



American Venous Forum

Promoting venous and lymphatic health



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VEIN SPECIALIST

NEWSLETTER

August 2019 | veinforum.org



JVS-VL HIGHLIGHTS

JVS - VENOUS AND LYMPHATIC DISORDERS IS THE LEADING JOURNAL IN ITS FIELD

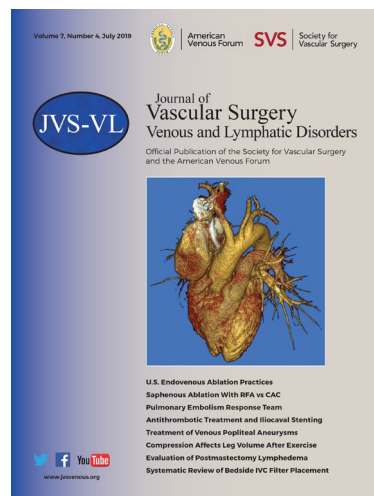
Peter Gloviczki, MD, & Peter F. Lawrence, MD, Past Presidents of AVF

"The only place where success comes before work is in the dictionary."

- Vidal Sassoon



Peter Gloviczki, MD



The recently released 2018 Impact Factor of 2.696, and the dramatic increase from the previous year, confirms that JVS-Venous and Lymphatic Disorders (JVS-VL), a joint venture of the American Venous Forum and the Society for Vascular Surgery, is the leading international journal in venous disease management. Success has been the result of collaboration and hard work by outstanding authors from throughout the world, as well as expert reviewers of both societies. During the past few years the JVS-VL has offered excellent articles on both acute and chronic venous and lymphatic disorders, and the September 2019 issue of JVS-VL will be no exception.



Peter F. Lawrence, MD

The Editor's choice article in September is entitled "Long-term computed tomography follow-up results of strut penetration of inferior vena cava filters", written by Shin Seok Yang and Woo-Sung Yun, from Daegu, Korea. In this study, 66 patients with an inferior vena cava (IVC) filter had follow-up with computer tomography at a mean of 14 months. IVC strut penetration was detected in all patients. In 36% all struts were outside the IVC lumen and in 35% strut penetration into adjacent organs was observed. The most important risk factor for organ penetration was indwelling time >30 months. This paper reinforces the need for retrieval of IVC filters as soon as they are no longer needed.



An interesting article by Aurshina and colleagues from Dr Enrico Ascher's group in Brooklyn, New York analyzed data from non-thrombotic iliac vein lesions (NIVL's) treated in 713 patients. The authors concluded that balloon angioplasty alone, without stents, was not an effective treatment of NIVL's.

Son and al. reported on 26,902 lymphedema (LE) patients enrolled in the Blue Health Intelligence database. In patients with underlying malignancy, breast cancer was the most frequent comorbidity. The study found that a sizable proportion of cancer-related LE patients did not receive appropriate treatment and venous leg ulcers were frequently untreated, when accompanied by lymphedema.

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JVS-VL HIGHLIGHTS *continued...*

JVS - VENOUS AND LYMPHATIC DISORDERS IS THE LEADING JOURNAL IN ITS FIELD

Peter Gloviczki, MD & Peter F. Lawrence, MD

An important article on catheter-directed thrombolysis versus suction thrombectomy in the management of acute pulmonary embolism (PE) was written by Avgerinos et al. from the University of Pittsburgh. In this retrospective study, suction thrombectomy in 18 patients and catheter-directed thrombolysis in 54 matched patients with acute massive or sub-massive PE resulted in similar clinical success, with no difference in complications such as major bleeding, stroke, or death rates. Suction thrombectomy appears to be a potential alternative or complementary option to catheter-directed thrombolysis for selected patients with PE's.

These were just a few of the many excellent articles from our September issue of the JVS-VL. To access these articles free in September please visit us on www.jvsvenous.org. Thank you for reading JVS journals and thank you for your valuable contributions.

Links:

- [Editor Summary Videos](#)
- [YouTube channel](#)
- [September JVS-VL Editor Summary \(link given says video unavailable\)](#)

Peter Gloviczki, MD, Past AVF President
Peter F. Lawrence, MD, Past AVF President
Editors

Fall Fellows/Residents/
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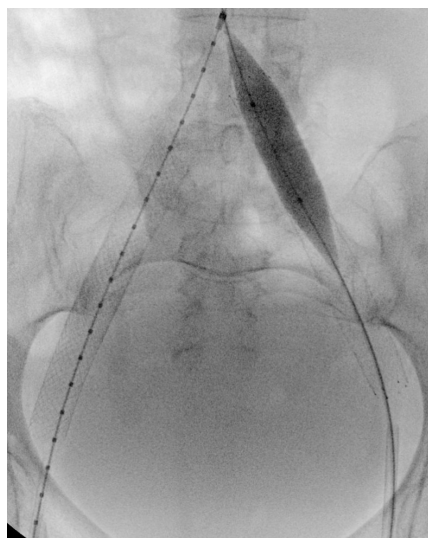


Windsor Ting, MD

ACCESSING VENOUS CIRCULATION

ACCESSING THE VENOUS CIRCULATION - HOW I DO IT

Windsor Ting, MD



Bilateral iliac interventions utilizing accesses from the right and left common femoral veins

How do you gain access into the venous circulation for your planned intervention? My decision is guided by several considerations. The common femoral vein (CFV) is probably the most straightforward entry point because the CFV is usually of significant caliber and superficial in location, allowing for a quick access to undertake the venography and subsequent venous intervention. It is probably the most commonly used access point. The downside of accessing through the CFV is the inability to fully evaluate the ipsilateral CFV. Any intervention will be limited to the proximal CFV. This limitation is less of a concern for those who do not routinely stent the CFV. The greater saphenous vein (GSV) or a tributary of the GSV is another access option, sharing similar advantages and disadvantages of the CFV. I

frequently use a GSV access for my vein stent cases. When a complete evaluation of the CFV is essential or stenting of the CFV is planned, I usually access through the femoral vein (FV). Even though the FV is deep to the superficial femoral artery, a segment of the FV usually deviates either laterally or medially that allows for potential access. In an obese individual, the FV can be quite deep. If the ipsilateral FV is not an option, I will access from the contralateral CFV using an up and over approach. I seldom access the popliteal vein (PV) or small saphenous vein (SSV) for vein stenting although these are potential entry points. While the PV is accessible with the patient in a supine position, it is usually done with the patient prone. Consider the possibility that compression of the left common iliac vein may be altered when the patient is placed in a prone position. I seldom access the iliac veins from the jugular vein or subclavian vein except in special circumstances because of the greater distance of these veins to the iliacs.

Access for acute DVT intervention is more variable and different from case to case, guided primarily by the extent of the DVT. I will try various access options until one is successful but infrequently, satisfactory access cannot be achieved. In DVT cases involving the FV, I will access the PV, SSV and other calf veins. Access from the contralateral limb is also an option to consider. In extensive DVT, I will try to gain access from various sites until I am able to pass one or more guidewires through the entire length of the thrombus. These various access points may include the contralateral CFV, the jugular vein superiorly, the ipsilateral GSV with one guidewire going to the iliac veins and a second guidewire advanced to the calf veins, or even accessing through an engorged muscle vein or calf perforator vein.

Clearly there are many options to access the venous circulation. As we gain in experience, various accesses can be utilized for an expeditious entry into the venous circulation to begin the intervention.

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Maria Urso, PhD

BTG RESEARCH UPDATE

OBSERVATIONAL STUDY OF THE EFFECT OF VARITHENA® ON WOUND HEALING IN THE TREATMENT OF VENOUS LEG ULCERS RESULTING FROM CHRONIC VENOUS INSUFFICIENCY (VIEW-VLU REGISTRY)

Maria Urso, PhD

Chronic hypertension in the venous system, triggered by venous reflux, obstruction, and/or valve failure, leads to skin changes and venous leg ulcers (VLUs) (1). Treatment guidelines support the use of compression bandaging as standard of care (SoC) for VLUs but many wounds remain unhealed with high rates (~66%) of recurrence (2, 3). More recently, the Early Venous Reflux Ablation (EVRA) trial provided data to suggest that early intervention with compounded foam sclerotherapy, thermal ablation, Cyanoacrylate or Mechanochemical Ablation, leads to faster rates of healing, lower rates of recurrence, and more ulcer free days (4). In that investigation, the efficacy of FDA-approved Varithena® polidocanol injectable foam 1% was not studied since it is not yet commercially available in the UK. For that reason, a registry trial was initiated in the United States to study patient outcomes when refluxing truncal veins were ablated with Varithena® in patients with C6 disease.

Interim data from the VIEW VLU Registry were presented in April 2019 at the International Vein Congress in Miami, Florida by Michael Shao, MD, co-principal investigator of the study alongside Raghu Kolluri, MD. This multi-center, open-label registry is designed to collect data from 200 patients with VLUs from 40 sites across the US. This interim analysis provides data from 54 venous leg ulcers in 50 patients from 14 sites in the US and Canada. Patients enrolled had great saphenous vein (GSV) and/or anterior accessory saphenous vein (AASV) incompetence resulting in one or more VLUs. All patients were treated according to the site-specific standard of care and in accordance with the Varithena® prescribing information. Primary outcomes included rate of venous ulcer healing (mm/week) and venous ulcer closure at three months post-treatment. Secondary outcomes included VLU recurrence at three months post-treatment and pain at the ulcer location using an 11-point numeric pain rating scale (NPRS).

In the interim analysis, 50 patients with 54 ulcers were analyzed. The mean age of the patients was 65.0 ± 13.6 years and 98.1% had GSV incompetence. All patients were eligible for inclusion in the study, regardless of venous ulcer size. The mean VLU perimeter at baseline was 10.86 ± 9.87 cm, approximately the size of a soda can base. The mean VLU age was 27.5 weeks. The mean volume of drug injected was 4.4 ± 5.9 and 8.7 ± 4.6 mL, above and below the knee, respectively. Thirty-two percent of the patients received a second treatment of 1.8 ± 5.0 mL above the knee, and 9.2 ± 4.1 mL below the knee. There was a median reduction in wound perimeter of 2.0mm/wk for the first 12 weeks of healing. The percent of venous ulcers healed at three months post-treatment was 46.3%, which is encouraging considering the baseline perimeter of healed and unhealed VLUs was 7.73 cm (N=28) and 17.3 cm, respectively. The mean time to VLU closure was 76.1 days. In the patients with healed VLUs, recurrence at three months post-treatment was 17.9%. In all patients, the mean NPRS score decreased from 4.2 at baseline to 2.1 at three months.

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BTG RESEARCH UPDATE *continued...*

Early data from this registry indicate that post-treatment with Varithena®, there is an early surge in tissue migration measured by median reduction in VLU perimeter. Patients displayed continued improvement through 12 weeks post-treatment. These data are important because this registry is an all-comers study, which did not exclude patients based on VLU size or age. The registry continues to enroll patients to reach the target enrolment of 100 patients by the end of 2019. BTG is still seeking investigators to participate in the registry.

1. Bergan JJ, Bunke-Paquette N, Bunke N. The Vein Book: OUP USA; 2014.
2. Takahashi PY, Kiemele LJ, Chandra A, Cha SS, Targonski PV. A retrospective cohort study of factors that affect healing in long-term care residents with chronic wounds. *Ostomy Wound Manage.* 2009;55(1):32-7.
3. Gloviczki P, Gloviczki ML. Guidelines for the management of varicose veins. *Phlebology.* 2012;27 Suppl 1:2-9.
4. Gohel MS, Heatley F, Liu X, Bradbury A, Bulbulia R, Cullum N, et al. A Randomized Trial of Early Endovenous Ablation in Venous Ulceration. *N Engl J Med.* 2018;378(22):2105-14.



Patient 1, Pre-treatment



Patient 1, 3 months post-treatment



Patient 2, pre-treatment



Patient 2, 3 months post-treatment

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Patrick Muck, MD

AVF-SPONSORED SESSION AT THE SVS-VAM 2019

VENOUS DISEASE: ENSURING THE APPROPRIATE VENOUS CARE IN 2019

Patrick Muck, MD

The American Venous Forum (AVF) has a long history of collaborating with the Society of Vascular Surgery (SVS) and other vascular societies. This February, the societies joined together to present the AVF/SVS session at the AVF's annual meeting in Palm Springs, California. AVF President, Elna Masuda, and SVS President, Michael Makaroun were in attendance and facilitated discussion. This session was standing room only and a resounding success.

In June, SVS held its Vascular Annual Meeting, or (VAM), in Washington D. C. Each year the VAM sponsors The Post Graduate Education Course (PGEC), is a widely attended event and this year was held on Wednesday, June 15th. The PGEC covers several components of core vascular surgery including carotid, arterial and venous disease. The AVF and SVS continued their collaborative efforts in the PGEC Venous Session. The lectures focused on existing technologies available for both superficial and deep venous pathologies.

Vic Kashyap, the VAM PGEC program chair was instrumental in developing the program. Vic, along with PGEC Venous session leaders, Patrick Muck and John Carson created a comprehensive AVF/SVS session led by AVF leaders. The session was a 3-hour long session broken into two parts with six presentations each. Vic and the session leaders were fortunate to have presentations given by a current AVF leader. AVF Past Presidents, Lowell Kabnick and Elna Masuda, updated the attendees on new innovative superficial venous intervention options. Past President Marc Passman delivered an incredible presentation regarding IVC Filter retrievals.

AVF Executive Committee members, Hal Welch, Tony Gasparis, Glenn Jacobowitz and Bill Marston participated as well. These Key Opinion Leaders discussed Foam Ablation, Vein Center Accreditation, Venous Ulcer Guidelines and Thrombectomy Devices. AVF board members, Jose Almeida and Joseph Raffetto, as well as AVF leader Kathleen Ozsvath were on the panel. The session had full attendance and was highlighted by Ruth Bush's presentation on Appropriate Venous Care. This presentation tackled the difficult problem of appropriate use of venous interventions for patients with superficial venous interventions.

Overall, this combined AVF/SVS session at VAM 2019 was a resounding success. Vic Kashyap was ecstatic with the content and attendance. The attendees gave stellar evaluations for the speakers and content. Clearly the AVF/SVS collaboration is strong and beneficial to the VAM attendees. A similar session is already being planned for VAM 2020.



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Chair: Dan Monahan, MD

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