

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 regardless of whether or not we contract with their specific plan. 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, currently negotiating contracts with multiple insurers. 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 Medical Association, 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
Vein Center of Orange County
250 East Yale Loop, Suite D
Irvine, California 92604-4697
(949) 551-8855
www.vcoc.com



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ISSUE

Venous Disorders Update

An Educational Service from the Vein Center of Orange County

www.vcoc.com

Fall/Winter 2011



Welcome to the Fall/Winter 2011 issue of *Veno-gram*, an educational newsletter for the practicing physician which focuses on new applications of current research in venous disease. Access to previous issues is available at our web site www.vcoc.com; just click "News & Offers" under "Patient Resources" to find any topic.

This issue is devoted to the highlights of the 25th Annual ACP Congress held the first week of November, 2011 in downtown Los Angeles at the L.A. Live JW Marriott. A welcome departure from prior meetings, the ACP provided a flashdrive to all attendees containing most lectures and workshops. Because multiple sessions run concurrently, it is impossible for one person to attend all sessions. This year, I was able to enjoy my preferred sessions live and still review other lectures at my leisure later. Nice touch!

The congress contained many reports on the outcomes of various endovenous thermal ablation (EVTA) techniques. This represents the natural evolution to the next phase for newer technologic advances: the first phase was proof of efficacy and acceptance, and now research is focusing on delineating appropriate treatment parameters. Regardless of the heat source (laser, radiofrequency, or steam), excellent results were obtained if heat was provided in the proper fluence range. Although all lasers are capable of yielding good clinical results, longer wavelength lasers > 1300 nm provided good results without the short-term bruising and pain of shorter wavelength lasers < 1000 nm. Page 2 contains the latest treatment parameter data.

As the EVTA wave continues to gain momentum at a rapid rate, the other inevitable shoe is about to drop: steps by

Medicare and the insurance industry to contain costs. With large numbers of varicose vein patients clamoring for EVTA as its reputation and availability spread, insurers are moving to quickly erect barriers for both doctors and patients. That means more pre-treatment hoops to jump through for the patient (vein caliber prerequisites and previously utilized conservative measures) and for the doctor (professional qualifications, accreditation, and certification) before reimbursement will be allowed. Except for a privileged few, reimbursement drives utilization. This is not all bad, but the wise will take note.

A Message From the Founder

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Saturday's ACP keynote lecture addressed this very topic. Based on the meteoric rise of EVTA procedures in the USA during the past 7 years, Dr. David Flum presented a convincing argument ACP members should immediately start collecting outcomes data to provide evidence-based medicine with the tools needed to justify such treatment. The take-home message was: if we don't, the government and insurers will collect their own data and establish mandates for treatment. In other words, we physicians must prove what methods work to validate funding for those methods. This makes it worth your while to join the American Venous Forum's Registry, where we can accomplish just that. The AVF currently has research modules for varicose vein treatment as well as thrombectomy, venous stenting, and vena cava filters. Serious phlebologists should log on to www.veinforum.org and explore this significant opportunity before it is too late.

While ultrasound-directed foam chemical ablation continues to gain proponents, research continues to look for the cause of sclerotherapy-induced adverse events such as migraine, visual disturbance, chest pain, and dyspnea. It is obvious that patent foramen ovals cannot explain all such events, and that straight solution can also cause such events to a lesser degree. Although not yet fully explained, a

multifactorial theory is emerging as outlined on the following page.

Finally, we present our annual cumulative index of topics covered since the inception of *Veno-gram* back in the early 1990's. 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

Founder's Message

Call to Action

ACP Congress Highlights

2011 Cumulative Index

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2011 ACP CONGRESS HIGHLIGHTS

Endovenous thermal ablation. The French reported over **90% success** at one year using steam. Not yet FDA-approved, 80 GSVs were each treated in less than 20 minutes. GSV closure was > 90% successful in another study using either radiofrequency or ultrasound-directed foam. Animal research using goat GSVs showed both tumescent anesthesia and Trendelenberg led to better GSV destruction due to decreased intraluminal blood. Pre-treatment GSV diameter correlated with both CEAP and VCSS scores, and usually predicted the presence of reflux. Segmental radiofrequency ablation provided > 90% success at 4 years when measured by closure rate, symptoms, CEAP, and VCSS. A short-term study found the same success at 3 months after a 50% fluence reduction using a 1470 nm laser.

Adverse events after foam. Similar rates of EHIT bubbles were detected with both GSV and SSV treatments. The potent **vasoconstrictor Endothelin** is released after sclerosant foam > solution (Sotradecol or Polidocanol); multiple factors may be contributing to the development of adverse effects including the presence of PFO, percent of vasospasm achieved, effect of concurrent medication, and individual variation.

Superficial Vein Thrombosis. SVT is **not the innocuous entity** it was previously thought to be. The presence of SVT in either GSV or SSV is accompanied by concurrent DVT in 30-60% of cases if sought with ultrasound. SVT of a tributary means concurrent DVT in 13-25% of cases. Thigh SVT more likely to develop DVT than calf SVT. SVT was more likely with lower than higher concentrations of sclerosant (STS or POL). [Ed. We must educate our colleagues to stop sending SVT patients home with antibiotics, and instead send them urgently for duplex evaluation to rule out DVT.]

Anticoagulation. **Fondaparinux** 2.5 mg daily x 45 days is now suggested for SVT, but subgroups not yet defined. It is probably ok to treat calf SVT more conservatively and thigh SVT more aggressively (see above).

Venous Ulcers/Chronic Venous Insufficiency. Evidence suggests that correction of superficial venous insufficiency (SVI) prevents ulcer recurrence, but initial healing not yet proven. Meanwhile, two thirds of ulcers will heal within 4 months using only compression; the other third who don't heal may be helped by **SVI correction**. **Obesity** as a factor independently exacerbates CVI, but not by causing reflux. Obesity also increases the chance of popliteal vein compression syndrome (>90% occlusion with knee hyperextension).

Veno-gram Cumulative Index by Topic

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