C1 Disease And Truncal Incompetence: To Ablate Or Not To Ablate?

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An association between telangiectasia and reflux in adjacent reticular veins has been documented by Weiss and Weiss


Somjen et al. studied, with continuous wave Doppler ultrasound, 37 legs (53 sites) with lateral and/or medial thigh telangiectasia.

In 47 (89%) sites, they found reticular vein incompetence close to telangiectasia

CONCLUSIONS:
US mapping of the GSV in women with telangiectasia is justifiable, even in asymptomatic extremities.
Further research will determine if segmental reflux should be treated to avoid evolution to severe valvular insufficiency

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CEAP 1 and Saphenous Ablation?

Patterns of Saphenous Venous Reflux in Women Presenting with Lower Extremity Telangiectasias

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BACKGROUND: Telangiectasias have been treated with sclerotherapy without concurrent assessment or treatment of saphenous veins.

OBJECTIVE: To clarify if ultrasound (US) mapping of saphenous veins is justifiable, this investigation determined prevalence of specific patterns of saphenous vein reflux in women with telangiectasias.

METHODS: US mapping of the great and small saphenous veins (GSV, SSV) was performed in 1,740 extremities of 850 consecutive patients, mostly women (86%). A subgroup of 259 limbs of women with telangiectasias (CEAP C1 class) was included in this study. Patterns of GSV and SSV reflux were classified as perifemoral, proximal, distal, segmental, multisegmental, and diffuse.

RESULTS: Reflux was detected in 124 extremities (36%): 9% had reflux in both the GSV and the SSV, 38% had GSV reflux, and 2% had SSV reflux. The most common pattern of GSV reflux was segmental (75%), followed by diffuse (14%). The prevalence of reflux was significantly greater in GSV versus SSV (p < .01). GSV segmental plus diffuse pattern was significantly more prevalent than saphenous-saphenofemoral junction or more distal reflux (p < .01).

CONCLUSIONS: US mapping of the GSV in women with telangiectasias is justifiable, even in asymptomatic extremities.
Further research will determine if segmental reflux should be treated to avoid evolution to severe valvular insufficiency.

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The Edinburgh Vein Study population comprised 1566 subjects (699 men and 867 women).

There was a statistically significant trend for increasing incompetence in either the superficial or deep veins (P < 0.001) to be associated with advancing grade of telangiectasia.

84% of subjects with grade 1 telangiectasia
66% of those with grade 2/3 telangiectasia
... have no detectable saphenous reflux, indicates that the association is not strong.

**Our Approach To C1 Disease**

1. C1 Disease- without lower extremity symptoms, no duplex
2. C1 Disease – with lower extremity symptoms, duplex performed (more to satisfy patients concerns) - rarely find saphenous reflux
3. C1 Disease – duplex shows saphenous reflux, on rare occasion perform saphenous ablation (5 cases in past 15 years). We will perform sclerotherapy in presence of uncorrected saphenous reflux
4. C1 Disease – came from another center with report “critical 4-vessel disease- need 4 staged saphenous ablations”, we repeat duplex ultrasound and rarely find any reflux

**Conclusion:**

Saphenous Ablation Is Not The Treatment for C1 Disease
Sclerotherapy Is The Treatment for C1 Disease

Thank you!