surgical treatment of complicated varicose veins should be challenged given the lack of evidence to support this practice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BUDGET TODAY
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FINANCIAL IMPLICATIONS

- US Data-2011
- Cleveland clinic study
- $ 16 524 per patient /year – R 247 860
- Leg Ulcer Therapy

FINANCIAL IMPLICATIONS

- In a resource constrained country like South Africa the routine surgical treatment cannot be justified

- THANK YOU