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SUGGESTED RESPONSE to EJVES about ESVS guidelines :

Do you agree to sign this letter to the editor ….with your corrections ( English, contentent)

Re: Management of Chronic Venous Disease

Clinical Practice Guidelines of the European Society for Vascular Surgery (ESVS)

About CHIVA and ESVS guidelines 2015

Bahnini A., Cappelli MErmini S., Escribano JM., Franceschi C., Juan J., Mendoza E., Pares O. , Passariello F., Zamboni P

As CHIVA European association, here are our comment about the EAVS guidelines (Eur J Vasc Endovasc Surg (2015) 49, 678e737)

The guidelines authors wrote: “In another study [2] all stripping procedures were done under general or epidural anaesthesia whereas the CHIVA treatments were performed under local anaesthesia, which acted as a confounder for the evaluation of the post-operative side effects.” In fact, Stripping procedures were done only under epidural anaesthesia that lasted not more than 2 hours, which didn’t impact the side effects assessed along 8-10 days following the operation which were defined as DVP, PE, hematomas, bruises, saphenous nerve injury, pain and days of convalescence. In addition, the potential effect of epidural anaesthesia respect to CHIVA as thromboembolism didn’t occur. So the different types of anaesthesia didn’t interfere with the statistical analysis of the results. On another hand the post operative treatments were identical in CHIVA and Stripping groups.

The guidelines authors state: “The most serious limiting concerns in both studies were how “failure” by recurrence was defined: it is unclear if the presence of visible recurrent varicose veins or the presence of refluxing veins during the DUS evaluation or both were considered to define the failure of the treatment”. In the Carandina and al[1] and Pares and al [2] RCTs the first-level research variable of intention-to-treat analysis were the clinically visible varicose veins caliber evaluated at 5 years follow-up according to Hobbs classification, so independently of the flow direction. This includes "absent or non visible recurrence" (patient clinically cured) and "visible recurrence" (patient in situation of clinical failure), with or without a simple reflux point. Duplex ultrasonography imaging was used to study the location of recurrence by examining different anatomic types of shunts. In this regard, we must remind that after a CHIVA procedure, a “refluxing vein” is not an hemodynamic failure if its caliber is normalized and it is no more overloaded by new or redo escape point. Moreover this is not a reflux with recirculation from the deep vein, but a footward drainage of the natural tributaries of the saphenous vein into a perforator.

1 additional RCT reference CHIVA vs Stripping published in 2006 [2] is not cited in this review .

The fact that CHIVA preserves in all cases the GSV, should be stressed as it is with compression the only treatment which allows the possibility of future arterial by-pass (still performed and vital despite the endo-vascular procedures progresses).

A Cochrane Review [5] was published on June 2015, so just after ESVS January 2015 review, with the authors’ conclusion “The CHIVA method reduces recurrence of varicose veins and produces fewer side effects than vein stripping. However, we based these conclusions on a small number of trials with a high risk of bias as the effects of surgery could not be concealed and the results were imprecise due to low number of events. New RCTs are needed to confirm these results and to compare CHIVA with approaches other than open surgery”.

These considerations should improve the current ESVS grade into IIb B.

1. Carandina S, Mari C, De Palma M, Marcellino MG, Cisno C, Legnaro A, et al. Varicose vein tripping vs haemodynamic correction (CHIVA): a long term randomised trial.Eur J Vasc Endovasc Surg2008;35:230e7.
2. Pares JO, Juan J, Tellez R, Mata A, Moreno C, Quer FX, et al. Varicose vein surgery: stripping versus the CHIVA method: a randomized controlled trial. Ann Surg2010;251:624e31
3. Iborra-Ortega E, Barjau-Urrea E, Vila-Coll R, Ballon-Carazas H, Cairols-Castellote MA. Comparative study of two surgical techniques in the treatment of varicose veins of the lower extremities: results after five years of follow-up [Estudio comparativo de dos técnicas quirúrgicas en el tratamiento de las varices de las extremidades inferiores: resultados tras cinco años de seguimiento]. Angiología 2006;58(6):459-68.
4. Sergi Bellmunt-Montoya, Jose Maria Escribano, Jaume Dilme, Maria José Martinez-Zapata CHIVA method for the treatment of varicose veins. Cochrane Database of Systematic Reviews 2013 ; Issue 7.

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**Comment on Fausto, do not know, if I got the thing correctly, but: A surgical procedure can not be double-blinded, because the surgeon hopefully knows what he is doing. I know that is always claimed in the evaluations, but can not be solved - not for CHIVA Studies nor from another ones.**

**The side effect of epidural would be higher thrombosis and Claude pointed that out. Perhaps the only thing to be commented is that the first evaluation was 8 days after the intervention and thus the effects of the type of anesthesia were no longer present?**

**We should also try to answer to the following different interpretation:
*patients treated with epidural anaesthesia are easily recognized by the operators in the precox post-operative follow-up, compared to the local anaesthesia. This could be a bias because the patient and the operator too can understand which therapy was applied, thus confounding the blind and double blind evaluation.***

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