VSI-ASVS 2026 SPECIAL EDITION

VESSOMAG's Inside the VESSEL...

Official Quarterly Newsletter of the Vascular & Endovascular Surgeons of Maharashtra and Goa



THEME

VARICOSE VEINS



Must Reads ....

1. Are these patient's leg symptoms really VENOUS ?
2. What's expected from a Duplex Ultrasound..
3. Thermal Ablation Options and How do I choose ?
4. Non Thermal options in Varicose Veins Therapy ?
5. Do Varicose veins keep coming back ?
6. Aftercare following Varicose Veins therapy...

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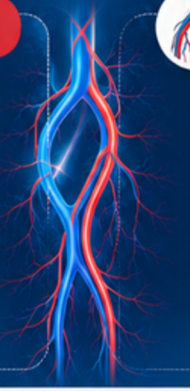
VTE: WHEN TO INTERVENE

- When to Intervene
- How to Intervene
- Role of Medical Management



ILIAC VEIN INTERVENTIONS

- How to Investigate
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President Speaks ...

Dr. R. Sekhar
Vascular & Endovascular Surgeon
MUMBAI





Esteemed Colleagues ....

It is with a profound sense of duty that I address you today, regarding the current landscape of our specialty. As vascular surgeons, we dedicate our lives to understanding the intricate, unforgiving flow of the human circulatory system. Yet, as we look across the medical landscape in India today, we are forced to confront a deeply concerning crisis centered around one of the most ubiquitous conditions we treat: *varicose veins*.

Chronic venous disease is incredibly common, but paradoxically, it remains profoundly misunderstood. Because it is so prevalent, it has been tragically trivialized. Today, the management of varicose veins has become a crowded, heavily commercialized space, enthusiastically taken up by multiple medical and surgical specialties. While true multidisciplinary care can be a boon, the reality we are witnessing is far more insidious.

We are seeing a rapidly growing trend of unscrupulous management by practitioners who possess a dangerously inadequate understanding of venous pathophysiology. To them, a varicose vein is merely a cosmetic blemish or a quick outpatient procedure, rather than a manifestation of complex, systemic hemodynamic failure. They approach these interventions with no fear of the consequences of a poor outcome. This reckless disregard extrapolates into something far darker: a fundamental lack of empathy for the patient.

As vascular surgeons, we are the ones who see the aftermath. We see the patients who return with agonizing recurrent ulcers, devastating deep vein thromboses and irreversible tissue damage resulting from botched, medically unjustified procedures. We see the financial and emotional ruin of patients

President Speaks ...

who placed their trust in practitioners prioritizing commercial expediency over clinical ethics and anatomical science.

We cannot remain silent spectators to this deterioration of patient care. Therefore, as we look to the future of the Vascular & Endovascular Surgical Society of Maharashtra and Goa, I ask every one of you to join me in a solemn pledge.

Let us pledge, as the true custodians of vascular health, to actively rectify this dangerous trend. We commit to elevating the standard of varicose vein care in our region through rigorous public awareness, peer education, and our own unwavering ethical practice. We pledge to firmly establish that the treatment of this condition requires a vascular specialist who understands the science, fears the complications, and deeply empathizes with the patient.

We vow to put pathophysiology before profit, empathy before expediency, and the safety of our patients above all else. Together, let us ensure that the highest standard of scientific, compassionate care remains the defining hallmark of our society.

Thank you

Are these patient's leg symptoms really VENOUS ??

Dr. Paresh Pai
Vascular & Endovascular Surgeon
MUMBAI, INDIA





JUDGEMENT

THE CLINICAL DILEMMA

Leg pain, swelling and skin changes are common presentations of chronic venous insufficiency—but they are not synonymous with venous disease. Chronic venous insufficiency (CVI) results from impaired venous drainage due to reflux, obstruction, or both. Persistent venous hypertension can cause aching, heaviness, swelling, varicose veins, pigmentation, skin induration and ulceration. CVI can have a substantial physical, socioeconomic and psychological impact.

Yet there is an important clinical trap: a patient may have venous reflux without venous disease being the principal cause of the symptoms. Arterial, neurological, spinal, musculoskeletal, lymphatic or systemic conditions may mimic or coexist with venous insufficiency. The challenge is not simply to identify reflux—but to determine whether it explains the patient's presentation.

THE 5-QUESTION CLINICAL CHECK

Before blaming the veins, ask: **Is the symptom pattern venous?** Does pain or heaviness increase with prolonged standing and improve with walking, rest or elevation? **Are there objective signs of venous hypertension**, such as varicose veins, oedema, gaiter-area pigmentation, eczema, lipodermatosclerosis or ulceration?

Could another condition be responsible? Do the investigations correlate with the clinical picture? Does the site and severity of reflux explain the symptoms and findings? Which problem should be treated first? When pathologies coexist, identify the condition primarily responsible for disability and requiring priority treatment. The objective is not to treat the abnormal scan. It is to treat the patient.

Are these patient's leg symptoms really VENOUS ??

LEG PAIN: IS IT REALLY VENOUS?

Typical venous symptoms include aching, heaviness, fatigue, swelling and sometimes nocturnal calf cramps. The classic pattern is less in the morning, increasing during the day, worse with prolonged standing and improving with walking, rest or elevation. But several common conditions can mimic this presentation, making careful assessment of the symptom pattern essential.

Arterial disease: Cramp-like pain in the calf, thigh, buttock or foot, reproducibly precipitated by walking and relieved by stopping, is characteristic of intermittent claudication. The important point is that arterial and venous disease can coexist. A duplex demonstrating reflux should not end the vascular assessment.

Neurological/spinal disease: Burning, tingling, numbness or shooting pain radiating from the back through the buttock and posterior thigh into the leg or foot suggests a neurological or spinal origin. Aggravation by standing, coughing, sneezing or straining, with relief on sitting or lying down, provides another clue.

Musculoskeletal disease: Pain in the feet, ankles, knees or hips, prominent after inactivity and improving with movement, may be musculoskeletal. Peripheral neuropathy: Bilateral burning or tingling feet, worse at night and associated with numbness, should prompt consideration of neuropathy. Diabetes and vitamin B12 deficiency are possible causes.

LEG SWELLING: FOLLOW THE PATTERN

Swelling is often labelled "venous" without sufficient consideration of its distribution and behaviour.

Unilateral, position-dependent swelling: Swelling increasing with standing and decreasing with elevation may occur with venous disease or early lymphatic dysfunction.

Are these patient's leg symptoms really VENOUS ??

Post-thrombotic syndrome: Previous DVT followed by persistent swelling, varicosities, pigmentation, induration or ulceration should raise this possibility. Advanced cases may show an "inverted champagne bottle" appearance.

Acute unilateral swelling: New swelling with pain, tenderness or warmth requires consideration of DVT, rather than automatic attribution to CVI. Accompanying breathlessness or chest pain requires urgent consideration of pulmonary embolism.

Bilateral swelling: Bilateral dependent oedema may be venous, but cardiac failure, renal or hepatic disease, fluid overload, medication-related oedema and severe anaemia should also be considered. Exertional dyspnoea, orthopnoea, paroxysmal nocturnal dyspnoea and nocturia can provide useful clues.

LEG PIGMENTATION: NOT ALL COLOUR CHANGE IS VENOUS

Typical venous pigmentation affects the gaiter region, often with oedema, varicose veins, eczema or lipodermatosclerosis. A new, painful, warm, tender cord along a superficial vein suggests superficial thrombophlebitis. Redness, warmth, tenderness and swelling with infection/systemic symptoms suggest cellulitis. Cold feet, pallor or other evidence of impaired perfusion should prompt arterial assessment.

Bilateral pigmentation or unusual skin changes without convincing venous hypertension should prompt consideration of alternative causes, including metabolic and medication-related conditions.

THE DUPLEX DILEMMA

"REFLUX PRESENT" DOES NOT AUTOMATICALLY MEAN "SYMPTOMS CAUSED BY REFLUX." Duplex ultrasound is indispensable, but its findings must be interpreted alongside the clinical examination. Where is the reflux? Where are the symptoms? Are there corresponding clinical signs?

Are these patient's leg symptoms really VENOUS ??

Is the severity and distribution of reflux sufficient to explain the presentation? Only then should the treatment target be determined.



THE TAKE-HOME MESSAGE

DIAGNOSE THE PATIENT—NOT THE DUPLEX SCAN. Not every patient with varicose veins has symptomatic venous insufficiency. Not every swollen or painful leg is venous. And not every abnormal duplex finding requires intervention.

A thoughtful assessment combines history, symptom pattern, examination, arterial and neurological assessment where appropriate, and targeted imaging. When pathologies coexist, ask: "**Which pathology is actually responsible for the patient's symptoms, and which should be addressed first?**" The goal is not simply to find an abnormality. The goal is to find the cause.

What's expected from a Duplex ultrasound ...

Dr. Aniruddha Bhuiyan
Vascular & Endovascular Surgeon
MUMBAI, INDIA





JUDGEMENT

Kindly correlate clinically !!!!

Somewhere in every vascular surgeon's OPD, a patient gets a report that reads: "**Bilateral lower limb venous Doppler: no obvious DVT. Kindly correlate clinically.**" It is a sentence with the texture of a diagnosis and a shift of responsibility towards a clinician. The patient has travelled, paid, done multiple valsalvas and gone home with a document that hands the entire diagnostic burden back to the person who ordered it.

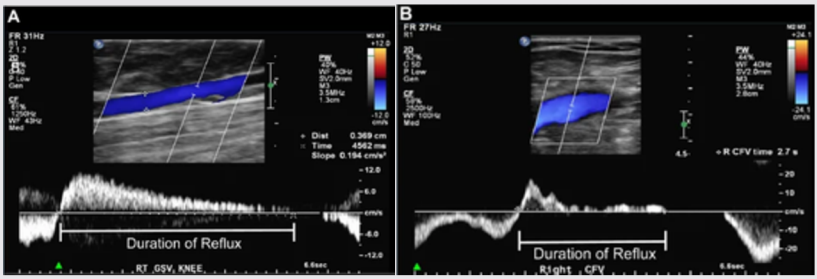
The fault is not always at the probe's end. A duplex answers the question it is asked and most of us ask badly. "**?Vascular**" is not a clinical question. Neither is "**Doppler/Ultrasound both legs**".

A reflux study and a thrombosis study are two different examinations. Different position, different manoeuvres & different segments. They can be done in one sitting, but they are not the same test, and a request for "Venous Doppler" leaves the sonologist to guess which one you meant. Its mandatory to write the side, write the finding: ulcer above the medial malleolus, calf swelling for four days, recurrent varices after previous surgery. That last one changes everything about how the groin is examined, especially for deep venous reflux.

Reflux is a gravity problem, so the test needs gravity. The patient stands, weight taken on the opposite leg, or at minimum in steep reverse Trendelenburg. A reflux study done supine is a roof inspection carried out in the dry season. The manoeuvre matters as much as the posture. Valsalva interrogates the saphenofemoral junction and not much below it, since one competent valve upstream will swallow the signal. Distal to the groin, reflux is provoked by manual compression and sudden release or by a cuff.

What's expected from a Duplex ultrasound ...

Position also decides the numbers you are handed. Van der Velden and colleagues measured saphenous trunk diameters standing and lying in 241 limbs and found a median postural change of 19% in limbs with reflux and 24% in limbs without. Roughly a fifth of the calibre vanishes when the patient lies down. A great saphenous vein reported at 5 mm may be nearer 6.5 mm when she is on her feet, which is the state in which you intend to treat her. A diameter given without the position and the level of measurement is a number without a unit.



In superficial truncal veins, reversed flow beyond 500 ms is reflux. In the common femoral, femoral and popliteal veins the threshold is one second. The 2022 SVS/AVF/AVLS guideline calls a perforator pathological at 500 ms or more of outward flow together with a diameter of 3.5 mm or more, and gives the most weight to perforators sitting under a healed or open ulcer. Hold on to that last clause. A thorough scan will turn up five incompetent perforators in an otherwise cosmetic C2 leg and treating all of them is a hobby not a strategy. Ask for perforators to be marked on the skin and measured from the floor or the malleolus. "Incompetent perforator in the mid calf" helps nobody on the table.

Deep venous reflux gets one line near the bottom or the top of the report and is rarely read (mostly as it is UNBOLD). It deserves better. When a patient has deep reflux and no history of thrombosis, the question worth asking is what is happening upstream, because obstruction in the pelvis can generate reflux below it.

What's expected from a Duplex ultrasound ...

The common femoral vein waveform costs nothing and takes twenty seconds. Kayılıoğlu and colleagues compared duplex waveforms against venography and intravascular ultrasound in 86 patients with C3 to C6 disease. Monophasic flow at rest, combined with continued forward flow through a Valsalva, was 100% specific for iliocaval obstruction, with a positive predictive value of 100%. Sensitivity was 38%. A flat waveform is an answer. A normal waveform is not, and in that same cohort the left common iliac vein was obstructed in 80% of patients. The young woman with a swollen left leg still earns her CT or MR venogram, whatever the femoral vein looks like.

An arterial doppler on the other hand has the same principle. **"Flow seen in all vessels" is not a report.** A peak systolic velocity ratio across a lesion of 1.5 to 2 suggests 30% to 49% narrowing, 2 to 4 suggests 50% to 75%, above 4 suggests more than 75%. Waveform shape at the ankle summarises everything the limb has been through. And a line conceding that the iliac segment was lost to bowel gas is worth more than a confident normal.

What a usable report contains

- the position of the patient and the manoeuvre used
- named segments, with diameters and the level at which each was taken
- reflux times in milliseconds rather than adjectives
- the segments that could not be seen, and why

None of this needs a better machine. It needs somebody who knows what the vascular surgeon is planning to do next. The best duplex reports come from radiologists who ask that before they pick up the probe and those reports have never once instructed me to correlate clinically.

Thermal Ablation options and How do I choose ?

Dr. Amish P Mhatre
Vascular & Endovascular Surgeon
MUMBAI, INDIA





DECISION MAKING

From bare-tip laser to radiofrequency and radial fibres—a personal perspective

For much of the past century, surgical high ligation and vein stripping were the mainstay of treatment for severe varicose veins associated with chronic venous insufficiency. Although effective, surgery often involved postoperative pain and delayed healing. Endovenous thermal ablation changed this approach by delivering heat within the vein to achieve closure, generally with less discomfort and without an inpatient hospital stay.

The thermal techniques discussed here include endovenous laser therapy (EVLT), radiofrequency ablation (RFA), endovenous microwave ablation (EMWA) and endovenous steam ablation (EVSA). My practical experience has centred on laser and RFA, and the evolution of these technologies has influenced how I choose between them.

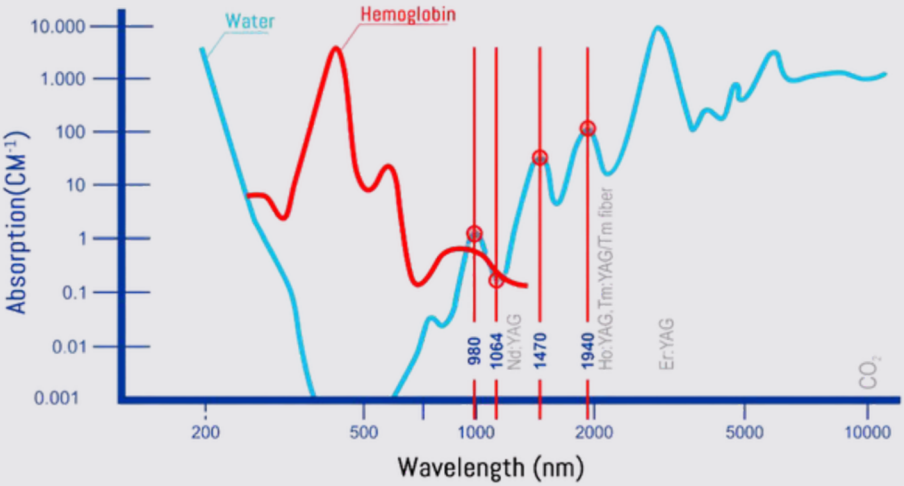
HOW THE TECHNOLOGY EVOLVED

The development of endovenous laser treatment gathered momentum in 1999, when Dr Carlos Boné described delivering laser energy directly into the vein lumen to produce thermal injury and closure. In 2002, the US Food and Drug Administration approved Diomed's 810 nm diode laser system for treatment of the great saphenous vein.

Early laser systems used wavelengths such as 810, 940 and 980 nm, with energy absorption predominantly associated with haemoglobin. Post-procedure bruising and pain were important limitations. Later systems introduced wavelengths such as 1470 and 1940 nm, with greater absorption by water, changing how energy could be delivered to the vein wall.

Thermal Ablation options and How do I choose ?

Fibre design also evolved, with radial fibres offering a different pattern of energy delivery from traditional bare-tip fibres.



RFA emerged in the late 1990s, with FDA approval of the bipolar VNUS Closure system in 1999. Early systems used a continuous pullback mechanism. The subsequent ClosureFast system introduced controlled, segmental heating at 120°C in short treatment cycles, making energy delivery more uniform.

Microwave energy was initially used for tumour treatment in the mid-1990s. Clinical studies exploring its use in varicose veins followed between 2008 and 2012, with a dedicated endovenous microwave device introduced in 2016. Microwave ablation produces heat within the treated tissue. Steam ablation provides another thermal approach, although neither microwave nor steam forms part of my personal experience.

Thermal Ablation options and How do I choose ?

MY STARTING POINT: BARE-TIP LASER

My first experience with endovenous thermal ablation was with a 1470 nm diode laser and a bare-tip fibre. The fibre delivered a forward-directed beam and was positioned approximately 2–2.5 cm below the saphenofemoral junction (SFJ).

The fibre was introduced through a sheath. On a few occasions, the sheath was damaged when the activated fibre was inadvertently withdrawn into it. The forward-directed beam also presented limitations in delivering energy uniformly to the vein wall. Looking back at my experience, bruising, pain and recurrence were more frequent with bare-tip fibres than with the techniques I subsequently adopted.

WHY I MOVED TO RADIOFREQUENCY ABLATION :

My transition to RFA began when laser fibre availability became an issue. The large heating element and ease of use encouraged me to adopt RFA for the great saphenous vein (GSV), alongside below-knee sclerotherapy.

In my practice, RFA produced considerably less bruising and pain than bare-tip laser treatment. When I later used radial fibres with the 1470 nm diode laser, I found the results comparable to those achieved with RFA. This distinction is important in describing my experience: the performance of a bare-tip laser fibre should not be assumed to represent that of a radial fibre.
I have not personally used 1940 nm laser systems, microwave ablation or steam ablation.

HOW I CHOOSE IN PRACTICE :

In my experience, both RFA and 1470 nm radial-fibre laser treatment have delivered good results, with little postoperative discomfort and no bruising in the cases described. My choice depends primarily on the size and tortuosity of the saphenous vein and whether associated perforators require treatment.
For veins measuring 5–10 mm, I consider either RFA or radial-fibre laser suitable

within my practice. For veins larger than 10 mm, combined saphenous and perforator treatment, or tortuous, twisted and branching veins, my preference is laser.

In recurrent varicose veins, I favour RFA when the vein is relatively straight and laser when the recurrent vein is tortuous. My personal approach to recurrent disease has been high ligation of the SFJ followed by thermal ablation of the GSV.



THE TAKE-HOME MESSAGE

My experience has taken me from bare-tip laser to RFA and radial-fibre laser, with the latter two providing similarly satisfactory results. The choice is guided by the vein's anatomy, the treatment required and my experience with the device. These are the practical considerations that shape my selection for each patient.

Non Thermal Options in Varicose Veins Therapy

Dr. Vinit Paliwal
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DECISION MAKING

No heat, no tumescent anaesthesia and rapid recovery—cyanoacrylate closure offers an alternative to thermal ablation. But how does it compare in everyday practice and over the long term?

The treatment of varicose veins has evolved to offer several minimally invasive options. Among these is cyanoacrylate adhesive closure (CAC), commonly referred to as "**vein glue**"—a non-thermal, non-tumescent, catheter-based treatment for superficial venous reflux.

Unlike endovenous laser ablation (EVLA) and radiofrequency ablation (RFA), which use thermal energy to destroy the vein, glue closes the incompetent vein through chemical polymerisation and mechanical adhesion of the venous walls. This difference explains many of its practical advantages and its characteristic complications.

How does vein glue work?

The procedure is performed under ultrasound guidance. The incompetent truncal vein is punctured and a catheter is positioned within it. Small aliquots of medical-grade cyanoacrylate adhesive are then delivered into the vein while compression brings the venous walls together.

On contact with blood, the adhesive rapidly polymerises, producing adhesion of the vein walls and permanent occlusion. There is no thermal injury and therefore no requirement for tumescent anaesthesia.

Who is a suitable candidate?

The principal indication is symptomatic superficial venous reflux with saphenous incompetence. This includes great saphenous vein (GSV) and small

saphenous vein (SSV) incompetence, as well as anterior or accessory saphenous reflux in selected patients.

Patients may present with symptomatic varicose veins associated with truncal reflux, pain, heaviness, swelling or venous discomfort. Selected patients with skin changes related to chronic venous disease may also be considered.

As with other endovenous procedures, duplex ultrasound is essential to document reflux, assess the truncal anatomy and plan treatment.

When should glue be avoided?

Patient selection remains central to successful treatment. Absolute or major contraindications include:

- Known hypersensitivity to cyanoacrylate
- Acute superficial thrombophlebitis
- Thrombophlebitis migrans
- Acute systemic infection or sepsis
- Acute deep vein thrombosis (DVT)

Large-diameter veins also require careful consideration. Some guideline data suggest increased recanalisation when the treated vein measures more than 8–10 mm.

What makes glue appealing?

For patients, much of the appeal lies in the experience of the procedure and recovery. Because CAC uses no heat, it eliminates thermal injury and reduces concern regarding injury to adjacent nerves. It also avoids the multiple injections required for tumescent anaesthesia, making the procedure faster and more comfortable.

Postoperative pain and bruising can be low because there is no thermal injury or extensive tumescent infiltration. Patients can generally ambulate immediately and return rapidly to normal activities. In one post-market study, the mean return to work was approximately 0.2 days, while return to normal activities was approximately 2.4 days.

Another practical advantage is that routine postoperative compression is not necessarily required after CAC, although individual clinicians may still recommend it.

Patient acceptance has also been encouraging. In the five-year VeClose follow-up, approximately 9 out of 10 patients were willing to choose the procedure again.

The trade-off: inflammation and other complications

The characteristic complication of cyanoacrylate treatment is a phlebitic or inflammatory reaction along the treated vein.

Patients may develop local erythema, tenderness, induration, warmth or a cord-like sensation. Reported rates are approximately 11–20%, although these vary between studies. Most cases are self-limiting and respond to conservative treatment.

Bruising and local discomfort are usually mild and transient. Skin irritation may also occur around the treatment area or access site.

Uncommon but important complications include hypersensitivity or allergic reactions, glue granuloma, infection, DVT, pulmonary embolism, persistent inflammatory reactions and recanalisation. Rarely, extension of adhesive into the deep venous system may occur.

The absence of thermal injury therefore offers clear benefits, but the possibility of an inflammatory or hypersensitivity reaction remains an important part of patient counselling.

Does the closure last?

The long-term evidence for cyanoacrylate closure is encouraging. Early studies reported approximately 99% occlusion rates at 3 months. The most important long-term comparison comes from the VeClose randomised study extension, which compared cyanoacrylate closure with RFA. At five years, freedom from recanalisation was approximately 91.4% with CAC and 85.2% with RFA. CAC remained non-inferior to RFA in the study population. Both groups demonstrated sustained improvements in symptoms and quality of life,

with no new recanalisation events between 36 and 60 months. Manufacturer-reported five-year data from the same clinical programme also report a 94.6% closure rate, with substantial improvement in the Venous Clinical Severity Score (VCSS).

Where does glue fit in practice?

Cyanoacrylate glue ablation is a highly effective option for symptomatic saphenous venous reflux. Its major advantages are the avoidance of thermal injury and tumescent anaesthesia, minimal needle punctures, low postoperative discomfort and rapid return to activity.

Its principal limitation is the possibility of a post-procedure inflammatory or phlebitic reaction, with hypersensitivity and extension of adhesive into the deep venous system occurring rarely.

For appropriately selected patients, the available five-year evidence is reassuring: durable vein closure, sustained improvement in symptoms and quality of life and efficacy comparable to RFA.



Fig 1. Endovenous Glue Ablation Procedure

Do Varicose Veins keep coming back ?

Dr. Pranjal Melge
Vascular & Endovascular Surgeon
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PERSPECTIVE

Varicose veins, often described as a consequence of human evolution, are a condition that predates even Hippocrates. One of the earliest known references to varicose veins appears in the Ebers Papyrus, dating back to around 1550 BC. The treatment of varicose veins has evolved remarkably over the centuries. From the ancient Greeks and Romans, who largely discouraged surgical intervention because of its life-threatening risks, to modern medicine, where increasingly minimally invasive techniques have made intervention safer and more widely accepted, the management of varicose veins has undergone a remarkable transformation.

Despite the long-standing evolution of treatment strategies for varicose veins, recurrence continues to represent one of the major challenges in their management. The reported incidence of recurrence varies widely, ranging from approximately 2–10% within the first year to 50–65% at 10 years. This recurrence is multifactorial, involving a complex interplay of patient-related physiological, pathological and ergonomical factors as well as technical and strategic factors related to the treating clinician.

Factors Contributing to Recurrent Varicose Veins



The recurrence of varicose veins is multifactorial and may reflect inadequate treatment, persistent or newly developed venous pathology, anatomical variations, and patient-related risk factors.
These factors can be broadly categorized as follows:

Do Varicose Veins keep coming back ?

1. Anatomical and Venous Hemodynamic Factors

- Incompletely recanalized preoperative deep vein thrombosis (DVT), resulting in persistent venous outflow obstruction and altered venous hemodynamics.
- Deep venous obstruction or reflux, which may persist despite treatment of superficial venous incompetence or develop during follow-up.
- Valvular anomalies of the iliac or femoral venous segments, contributing to persistent proximal venous reflux.
- Duplicated great saphenous vein (GSV) or small saphenous vein (SSV), which may be overlooked during initial treatment and subsequently act as a source of recurrent reflux.

2. Treatment and Technical Factors

- Incomplete identification or treatment of all incompetent venous segments, including residual tributaries, perforators or duplicated saphenous veins.
- Inadequate treatment of the underlying source of reflux, resulting in persistent venous hypertension.
- Technical limitations or suboptimal surgical management, which may contribute to early recurrence or persistence of varicosities.
- Lack of specialized venous expertise, where inadequate preoperative venous mapping, incomplete treatment, or inappropriate selection of the intervention may increase the risk of recurrence.

3. Patient Related and Lifestyle Factors

- Obesity (BMI >30 kg/m^2), which is associated with increased venous pressure and may contribute to disease progression.
- Occupational exposure to prolonged standing or sitting, which can increase venous hydrostatic pressure and impair venous return.
- Factors associated with increased intra-abdominal pressure, such as chronic constipation and recurrent straining, which may exacerbate venous hypertension.

4. Hormonal and Physiological Factors

• Hormonal changes, particularly during pregnancy and menopause, which may influence venous wall compliance and valvular function.

• Hormone replacement therapy, which may contribute to venous dilation and changes in venous hemodynamics.

• Pregnancy-related physiological changes, including increased blood volume, hormonal effects on the venous wall, and mechanical compression of the pelvic veins.

5. Age and Genetically Related Factors

• Age-related degeneration of the venous wall and valves, resulting in progressive venous dilatation and valvular incompetence.

• Genetic predisposition, including inherited susceptibility to venous wall weakness, valvular dysfunction and chronic venous disease.

Patterns of Recurrence

Three distinct patterns of variceal recurrence have been described:

1. Residual veins: Veins that remain untreated following a procedure performed within the preceding month.
2. True recurrent veins: Previously treated veins that have undergone recanalization and subsequently developed reflux one month or more after the initial procedure.
3. New refluxing veins: Newly developed veins with reflux arising in an anatomical area where no venous vessels were previously present.

While prevention of neovascularization or the development of new refluxing veins remains a challenge, particularly in younger patients with varicose veins, the persistence of residual veins is largely preventable through meticulous venous mapping and comprehensive pre-operative planning. True recurrent varices may also result from inadequate treatment of the underlying venous pathology. Therefore, identifying and appropriately addressing the underlying cause at the initial stage of treatment should remain a primary focus to minimize the risk of recurrence.

Do Varicose Veins keep coming back ?

Prevention of Recurrence

Recurrence can be minimized through the following measures:

a) Adequate management of the underlying or precipitating cause

b) Appropriate and comprehensive surgical treatment during the initial procedure

c) Strict adherence to post-operative care and instructions

d) Regular and appropriate use of certified graduated compression stockings

e) Maintaining a regular exercise regimen to promote venous circulation and enhance the calf muscle pump

f) Avoiding prolonged periods of standing or sitting; changing position and walking periodically can improve circulation.

g) Elevating the legs when resting, particularly after prolonged standing or sitting.

h) Attending regular follow-up examinations, especially if symptoms such as swelling, pain, skin changes, or new prominent veins develop.

Why it is important to choose the right specialist?

Varicose veins are not merely a cosmetic concern; they may be associated with significant morbidity. *They arise from an underlying physical or physiological factor that may easily be overlooked.* Therefore, effective management of primary varicose veins prevents recurrence of varicose veins.

It requires accurate identification of the underlying cause, appropriate treatment of the pathology, and implementation of measures to minimize the risk of recurrence. Failure to adequately address any one of these three aspects may increase the likelihood of recurrence. Hence, evaluation and treatment by a specialist with appropriate expertise and training in venous disease is essential from the outset to ensure comprehensive and effective management.

Conclusion:

It is important to recognize that recurrence of varicose veins may result from either inadequate initial treatment or poor patient adherence to post-operative recommendations. Furthermore, new sites of venous reflux or

Do Varicose Veins keep coming back ?

progression of the underlying venous disease may develop despite technically successful treatment. Conversely, even with strict compliance with post-operative instructions, recurrence may occur if the underlying venous pathology was inadequately addressed during the initial treatment.

Varicose veins may recur after treatment, with some recurrences being preventable while others may be inevitable. Although inevitable recurrence may not always be within our control, every effort should be directed toward identifying and addressing the modifiable and preventable factors that contribute to recurrence.



Aftercare following Varicose Veins Therapy

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PERSPECTIVE

The landscape of venous medicine has undergone a profound transformation over the past two decades. With the transition from traditional high ligation and stripping to minimally invasive modalities—such as endovenous thermal ablation (EVTA), ultrasound-guided foam sclerotherapy (UGFS) and non-thermal, non-tumescent (NTNT) techniques—procedural morbidity has plummeted. However, a successful procedural outcome is only half the battle. The quality of aftercare directly dictates the long-term success of the intervention, patient comfort and the prevention of complications.

In line with the latest clinical practice guidelines from the European Society for Vascular Surgery (ESVS), the Society for Vascular Surgery (SVS) and the American Venous Forum (AVF), modern postoperative care has firmly shifted away from prolonged immobility towards active recovery, targeted compression and structured follow-up.

The Cornerstone of Recovery: Compression Therapy

Despite the advent of newer technologies, compression therapy remains the bedrock of post-procedural care. The primary goals of postoperative compression are to reduce postoperative oedema, minimise the inflammatory response, compress the treated venous segments (preventing blood pooling and recanalisation) and decrease postoperative pain.

According to the latest ESVS and SVS guidelines, patients should apply medical-grade graduated compression stockings immediately following the procedure.

Pressure Gradient: A targeted ankle pressure of 20 to 30 mmHg is generally recommended for most standard, uncomplicated ablation and sclerotherapy

procedures. Higher pressures (⩾40 mmHg) are strongly recommended for patients presenting with active venous leg ulcers (CEAP C6) to accelerate ulcer healing.

Duration: While consensus on the exact duration varies slightly depending on the specific intervention, standard practice dictates continuous wear for the first 48 to 72 hours (24 hours a day, removing the stockings only to shower). Following this acute phase, daytime wear is highly encouraged for an additional one to two weeks to support the fibrotic occlusion of the treated vein.

Medical-grade compression stockings remain the gold standard for post-procedural oedema control.

Early and Frequent Ambulation : The historical approach of prescribing strict bed rest after venous surgery is obsolete. Today, early and frequent ambulation is universally mandated to activate the calf muscle pump, which drastically reduces venous stasis and mitigates the risk of deep vein thrombosis (DVT).

Vascular specialists advise that patients should begin walking within hours of the procedure. A daily routine of 30 to 45 minutes of low-impact walking is considered optimal for the first two weeks after treatment. Patients should be informed that while walking is mandatory, standing or sitting still for prolonged periods is detrimental. Sustained hydrostatic pressure can cause treated veins to reopen or trigger excessive inflammatory responses. If a patient's occupation requires prolonged sitting, they must be instructed to perform ankle pumps or take brief walking breaks every hour and to elevate their legs above heart level whenever they are at rest to depressurise the venous system.

Activity Modifications and Environmental Precautions

While active recovery is essential, patients must avoid activities that cause sudden spikes in intra-abdominal pressure or induce peripheral vasodilation:

Aftercare following Varicose Veins Therapy

- **Strenuous Exercise:** High-impact exercises, heavy weightlifting (exceeding 10–20 lb) and intense cardiovascular workouts should be strictly avoided for 7 to 14 days. These activities increase venous pressure, which can disrupt the closure of treated vessels.
- **Heat Exposure:** Patients must be counselled to avoid hot baths, saunas, hot tubs and direct sun exposure to the treated leg for at least two weeks. Heat induces vasodilation, which counteracts the goals of ablation and sclerotherapy. Lukewarm showers are permitted after the initial 24 to 48 hours.
- **Air Travel:** To minimise the risk of venous thromboembolism (VTE), long-haul flights should be delayed for at least two to four weeks after the procedure.



Pain Management and Wound Care

Post-procedural discomfort is typically mild and self-limiting. Patients often report a “tight” or “pulling” sensation along the course of the treated vein, accompanied by palpable, tender lumps. This is a normal part of the fibrotic healing process and the reabsorption of trapped blood.

- **Analgesia:** Mild discomfort is best managed with acetaminophen. Non-steroidal anti-inflammatory drugs (NSAIDs) may be used if required, though some practitioners prefer to avoid them in the first 48 hours to allow the therapeutic inflammatory cascade to initiate vein closure.
- **Site Care:** For patients who undergo adjunctive ambulatory phlebectomy, incision sites must be kept clean and dry. Patients should be explicitly warned against aggressively massaging the treated leg in the early postoperative period, as this can disrupt sutures or the ablation tract.

Aftercare following Varicose Veins Therapy

Fig 1. An Ideal Patient with an Ideal Outcome



Clinical Surveillance and Follow-Up :

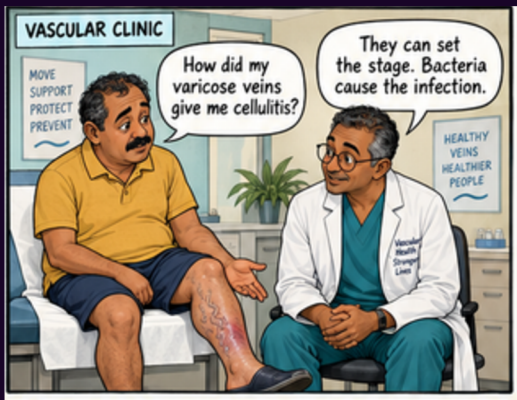
Postoperative duplex ultrasound remains a critical component of the aftercare pathway. A routine follow-up scan is typically performed between 3 and 7 days after the procedure if symptoms persist, to confirm the successful occlusion of the target vein & rule out procedure-induced complications, specifically endovenous heat-induced thrombosis (EHIT) extending into the deep venous system or deep vein thrombosis (DVT).

Conclusion

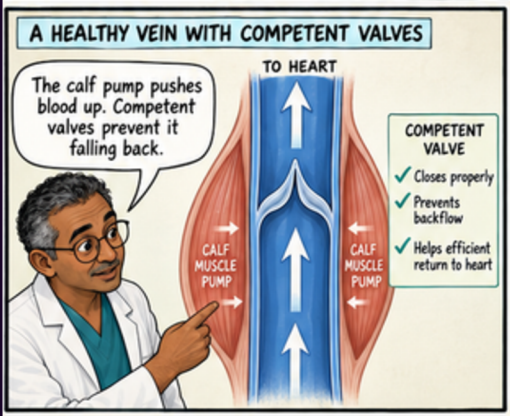
The evolution of varicose vein therapy has drastically improved the patient experience, but the physiological demands of healing remain. Proper aftercare is an active partnership between the physician and the patient. By adhering to global guidelines that champion immediate compression, early ambulation, sensible activity restrictions and timely ultrasound surveillance, we can ensure that our patients achieve the highest rates of target vein closure, the lowest rates of complications and a swift recovery with an improved quality of life.

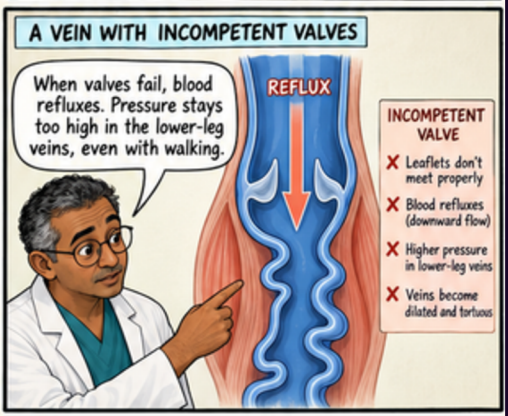
The Leaking Valve ...

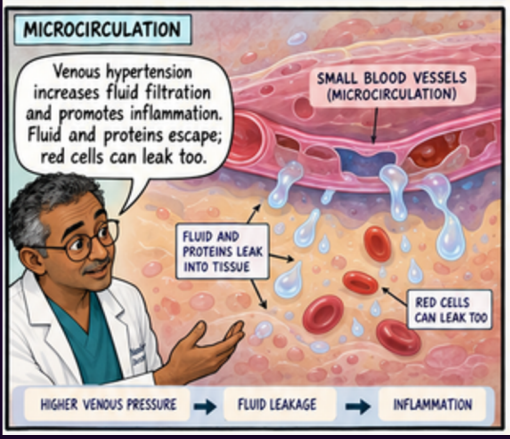
COMICS













The Leaking Valve ...

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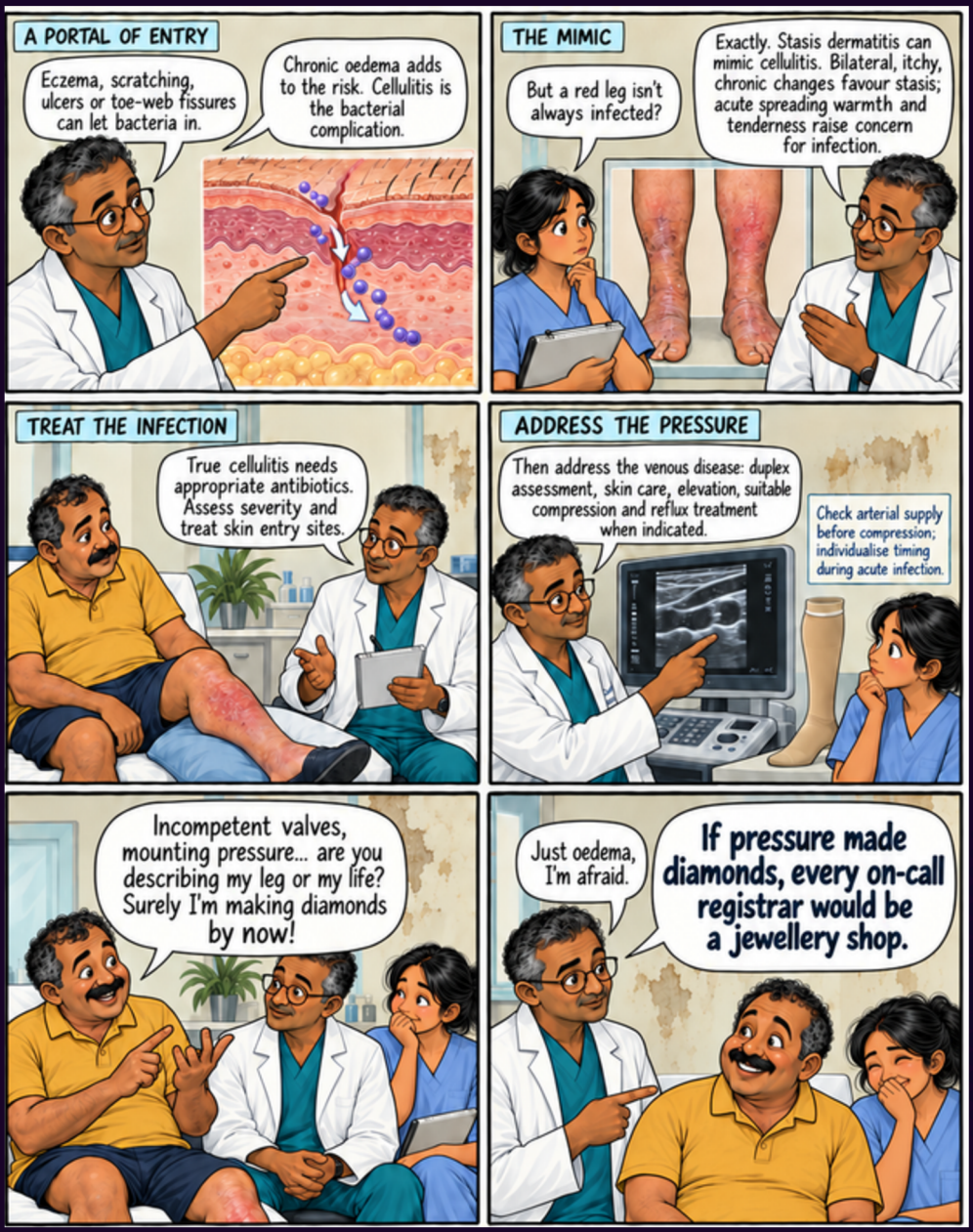

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Dr. Robert L Kistner

"They say with arterial disease you may lose a limb, but with venous disease you may lose use of the limb."

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