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MARRIOTT RIVE GAUCHE & CONFERENCE CENTER
PARIS, FRANCE

Treatment of telangiectasias by foam sclerotherapy under ultrasound guidance

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Disclosure for this presentation

Claudine Hamel-Desnos:

I do not have any potential conflict of interest

THE RIGHT TACTIC

- **Good initial venous examination**
- **Treatment of the veins involved from largest to smallest**
- **End with telangiectasia**

Successful sclerotherapy requires thorough planning. Sclerotherapy is generally performed in the order of proximal to distal leakage points, and proceeding from the larger to the smaller varicose veins.

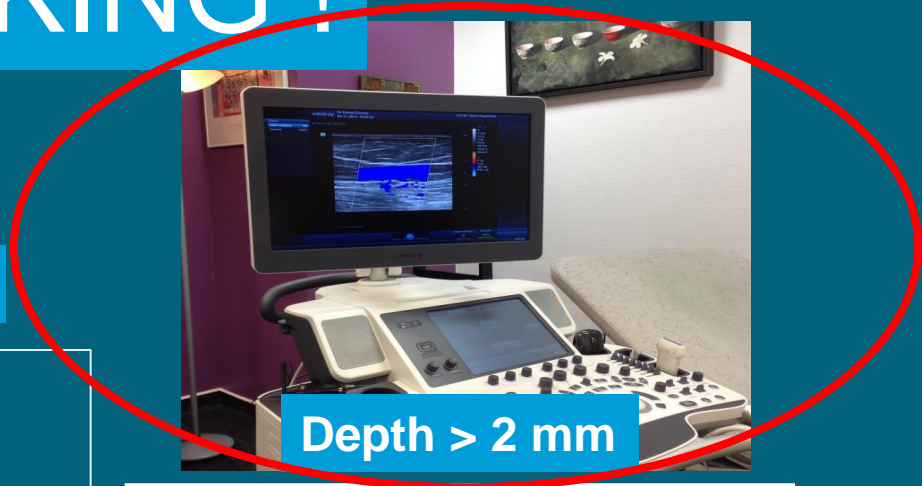
(European Guidelines – Rabe E. et al. Phlebology 2013)

How to perform a good initial examination?

By LOOKING !



Vessels just beneath the skin



Depth > 2 mm

Three tools:

1. The eyes
2. The US imaging
3. The cold light



Depth < 3 mm

1. Patient standing

- Clinical examination
- **AND DUS** assessment

*Use high frequency
linear probe : 13 to 16
MHz (or even 18 MHz)*



**This examination makes it possible
to map the vein layout.
*Sometimes you can make a mark on
the skin***



Before treatment



After treatment



A good assessment is vital
to achieve good results

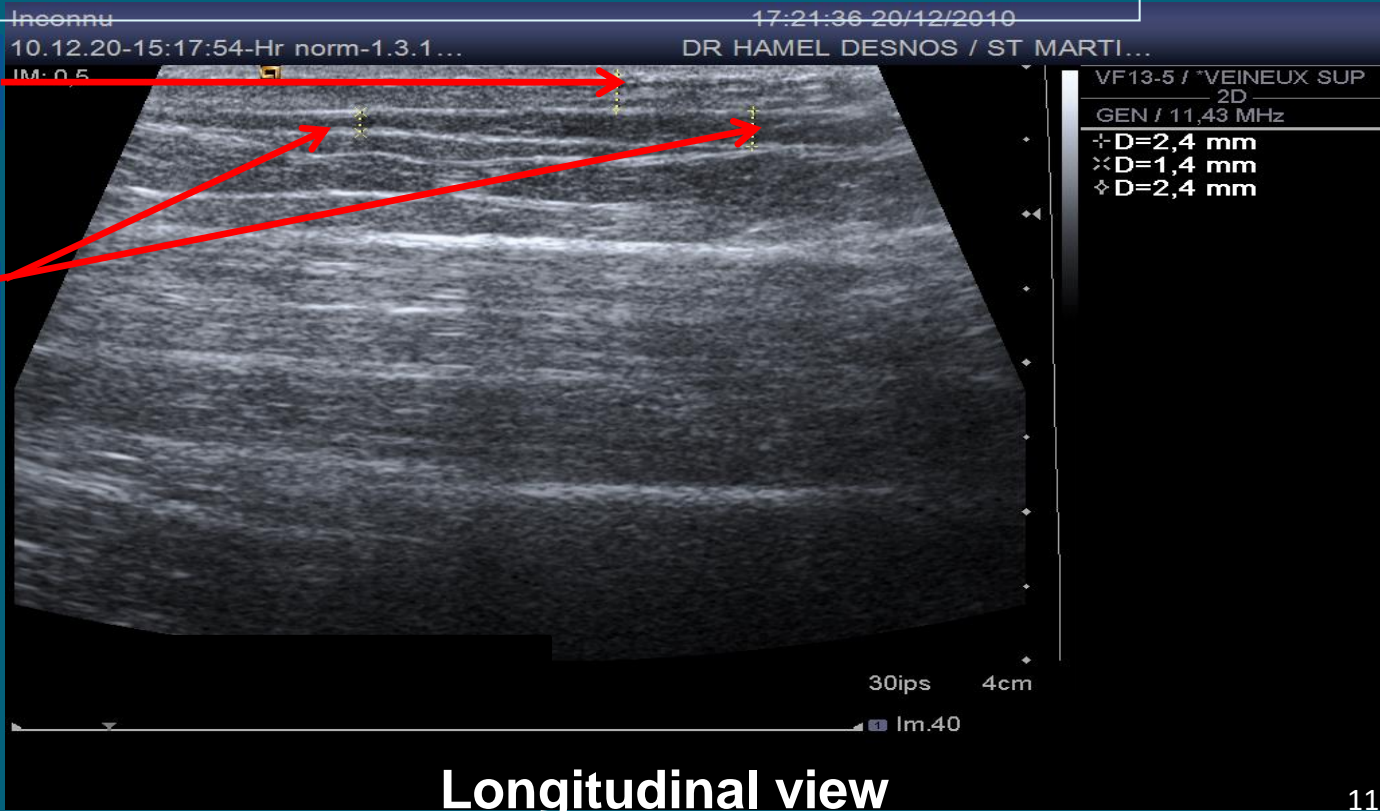
Presence of an underlying reflux (or connections)

**This must be treated first, under
ultrasound guidance if necessary**

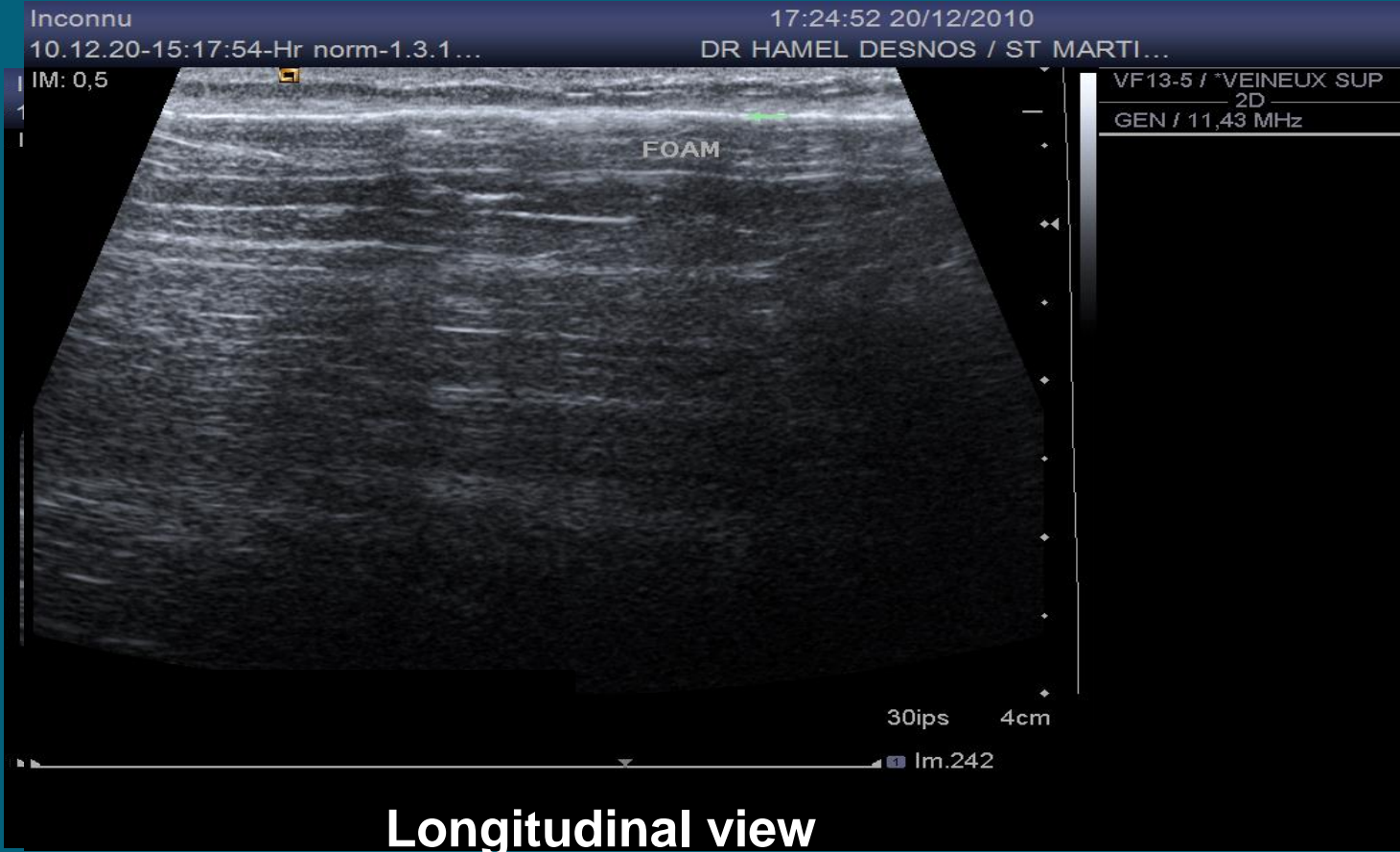
It is POSSIBLE to treat small and very superficial veins under US guidance

Depth 2.5 mm

Vein \varnothing =
1.5 to 2.5 mm



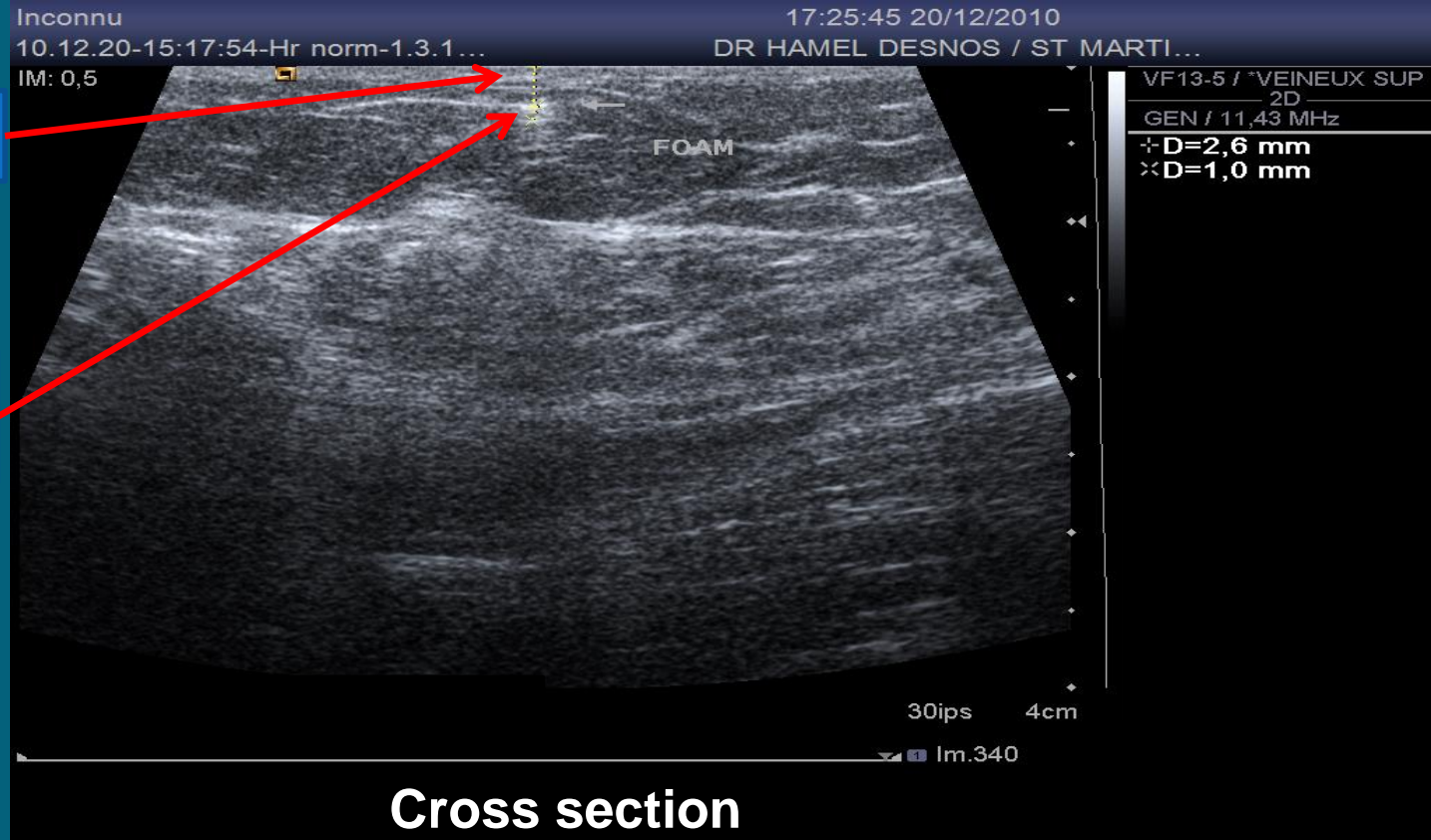
Longitudinal view



Just after USG Foam sclerotherapy

Depth 2.5 mm

Vein $\varnothing =$
1 mm



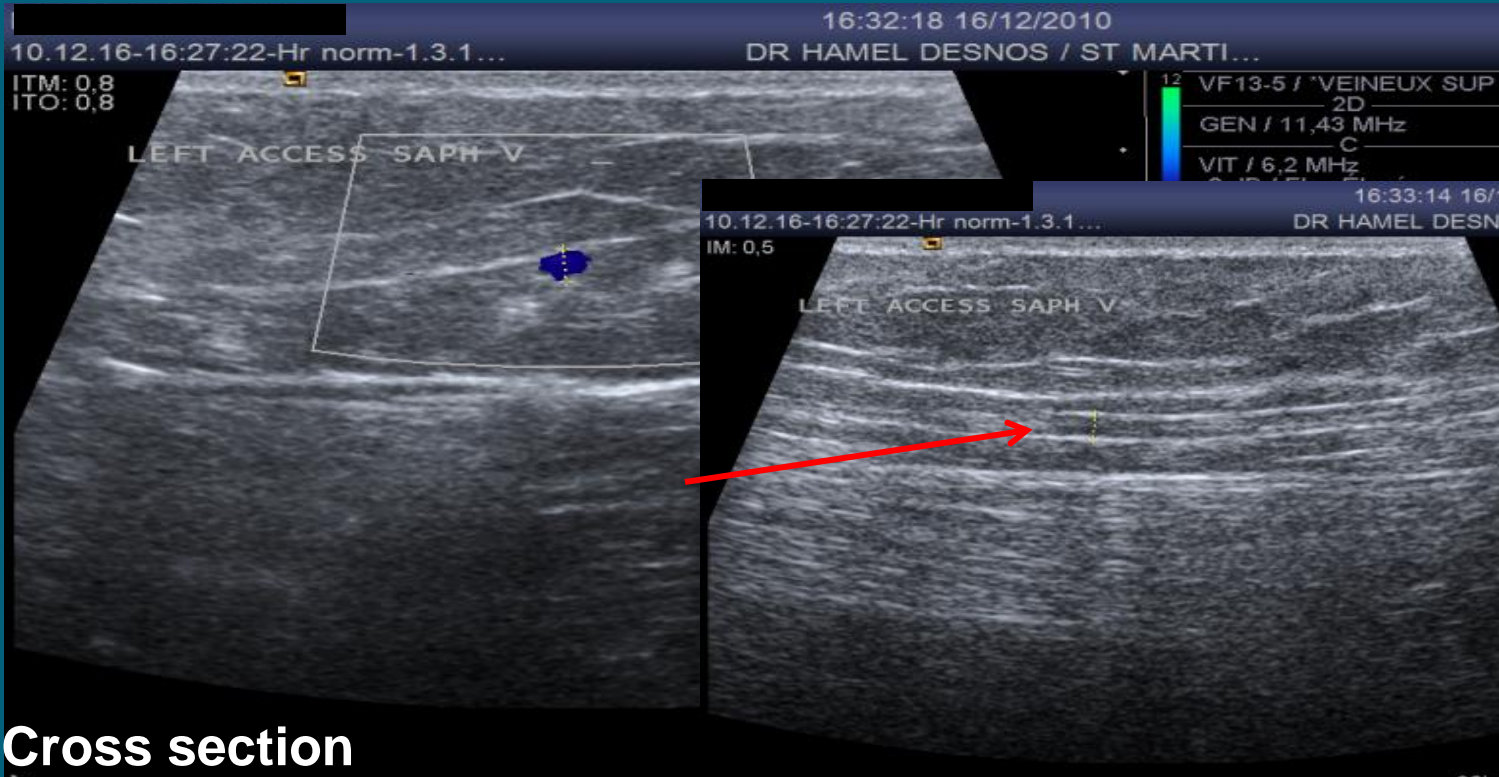
1

Clinical cases





Contribution by the anterior accessory saphenous vein (ASV)



Cross section



Ø 2 mm

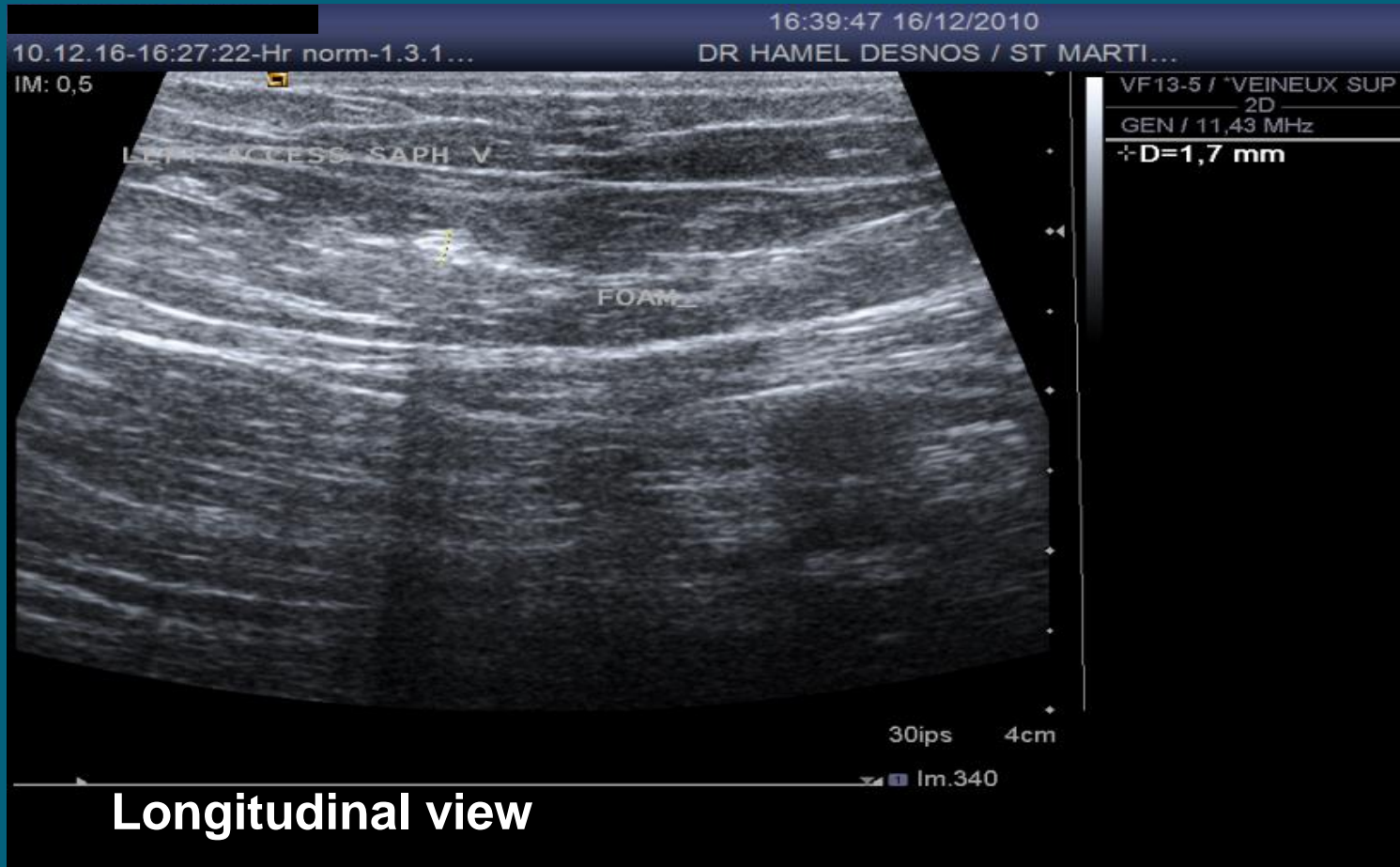
Longitudinal view



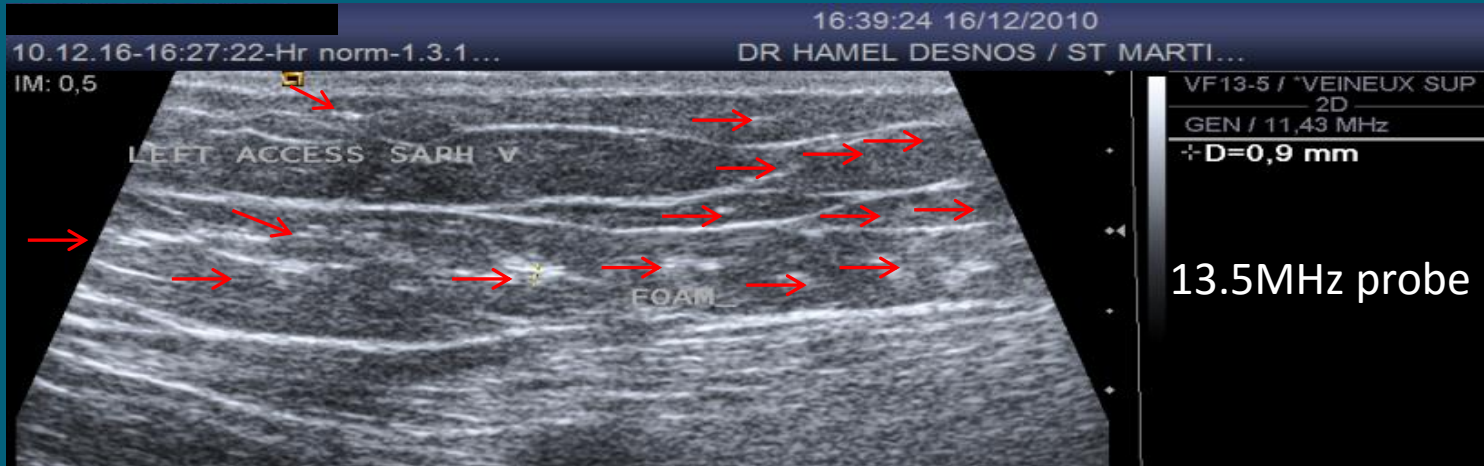
Filling of the vein with foam



Filling of the vein with foam



Filling of the veins with foam



It is worth noting that the foam is visible even in very small incompetent telangiectasias

Vincent et al. J Vasc Surg 2011

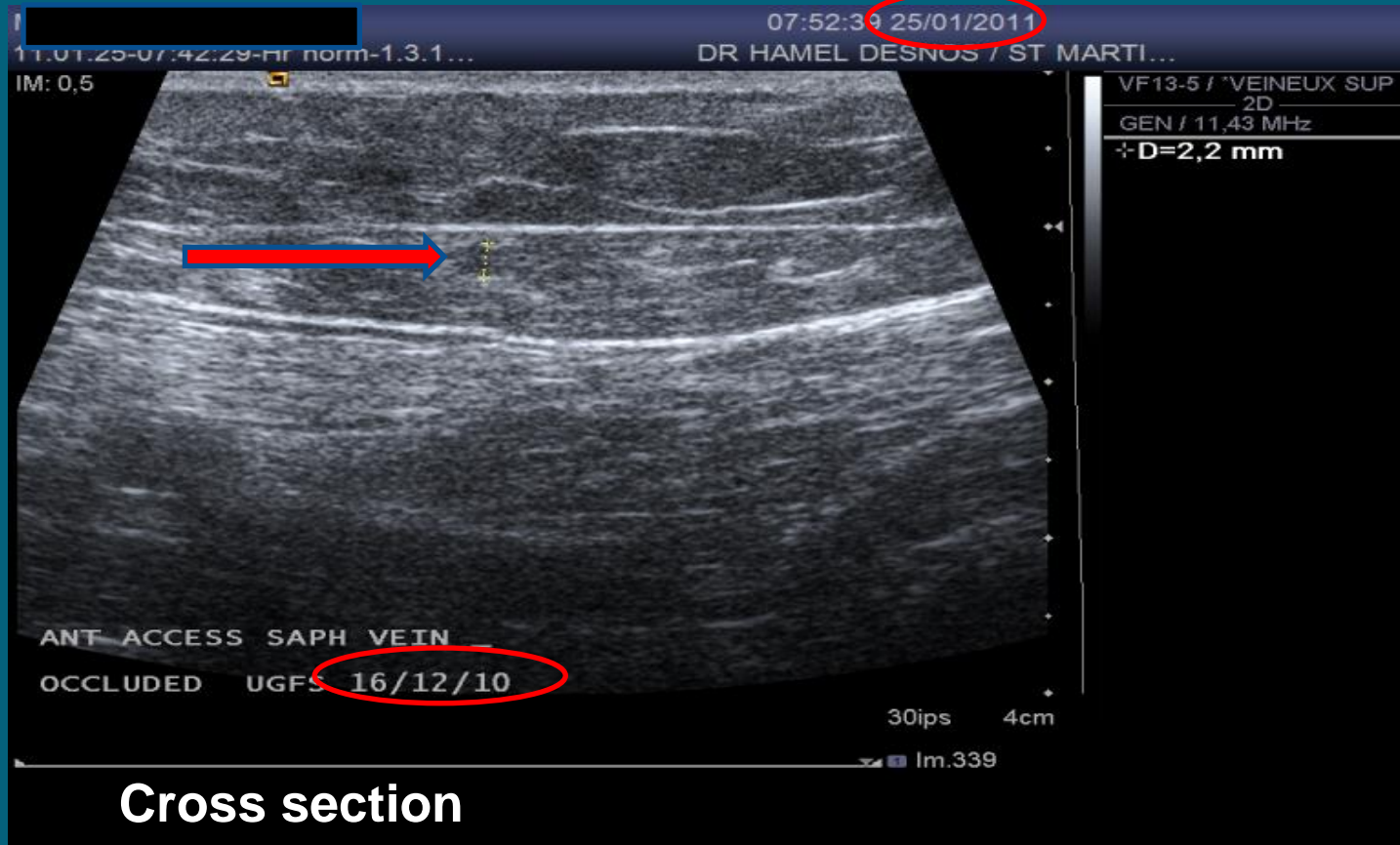
-> Valves are present down to the 6th generation

Cross section

A total of two injection points :
1 in the ASV
1 in the telangiectasia



D 40 : the ASV has been occluded



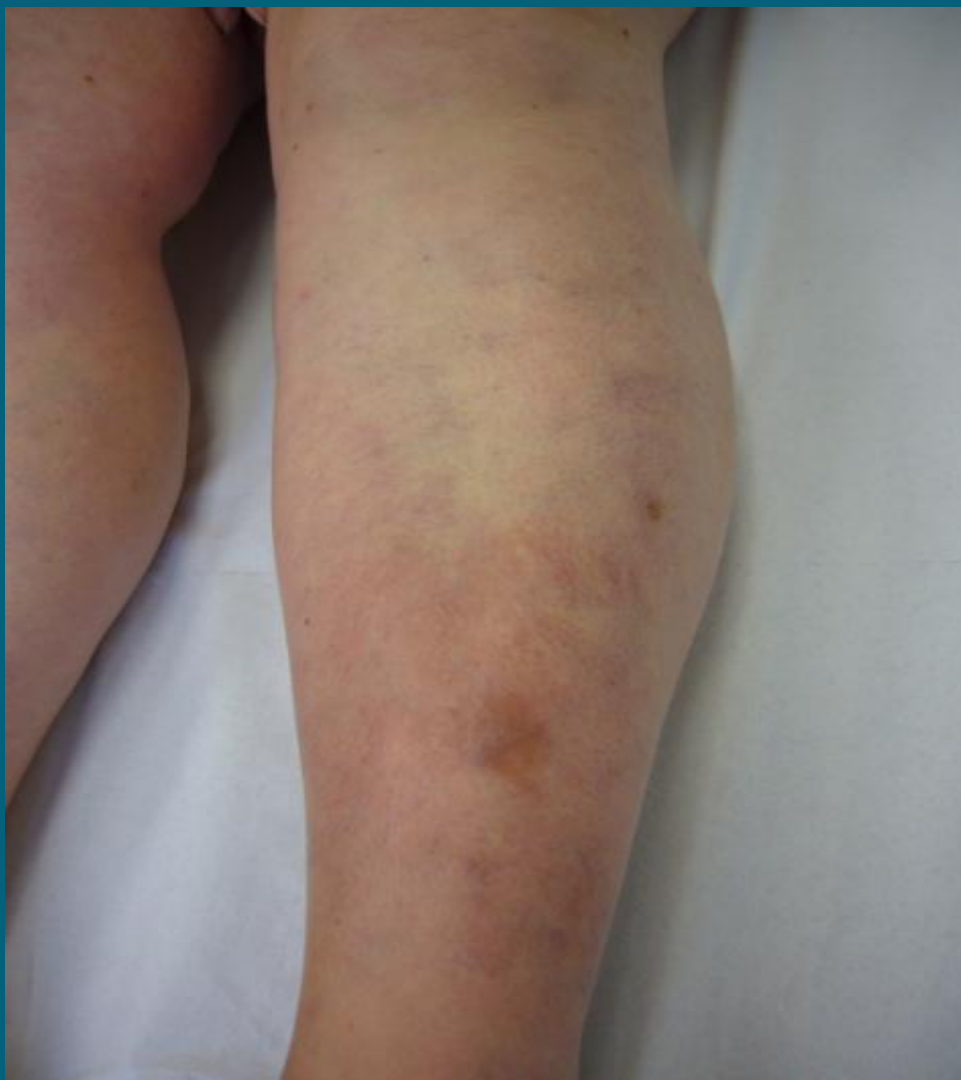


2

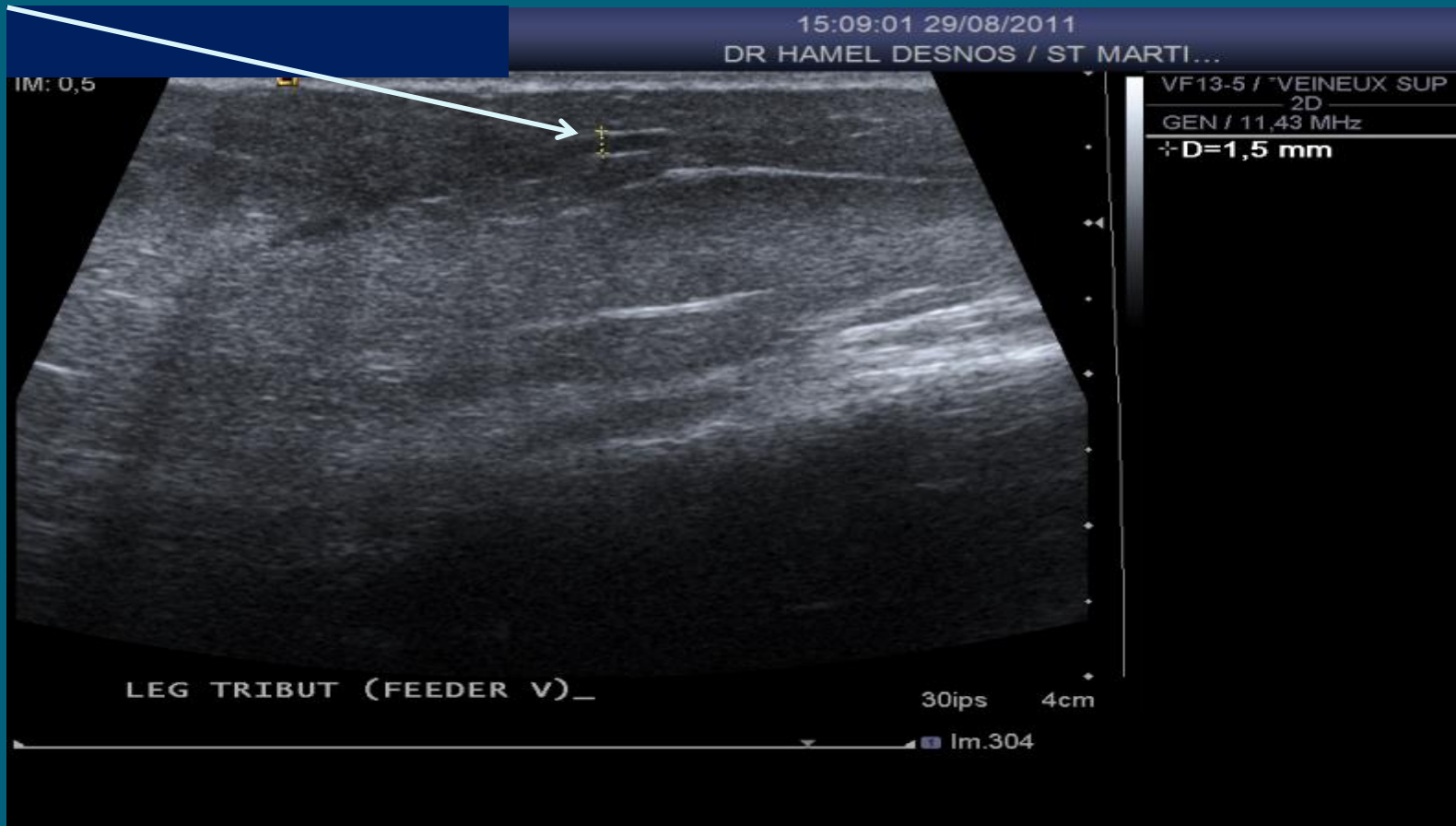


VIDEO

3

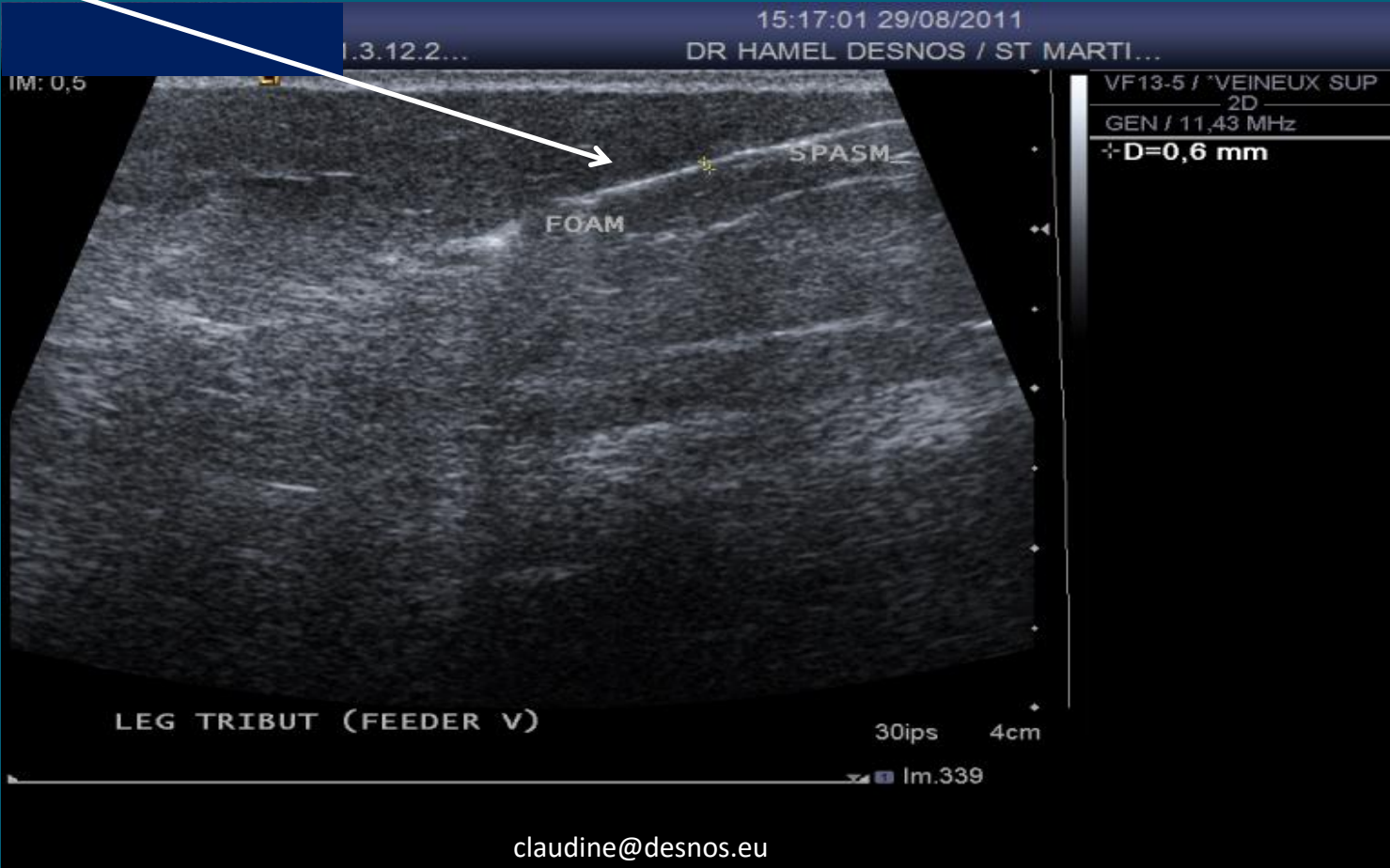


Feeder vein

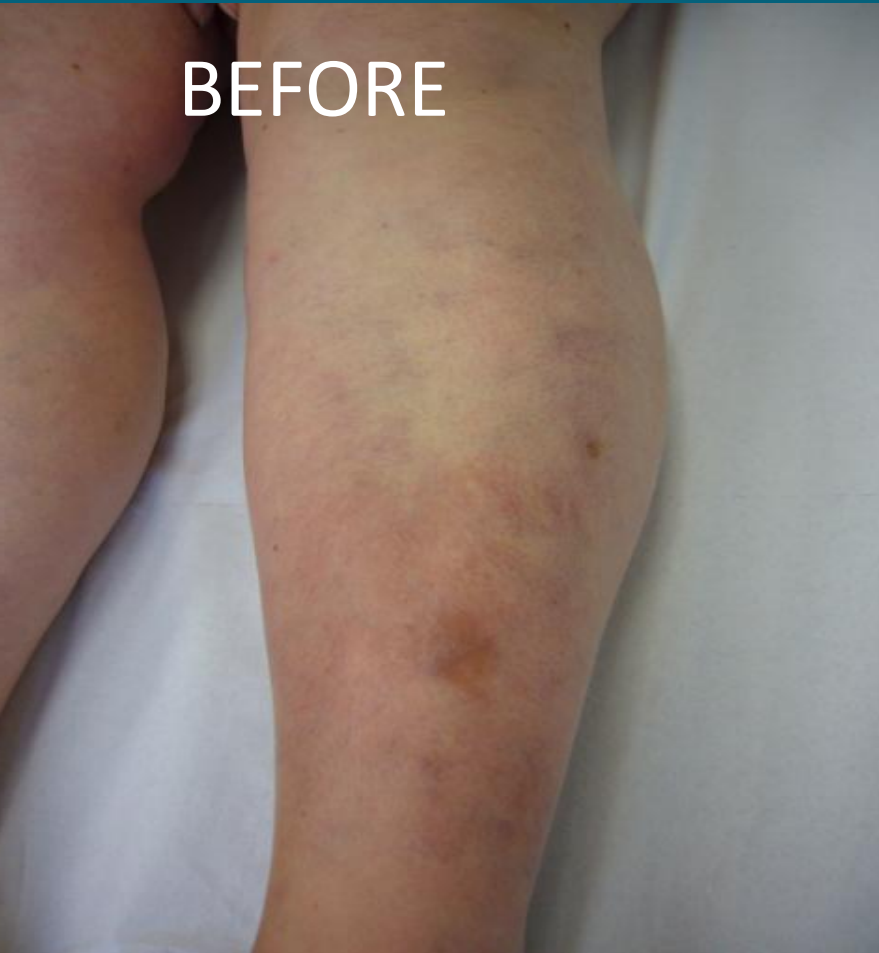




Feeder vein



BEFORE



AFTER 1 single injection

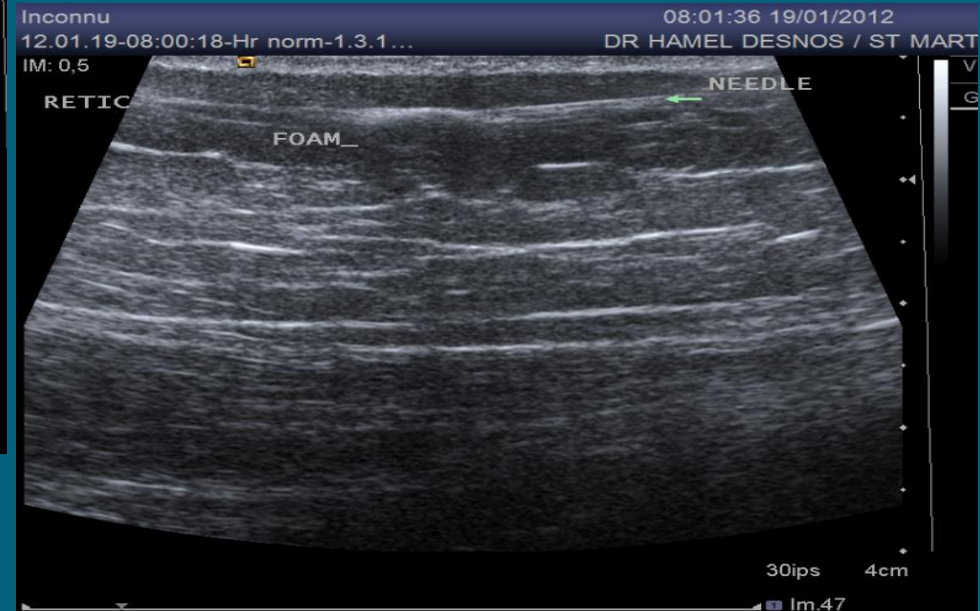
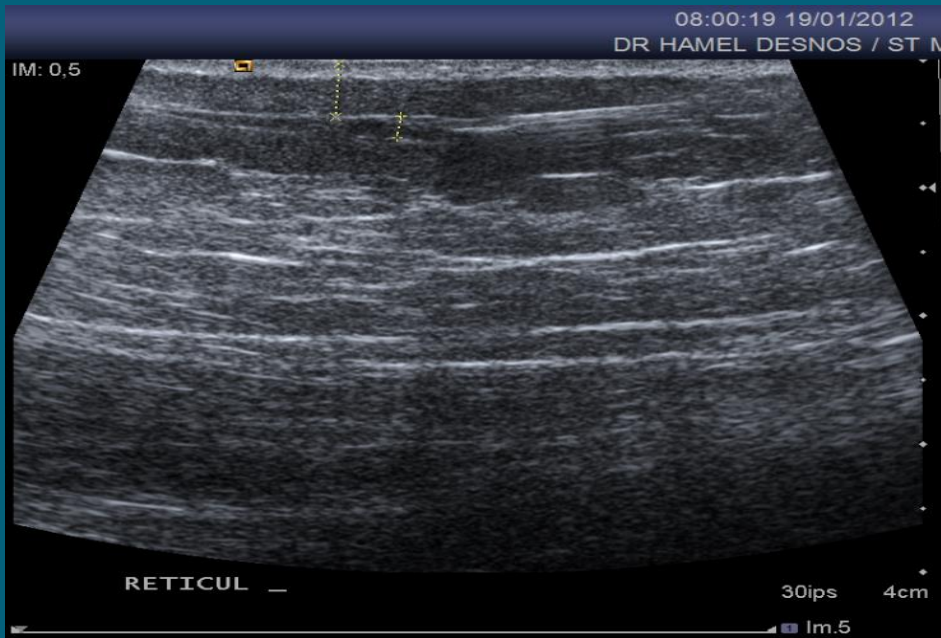


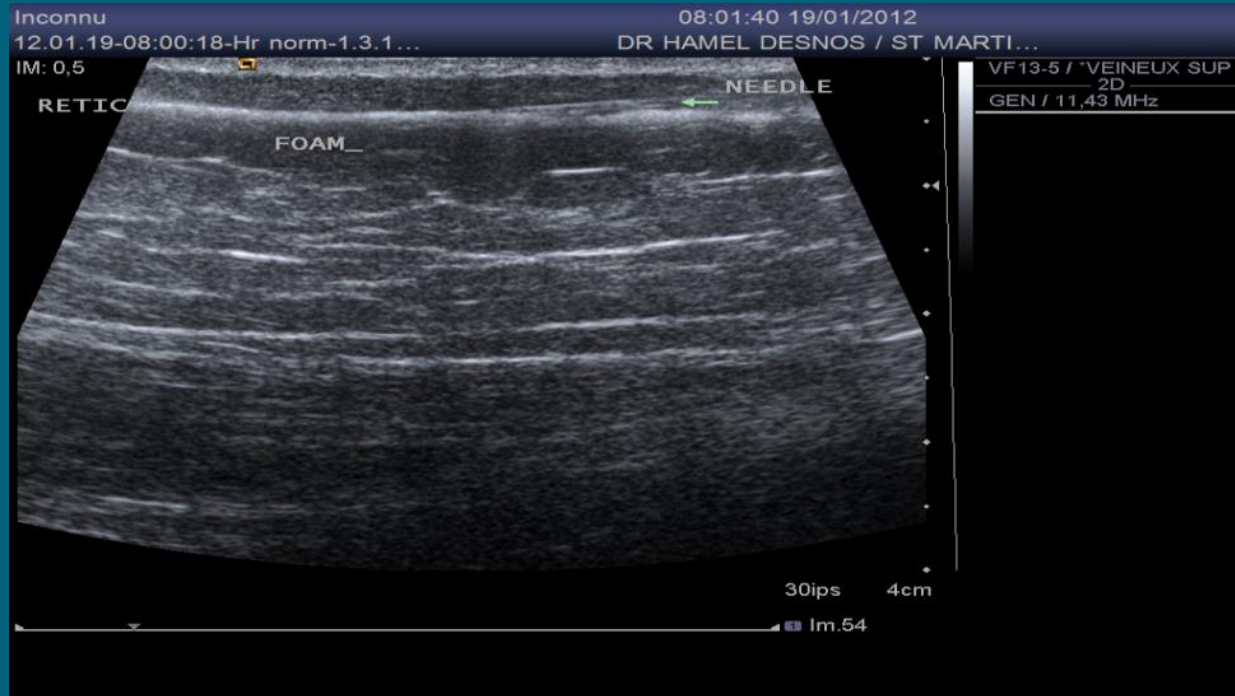
We can sometimes miss the target,

**but we notice
it very fast!**



An example





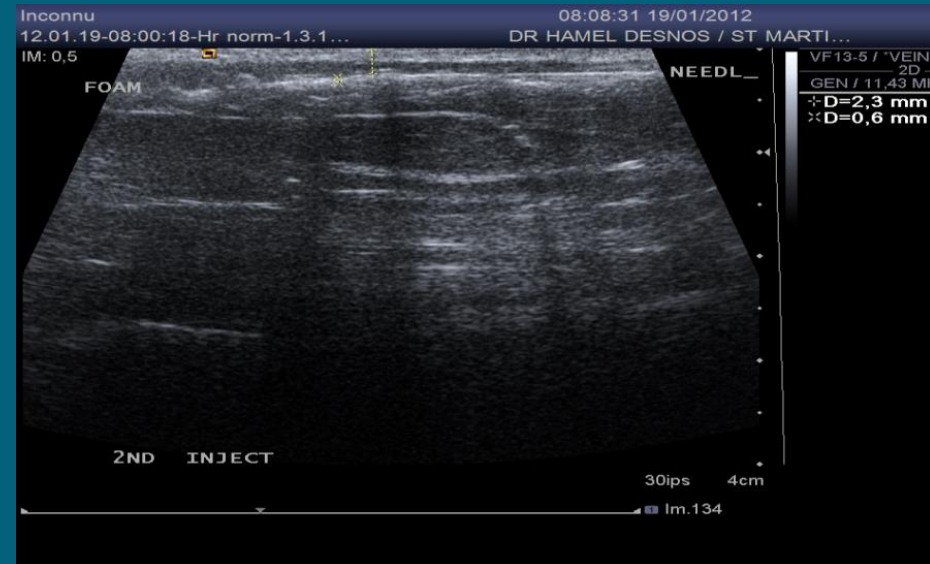
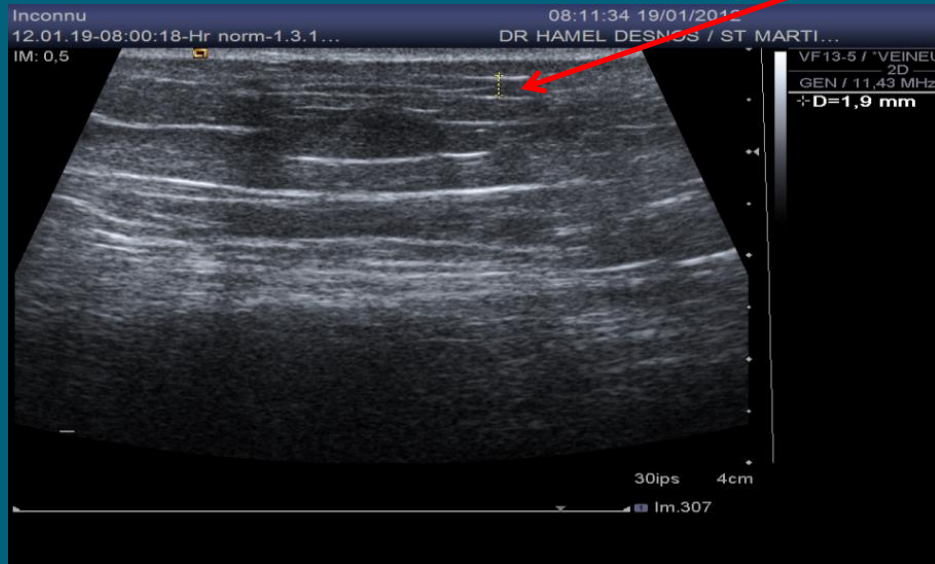
After the 1st injection

USGFS: 1st injection



2nd USGFS injection

reticular





Matting

(European Guidelines – Rabe E. et al. Phlebology 2013)

Inadequate or no treatment of the underlying reflux is the cause in many cases of matting.

In summary, the advantages of US guidance and foam in the treatment of C1s by sclerotherapy, perfectly match those observed and recognized for any varicose veins



- . DUS assessment is crucial for the tactic**
- . Leads to more relevance and safety and more efficiency**
- . Less risks of overdoses, less risks of bad esthetics outcomes like matting, pigmentation...**



- . More efficiency with less sclerosing agent and fewer injections and sessions**
- . Less risk for extra-vascular injections**
- . Good echogenicity (B mode) → allows monitoring the distribution of the foam**

INTEREST OF ECHO-DOPPLER AND FOAM IN TELANGIECTASIAS

Claudine Hamel-Desnos

http://freemusicarchive.org/music/The_Ananas/THE_ANANAS/11_decapotable

In the years to come, the usage of US and foam will be more and more frequent for C1s treatment

Other techniques than sclerotherapy can be used as additional or accessory treatments but cannot replace sclerotherapy

Thank you for your attention