

EVLA a varicose vein gamechanger

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Back in 2017, the RACGP reported that varicose veins were a common reason for presentation to general practitioners, with many patients reporting symptoms such as aches and pains, cramps, restlessness and heaviness in the lower limbs.

According to the college's summary of international treatment guidelines for varicose veins, swelling or skin damage, secondary to chronic venous insufficiency, occur in about 15% of the population and varicose ulcers develop in about 1% of the population.

With increasing levels of obesity in the community, and an ageing population, venous disease is expected to place an increasing burden on the Australian healthcare system in the future.

Truncal reflux from incompetence of the great or small saphenous veins is a major contributor to clinically significant venous pathology.

Historically, superficial venous incompetence has been treated by in-hospital open surgical repair, which requires general anaesthesia and hospitalisation, with some significant degree of post-operative morbidity being not uncommon.

Recurrence of varicose veins after surgery was a long-recognised complication, with incidence rates of 25-50% within five

years. Neovascularisation in the saphenofemoral junction is thought to be a significant cause of this post-surgery recurrence.

However, there has been a shift worldwide in best practice guidelines of varicose veins management, particularly in the development of minimally invasive technologies.

The European Society for Vascular Surgery's 2022 Clinical Practice Guidelines on the Management of Chronic Venous Disease of the Lower Limbs (ESVS) reports that endovenous thermal ablation of truncal veins, with or without phlebectomies, is now widely acknowledged as the established standard of care and, ideally, should be performed in the ambulatory setting, in a properly equipped treatment room.

Endovenous thermal ablation (EVLA) causes an irreversible thermal injury in the vein wall, leading to fibrosis and, eventually, complete resorption over several months.

The ESVS now recommends that for patients with superficial venous incompetence, the procedures should be performed in the outpatient setting where possible.

In Australia, the efficacy and convenience of the minimally

invasive endovenous laser ablation has become the first-line treatment of choice for varicose veins for patients and practitioners alike. Alternatively, cyanoacrylate adhesive glue closure can also be used to close incompetent veins.

The in-rooms procedure takes about 45 minutes and begins with a locally anaesthetised incision above the knee followed by an insertion of a thin laser wire - either near the knee or ankle. This is followed by tumescent local anaesthesia to protect the surrounding tissues from thermal injury and to reduce perioperative pain. Subsequently, with ultrasound-guided precision, the laser heats the vein and seals it shut.

More than 95% of patients achieve vast improvement in their symptoms and return to normal activity in a fraction of the time of the open-surgical option.

Typically, this is 'walk-in, walk-out' procedure performed in the outpatient setting, with very little downtime. Most patients return to normal activities within a day, although it is recommended that strenuous exercise be avoided for a couple of weeks to ensure optimal healing.

Follow-up ultrasound imaging and appointments are crucial to monitor progress. 