

## 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 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, "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](http://www.vcoc.com) web site.

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Venous Disorders Update  
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## Venous Disorders Update

An Educational Service from the Vein Center of Orange County

[www.vcoc.com](http://www.vcoc.com)

Spring 2008



Welcome to the Spring 2008 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-grams* online ([www.vcoc.com](http://www.vcoc.com)), facilitating access to back issues thereby making the annual cumulative index more helpful.

This issue of *Veno-gram* contains the highlights from both the 20th Annual AVF Meeting in Charleston last February and the 21st Annual ACP Congress in Tucson last November. As a member of both organizations, I was able to attend both conferences this past year. However, instead of devoting an entire *Veno-gram* issue to each meeting, I am trying something different this year. By being more selective I squeezed the "best" of both meetings into one issue, leaving more room for other sources in subsequent issues. In keeping with our mission to present pragmatic concise updates for practicing clinicians, I hope you find this to your liking.

As most of you know the field of Phlebology is now recognized by the AMA, AOA, and the Medical Board of California. To accommodate more applicants the newly formed American Board of Phlebology (ABPh) has changed the dates for board certification exams from April to May, 2008 at Pearson VUE testing sites. Upon acceptance to sit for the exam an applicant will receive detailed scheduling instructions. I enjoyed meeting some of you at the

## A Message From the Founder

March ACP Review Course in Dallas. To those of you joining us in taking this historic inaugural exam, I wish you success along with a prayer that our aging synapses can handle it. Information including prerequisites and deadlines for the exam may be found at [www.AmericanBoardofPhlebology.org](http://www.AmericanBoardofPhlebology.org).

In the last issue's "Message" I applauded the move toward another mandatory certification for phlebology - ultrasonography skills. 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.

While I have repeatedly emphasized the importance of proper venous duplex examinations and taught duplex symposia at conferences, I must admit I myself have received no formal training aside from expert apprenticeship. In accordance with the respected axiom that one practice what one preaches, I hope to acquire RVT certification in Vascular Technology this year from the American Registry of Diagnostic Medical Sonography (ARDMS).

You may recall my recent statement of support for the proposed development of an ultrasound certification program limited to the lower extremity only. While my position has not changed, I did not feel comfortable waiting for this new credential to become available and then accepted. I therefore thought it wise to acquire the broader spectrum RVT

certification with its longstanding widespread acceptance.

Thus, I hope to strengthen your confidence in our office to provide your referrals with the best possible care by the addition of two credentials this year: ABPh certification and RVT.

As most of you know, our own [www.vcoc.com](http://www.vcoc.com) web site helps educate patients on vein disorders and prepares your referrals prior to consultation at VCOC. Updates to modernize the site for easier navigation are in progress.

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, FACP  
Founder & Medical Director

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## 2007 ACP & 2008 AVF MEETING HIGHLIGHTS

**Research End-Points.** In his presidential address, Dr. Mark Meissner called for an end of reliance on surrogate end-points (e.g., GSV closure rate), and a switch to real clinical end-points (e.g., VCSS score) for better evidence-based medicine outcomes to drive the market.

**Lymphedema.** Keynote speaker Dr. Neil Piller from Australia pointed out the typical 3-year latency period between limb insult and the appearance of overt symptoms, as well as the vicious cycle of increased adiposity and impaired lymph flow.

**Sciatic Nerve Varices** may present as pain with sitting, walking, and menses. Treatment is by ultrasound-guided sclerotherapy.

**Conservative Measures for SVI.** A 3-month trial of compression stockings and leg elevation failed to improve leg symptoms by QoL and objective GSV measurements despite good compliance. This familiar insurance treatment prerequisite is therefore a waste of time.

**A New Saphenous Sparing Approach** called “ASVAL” (Ambulatory Selective Varices Ablation) was presented by a French group which found normalization of 2/3 GSVs < 8mm after treating only the varicose tributaries with resultant 80% symptom relief and 90% cosmetic improvement at 4 years. Of 19% recurrent varicose veins at 3 years, 68% GSVs were still without reflux, 23% with reduced reflux, and 8% persistent reflux. Failure of this approach predicted if initial axial reflux extended to ankle and with multiple reflux sites. This differs from the older “CHIVA” which leaves varicosities intact and does not preserve junction. Saphenous sparing is based on the ascending theory of incompetence, and is more likely to work when only mild axial reflux is present in smaller vessels.

**Ligation 2 cm Below Junction** with saphenous stripping spares/preserves the junctional tributaries and lymph system yielding less recurrent groin reflux at 3 years. [Thus, each case must be carefully evaluated without reflexive saphenous ablation.]

**GSV Caliber** correlates with reflux: 100% for 6+ mm, 90% for 5mm, 50% for 4mm, 10% for 3mm, 5% for 2mm.

**EVTA (Endovenous Thermal Ablation).** **Neuropathy** may be avoided by not lasering below mid-calf and identifying adjacent nerves on duplex – distal saphenous nerve (GSV) and sural nerve (SSV). **Laser Fibers** are quite durable and hard to damage with needles.

**Concurrent UGS** distal to lasered saphenous vein decreases persistent residual varicosities primarily from IPVs. **NTG** ointment yields 69% dilatation of GSV/SSV for cannulation.

**100%** success achieved for epifascial accessory GSVs without skin burns.

**IPV Interruption.** **SEPS** now considered outdated. **MEASUREMENT** should be at fascial plane with treatment extending just below. May take 4-6 weeks to fully close after laser. 89% closed @ 2 weeks after RFA. Decision to treat IPVs concurrent or after saphenous axis individual. **DVT after UGS** rare.

**Medicolegal Issues.** **Compounding** ok if drug not otherwise available, Rx is for individual, and pharmacy not producing in bulk. Local MD working with local pharmacy is low on FDA radar, technically still illegal if substance commercially available. 2003 FDA study showed quality analysis failure for < 2% approved vs > 34% compounded drugs. Aside from safety issues and even with informed consent, any cost-saving rationale would incur punitive damages. **Foaming** is considered investigational but may be defensible if shown to be standard practice. **Web Site** is an implied promise to deliver, so check content, claims, and photos for expectations. **E-mail** may be more problematic than phone calls; former is hard irrefutable data requiring indefinite archiving/storage, latter “he-said-she-said” more defensible. **Refunds** to unhappy patient even with release sends message/precedent and is likely to escalate.

## 2007 ACP & 2008 AVF MEETING HIGHLIGHTS

**Foam Bubbles** detected in MCA by transcranial doppler in 13% within 32 seconds after GSV injection. Another study found MCA bubbles in 42% one hour after GSV injections with competent junctions regardless of volume (average 17 ml) of which 60% were symptomatic (headache, visual disturbance, cough). More “physiologic” 70%/30% CO<sub>2</sub>/O<sub>2</sub> foam resulted in fewer adverse effects but no change in VS vs air when monitored 24 hours. Tc99 lung scan showed diffuse homogeneous bubbles in lungs 30 seconds-3 minutes after injection, begging the question, “Is foam still active when it reaches the lungs, which might induce pulmonary hypertension?”

**Sclerosant Approvals** were said by credible sources to be imminent for Fibro-Vein (the U.K. version of Sotradecol) and Polidocanol liquids.

**Vena Cava Filters** have enjoyed increasing use despite paucity of studies documenting efficacy. Proven benefits shown for bariatric surgery.

**In Presence Of Deep Venous Disease** treat associated superficial reflux first including GSV; stenting is first procedure of choice for obstruction regardless of reflux.

**Post-Thrombotic Syndrome** after thigh DVT may be predicted by high peak reflux velocity in the femoral and popliteal veins (6-year follow-up).

**Thombolysis** especially beneficial for iliofemoral DVT to prevent morbidity and recurrence.

**Pre-Op D-Dimer** and leg duplex does not predict post-op VTE risk.

**Ulcer Risk Factors** in patients with varicose veins include signs of stasis, corona, and popliteal vein reflux > obesity, smoking, and poor ankle movement. Risk factors for failure to heal w/ compression include impaired calf muscle pump, large size, and long duration. Extensive literature review concluded it is unknown whether treatment of IPVs alone helps heal ulcers; most studies included concurrent GSV treatment.

**New 2007 ICAVL Reporting Standards** includes venous mapping, **standing** reflux exam, assessment of femoral vein at multiple sites, scan of posterior tibial and peroneal veins, and assessment of thrombus age.



*Dr. Kanter at Point Reyes National Seashore's Great Beach.*