We don't need to treat perforating veins !

JJ Guex, Nice.

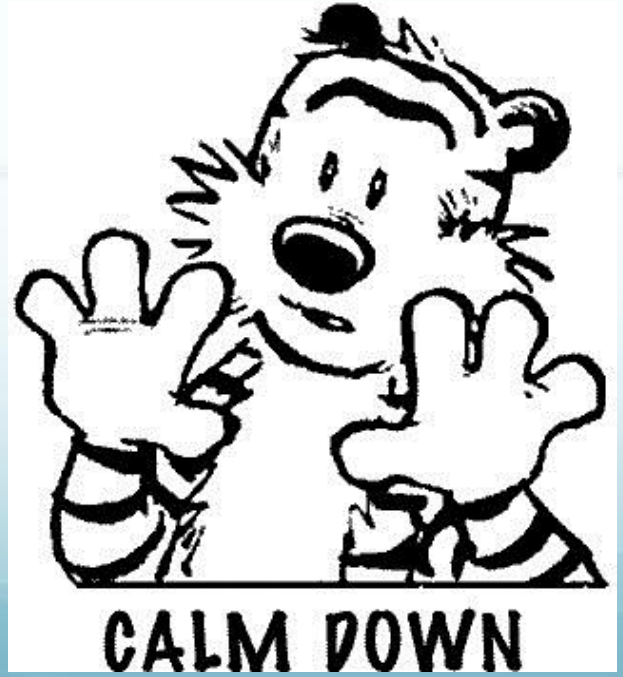
Disclosures

- Innotech
- Servier
- Vascular Insights
- Thuasne
- Kreussler

Two categories of P.Vs:

- **medial leg perforators** (formerly Cockett's + Boyd's + Dodd's, etc ...) **MLPVs**
- Others
  - **femoral canal**
  - Others
    - **Lateral**
    - **sub gluteal**
    - etc ..

Incompetent or not, we don't need to treat MLPVs



But we need to treat other IPVs, and to do something

Reasons for not treating MLPVs:

- They are an epiphenomenon of GSV insufficiency
- They usually disappear after treatment of GSV
- They are not usually responsible for skin changes
- Their treatment
  - does not improve clinical results
  - does not reduce recurrences
  - Is not satisfactory

They are an epiphenomenon of GSV insufficiency

- They act as re-entry point for the above situated reflux and must be spared (at least as long as long reflux remains)
- Their ablation does not improve Hemodynamics
  - Fitridge 2009

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MLPVs usually regain competence after treatment of GSV

- *Campbell 1995*
- *Mendes 2003*
- *Al Mulhim 2003*
- *Blomgren 2005*

Except in case of deep incompetence,

- *Kalra 2002, Gloviczki 1999*

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MLPVs « per se » are not usually responsible for skin changes

Not much published since

- *Cockett 1953,*
- and *Fegan 1963*

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Their treatment

- Can’t be separated from the treatment of superficial insufficiency (GSV+++, SSV+)
- Is not satisfactory when isolated
  - surgery: Linton, *Linton 1938*, SEPS, Stab avulsion
  - Sclerotherapy: in the PV itself
- Doesn’t help much in PVI, is doubtful in PTS
- does not significantly improve clinical results nor reduce recurrences in both PVI and PTS

So what is left ?

- Criteria for possible treatment of a MLPV:
  - PV has criteria of incompetence:
    - ⦸> 5mm,
    - reflux > 0.5 sec
  - PV remains huge (>5mm) and refluxing even after GSV ablation
  - or there is NO incompetent GSV
  - Is above a significant varicose cluster
  - Rx of GSV not followed by clinical improvement

So what is left ?

- Possible treatments
  - US Guided foam ablation (not in PV itself since a small collateral artery may be injected)
  - Thermal ablation with special probes under US guidance
  - have outdated all surgical techniques
- **In scant selected cases**
- **After treatment of superficial network if IPVs remain**

Other PVs ?

- Femoral canal PVs have the same role as SFJ and SPJ and must be taken care of !
- Lateral PVs as well as long as they "feed" a varicose network
- Subgluteal as well
- Gastrocnemian PVs are possibly reentries for SSV incompetence, same strategy as GSV and MLPVs
- Therapeutic options are the same: foam or thermal, with preference for foam

In conclusion

- Treat superficial network
- Defer treatment of incompetent MLPVs
- Re-assess after several weeks
- Evaluate outflow obstruction, consider ilio-caval angioplasty and deep valve repair
- Foam IPVs if needed


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