ABOUT DR. KANTER

A native of Boston, Alan Kanter received his M.D. degree from the University of Vermont in 1975. After his residency at Memorial hospital in Long Beach, he practiced internal medicine in Torrance until 1990. At that time, he decided to devote his full-time to the emerging specialty of phlebology (the field of venous disorders), and took a fellowship based on European techniques recognized worldwide.

Since opening the Vein Center of Orange County, his expertise and clinical research have earned him several grants in collaboration with UCI, and a reputation as the local vein expert other doctors turn to. As a result of his published studies on the use of duplex ultrasound for real-time guidance of sclerotherapy to treat varicose veins, physicians from several continents have made the trip to Irvine to observe his treatment protocol. Dr. Kanter is a frequent speaker at the American College of Phlebology's (ACP) Annual Congress, and has served on their Program Committee as well as committees of Public Education and Ethics & Professional Standards of Care. He has also been a guest speaker at numerous hospital and university CME courses, as well as phlebology meetings in Canada, England, Italy, and Australia. In recognition of these academic and clinical contributions, Dr. Kanter was granted "Fellow" ACP membership status in 2004, and "Honorary Fellow" membership status in the Australasian College of Phlebology in 2005.

Dr. Kanter is a member of the Orange County Medical Association and American Medical Association, and strongly believes that his sole focus on treating venous disorders enables him to provide the highest quality service utilizing the latest technology.

ABOUT OUR OFFICE

The Vein Center of Orange County (VCOC) is conveniently located in Irvine between the 5 & 405 Freeways. Dr. Kanter performs all consultations and treatments at VCOC including a duplex examination at the time of consultation when indicated. Included on his team is a highly specialized vascular ultrasound technician using the latest on-site dedicated color-flow duplex ultrasound. All referring doctors are sent timely consultation summaries and follow up notes on their patients. Specializing primarily in the medical treatment of varicose and spider leg veins, advanced out-patient treatment for venous leg ulcers is also available. Treatment of cosmetically undesirable face, chest, and hand veins is also offered. When medical necessity exists, our friendly staff will assist patients in obtaining insurance reimbursement; however, **we have opted out of Medicare**, which means Medicare patients can be treated at VCOC only if they agree to forego Medicare reimbursement. VCOC is a private fee-for-service practice, with self-supported clinical research activities since 1993. For a list of publications, brochure, or more information about our services, call 949-551-8855, or visit our **www.vcoc.com** web site.

Venous Disorders Update
Vein Center of Orange County
250 East Yale Loop, Suite D
Irvine, California 92604-4697
(949) 551-8855
www.vcoc.com

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INDEX ISSUE

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A Message From the Founder

Welcome to the Fall/Winter 2006 issue of *Veno-gram*, an educational newsletter for the practicing physician which focuses on clinical applications of current research in venous disease. For your convenience we have recently started posting *Veno-grams* on our web site **www.vcoc.com**, facilitating access to back issues thereby making the annual cumulative index more helpful.

It has been my pleasure to accept your kind referrals over the past sixteen years, and to watch my practice steadily grow as a result. During that time, I have observed certain recurring misconceptions shared by primary care physicians about common phlebology issues.

Accordingly, our "Advances" column offers clinical pearls regarding pseudovaricosities, phlebitis, the superficial femoral vein, ankle spider veins ("corona phlebectatica'), and the use of compression stockings, while offering guidelines for appropriate referral. These topics are routinely encountered in primary care practices, making this information extremely practical for FPs, internists, and OBGYNs. Armed with this knowledge, you can more effectively treat patients' suffering and provide updated guidance.

This is followed by an update on Pelvic Congestion Syndrome, which can present with a myriad of premenstrual genitourinary and lower extremity symptoms. Fortunately, as with saphenous vein treatment, several non-surgical treatment options are now available for ovarian vein interruption. Rounding out this issue is the annual cumulative index of *Veno-gram* articles.

As we go to press, I am heading off to the ACP Annual Congress in Florida where I hope to see some of you. If not there, then perhaps at the annual American Venous Forum meeting in San Diego next February. After attending both meetings I should have a lot to report in the Spring.

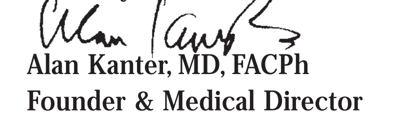
Besides the traditional clinical update, I will seek information on Blue Shield of Northern California's recent arbitrary decision to reimburse only surgeons for endovenous ablation. To exclude reimbursement to qualified phlebologists from other specialties is capricious and must be swiftly addressed before allowed to set a precedent.

I would like to share a recent observation with you regarding Sotradecol (STS). As most of you know, the only legal source of STS during the past several years has been pharmaceutical compounding. We found a noticeably lower efficacy for saphenous veins with compounded STS. However, when we switched to Bioniche's FDA-approved STS made available earlier this year, we immediately noted improved efficacy consistent with our past experience. The difference is so remarkable I thought it worth reporting.

As most of you know, our own **www.vcoc.com** web site helps educate patients on vein disorders and prepares your referrals prior to consultation at VCOC. Besides providing a link to the ACP web site, it covers VCOC office policy, phlebology FAQs, professional background and qualifications. publications, before/after pictures, and a video of duplex ultrasound-guided injection.

You are encouraged to contact me with feedback and questions about the contents of our newsletter and website, suggestions for future issues, or reference requests. With your continued input, I hope to achieve the above-stated goal and look forward to hearing from you.

Sincerely,



Alan Kanter, MD, FACPh
Founder & Medical Director

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Advances in Treating Varicose Veins

Clinical Pearls for Primary Care Physicians

Family Practitioners, Internists, and OB-GYN physicians are expected to evaluate patients for a wide variety of disorders. This includes knowing when referral to a specialist is appropriate, and what conservative measures may be employed in the interim. Here are some tips regarding five common issues we encounter based on patients referred to VCOC.

Is it really a varicose vein? Localized 1-2 cm non-tender, soft, easily compressible, round skin "blebs" on the shins masquerade as varicose veins, but are simply fascial hernia defects. You can save the patient a referral if the "pseudovaricosity" is Doppler-negative, or even easier, if it disappears during anterior compartment muscle contraction and reappears during relaxation. No treatment beyond reassurance is necessary.

Treating phlebitis. Most of us were taught to treat superficial vein thrombosis (SVT or phlebitis) with hot compresses, leg elevation, and NSAIDs. A more modern and physiologic treatment with better patient acceptance includes cold compresses, Class 1 compression stockings, and regular ambulation with continuation of normal activities. A caveat: SVT occurs frequently in association with both DVT and thrombophilia, so guard against a cavalier attitude toward SVT especially when it involves the proximal great saphenous vein. When in doubt, especially when edema is present, promptly refer the patient for duplex.

The superficial femoral vein (SFV) is NOT really "superficial"! SFV is an outdated misnomer; it belongs to the DEEP venous system and must be treated as DVT when thrombosis is diagnosed; i.e., full-tilt therapeutic anti-coagulation on an emergent basis. As discussed in a recent *Veno-gram* issue, the official CEAP terminology for this vein was changed to "deep femoral vein" and the term "deep femoral vein" changed to "femoral vein" in 2002 precisely to avoid such potentially dangerous confusion. (J Vasc Surg, August, 2002)

Ankle spider veins. When spider veins (telangiectasia) become especially numerous in the ankle and/or distal shin, this is called "corona phlebectatica" and is a marker for more proximal reflux usually from the saphenous vein even when surface varicosities are absent. Treatment directed to these fine veins is futile yielding transient results at best until the proximal floodgate has been neutralized; i.e., saphenous vein ablation.

If you have added sclerotherapy of telangiectasia to your repertoire, remember to first refer the patient with "corona" to a qualified phlebologist for saphenous vein evaluation before attempting treatment. Sending the patient with corona to an imaging center for duplex study is usually superfluous; as detailed in our *Summer '05 Veno-gram*, most stand-alone and hospital-based imaging centers do not perform sufficiently detailed mapping studies in the standing position, and the study must therefore be repeated by the phlebology consultant.

Compression stockings. Many patients are not advised that wearing support hose can alleviate their symptoms and prevent phlebitis or thrombosis. Patients who are so advised usually choose OTC support hose from a supply house without physician prescription or proper fitment. For compression hosiery to be effective, they must be worn by the patient and be of correct size and strength. Compliance is difficult even when hosiery is comfortable and fits correctly. Class I (20-30 mm) stockings are usually appropriate for uncomplicated mild vein problems and Class 2 (30-40 mm) for more serious disease with edema, while prescription of Class 3 and 4 stockings is best left to the specialist.

Wearing support hose during pregnancy is also often overlooked; it can significantly improve symptoms and limit the appearance of new veins when worn starting in the first trimester. Finally, recommending a Prenatal V2 Supporter will make you a hero for the patient with painful vulvar varicosities (517-386-6038).

Pelvic Congestion Syndrome (PCS)

Pelvic Congestion Syndrome (PCS) is an under-appreciated but common clinical entity due to ovarian vein incompetence. Unexplained pelvic pain was found due to pelvic vein insufficiency in 91% cases in a 1984 study. However, symptoms of PCS may be misleading and include: groin pressure, premenstrual pelvic pain and leg heaviness worse with standing and exercise; collisional or orgasmic (not penetration) dyspareunia; post-coital pain; secondary frigidity; urinary urgency; constipation; psychological problems. Clinically, PCS is associated with vulvar/posterior thigh varicosities, retroverted uterus, and variable GSV (great saphenous vein) reflux. It is interesting to note that most vulvar varicosities are due to multiparity with competent ovarian veins.

Even when the astute clinician suspects PCS, diagnosis can be elusive. First, symptomatic improvement with Lupron for presumed endometriosis may lead to a missed diagnosis of PCS. Second, laparoscopy is usually negative due to Trendelenburg position and gas insufflation obscuring pelvic veins. The diagnosis is best made by retrograde selective venography; diagnosis by duplex has proven difficult. Since ovarian veins frequently cross-anastomose with each other and "dump" into the leg veins, both ovarian veins are usually treated simultaneously. Treatment methods include surgical ligation, foam sclerotherapy, coil embolization, and more recently endovenous laser ablation. Symptoms may improve spontaneously without treatment over time (2-3 years) or after menopause. Therefore, management decisions must be individualized considering the invasive nature of both definitive diagnostic and treatment methods.

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