Sclerotherapy and Treating Telangiectasias: What You Need to Know

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This is Your Office…
ABLATION
ClosurePlus

ClosureFast

8 Fr

6 Fr

7 cm
Bare, Covered, & 360 Fibers
TT and NTNT Technology

Thermal Tumescent
- Radiofrequency (RFA)
- Laser (LA)

Non Thermal Non Tumescent
- Mechanical Occlusion
- Cyanoacrylate Embolization (MOCA, CAE)
VenaSeal® Procedure

1) Access GSV using catheter technique
2) Position 5 cm from SFJ
3) Compress cephalad to catheter
MOCA: Mechanism of action
PIM: Polidocanol Injectable Microfoam

Varithena™

- Status of trials - safe
- Status of results – 75- 85%
- GSV/SSV/VV/VM
- Approved in US 12/13
- Available in US

Microfoam generation mechanism

CO2/O2 gas

Polidocanol liquid
<table>
<thead>
<tr>
<th>TT (10-15%)</th>
<th>NTNT (85-90%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Big veins</td>
<td>GSV/SSV/C6/BK GSV</td>
</tr>
<tr>
<td>Good F/U</td>
<td>Shorter F/U but equal</td>
</tr>
<tr>
<td>Nerve - concern</td>
<td>Nerve – no issue</td>
</tr>
<tr>
<td>Patient comfort –</td>
<td>Patient comfort: better</td>
</tr>
<tr>
<td>tumescence (learning curve)</td>
<td>Shorter learning curve?</td>
</tr>
</tbody>
</table>
Ambulatory Setting
Microphlebectomy

- Previously mapped vein (with sterile pen)
- Small microincisions of 1 to 2 mm in diameter are placed a 2 to 3 cm from each other over mapped vein
- Small microhook is used to remove the varicose veins
Sclerosant Set-up

- Alcohol prep
- Compression post procedure
Veinlite/ Transillumination
What is Sclerotherapy?

- Injection of a substance into a vein, causing endothelial destruction and resulting in fibrosis and obliteration of the lumen
- Easily performed, well tolerated, useful as primary or adjuvant treatment
- Effective use requires understanding of venous anatomy and sclerosant profiles
Red Flags

- The larger and more superficial the vessel, the higher the likelihood of complications
- Obvious vessels refluxing into the area must be treated first
Sclerosants

- Detergents: sodium tetradecyl sulfate*, polidocanol*, sodium morrhuate*, ethanolamine oleate*

- Osmotic agents: hypertonic saline, sclerodex (23.4% saline and 50% glucose mixed 1:1)

- Irritants: glycerin, iodinated iodine

*FDA approved
<table>
<thead>
<tr>
<th>Condition</th>
<th>STS (vol%)</th>
<th>Polidocanol (vol%)</th>
<th>Glycerin</th>
<th>Hypertonic Saline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telangiectasias</td>
<td>.1-.2%</td>
<td>.5-.75%</td>
<td>72% mixed 2:1 with buffered lidocaine</td>
<td>23.4% mixed 2:1 or 1:1 with buffered lidocaine</td>
</tr>
<tr>
<td>Reticular veins</td>
<td>.2-.4%</td>
<td>.5-1%</td>
<td>May not be effective</td>
<td>23.4% mixed 2:1 with buffered lidocaine</td>
</tr>
<tr>
<td>Varicose veins</td>
<td>.5-3%</td>
<td>1-5%</td>
<td>Not effective</td>
<td>23.4% may be effective, but painful on Rx</td>
</tr>
</tbody>
</table>
Sclerotherapy of Telangiectasias: Technique
Post-procedure instructions

- Immediate ambulation; walk 30 minutes/day
- Graduated compression – 3 days to 2 wks
- Return for follow-up at one month
Sclerotherapy Results

Before

After
“Matting”
CONCLUSION

- Sclerotherapy isn’t EVAR, TEVAR, PEVAR, FEVAR
- These folks come to our office
- Sclerotherapy is effective
- Thank you
Sclerotherapy is

- useful for reducing superficial reflux in most veins
- effective for relieving symptoms
- As long as we keep in mind that
- consideration of anatomy, hemodynamics, and sclerosants is essential
- reasonable expectations are crucial
- duplex exam may be necessary to determine what veins need treatment and to r/o underlying reflux
These Days Are Over