

Interview

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by Stefano Ricci
literatureSpider@vasculab.org

In this section, the JTAVR Editorial Team interviews an international protagonist in biomedical scientific research, to deepen unusual aspects among the current most discussed topics.



Bird eye view of saphenous incompetence from a veteran of angiology

C Allegra

Private practice, Rome. Email: allegra@mc-link.it
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Question - Is the saphenous vein the real enemy of the phlebologist? For more than 150 years, people have been lashing out against this vein, which is certainly a cause, but is not responsible for all venous pathology.

Reply - The problem of "saphenous YES-saphenous NO" in chronic venous insufficiency has involved angiologists and vascular and general surgeons for about 50 years and has been exacerbated after the launch of CHIVA: hemodynamic conservative treatment of venous insufficiency on an outpatient basis.

Q - Is this a real revolution or just another variable?

R - The three points that characterized this new technique devised by Claude Franceschi were the

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Abstract Conversation with Claudio Allegra, a "veteran" of angiology, a protagonist of all the seasons of Phlebology, former President of the International Union of Phlebology (IUP) and of the International Union of Angiology (IUA). A chat with Stefano Ricci.

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ambulatory nature of the procedure, sparing of the great saphenous vein for its possible use in coronary or peripheral bypass, and the hemodynamic study (as the basis of sparing procedure).

Regarding the ambulatory nature of the procedure, it has long since ceased to be a feature of the technique as almost all minimally invasive surgery is now practiced under loco-regional or local anaesthesia by infiltration.

Regarding the possible use of the incompetent great saphenous vein in steno obstructive coronary artery disease for a bypass, it is currently reduced as cardiac surgeons basically prefer to use mammary arteries that guarantee greater success over time. Vascular surgeons still consider saphenous veins to be the best arterial

substitutes, especially below the knee (BK), even though revascularization techniques have evolved a lot. The use of pathological saphenous veins (refluxing, dilated, recanalized) remains a matter for discussion, but they can still be used, especially if covered with prosthetic material (see F Spinelli's experience, DOI: <https://doi.org/10.24019/jtavr.171>).

Q - Surface anaesthesia is now an established practice, revascularization with saphenous veins is generally preferred to that with other prostheses, the use of reworked incompetent saphenous veins is under discussion. What is missing for an acceptance of Franceschi's proposals?

R - The hemodynamic issue remains and I believe that there is still a great deal of confusion about this, particularly in the literature that compares the different traditional ablative techniques, such as stripping with crossectomy, endovascular techniques such as endolaser, radiofrequency, sclerotherapy with and without foam, glue and conservative surgery such as CHIVA.

The difference between this last technique and the others is that CHIVA would like to restore a normal venous hemodynamics, therefore with a reparative attitude.

Q - I believe that Franceschi has made a great contribution by forcing us to address the problems with a pathophysiological view based on hemodynamics, whatever treatment technique is adopted.

R - Both traditional sclerotherapy and hemodynamic surgery seek the most suitable solution to correct refluxes, either exclusively of the saphenous-femoral outlet (hemodynamic surgery) or of the entire saphenous region (traditional sclerotherapy). Traditional sclerotherapy has two distinguishing points: the repeatability of the medical act and the identification of reflux escape points, generally at the level of the perforating veins. This research requires a hemodynamic study of the superficial venous circulation in the two territories of the great and short saphenous veins and a sparing of the saphenous trunks, when an intervention on them is not necessary.

Q - In the light of a more accurate study with ultrasound, is sclerotherapy still a valid technique? The impression is that it never leads to a definitive result.

R - The repetition of the therapeutic medical act in traditional sclerotherapy is not to be considered as recurrence and this concept is not of no relevance both in the evaluation of the results at the various techniques in comparison and in giving information to the patient and in the training of the Phlebologist.

Q - CHIVA also sometimes requires repeated corrective gestures

R - As far as CHIVA is concerned, the division of surgical time in the so-called CHIVA II is not repetition, but a corrective strategy (related to cases of shunt III)

Q - Has the introduction of foam made sclerotherapy less obsolete?

R - In the field of sclerotherapy, which is still widely practiced, there is a strategic difference between the use of liquid formula compared to foam formula:

Firstly, the escape points are searched for which aggravate the varicose syndrome (FEGAN) over time, by generating reflux; once identified, the escape point is closed without removing or attacking the great and small saphenous vein in its entirety.

On the contrary, when sclerosing foam is used, the entire vein is closed without any hemodynamic criteria. In the case of the great saphenous vein, the section below the knee is spared especially when negligible in size, basically, a chemical short stripping.

Q - But in the end, what is the best treatment?

R - It is difficult to compare the follow-up of different treatment methods and decide which criterion is the most reliable.

The comparison of the percentage of positive results of one technique compared to another, using different evaluation parameters, produces a total misinformation (it is not clear whether intentional or random) on the validity of one technique compared to another and does not inform us about the reason for the recurrence of varicose syndrome and therefore does not enrich us with questions and consequent possible solutions.

The most striking example is the comparison of remote results in patients who have undergone crossectomy/stripping surgery and patients who have undergone endolaser, radiofrequency or foam sclerotherapy.

While in patients undergoing stripping surgery with crossectomy, recurrence is the appearance of varicosity in the operated area, for other techniques the recurrence is the recanalization of the treated vein. It must be said, however, that an "organized" recurrence is more favourable to correct than an "anarchist" typical of the post-stripping period.

The difficulty therefore lies in the comparison of results between techniques with different purposes.

Q - It was once said that groin recurrences were due to the surgeon's inexperience/inattention. Are the operators always responsible for this?

R - The analysis of the saphenous-femoral outlet is a significant problem that until recently placed the missing

flush ligation of the great saphenous vein with the femoral vein and the failure to ligate all the tributaries of the saphenous arch among the most frequent and relevant causes of recurrence.

Recently, ablative techniques of the great saphenous vein (Endo laser, radiofrequency, and foam sclerotherapy) stop at about 2 centimetres from the saphenous-femoral junction, sparing the pudendal and epigastric tributaries, and creating a saphenous stump.

Despite this, the results at a distance are certainly much better than those related to traditional stripping.

This would mean “no” to crosssection, “yes” to the ablation of the saphenous axis, resulting in 150 years of truth, dogmas, and trend reversals.

Q - How can we arrive at a more precise assessment of this aspect?

R - Perhaps the presence or absence of the terminal valve and/or valves in the femoro-iliac tract should be investigated (about 50% of the refluxing saphenous veins are continents at the junction (Cappelli - Int Angiol. 2006), before establishing an interventional strategy, and especially the presence of pelvic varices.

Q - Recurrences are therefore not all linked to incorrect treatment

R - In many or almost all studies on long term outcomes after invasive therapy, the distinction between

varicose syndrome with primary or secondary saphenous involvement to DVT is not made in the enrolled population.

This missing etiopathogenetic distinction generates fundamental errors in the rate of later recurrences as in post-thrombotic varicose syndrome the possibility of recurrence is obviously higher.

Ultimately:

- a. any therapeutic approach to varicose syndrome requires a precise hemodynamic study*
- b. the hemodynamic study should be extended to the femoro-iliac valve apparatus and the pelvis*
- c. careful study of the pelvic tributaries should be complete.*
- d. the need for comparative studies between different therapeutic techniques using the same benchmarks.*
- e. not to consider essential the sparing of the great saphenous vein exclusively to use it for possible by-passes, but basically as an example of a hemodynamic approach to the problem*
- f. to make a distinction in long term results between primary and secondary varicose syndrome*
- g. not to consider the invasive therapy of varicose syndrome as a manual exercise but as a service aimed at improving the patient's quality of life.*
- h. give back maximum respect for what nature has given us.*