

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 has been 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 throughout North America, Europe 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.

Dr. Kanter is board certified by the American Board of Phlebology, and is also certified as a Registered Vascular Tech by the American Registry for Diagnostic Medical Sonography. Acquisition of these formal qualifications acknowledges his personal achievement of highly recognized professional standards of excellence, validating the distinguished reputation he has earned during the past twenty years in Orange County.

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 all list of publications, brochure, or more information about our services, call 949-551-8855, or visit our www.vcoc.com website.

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.

Venous Disorders Update
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ISSUE

Venous Disorders Update

An Educational Service from the Vein Center of Orange County

www.vcoc.com

Fall/Winter 2009



Welcome to the Fall/Winter 2009 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* online (www.vcoc.com), facilitating access to back issues which are listed by topic in the annual cumulative index.

It is gratifying to see patients taking advantage of our recession aids. Despite what we hear in the media, most folks are reluctant to proceed with major expenditures and appreciate the opportunity to recapture their consultation fees when they have treatment. We will continue this policy until a recovery is obvious.

This issue contains a summary from the 2009 ACP Conference held in Palm Desert this past November. For the most part it was a strong endorsement of both radio frequency's "Closure Fast" (RFCF) and endovenous laser in treating saphenous veins. While many different lasers were utilized, little if any differences emerged. All were highly effective (> 95%) without significant pain or bruising, especially the higher frequency lasers > 1300 nm which target water like we use here at VCOC.

However, a European group presented data which questions the overall approach in treating large varicose veins. Citing various hemodynamic arguments, they make the case that tributary valve failure induces GSV reflux by causing excessive reservoir volume leading to ascending incompetence. Thus, when GSVs are relatively small with terminal valve competence, treating only the tributaries yields good results for at least

A Message From the Founder

a few years. However, Dr. Mark Meissner, AVF President, urged skepticism until more high quality studies prove clinically relevant outcomes (symptoms and QoL) rather than surrogate outcomes (physical and ultrasound).

Dr. Elias presented a poster which outlined a new treatment modality for varicose veins. Using a combination of endovenous mechanical and traditional chemical ablation, the ClariVein instrument provided results similar to EVLA without the need for tumescent anesthesia thereby reducing procedure time to 15 minutes. Whether we will all be using this method in the future will have to wait for longer studies.

Regarding microbubbles, no migraines were observed after foam sclerotherapy in patients prone to migraines, and no significant advantage was demonstrated by using room air vs. CO₂/O₂ to make foam.

Finally, it was remarkable to find several advances in the vendor arena. First, the "Venowave" is now available for patients needing a portable compression device. It uses two AA batteries to power a calf compression pump affixed to the leg by Velcro, and sells for a reasonable \$425. Although expensive (> \$9,000), the FotoFinder uses a point-and-shoot Canon camera on a vertical track linked to photo software and a laser pointer to provide perfect pictures. Lastly, the Veinwave is an RF-based technology that uses tiny needles to eliminate otherwise resistant spider veins. This leaves tiny bruises which heal within 1-2 weeks, and may be performed by a medical assistant. I believe you will be hearing more about these three in the future.

And for those who waited, the Registered Phlebology ultrasound degree will be offered after the inaugural test this January. Although it certainly fills a need,

it remains to be determined whether the RPh will obviate the need for the more widely accepted traditional RVT certification.

As most of you know, our www.vcoc.com web site helps educate patients on vein disorders and prepares your referrals prior to consultation at VCOC. We have recently completed an extensive update to modernize the site for easier navigation and hope you find it informative. Besides providing a link to the ACP web site and our own *Veno-gram* archives, 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. Best wishes to you all for a happy holiday season.

Sincerely,

Alan Kanter, M.D., R.V.T., F.A.C.Ph.
Founder & Medical Director

INSIDE

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2009 ACP CONFERENCE

O'Donnell Keynote Address: While IPV diagnosis and treatment is yet to be defined by clinical (vs. surrogate) parameters, IPV's are currently treated in C₅-C₆ patients when > 3.5 mm in diameter with high volume flow.

Wright: A retrospective study of > 2,000 patients with leg **ulcers treated by GSV-EVLA** vs. no EVLA over seven years showed 14% vs. 58% recurrence.

Bjoern: Three-year randomized controlled trial of **EVLA + AP vs. stripping** showed similar efficacy for both.

Shepherd: While RF was somewhat less painful than **EVLA/RFCF**, it did not permit earlier RTW.

Elmore: 3 second - 3 minute delay **between laser on and visible coagulation** in 17% of bare-tip EVLA cases.

Kabnick: Fiber diameter inversely correlated to joules delivered; similar pain and bruising after either **980 nm** laser at 12 Watts, 100 j/cm jacket-fiber vs. **RFCF**.

Karamanoukian: GSV ablation by either RFCF or EVLA was both safe and effective in patients with past **history of DVT** > 5 years ago + negative thrombophilia screen.

Mauriello: 1470 nm **laser and RFCF** have equal efficacy and post-op pain.

Proebstle: **RFCF + AP** 95% successful @ 2 years using 100 j/cm.

Vasquez: Recommends **waiting 4-5 months after GSV ablation** to see if (non-cosmetic) adjunctive treatment needed.

Klein: Maximum **safe tumescent lidocaine dosage = 35 mg/kg**. Arbitrary FDA limit of 7 mg/kg unfounded. Tumescent toxicity lower due to slow systemic absorption. Lido toxicity starts at 6 mcg/ml.

Calcagno: Insurance mandated **compression trial** (average 3 months) had **minimal effect** on subsequent intervention; 62/69 still wanted treatment. Thus, # saved procedures vs. pain/complications during delay.

Pittaluga: While multiple varicosities in the calf was predictive of recurrence after saphenous-sparing ASVAL, most required AP, not GSV treatment, even with SFI.

Ferraro: Post EVLA and UGS **"DVT" usually chad** @ junction; no documented PE or propagation.

Chastanet: Isolated **AP eliminated GSVI**, some SFI, and decreased GSV diameter.

Karamanoukian: Efficacy and post-op bruising/pain same for 810 nm EVLA vs. RFCF bilateral treatment.

Mok: Same efficacy and post-op bruising/pain for **1320 nm** @ 15 Watts vs. **RFCF** at one year.

Shortell: **No migraines** after 16-20 ml UGFS for SFI in migraine-prone patients both with and w/o TCD bubbles (L->R shunt).

Neuhardt: Equal number of HITS (bubbles) from both room air vs. CO₂O₂ after UGFS for GSV w/ competent SFJ using 1:4 ratio.

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