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 Forance until 1990. At that time he decided to devote his full-time to the field 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 UCLA 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 all over the continent 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 varous 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, if they agree to forgo Medicare reimbursement. VCOC is a private fee-for-service practice, with self-supported clinical research activities since 1993. For all of list of publications, brochure, or more information about our services, call 949-551-0895, 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-guided techniques to selectively treat varicose veins and their sources, physician referrals are always welcome.

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A Message From the Founder

Welcome to the Spring 2011 issue of Veno-gram, an educational newsletter for the practicing physician which focuses on new applications of current research in venous disease. This issue reports news from three continents (none from the U.S.) demonstrating the international reach of phlebology.

First, based on extensive worldwide experience, neurologic symptoms after foam injection are mostly benign transient phenomenon. To better characterize these occurrences the French Society of Phlebology performed a multicenter prospective study of visual disturbances using both clinical and MRI measures. No evidence of cerebrovascular ischemia was found. Instead, the authors propose these events represent a migraine aura induced by endothelin release via a patient foramen ovale (PFO) similar to that experienced by some patients after angiography. Unfortunately, PFO were not documented in this study.

Second, moving east from France to Italy, we review Dr. Zamboni’s latest report of treating symptomatic sciatic nerve varices. After initial case reports presented here in 2008, he now gives us two-year follow-up of patients treated with UGS, proving it is no longer safe to dismiss patients with sciatic symptoms as having a non-venous etiology. Incidentally, Dr. Zamboni is the same researcher who recently provided evidence for a connection between cerebrospinal venous insufficiency and multiple sclerosis.

Next, our friends from ‘Down Under’ provide an instructive case regarding patients with significant venous insufficiency who have normal venous testing. Should an obese patient develop early recurrence after rational axial treatment, consider popliteal vein compression syndrome. While most venous tests will be normal, these patients exhibit markedly reduced popliteal vein caliber on duplex after standing with the knee extended. Dr. Rod Lane may be better known for his “Veno-Cuff” studies, but makes another welcome contribution here.

Finally, we look at a paper by our English colleagues treating incompetent perforator veins using the radiofrequency Closure stylet. This is more of a case report because certain basic measurements were left out of the study design, such as reflux duration and perforator caliber. However, it does showcase the most recent FDA-approved indication for RFA, and is worth a read.

I attended the recent American Venous Forum annual meeting in San Diego, and promise to report the highlights in our upcoming Summer issue. For those of you planning ahead, the next ACP annual meeting will be very accessible to all of you; it will be held in Los Angeles November 3-6, 2011 at the LA Live JW Marriott. Although further away, the 2013 17th Annual International UIP meeting will be closer than usual – Boston.

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 are constantly updating the site to keep current 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., FA.C.Ph.
Founder & Medical Director
ADVANCES IN PHLEBOLOGY

Visual Disturbance after Foam Sclerotherapy

The French Society of Phlebology undertook a prospective multicenter study to evaluate visual disturbances (VD) occurring immediately after foam sclerotherapy (FS). This occurs after approximately 1.4% of FS injection sessions. Subjects received 2-10 ml of polidocanol 0.25%-3% using a 1:4 liquid/air ratio by direct venipuncture within 60 seconds of foam preparation. Their experiences gleaned from reporting forms were reviewed by neurologists using the International Headache Society criteria, and all patients had an MRI.

Twenty patients developed either monocular or binocular VD lasting 30 minutes to three hours starting approximately seven minutes after FS injection. One-half experienced concurrent headache and one-half did not. Most had either a personal or family history of migraine, and several experienced additional neurologic symptoms (extremity or tongue paresthesia, dysphasia).

All MRIs were normal, and all VDs presented clinical features consistent with migraine aura. Because the MRIs were ‘diffusion-weighted’ and therefore highly sensitive to ischemia, cerebrovascular ischemia was thought to be reliably ruled out.

It is documented in the literature that angiography can provoke migraine aura, presumably through release of endothelin, a potent vasoconstrictor. The association of patent foramen ovale (PFO) with neurologic symptoms after foam injection was the final piece of the puzzle postulated by the authors to account for VD after FS.

From the same Italian author who recently postulated chronic cerebrospinal venous insufficiency may cause instances of VD after large volumes of 3% Sotradecol FS to treat saphenous veins. Instead, all our VD cases have occurred sequentially with the knee slightly flexed and then locked in extension during standing. The latter maneuver caused >90% caliber reduction of the popliteal vein in PVC patients, who then underwent surgical decompression with resolution of symptoms. PVC was clearly associated with obesity (BMI =35 vs. 25) and debulking of excessive popliteal fat from the fossa was part of the surgery.

The authors point out certain patients who may benefit from this information. Specifically, obese patients with chronic venous insufficiency, normal venous valves, and early recurrence after venous ablation should be considered for this syndrome. The next time you encounter a patient with venous insufficiency and otherwise normal venous studies, or a patient who does not respond to the usual treatment, consider PVC and perform the above dynamic duplex study.

Radiofrequency Ablation of IPVs

Back in merry-old England, physicians used a special RFA stylet to close incompetent perforator veins (IPV) with an 82% success rate at 14 months. All IPVs were treated regardless of caliber. Unfortunately, IPV caliber measurement was not performed during duplex exam.

Anyone following the phlebology literature will recognize this to be a major study flaw. In addition, the chronologic definition of perforator incompetence was also omitted, making this more a case report than well-designed study.

The question of perforator incompetence has become more uncertain in recent years. Most would accept reflux (flow from deep to superficial veins) > 0.5 seconds as incompetent for perforator or truncal veins. Consensus for the remaining questions regarding perforators is, however, lacking.

In general, size may not be an absolute indication for treatment. Although larger perforators (>3 mm) are suspect, they may represent functioning reentry points. Even when reflux is present, untreated IPVs may normalize and shrink after superficial vein treatment. Don’t forget we are assessing perforators statically using external compression, hardly the physiologic correlate for an active intrinsic venous pump during walking.

Certainly large IPVs that persist/appear after truncal ablation and cause clinical recurrence deserve closure. Beyond that, we currently have more questions than answers regarding indications for treating IPVs. In my opinion, most perforators are best left untreated during the initial treatment of concurrent axial reflux.
