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 coincident with the introduction of ultrasound-guided sclerotherapy

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-guided sclerotherapy to treat saphenous-derived 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 phiebology 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, "Fellow Emeritus" membership status in the Australasian College of Phlebology in 2005, and full membership in the American Venous Forum in 2007.

As a member of the Orange County and American Medical Associations, Dr. Kanter strongly believes that his sole focus on treating venous disorders enables him to provide the highest quality service utilizing the latest technology. As the most experienced practitioner in Southern California using ultrasound-imaged guidance to selectively treat varicose veins and their sources, physician referrals are always welcome.

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 who participated in the original FDA study leading to approval of endovenous laser ablation. 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
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INDEX ISSUE

An Educational Service from the Vein Center of Orange County **www.vcoc.com** **Fall/Winter 2007**

A Message From the Founder

Welcome to the Fall/Winter 2007 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 started posting *Veno-gram* on our web site **www.vcoc.com** for easier access to back issues.

The field of Phlebology is finally emerging as an acknowledged U.S. specialty in its own right. Last year it was announced that Phlebology had been officially recognized by the AMA as a "Self-Designated Practice Specialty." Earlier this summer the State Medical Board of California joined the AMA officially recognizing Phlebology as a specialty. As a logical next step the ACP has recently declared the first Phlebology Board Certification test will be offered in April, 2008. Pre-test courses will be organized along with advice regarding the evolution of Phlebology-specific duplex ultrasound certification examinations currently in development.

For years veteran *Veno-gram* subscribers have read repeatedly in these pages about the importance of properly performed duplex ultrasound mapping examinations with specifics clearly outlined in the Summer '05 issue (available online). With the certification of qualified ultrasonographers who follow standardized venous duplex testing procedures and parameters, the care of patients with venous disease will be dramatically advanced. Their diagnoses will be more precise, recommended treatment options more appropriate, and outcomes more favorable.

In Europe many phlebologists are considered "angiologists," a non-surgical specialty which includes both arterial and venous ultrasound diagnostic skills. As a dedicated American phlebologist I am quite content to leave the diagnosis of arterial and central venous pathology to those skilled in that area while remaining focused solely on lower extremity ultrasonography. I therefore support and look forward to the development of such a purpose-driven limited certification.

The last two *Veno-gram* issues were devoted to highlights of the most recent annual ACP and AVF meetings. This combined issue contains our usual year-end cumulative index and two topics under "Advances in Treating Varicose Veins:" a statement on the currently accepted place of endovenous thermal ablation in the war on varicose veins, and helpful hints to differentiate ischemic vs migrainous cerebrovascular events after foam sclerotherapy.

In our last issue I shared my concept of a "Do Different" list gleaned from CME congress attendance and provided an example. Here is my list derived from the 2008 AVF meeting: 1) Scan for sciatic nerve venopathy in patients with sciatica relieved by standing. 2) Test for blood type A+ when considering indefinite anti-coagulation after VTE. 3) Document time of exams and repeat later in day for equivocal AM findings. 4) Look for newly reported double-line duplex sign of acute DVT. 5) Use flexible guidewires for endovenous thermal ablation of tortuous vessels. 6) Prescribe Circ-Aid garments for those who have difficulty donning compression stockings. 7) Consider using QoL (Quality of Life) forms as part of patient history.

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, and reference requests.

Sincerely,

Alan Kanter, MD, FACPh
Founder & Medical Director

INSIDE

Advances in Treating Varicose Veins

Endovenous Thermal Ablation - Are We There Yet?

During the past several years endovenous thermal ablation (ETA) techniques have been embraced by both patients and phlebologists as the advance of the century for the treatment of superficial axial venous insufficiency. In suitable candidates it provides outcomes superior to the surgical gold standard at a lower cost, with fewer risks, and essentially no recuperative period. Accordingly, forward-thinking practitioners have acquired radiofrequency and/or laser generators and are learning the skills of duplex mapping for guided thermal ablation.

Although surgery has enjoyed many decades of practice providing data for long-term studies, ETA is barely one decade old. This leaves us without a prospective long-term study comparing ETA with surgery. However, as reported in our last newsletter, advances do not exclusively require Grade 1A studies to recommend them.

In an attempt to make sense of the available data Mundy et a! performed a meta-analysis of thirteen high quality endovenous laser ablation (EVLA) published studies between 2001-2004.[1] Consistently > 90% of treated saphenous veins were found to be successfully closed with follow-up as long as 24 months. Serious adverse events were rare, and it was concluded that EVLA is safe, effective, and superior to surgery for the documented time-frame.

Since then at least two high quality "mid-term" studies have been published duplicating these results. In the U.S. Almeida and Raines compared radiofrequency ablation (RFA) vs EVLA and found 85% and 92% success rates, respectively.[2] A Taiwanese study likewise found a 94% success rate after EVLA.[3]

I have purposely not specified laser wavelength in the above studies because it is irrelevant. EVLA outcome is related to expert technique and delivered fluence regardless of wavelength.

Certainly, prospective randomized studies comparing surgery to ETA for treatment of saphenous-derived varicose veins is needed and will be welcomed by a!! Phlebologyst. However, given the widespread publicity and early acceptance of ETA coupled with the above superior mid-term outcomes, it may be difficult to execute such a study after proper informed consent due to patient preference. This barrier will be less of a factor for studies comparing ETA with chemical ablation.

Meanwhile, many internationally recognized surgeons have gone on record declaring ETA the new standard of care for treating superficial axial vein reflux. I humbly add my voice to this growing chorus.

1. Mundy L et a! Systematic review of endovenous laser treatment for varicose veins. Br J Surg 2005;92:1190-1194.

2. Almeida JI, Raines JK. Radiofrequency ablation and laser ablation in the treatment of varicose veins. Ann Vasc Surg 2006;20:547-552.

3. Chih-Hsun Y et al. Incompetent great saphenous veins treated with endovenous 1,320 nm laser. Dermatol Surg 2006:32:1453-1457.

Visual Disturbance After Foam Sclerotherapy: Migrane or Ischemia?

In our Summer '07 *Veno-gram* we reviewed the latest information on a troubling but inconsequential adverse event that occurs in a small percentage of patients receiving foam scierotherapy (FS) - cerebrovascular and visual disturbances. Although possibly related to patent foramen ovale, proof of such an etiology is yet forthcoming.

Until then, it would be reassuring to differentiate between ischemic and migrainous symptoms, the latter being less ominous. Visual disturbances of migrainous origin are usually bilateral, bright, mobile, and last 15-60 minutes, while those of ischemic origin are unilateral, dim, static, and last only 2-5 minutes. Migrainous paresthesia have a gradual onset, last 20-30 minutes, and resolve in the reverse order it appears vs isehemic paresthesia which have an abrupt onset, last 5-10 minutes, and resolve in order of appearance. Although disconcerting, such disturbances after FS are generally benign migrainous occurrences, with most patients admitting to a past history of migraine events in our experience.

Veno-gram Cumulative Index by Topic