

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 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.

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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Venous Disorders Update

An Educational Service from the Vein Center of Orange County

www.vcoc.com

Spring 2009

A Message From the Founder



Welcome to the Spring 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.

I hope you have not been too adversely affected by the current economic downturn. Because the majority of our patients seek at least some component of cosmetic improvement which can be safely postponed, my practice is feeling the pinch. However, some patients also postpone medically necessary symptomatic treatment, exposing them to the complications of venous insufficiency. Since the current economy is expected to very slowly recover over the next year or so, this places our patients at risk for increased morbidity from symptoms and increased mortality from thromboembolism.

Drastic times call for drastic solutions. Therefore, we have recently instituted three measures designed to help patients proceed without delay: two permanent and one temporary. First, we have permanently **lowered our fee 10%** for duplex-guided endovenous ablation. Second, we have added financing through **Care Credit**. Finally, we now offer **reimbursement of consult fees** including duplex mapping by applying them to treatment fees **if treatment is started within 60 days**. This is a temporary offer that will expire when the economy recovers, providing a "win-win" situation that allows patients to avoid postponing necessary treatment, and helps us avoid layoffs.

If our consultation and duplex exam were brief encounters performed by ancillary staff with little or no physician

involvement (often described by our patients who have been elsewhere for "free" consultations), our reimbursement policy might be permanent. However, our consultations are comprehensive, take up to an hour, and are always performed exclusively by me, a board certified Phlebologist and ARDMS Registered Vascular Technician. Given the expertise and necessary equipment required to deliver this level of care, I am sure you can understand the justification for reinstating non-reimbursement of consultation fees. Meanwhile, we are gratified to see many of our patients taking advantage of this offer.

As my way of giving back to the community, VCOC joined the annual American Venous Forum's National Venous Disease Screening Program this past March. As one of over 200 participating nationwide locations, we performed free screening exams according to the AVF's strict protocol and transmitted the data collected for analysis. Patients were assessed for venous insufficiency and thrombosis risk factors, and given written results for their primary physician to act upon. I was happy to provide this community service and encourage interested readers with documented ultrasound qualifications to learn more about joining us next year at www.veinforum.org.

Our preliminary impression of the Biolitec 1470 nm laser will be presented in the next issue. Meanwhile, the rest of this issue is devoted to bringing you the highlights from the 2009 AVF Meeting in Phoenix held this February. On the opening day participants voted electronically from their seats both before and after hearing each side of several controversial topics. Read about these hot topics in detail on the following pages. Less controversial was endovenous thermal ablation, now widely accepted and discussed favorably by multiple highly-respected presenters. Foam sclerotherapy ("chemical ablation") also received the spotlight as a reasonable alternative to endovenous thermal ablation, with data presented on

complications, extemporaneous vs. yet-to-be approved "Varisolve," bubble migration, and AVM treatment. Another great read. As a non-invasive phlebologist, please excuse the omission of surgically-oriented symposia which I do not attend.

As most of you know, our www.vcoc.com website 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 website 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.

Sincerely,

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

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AVF Annual Meeting Highlights

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2009 AVF MEETING HIGHLIGHTS

GREAT DEBATES

The meeting opened with several “**Great Debates**” on controversial topics. It was interesting to see audience consensus was significantly influenced by presentations on some topics but not others.

- Fibrinolytic/Mechanical treatment vs. Anticoagulation for **iliofemoral DVT**: Lacking Level 1 proof for superiority of newer aggressive lytic methods in preventing PE and PTS from recurrent DVT, anticoagulation still recommended.
- Correction of superficial venous insufficiency for **leg ulcers**: While Level 1 evidence supports this to prevent ulcer **recurrence**, it is lacking for ulcer **healing**.
- High **risk trauma VTE prophylaxis**: data insufficient for superiority of retrievable VC filter vs. anticoagulation with non-retrievable VC filter.
- **Calf vein DVT**: anticoagulation (with 2% risk of major bleed) vs. costly conservative serial monitoring. Still a difficult call that depends on circumstances. Since the current ACCP guideline only suggests (not recommends) 3 months anticoagulation based on scant Grade 2B data, close monitoring for two weeks is considered reasonable for low-risk compliant ambulatory patients with mild symptoms from reversible

VARICOSE VEIN TREATMENT

- Dr. Almeida found the radial-firing tip of **Biolitec’s new 1470 nm laser** yielded 100% GSV closure (@ 3 months) using 30/joules/cm @ 5 watts, with less post-treatment pain and

risk factors. On the other hand, high risk cases, malignancies, and irreversible risk factors require anticoagulation.

- **Superficial vein thrombosis**: anticoagulation vs. NSAID. Similar to above, with ALL patients receiving initial ultrasound study to confirm thrombosis location and rule out concomitant DVT. ACCP guideline recommends LMWH x 4 weeks for thigh SVT, and NSAID with compression hosiery for calf SVT/varix thrombosis.
- **Perforator vein treatment** in advanced CVI – is it helpful? Unknown because most PV studies are confounded by concomitant GSV treatment. [My approach is to initially treat only large IPV and those found at recurrence sites.]
- **Thrombophilia testing for DVT**. Testing appropriate for 1st DVT when non-provoked, high-risk, < 50 year-old patient, all recurrent DVT, + DVT family history, DVT on hormones or pregnancy. Proven predictors of recurrent DVT are: male gender, past DVT, proximal location, unprovoked, associated malignancy, and + D-dimer 1 month after AC. Risk highest for recurrent DVT with homozygous Factor V Leiden and Antiphospholipid antibody.

bruising. [confirmed at VCOC] He was unable to perform treatment without anesthesia despite these lower energy settings. [also confirmed at VCOC] Fluence as a major prognostic factor

2009 AVF MEETING HIGHLIGHTS

VARICOSE VEIN TREATMENT

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now in question. While great saphenous nerve block was effective, the benefit of extrinsic compression from tumescent anesthesia absent.

- Dr. Vasquez found initial CEAP and VCSS scores inversely proportional predictor of symptomatic **need for adjunctive varix phlebectomy** after GSV radio-frequency ablation (RFA) alone. 70% did not require phlebectomy due to persistent symptoms if postponed 3 months after ablation.

- European retrospective study found equal efficacy for groin re-operation vs. isolated varix **treatment for recurrence** three years after GSV stripping, supporting the ascending theory of incompetence.
- Dr. Kabnick found **less pain and bruising** after RFA and bare laser fibers vs. jacket-tip fiber. (Radial-firing tip not evaluated.)

FOAM SCLEROTHERAPY

Remember last year’s conference when concerns were raised over bubble migration after leg foam injection? Bubbles were found in the MCA by transcutaneous doppler (TCD) and in the lungs by Tc scan. Here’s the latest on this scary topic.

- “Varisolve” FDA Phase II study showed MRI and clinical neurologic exam were 100% normal after **reformulated “Varisolve”** containing lower nitrogen content. 60% incidence of right->left shunts by TCD after Varisolve injection (all asymptomatic), but there is only a 25% general incidence of PFO! 73% of patients with PFO had TCD bubbles in MCA. Reassuring (unpublished) data was reported that no polidocanol was found in lung and brain bubbles after injection.
- Dr. Guex reported an extremely **low incidence of problems** after extensive nationwide experience with foam injection in France.

- Because of its proven track record in the real world, Dr. Cavezzi promoted the **continued use of extemporaneous foam** rather than waiting for Varisolve FDA approval. [Although considered investigational foam use may be defensible if shown to be standard practice.]
- Contrary to the European Consensus recommendation to use < 10 ml foam/session, Dr. Morrison reported no difference in either bubbles or **symptoms regardless of volume**. Although most bubbles were asymptomatic, fewer symptoms and less bubble migration occurred after Varisolve with 70%/30% mix of CO2/O2 vs. Varisolve with room air.
- Foam polidocanol was more effective than the liquid sclerosant in **treating AVM**. Although less effective than Ethanolamine, the latter requires general anesthesia and polidocanol does not.