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 a list of publications, brochure, or more information about our services, call 949-551-8855, or visit our **www.vcoc.com** web site.

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.

The VENO-GRAM

Venous Disorders Update

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The VENO-GRAM

Venous Disorders Update

An Educational Service from the Vein Center of Orange County | www.vcoc.com | Summer 2008

A Message From the Founder

Welcome to the Summer 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 recently started posting Veno-grams online **(www.vcoc.com)**, facilitating access to back issues thereby making the annual cumulative index more helpful.

In my last issue, I went out on a limb to announce my intention to sit for two certification exams this year: the American Board of Phlebology and the American Registry of Diagnostic Medical Sonography. Despite extensive clinical experience in Phlebology and attendance at current review courses, I was still intimidated by the whole process including prerequisite qualifications and the computerized testing procedure. After all, it has been decades since I had taken any such tests.

After much home study review I took the ABPh exam in May followed by both ARDMS exams in June. I am glad it's over, but more importantly, very happy to report my passage of all exams! Thus, as pledged to you in the last newsletter, I have earned board certification in Phlebology as well as certification by the ARDMS as a Registered Vascular Tech (RVT). I hope my acquisition of these formal qualifications serves to confirm and bolster the confidence and trust you have shown by your referrals over the past two decades. Should any of you wish to discuss my exam experience please feel free to call. Detailed information may be found at **www.ardms.org** and **www.AmericanBoardofPhlebology.org** web sites.

This issue's "Advances" column reviews a variation for treating saphenous vein reflux with foam sclerotherapy delivered via catheter. Catheter-based delivery of sclerosant has been around for at least a decade, having originated in Australia by Dr. Kurosh Parsi. The Swedish study reported a 100% closure rate by duplex at one week. Commentator Jose Almeida points out this is a very short-term follow-up, and goes on to discuss modifications his group in Miami has made to catheter-based sclerotherapy.

"In Other News" reports on three coagulation issues. First, the AHRQ (Agency for Healthcare Research and Quality) announces the publication of a new guide to help patients on anticoagulation. Second, community-acquired acute infections were shown to be associated with transient increased risk of VTE. Third, long-term low-dose aspirin was found to have little if any effect on the prevention of venous thromboembolism (VTE) in healthy women. This is in contrast to previous studies which have shown efficacy of ASA for prevention of arterial thrombotic events (stroke and heart attack). Our Mythology Series addresses the timing of vein treatment between pregnancies.

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.

Sincerely,

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

INSIDE

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Foam via Catheter

AHRQ Guide to Anti-coagulation

Infection Increases VTE Risk

ASA and VTE Prevention

ADVANCES IN TREATING VARICOSE VEINS

Catheter-Directed Foam Sclerotherapy

Foam sclerotherapy (FS) delivered via catheter to treat saphenous vein reflux is not a new idea. In its original form, Dr. Kurosh Parsi from Australia delivered FS continuously through a catheter with a single opening at the tip as it was withdrawn to the point of entry. Since then several variations have been proposed but not published.

Kolbel's Swedish group published short-term results after delivering FS via catheter by the traditional method described above.[1] They treated 50 great saphenous veins (GSV) mostly Class C_{4-6} using 5-8 ml of 3% polidocanol foam adjusting sclerosant volume according to vein length. At one week duplex ultrasound showed 100% closure; one pulmonary embolus occurred.

Since FS has been in common use for nearly ten years, a study documenting only one week follow-up is of limited value. Hopefully, longer-term follow-up is planned. What was more interesting was Dr. Jose Almeida's commentary on this study in Venous Digest.

Dr. Almeida had previously reported an 87% GSV closure rate at six months after 3% foamed Sotradecol or compounded STS via a catheter with an occlusive balloon at the SF-junction. Segmental patency was found four times as often with compounded STS than with Sotradecol. This is consistent with our own experience at VCOC using compounded STS during the time Sotradecol was off the market.

More recently Almeida completed a pilot study with a newly approved FDA catheter delivery system that provides FS spray under pulsed pressure.

While intuitively attractive for its theoretical enhancement of FS uniform contact with endothelium, I can't help but think this is an unnecessary dead-end avenue to "fix a problem that ain't broke." As I published ten years ago, STS solution by simple direct injection in expert hands can provide reasonable success for veins <10 mm in diameter.[2,3] The substitution of FS which has since occurred for this technique can only improve the outcome. However, because the results using endovenous thermal ablation are so superior, I believe FS should be used only in cases where thermal ablation is not possible.

Whether one uses a catheter or individual injections to deliver FS is probably less important than the expertise applied to achieve the endpoint of vasospasm.

1. Kolbel T, Hinchliffe RJ, Lindblad B. Catheter-Directed Foam Sclerotherapy of Axial Saphenous Reflux: Early Results. Phlebology 2007;22:219-222.
2. Kanter A, Thibault PK. Saphenofemoral incompetence treated by ultrasound-guided sclerotherapy. Dermatol Surg 1996;22:648-52.
3. Kanter A. Clinical determinants of ultrasound-guided sclerotherapy outcome, Part I: The effects of age, gender, and vein size. Dermatol Surg 1998;24:131-135.

IN OTHER NEWS – THROMBOSIS & COAGULATION

New AHRQ Patient Guide to Anti-coagulation

The new consumer's publication by the Agency for Healthcare Research and Quality "Your Guide to Coumadin/Warfarin Treatment" was recently released. It contains information that should be helpful to those taking Coumadin in an easy-to-read 20-page format also found online at www.ahrq.gov/consumer/coumadin.htm. A good idea considering there are approximately 4 million Americans taking Coumadin.

Risk of DVT/PE After Acute Community Infection

It is well-known that acute systemic infection increases the risk of arterial cardiovascular events. To determine if the same holds true for venous thromboembolism (VTE) a British group reviewed first VTE episodes in out-patients with acute respiratory and urinary infections.[1] A significantly higher VTE risk (incidence ratio > 2) occurred especially during the first two weeks and then gradually returned to baseline at one year. It appears acute infection should be added to the list of VTE precipitants.

Low-dose ASA and VTE Prevention

Although short-term ASA lowers the risk of VTE in high-risk patients, it is not known whether long-term ASA has the same effect in low-risk healthy adults. 40,000 healthy women were followed for VTE events over ten years.[2] The data showed no benefit from long-term low-dose ASA in preventing VTE in this healthy population.

1. Smeeth et al. Risk of deep vein thrombosis and pulmonary embolism after acute infection in a community setting. Lancet 2006;367:1075-1079.
2. Glynn RJ et al. Effect of low-dose aspirin on the occurrence of venous thromboembolism: a randomized trial. Ann Int Med 2007;147:525-533.

VARICOSE VEIN MYTHOLOGY SERIES

Vein Treatment Should Be Postponed Until After All Planned Pregnancies

[ ] True [ ] False

Like other chronic medical conditions, the best treatment is early effective control. This means: 1) primary prevention using properly fitted, graduated, **therapeutic** compression hosiery for leg veins and V_2 pelvic supporter for vulvar veins during pregnancy, and 2) active treatment to existing varicosities before/between pregnancies. Compression should be at least Class I (20-30 mm Hg) for mild disease and Class II (30-40 mm Hg) for more advanced cases. Ablative treatment should be directed by an experienced specialist in venous disorders after standing duplex ultrasound examination for accurate diagnosis. But what about the timing of treatment? While objective data is lacking anecdotal evidence suggests treatment should be performed at least 6-12 months prior to the next planned pregnancy to reduce the likelihood of early recurrence.

Dr. Kanter on the Beartooth Hwy between Yellowstone & Glacier Parks.