CONSIDERATIONS ON SCLEROTHERAPY

Phlebology cannot exist without sclerotherapy.

In my clinical practice, I never use any procedures to demolish the saphenous axe.

I use sclerotherapy in post-stripping recurrence where the reflux point is not surgically accessible, as well as in aesthetic finissage following haemodynamic surgery on the disconnected tributaries

My first (and only) work on ultrasound-guided sclerotherapy was presented at the UIP Conference in Montreal in 1992.

Sclerotherapy is a radical technique which consists in triggering a chemical phlebitis followed by the activation of fibrosis and thrombolysis mechanisms. The prevalence of one or the other will determine the final outcome of the reaction.

The critical point of sclerotherapy is the treatment of reflux points (diastolic), where the magnitude of the gradient frequently determines recanalization.

The gradient which affects a retrograde flow is influenced by the type of shunt (closed or open) and by the return capacity of the re-entry points, which in turn determine the filling volume and therefore the saphenous calibre, a discriminating factor for the results.

The "staying power" of sclerotherapy is conditioned by the presence of extensive treated segments and the absence of compressible areas.

This means that segmentary sclerosis is not easy to perform and, should the procedure be successful, it will not have a lasting result.

Limiting the segment that the sclerosis affects does not ensure achievable certainty, because if the diffusion of the sclerosing can be limited, the extent of the inflammatory process and subsequent thrombosis cannot be determined with certainty.

Therefore I believe that sclerotherapy continues to be a demolishing technique capable of controlling the varicose disorder provided that the patient is frequently monitored and treatments are repeated.

This is however a condition that is partly common to all methods.

In the case of closed shunts (i.e. saphenous veins with incontinent terminal valves) the entire saphenous vein must be treated and the problem becomes a more or less precocious recanalization. In the open shunt (continent terminal valve) the action cannot be solely limited to the collateral vein because the sclerosis will never heal smoothly.

An open question is therefore, how does one define the concept of "recurrence" in sclerotherapy.

Recanalization is an integral part of the method. The recanalization of the reflux point and saphenous axe does not necessarily need to be retreated.

The recanalization of the saphenous axe occurs at a reduced calibre and with a parietal fibrosis which prevents the adjustment of the filling volume in the shunt flow.

In comparison to the initial condition, the filling volume is reduced.

The energy of the system is therefore partially reduced, even if the pressure column is not fragmented.

The pump’s activity tends to increase the velocity of the retrograde diastolic flow so, over time the filling volume will increase and as a result, so will increase the saphenous calibre which will go hand in hand with the reduction of the parietal fibrosis.

The arrangement of the re-entry point will be decisive in regards to the clinic and the symptomatology.

The re-entry point in a collateral vein means that when the saphenous axe is re-canalized, the varicose veins will reappear.

If the re-entry point is placed on the saphenous axe, the recanalization of the vein with respect to the vessel flow at the height of the hydrostatic column and systolic events, the development of trophic disorders will be influenced.

In order to evaluate the results, prospective randomized trials must be organized starting with a uniform patient classification which can only be carried out by combining the CEAP with the shunt classification proposed in 1998 by the European Society of Chiva Operators, and where check-ups are carried out by independent operators.

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