

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.

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 for real-time guidance of sclerotherapy to treat 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, and "Honorary Fellow" membership status in the Australasian College of Phlebology in 2005.

Dr. Kanter is a member of the Orange County Medical Association, and strongly believes that his sole focus on treating venous disorders enables him to provide the highest quality service utilizing the latest technology.

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, using the latest on-site dedicated color-flow duplex ultrasound. 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, brochures, 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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An Educational Service from the Vein Center of Orange County

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Welcome to the Spring issue of *Veno-gram*, an educational newsletter for the practicing physician

which focuses on clinical applications of current research in venous disease.

This issue summarizes the highlights of the recent 19th annual ACP Congress in nearby San Francisco. The next page contains an overview and concise descriptions of important advances presented at the meeting. For those of you who could not attend in need of greater detail, contact my office for photocopies of specific abstracts. For those of you who want less detail, here is a brief summary of those trends and advances.

Once again, the same two topics dominated the conference: endovenous ablation (EVA) and foam sclerotherapy (FS). However, a surprise proclamation eclipsed the ceremonial opening: President Steve Zimmet proudly announced the approval of our application by the AMA for Phlebology to be officially recognized as a Self-Designated Practice Specialty (SDPS). After dramatic growth to over 1400 members this ACP goal was realized, clearing the way for the development of specialty board exams and elevating the field from its former step-child status in the shadows of medicine alongside other accepted legitimate specialties.

It was also announced that an ACP Foundation had been formed with

over \$2 million initial contributions from board members and supporting vendors. The purpose of the foundation is to support both public and professional education and research far beyond that which the membership alone could achieve.

Renewed efforts for the collaboration between the predominantly surgical American Venous Forum (AVF) and more eclectic ACP were evident by an exchange of sponsored symposia. The AVF presented an excellent endovascular symposium at the ACP Congress (see page 3), and the ACP will present a symposium at the 2006 annual AVF meeting in San Diego this November. In keeping with this spirit of unity, I applied for and was recently accepted into the AVF membership. In my opinion, both societies offer high quality programs, making dual membership worthwhile.

Two other items of interest came as no surprise. One was the pronouncement by laser pioneers Drs. David Duffy and Mitchel Goldman that with rare exceptions, "lasers have no place in the treatment of leg spider veins." Second, the UK makers of Fibro-Vein continue to navigate the FDA obstacle course of approval. After much fanfare and several delays, Sotradecol was re-introduced into the USA last year by Bioniche Pharmaceuticals - at 3 - 4 times the cost of Fibro-Vein. While more timely FDA approval of Fibro-Vein would therefore be most welcome, an FDA spokesman performed a song and dance about the arduous process necessary to protect us from dangerous drugs, leaving little

room for optimism.

The following information is a collation from abstracts, symposia, instructional courses, and the syllabus. By way of introduction, it was felt by most attendees that the five year "honeymoon" experience with both EVA and revitalized FS is over, and should yield to studies aimed at standardizing these procedures. Despite purported different mechanisms, it appears that all EVA laser wavelengths can be highly effective at a fluence of 80-100 joules/cm, although controversy exists whether to treat the calf portion of the great saphenous vein (GSV). Unless otherwise stated, the following EVA data derives from endovenous laser (vs radio frequency) ablation.

Sincerely,

Alan Kanter, M.D., F.A.C.P.
Founder & Medical Director

INSIDE

Phlebology Comes of Age!

ACP Congress Summary

About Dr. Kanter

About Our Office

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2005 ACP CONGRESS HIGHLIGHTS

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EVA Outcome. Outcomes by multiple authors using different wavelengths in thousands of limbs were reported as > 95% successful at 2+ years. As the newest endovenous laser on the market, CoolTouch lacks long-term data; reports of early failures at the recommended treatment fluence of 65 j/cm led to rumors of imminent increased fluence standards, and might explain CoolTouch's claim of less post treatment pain compared to other established wavelengths. Proebstle observed full recanalization occurred exclusively within twelve months post-treatment, while partial recanalization was demonstrated after one year. [This data was collected from pulsed laser at low (40j/cm) fluence; most practitioners now use 80-100 j/cm at the continuous setting.] Experts concluded if a treated vein is still visible by duplex at one year it must be partially open despite negative duplex flow testing. One comparative study showed less post-treatment pain after RF-Closure than after laser EVA, while another showed more paresthesia after RF-Closure than after Laser EVA. Several studies showed no neovascularization up to five years after successful RF-Closure, preserving flow from proximal SFJ tributaries similar to results from prior studies using duplex-guided sclerotherapy. Promising early results using EVA to treat isolated incompetent perforator veins were also reported.

EVA Complications. While the saphenous nerve is intimately associated with the entire GSV length in 17% of patients, it otherwise runs separately in the thigh. This explains why post-treatment saphenous neuropathy occurs more commonly in calf vein segments, and why most practitioners avoid deploying EVA past 10 cm below the knee. Dr. Robert Min, an interventional radiologist who helped pioneer EVA, expressed confidence that generous tumescent anesthesia often allows safe treatment of the calf GSV without neuropathy or skin necrosis. Self-limited, asymptomatic, clinically insignificant SF-junctional DVT was shown to occur rarely (<1%) at one week post-EVA by independent investigators; there is no data to

support treatment at this time. One investigator reported a 10% incidence (3/30) of popliteal DVT after SSV EVA, all of which exhibited the following characteristics: small segments (< 1 cm), asymptomatic, patients > 60 years old, resolved without embolism. Early detection at one week post-EVA from possible high catheter placement was postulated as an explanation. Because lidocaine can affect the sural nerve, temporary calf/ankle paresis can occur after SSV EVA. Chronic anti-coagulation did not result in bleeding problems during/after EVA.

EVA Technique. Twirling the J-wire facilitates insertion, and can allow direct placement of the laser fiber without an introducer in some cases. Keeping the patient warm and upright until just prior to EVA preserves venodilatation. Duplicated veins and interrupted vein segments may be treated sequentially in one session by simultaneous placement of two separate catheters, spacing them proximally to avoid melting the 2nd catheter.

Foam Sclerotherapy (FS). Dr. JJ Guex reported 0.4% incidence of clinically recognizable adverse events in > 6000 FS sessions; most were visual disturbances and headache after reticular (not varicose) vein injection, all of which resolved without sequela; there were no anaphylaxis, intra-arterial injection, necrosis, or lethal events. Shedding some light on the above, Dr. Morrison used simultaneous duplex imaging to follow a 2 ml bolus of 1% foam from the leg vein to the heart (15-120 seconds) and on to the middle cerebral artery in a patient with patent foramen ovale. Foam caused twice the (histologic) endothelial damage as an equal concentration of solution when injected to the GSV before stripping. A 1% incidence of neurologic symptoms occurred after 1% Varisolve injections despite the observation of right heart bubbles after all injections; successful vein closure was higher (91% vs. 75%) and DVT more common (2.9% vs. 0.4%) after Varisolve vs. extemporaneous FS; no DVTs have been observed since limiting Varisolve volume/session < 30 ml and

staying 5 cm below the SFJ.

Duplex Imaging. New nomenclature has the "cranial extension of the SSV" replacing both Giacomini and femoropopliteal veins. Perforator vein size does not always correlate with incompetence. Duplex demonstrated a 15% increased caliber and 168% increase in GSV reflux duration during the luteal phase presumably from progesterone's vasodilating effect.

Venous Thromboembolism. One year follow-up of 83 DVT patients showed femoral veins recanalized slowly with some residual occlusions while all calf veins fully recanalized; multi-segment and popliteal DVT had worse reflux with associated deep vein insufficiency. DVT recanalized faster and more often after combination low-molecular-weight heparin + NSAID than after unfractionated heparin alone.

Chronic Venous Insufficiency (CVI). Inelastic wraps work better for the treatment phase of more advanced CVI, while elastic compression hosiery may be more convenient to prevent recurrent symptoms. Contrary to some published studies, CVI was found to increase with age independent of obesity. 810 nm laser "debridement" accelerated chronic ulcer complete healing when added to basic treatment protocols.

American Venous Forum Endovascular Surgery Symposium.

DVT treatment is becoming more direct and aggressive using lysis, mechanical thrombectomy and stents via the endovenous route. The Angiojet Power Probe Lytic Spray with retrievable filter procedure takes 2 hours, and the Trellis 8 Peripheral Perfusion System with built-in sequestration balloons takes 1 hour. Newer lytic procedures on the horizon include ultrasonic micro-bubbles, mini-lithotripter, and photo acoustic lysis. Dr. Gloviczki reported a 70-85% success rate for iliofemoral stents at two years, now the treatment of choice for ilio caval obstruction; he uses EVA for 90% of saphenous veins, reserving invagination stripping for a select 10% cases, and envisions imminent endovenous deep valvuloplasty and endovenous incompetent perforator vein (IPV) ablation. Another surgeon decreased post-stripping recurrence due to IPVs at one year from 78% to 30% by adding SEPS; 80% recurrent IPVs without SEPS were found to be the same documented pre-op IPVs vs. 20% de novo. Serial duplex demonstrated striptract revascularization in 22% of 72 stripped GSVs at one year and was usually associated with immediate post-op hematoma; tracts seen as multiple coalescent channels in cross-section appeared as one vessel when viewed longitudinally.