Journal of Vascular Surgery: Venous and Lymphatic Disorders — May 2019 Audiovisual Summary

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Hi, I am Peter Gloviczki from Mayo Clinic, Editor-in-Chief of the *Journal of Vascular Surgery: Venous and Lymphatic Disorders*. We are pleased to let you know that our journal has been growing and it is well respected everywhere around the world. I am pleased to bring you four excellent papers of the May issue, which you can download this month free of charge.

The first paper I would like to introduce to you is entitled "Treatment pattern of consecutive patients with chronic venous disease," written by Dr Joel Crawford and colleagues from Stony Brook University in NY.[1] This is a retrospective review of 506 consecutive patients who visited the vein clinic of an academic medical center; 182 patients (45.5%) had no saphenous reflux, 40% underwent treatment of superficial reflux, and of these, 78% had ablation and 22% had microphlebectomy or sclerotherapy. Most patients who needed treatment were in their 50s, but age ranged from 21 to 80. There were 1.7 ablations per patient, more in those with higher CEAP classes. Our take home message from this paper is that almost half of the patients we evaluate at a vein clinic will not have saphenous reflux and that the average ablation per patient was 1.7, higher in those with more advanced disease. These data could serve as a benchmark to avoid overtreatment of patients with venous disease.

The next paper I would like to introduce dealt with the important problem of "Assessing radiation exposure to patients during endovascular treatment of chronic venous obstruction," written by Dr Mohammed Esmaeil Barbati and colleagues from Aachen, Germany.[2] In this prospective study, radiation exposure to 78 patients during endovenous recanalization procedures did not reach a level to have deterministic effects. Median operating time was 154 minutes and median fluoroscopy time was 43.7 minutes. Direct measurement of the effective dose of radiation correlated well with indirect parameters of radiation exposure (such as cumulative air kerma, kerma-area product, and fluoroscopy time). Body mass index did not correlate with fluoroscopy time nor with effective dose of radiation. There was no radiation-induced skin injury and most importantly, no patient reached effective dose levels of deterministic effects. The authors warned, however, that radiation dose should still be minimized to obviate against longer term possible stochastic effects of radiation.

The next paper I would like to introduce is entitled "Empirical systemic anticoagulation is associated with decreased venous thromboembolism in critically ill influenza A H1N1 acute respiratory distress syndrome patients," written by Dr Andrea T. Obi and colleagues from the University of Michigan in Ann Arbor.[3] In this retrospective study of 75 patients with severe adult respiratory distress syndrome, 31 had H1N1 viral pneumonia; this group had a 23-fold higher risk of pulmonary embolism, an 18-times higher risk of venous thromboembolism, and a 33-times higher risk of venous thromboembolism than those who were on empiric systemic anticoagulation. Main predictors of venous thromboembolism included H1N1 infection, bacterial pneumonia, and vasopressor requirement, while the use of empiric anticoagulation provided significant protection without increasing bleeding complications.

The Editors' Choice article, which is also our CME article this month, is on "Ultrasound-based topographic analysis of tributary vein connection with the saphenous vein in patients with chronic venous insufficiency," authored by Dr Sangchul Yun from Seoul, Korea.[4] This study calls attention to the fact that blood normally flows from the most superficial compartment of tributary veins toward the saphenous veins and then to the deep veins. Venous reflux occurs when blood is drained from the deeper to the more superficial compartment. In this retrospective study of 41 limbs of 30 patients, duplex ultrasound showed that 82% of escape points from refluxing great saphenous veins to tributary veins (EPSTs) were located below the knee and a mean of 1.9 $\pm$ 1.0 EPSTs were found per leg. Tributary veins near escape points were large and had mean diameters of 90% of the great saphenous vein. These data suggest that patients having above-knee saphenous vein ablation should have below-knee tributary vein treatment to prevent residual venous shunting and recurrence of varicose veins.

These were four of the many excellent papers from the May issue of the *JVS-VL*. To access these articles, please visit us at www.jvsvenous.org, and log on to Editorial Manager to send us great articles that you would like us to publish. We are here to serve our readers and our authors. See you next time for the Highlights of the July issue of the *JVS Venous and Lymphatic Disorders*.

The video accompanying this article may be found online at www.jvsvenous.org.

REFERENCES

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