How to ensure the success of pelvic congestion treatment: 10 rules to respect

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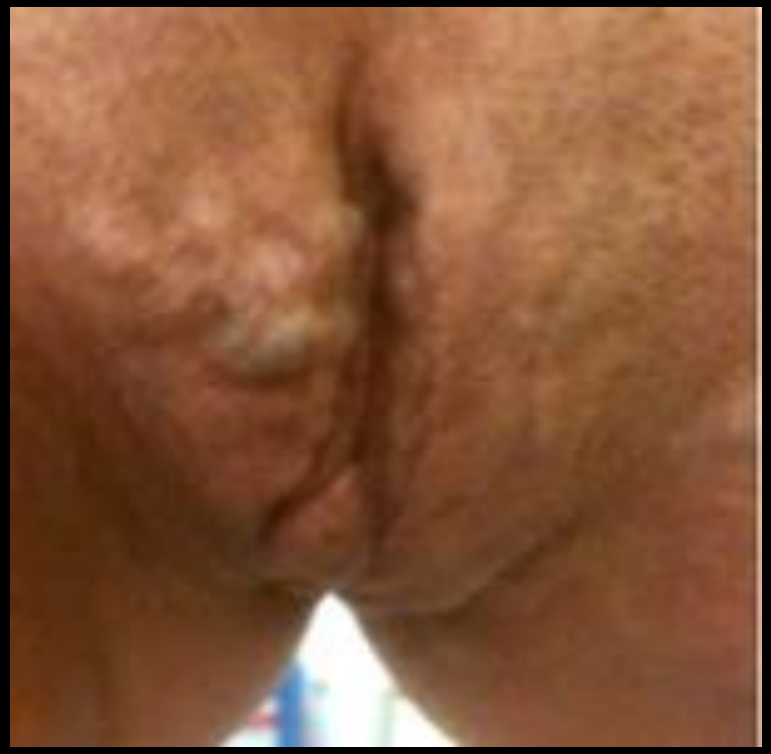
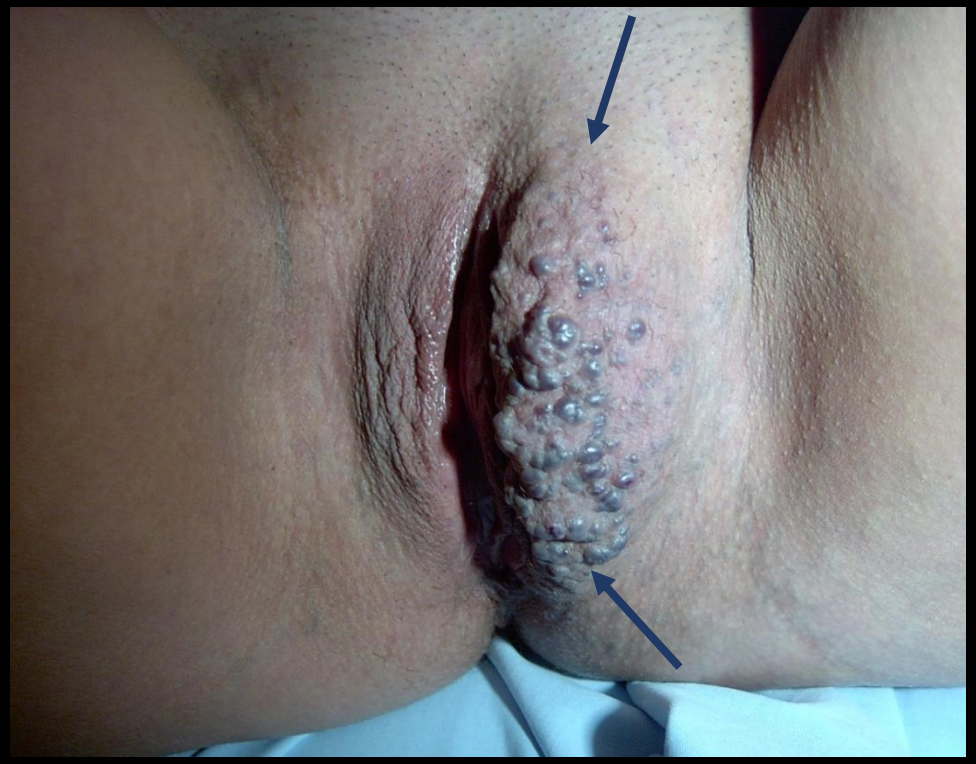
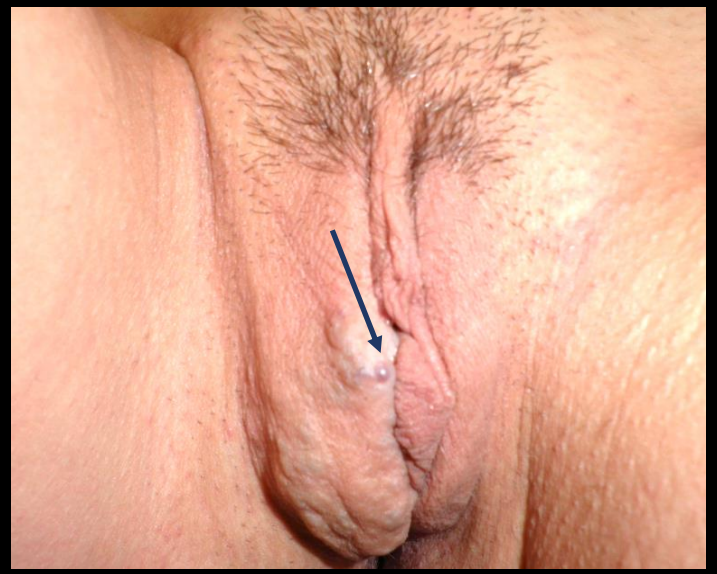
I do not have any potential conflict of interest

Know the difference between varices and venous malformations particularly
At the level of external genital organs

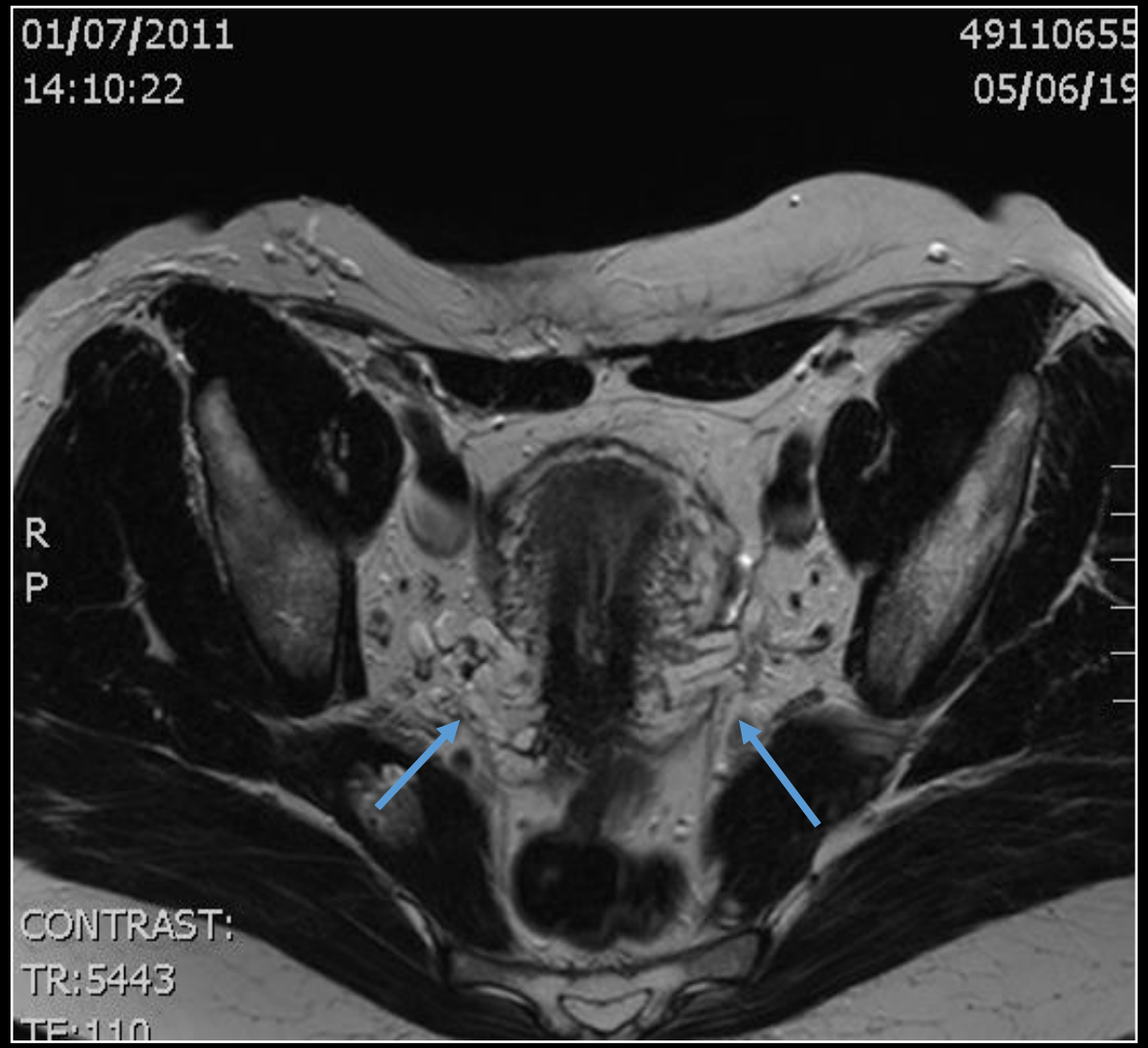


Genital varicose veins

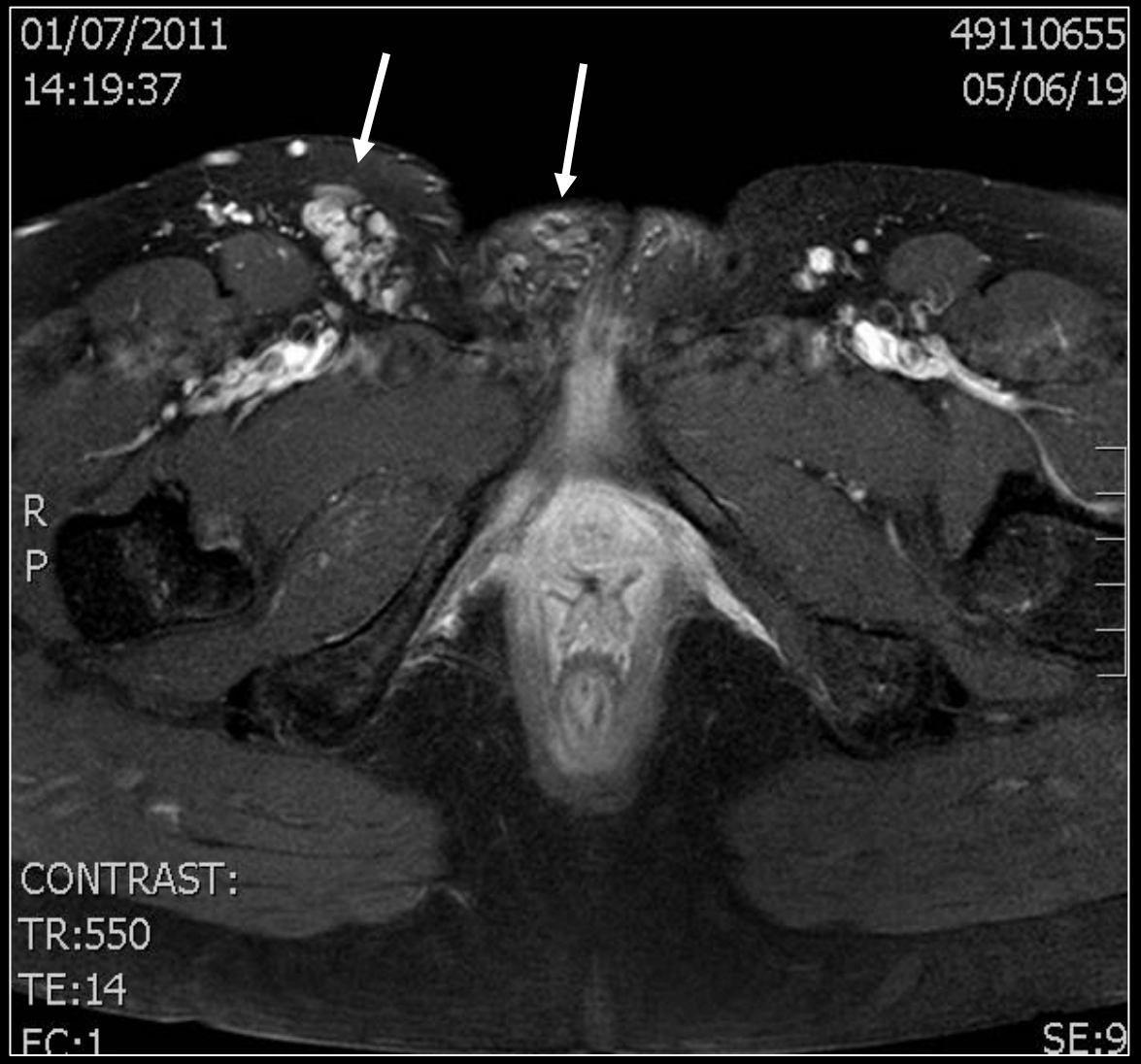




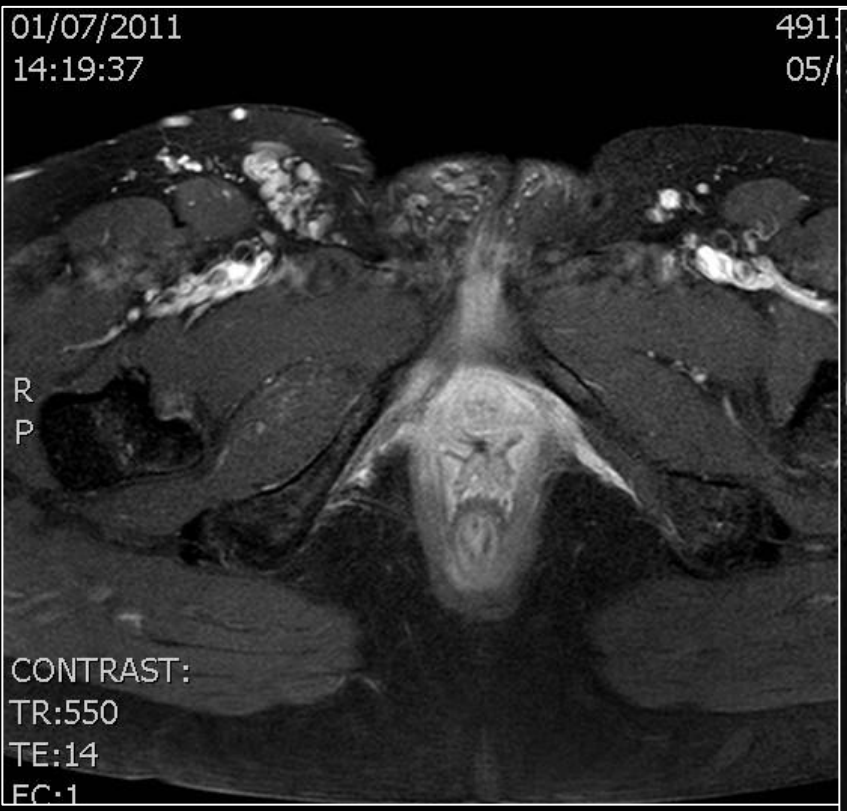
Genital venous mlaformations (arrows)

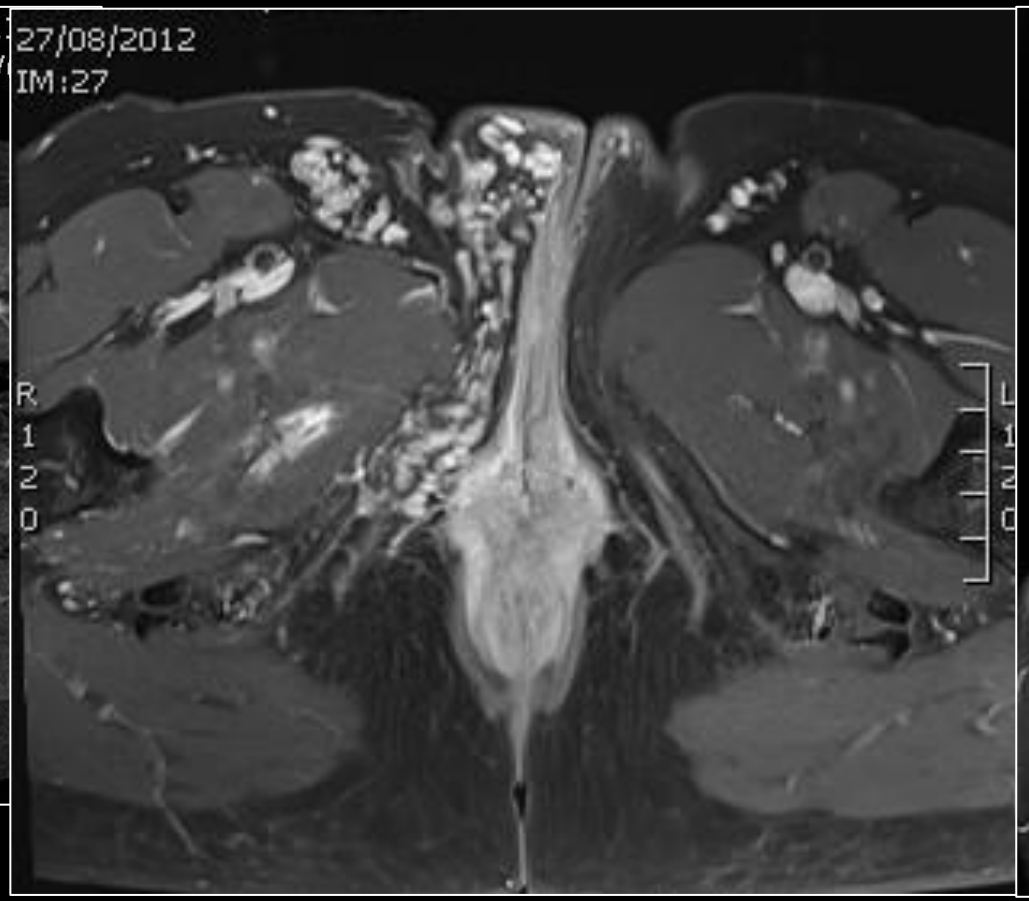


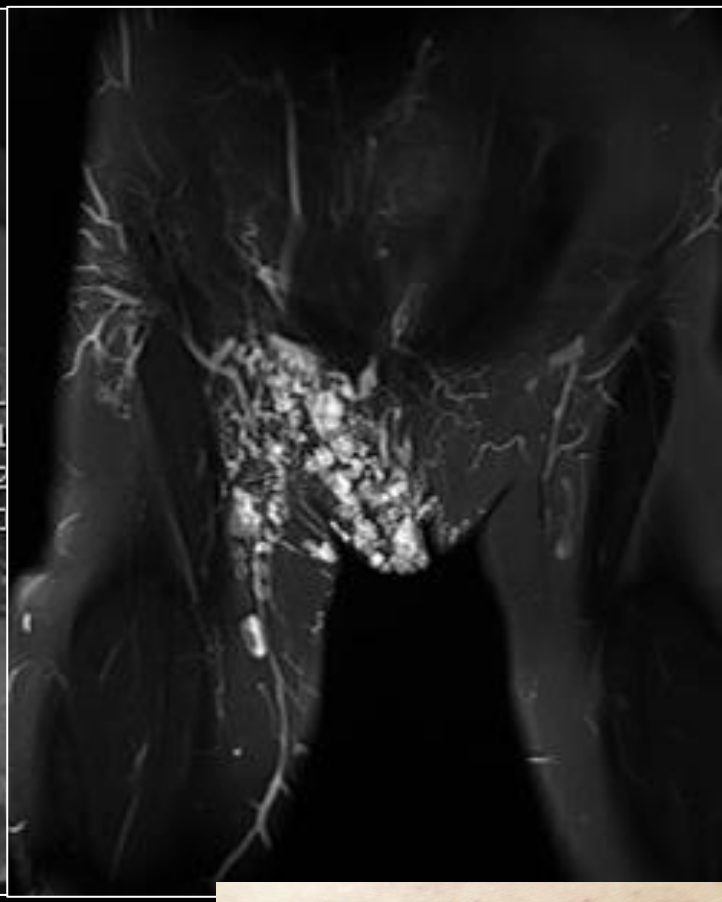
Pelvic varices (blue arrows)



Extratruncular venous malformation (white arrows)

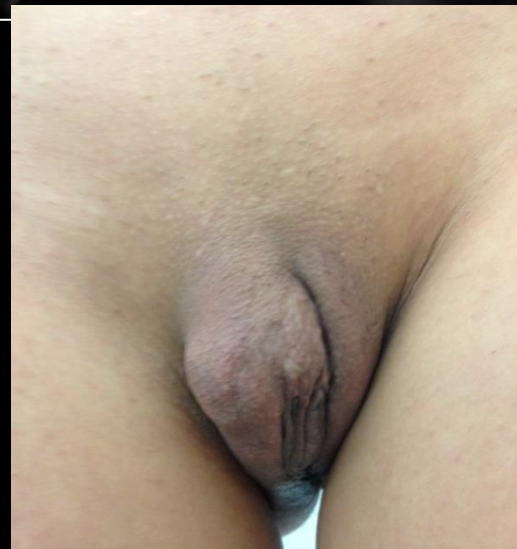






Before ovarian veins embolization

After left and right ovarian veins embolisation



Extratruncular venous malformations

- clusters of primitive vascular tissue

- **carry an inherent risk of proliferation or recurrence when stimulated:** during puberty or pregnancy, by injury, birth-control pills, as a result of clot formation within the lesion, **by isolated treatment of draining vessels**

Rules 1 to 4

1) Before pelvic congestion treatment, a clinical exam of pubis and perineal areas, genitals and lower limbs is needed in order to assess the venous pathology.

2) Before pelvic congestion treatment, eliminate an extra truncular venous malformation particularly in the genital area.

3) When there is a venous malformation, the isolated treatment of its draining vessels is dangerous.

4) A draining vein with a centripetal flow should not be occluded (e.g. dilated but draining right ovarian vein) except in special cases.

Rule 5 *(Clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum)*

- **We recommended (1C) non invasive imaging with transabdominal and/or transvaginal US, CT or MR venography in selected patients with**
  - ***symptoms of pelvic congestion syndrome or***
  - ***symptomatic varices in the distribution of the pubis, labia, perineum, or buttocks****

*Gloviczki P, Comerota AJ, Dalsing MC et al . The care of patients with varicose veins and associated chronic venous diseases: clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. J Vasc Surg ; 2011; 53: 2S-48S

"un syndrome de congestion pelvienne, des varices symptomatiques localisées au pubis, OGE, périnée ou fessières doivent faire l'objet d'un bilan complémentaire par techniques non invasives: échographie trans abdominale et/ou vaginale ou angio scanner veineux ou angio IRM veineuse" (1C).

Rule 6 *(Clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum)*

- We recommend retrograde and internal iliac venography (1C) in patients with pelvic venous disease, confirmed or suspected by noninvasive imaging studies, in whom intervention is planned*.

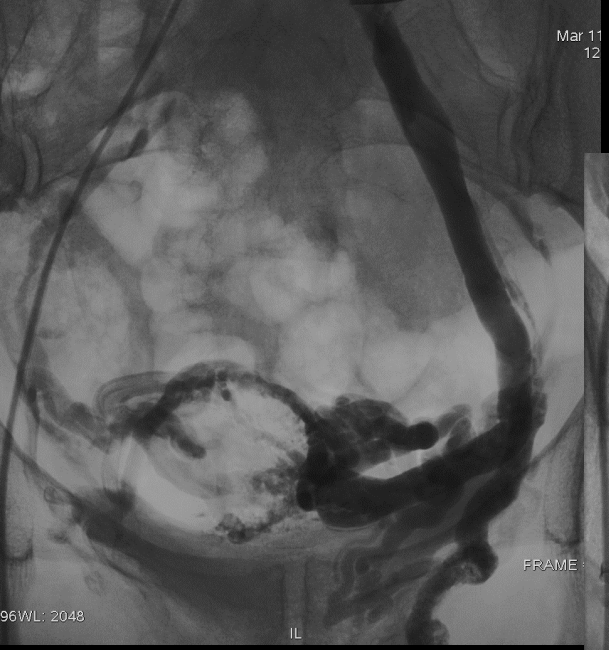
*Gloviczki P, Comerota AJ, Dalsing MC et al . The care of patients with varicose veins and associated chronic venous diseases: clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. J Vasc Surg ; 2011; 53: 2S-48S

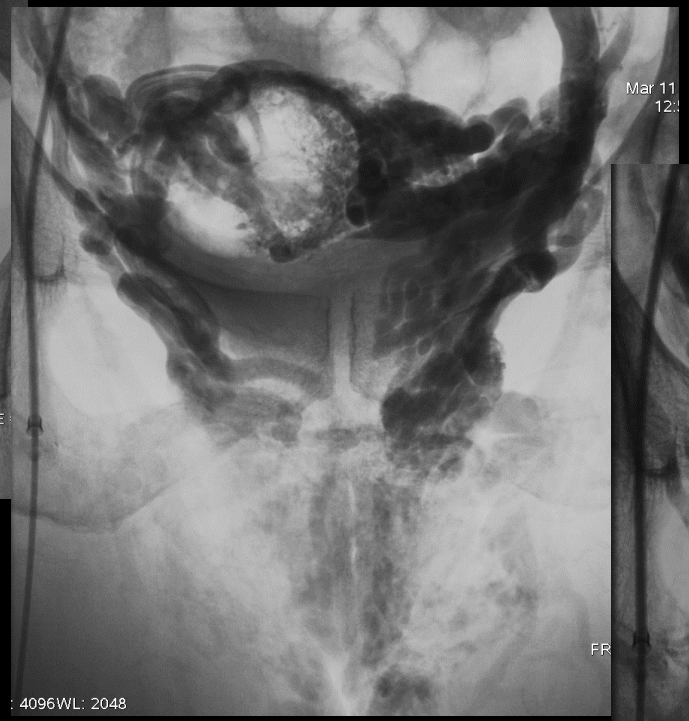
« Lorsqu'une intervention est programmée, la phlébographie rétrograde ovarienne et iliaque interne est recommandée (1C) chez les patients présentant une maladie veineuse pelvienne confirmée ou suspectée lors de l'exploration par imagerie non invasive ».

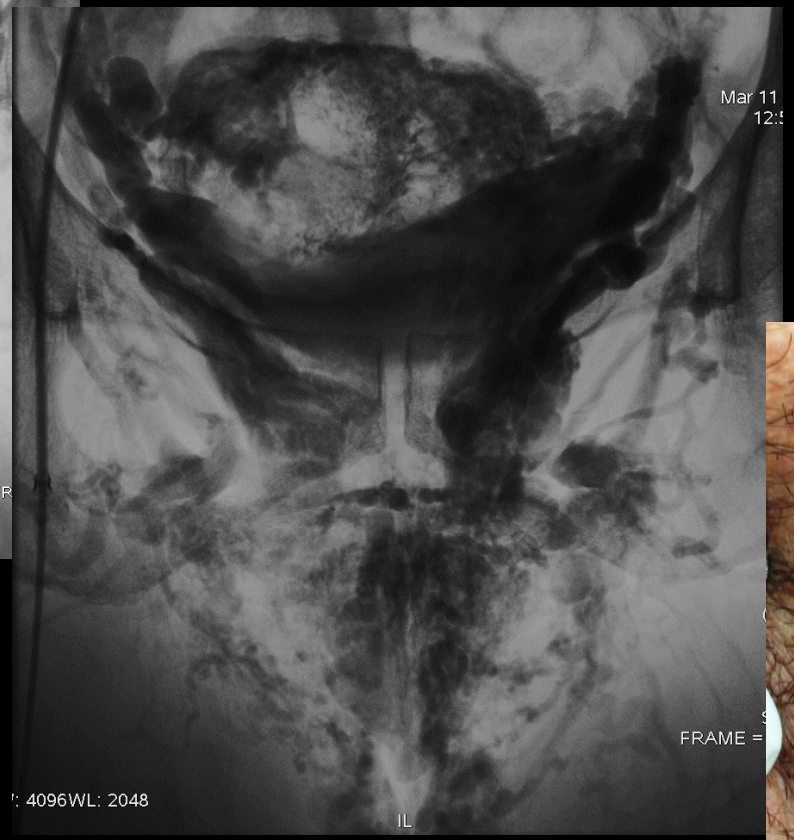
Rule 7

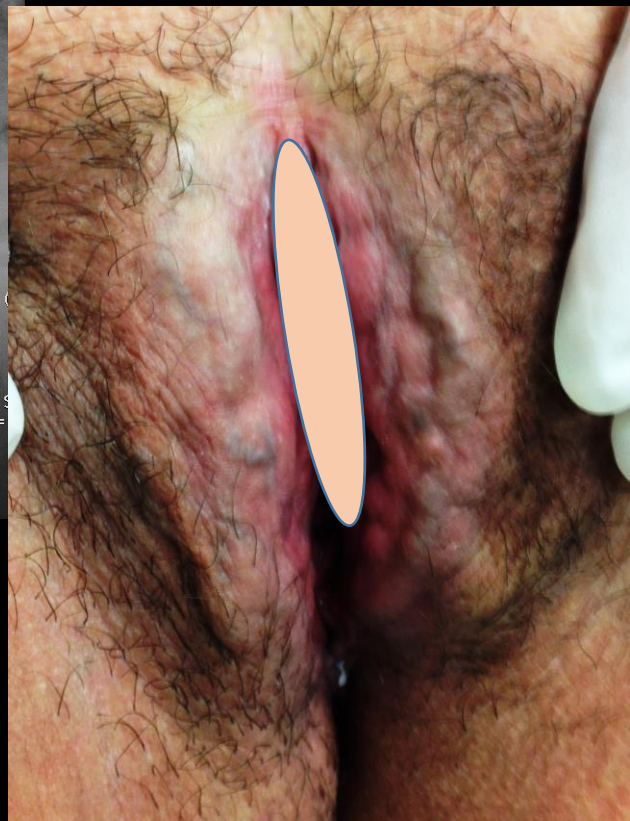
- **Vulvar, perineal , gluteal varices treatment without taking into account overlying pelvic venous condition is not advisable: on the mid-term basis, it makes the pelvic venous pathology more complex. It may be dangerous (see slides).**

- *See also guideline 14.4 of Clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum*



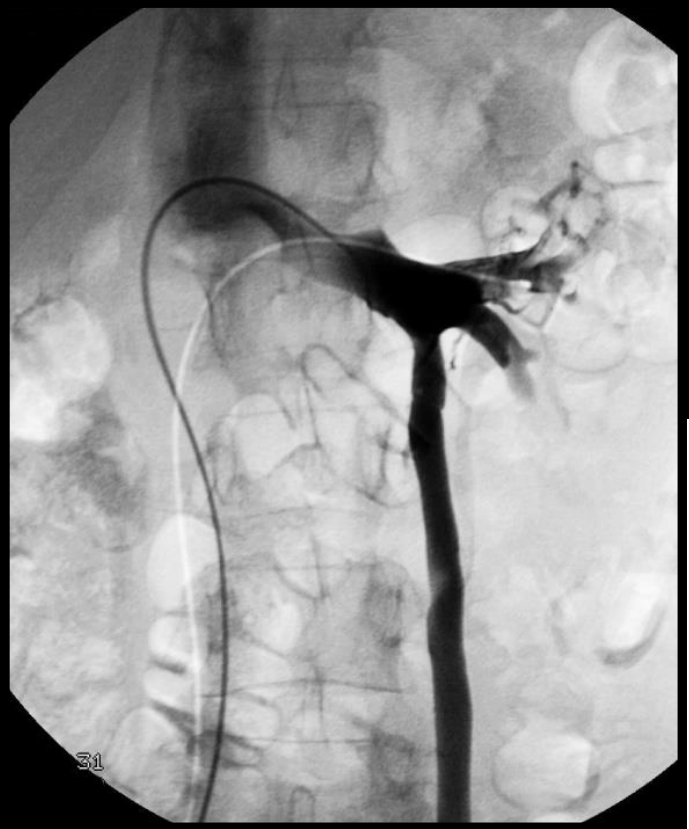


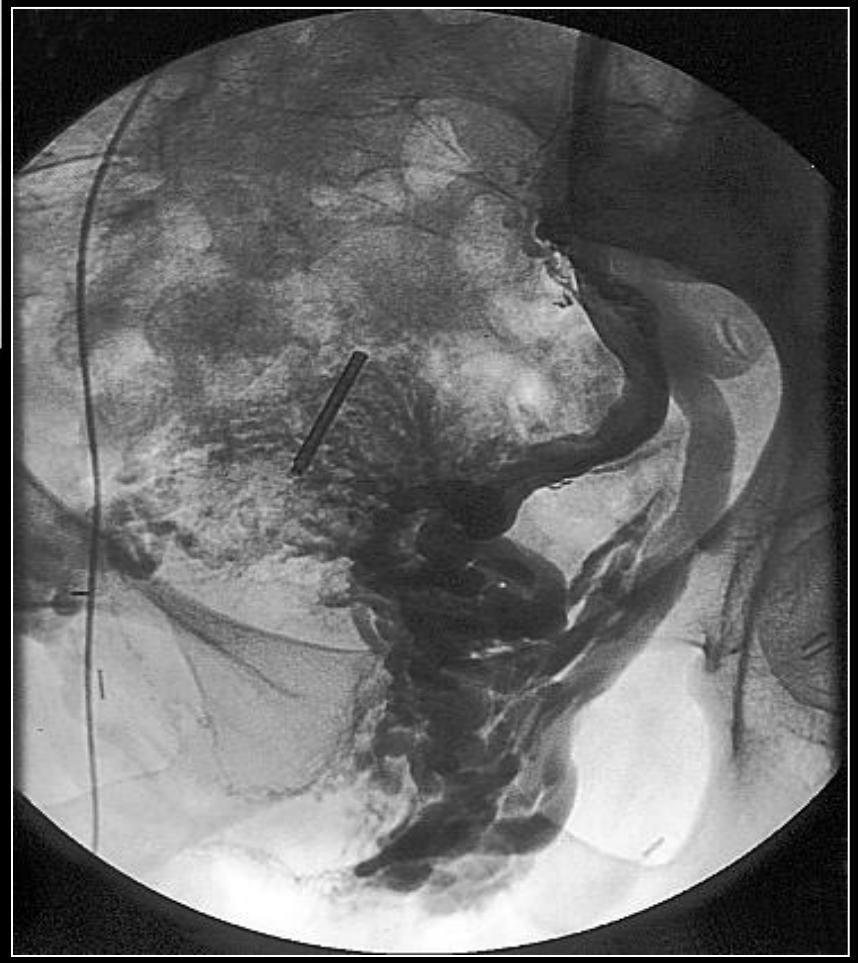


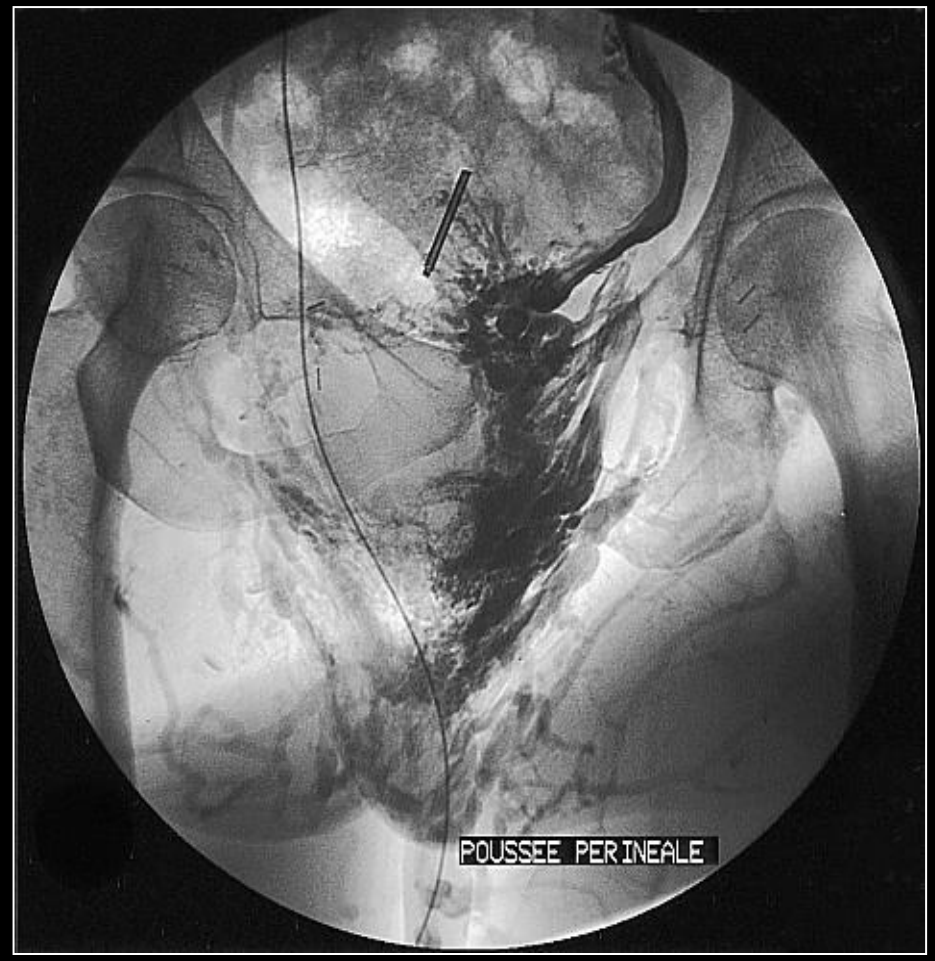


Same patient

three years after treatment of vulvar varices by sclerotherapy (2 sessions)



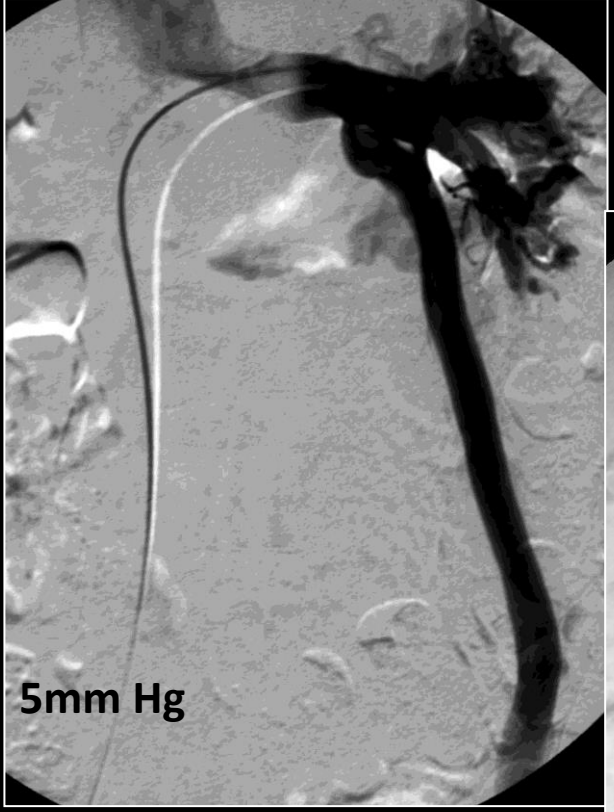




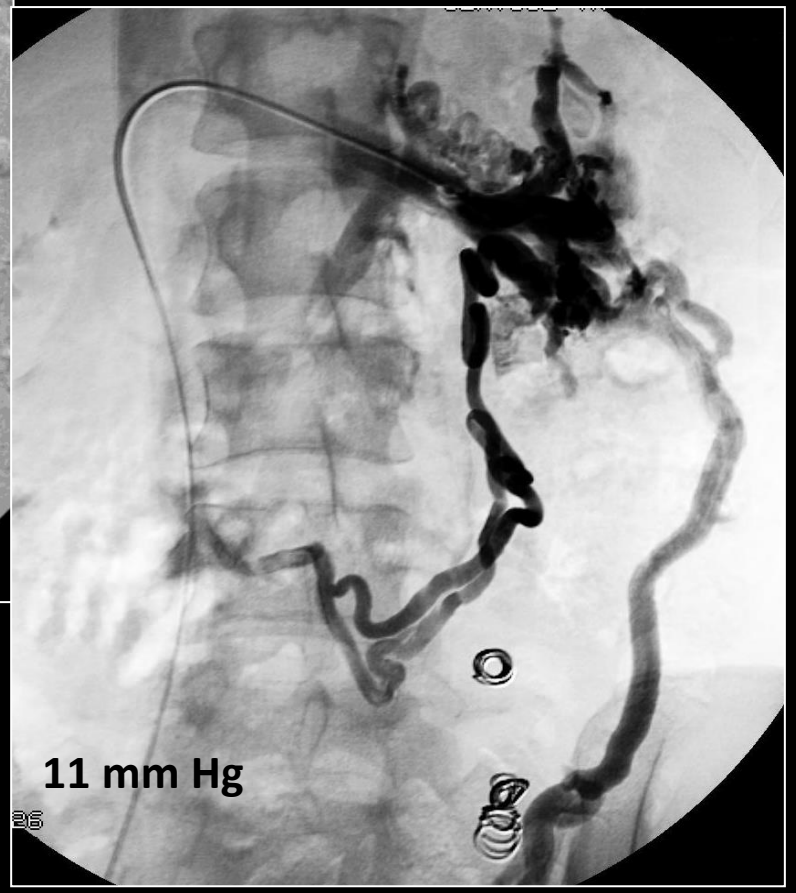
Rule 8

- Before pelvic congestion treatment, rule out any form of obstructive disease on main venous trunks (left renal vein compression, iliac veins compression…) (type 2 of MG classification)

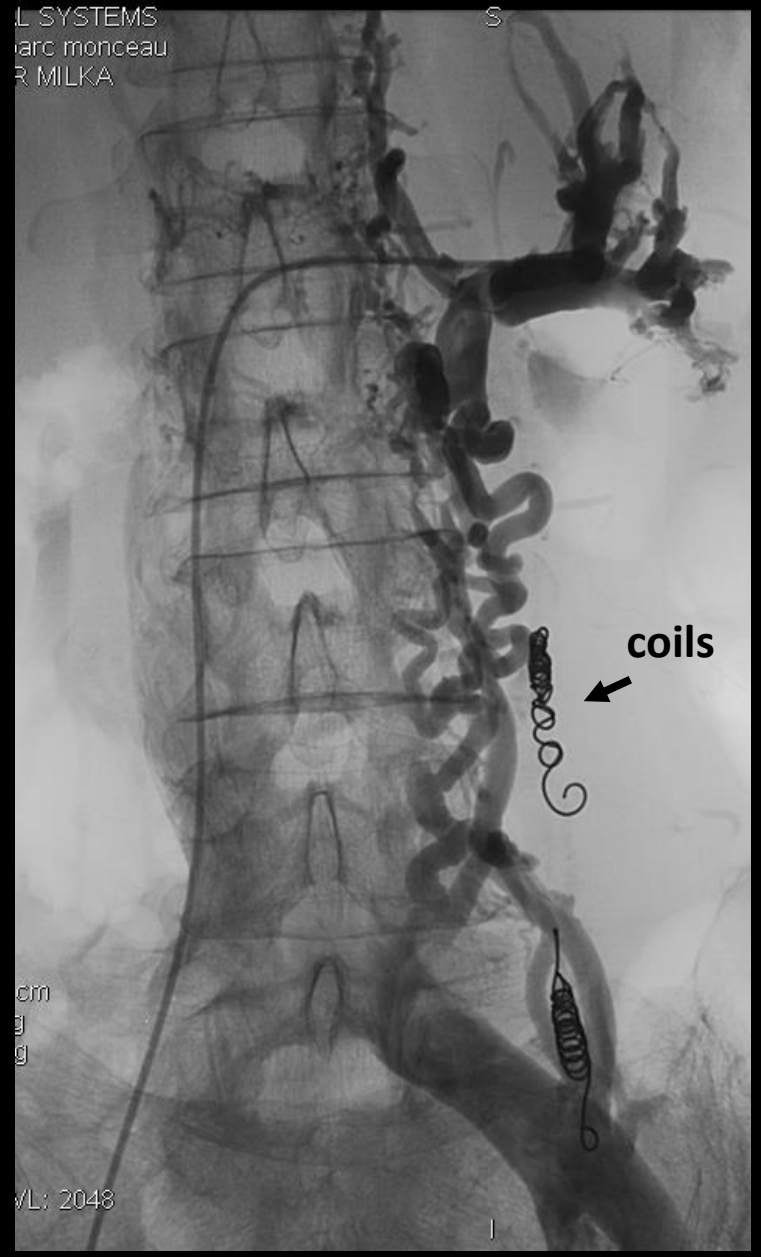
- The isolated treatment of reflux and substitute varicose veins without treatment of the obstacle can worsen abdominal, renal, pelvic and/or lower limb venous hyper pressure (hemodynamic nonsense).



First phlebography



four years after left ovarian vein embolization and a pregnancy: renal colic, permanent macroscopic hematuria, proteinuria, anemia



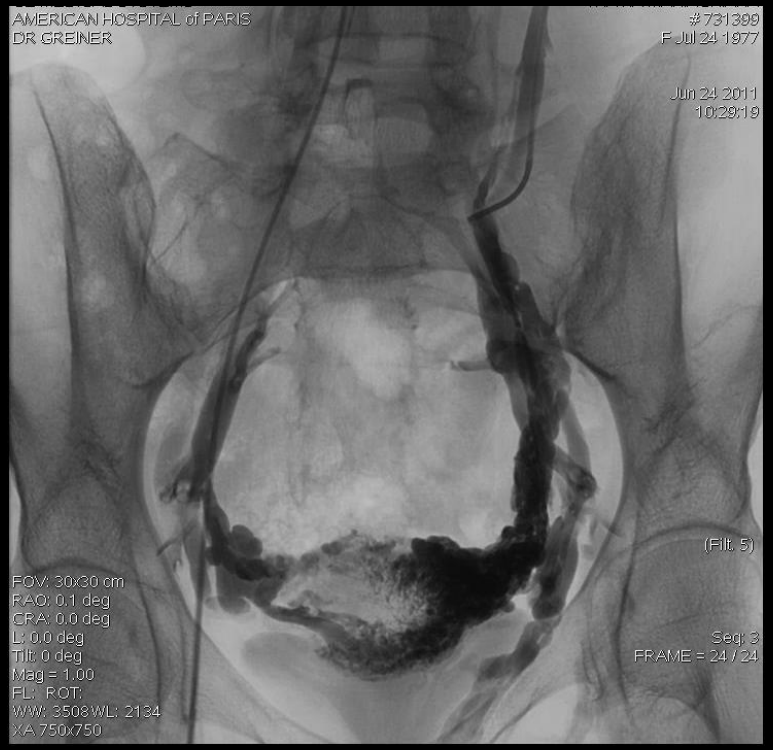
three years after ovarian vein embolization: left lower limb oedema, hemorrhoids

Rule 9

- Female pelvic varices should not be treated as male varicocele by isolated occlusion of refluxing left ovarian vein.

In a large number of cases, female pelvic varices are fed/connected by/with several refluxing internal iliac tributaries.

the only way for getting a complete remission of symptoms is to treat the ovarian upper pole and the inferior internal iliac pole of pelvic varices.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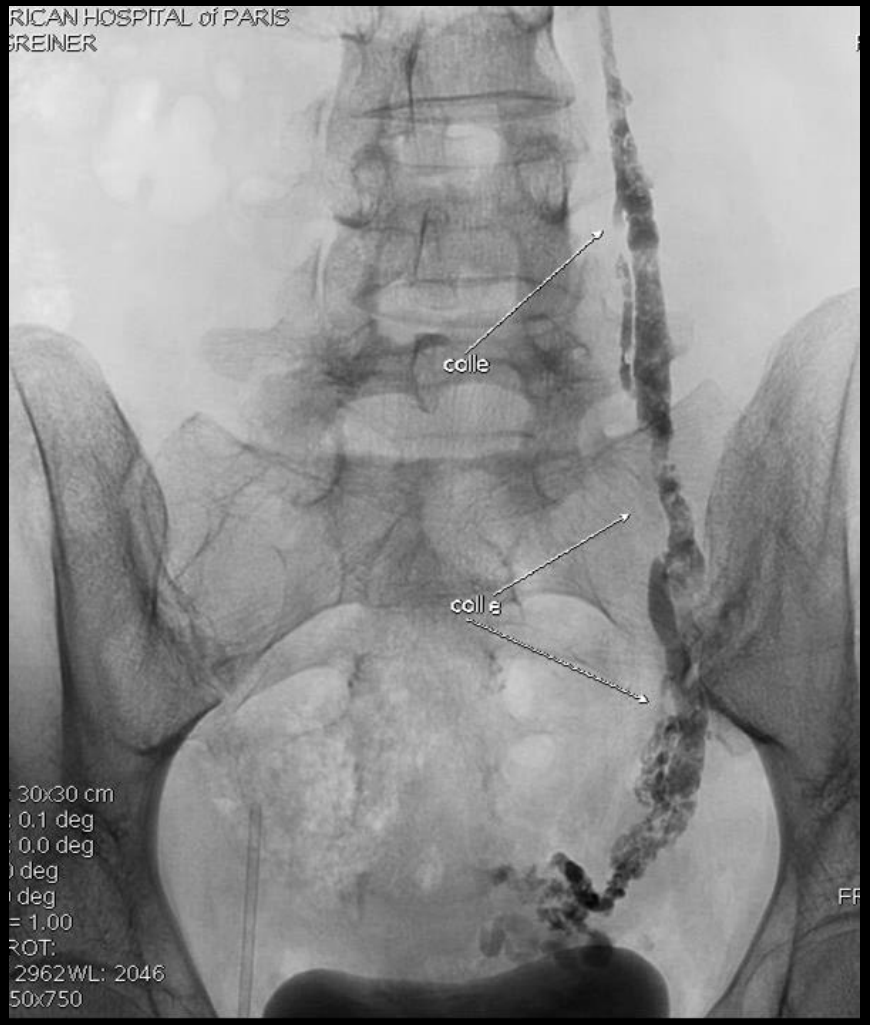
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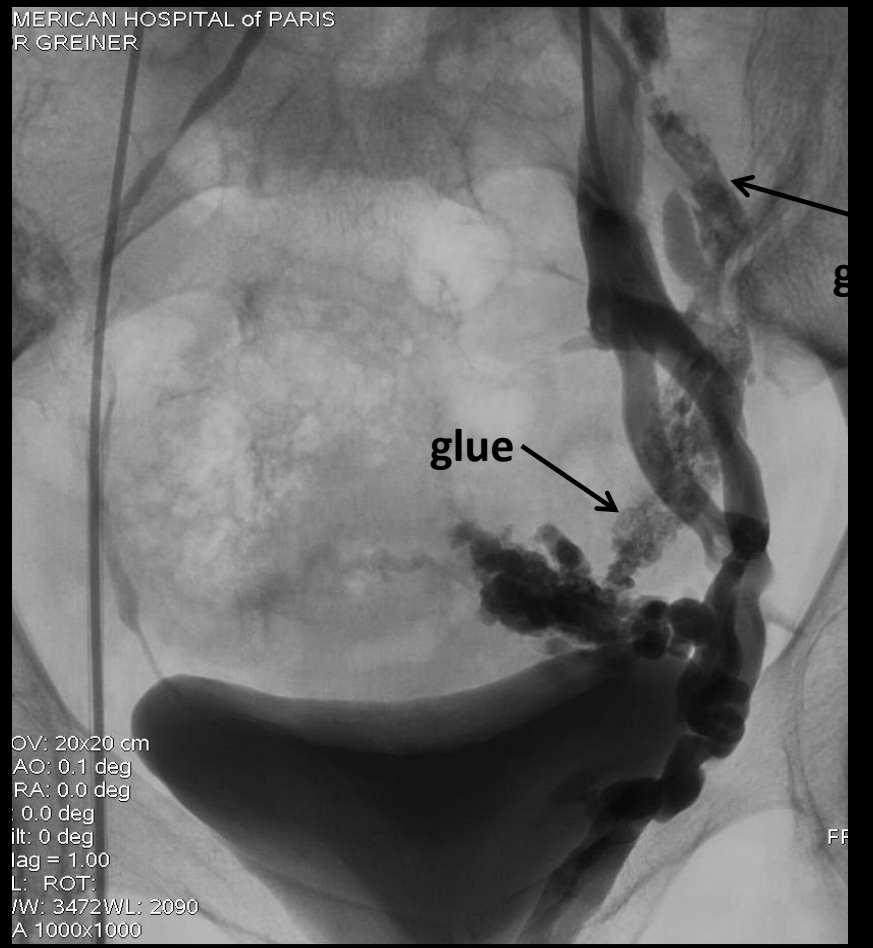
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glue
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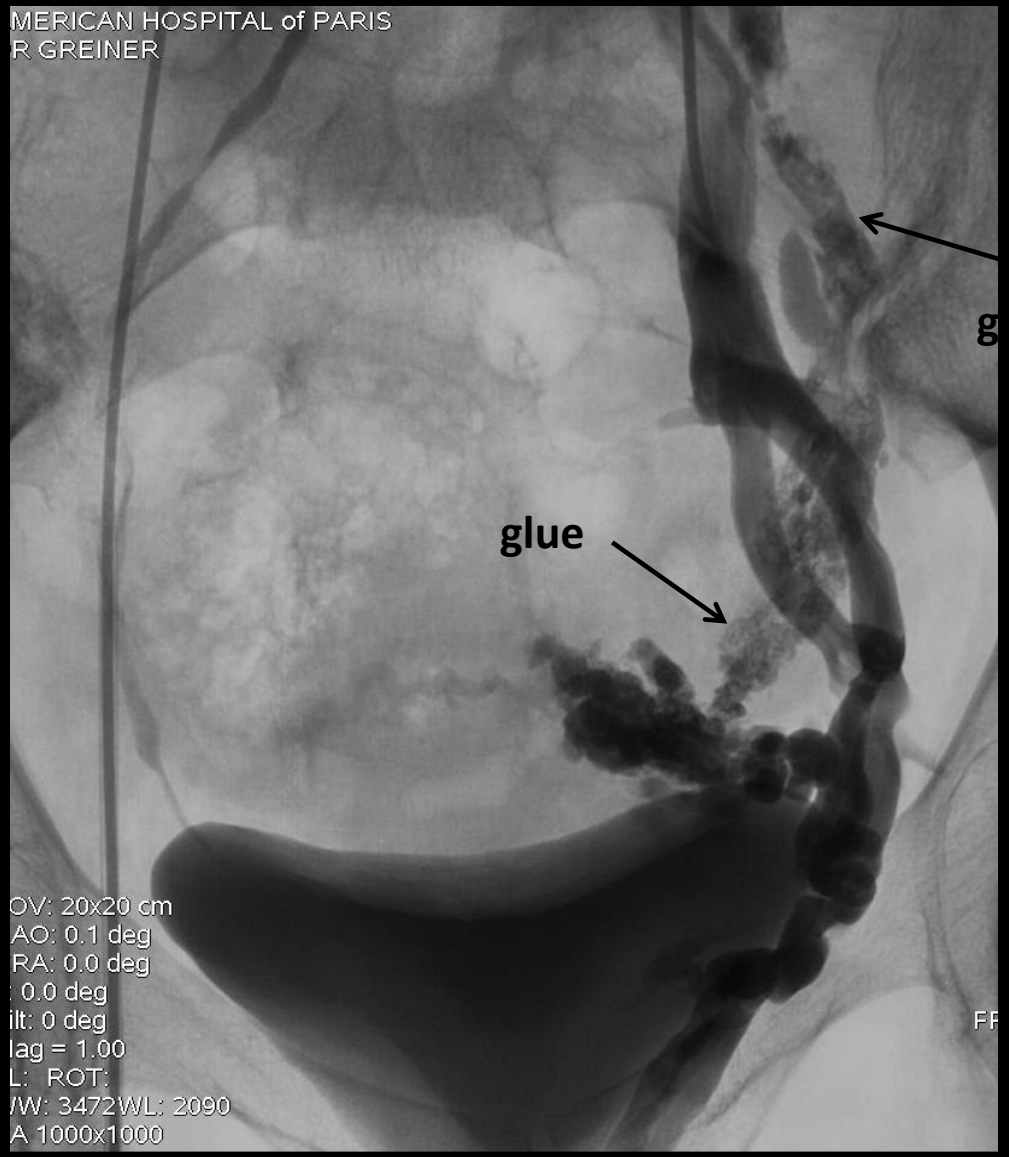
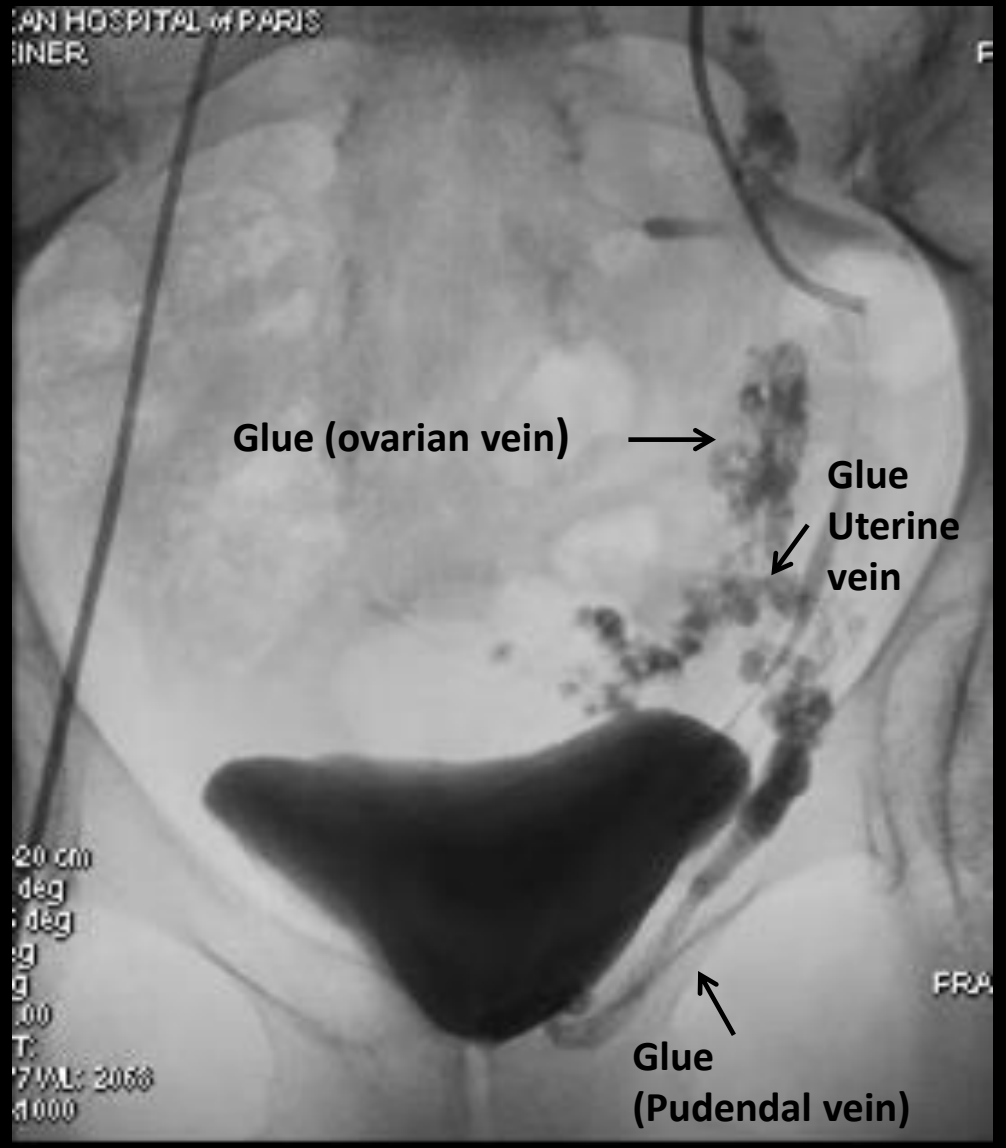
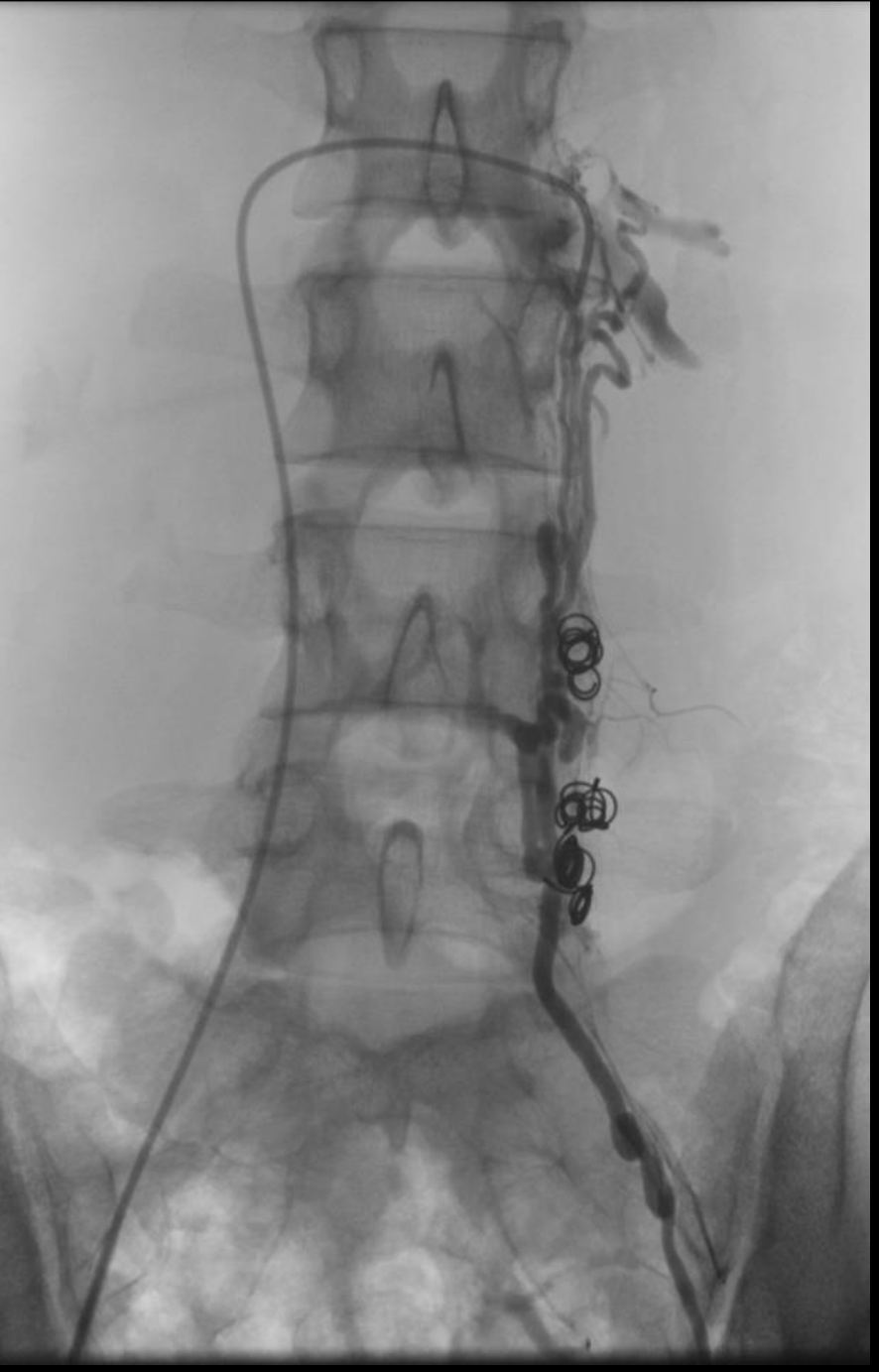

glue

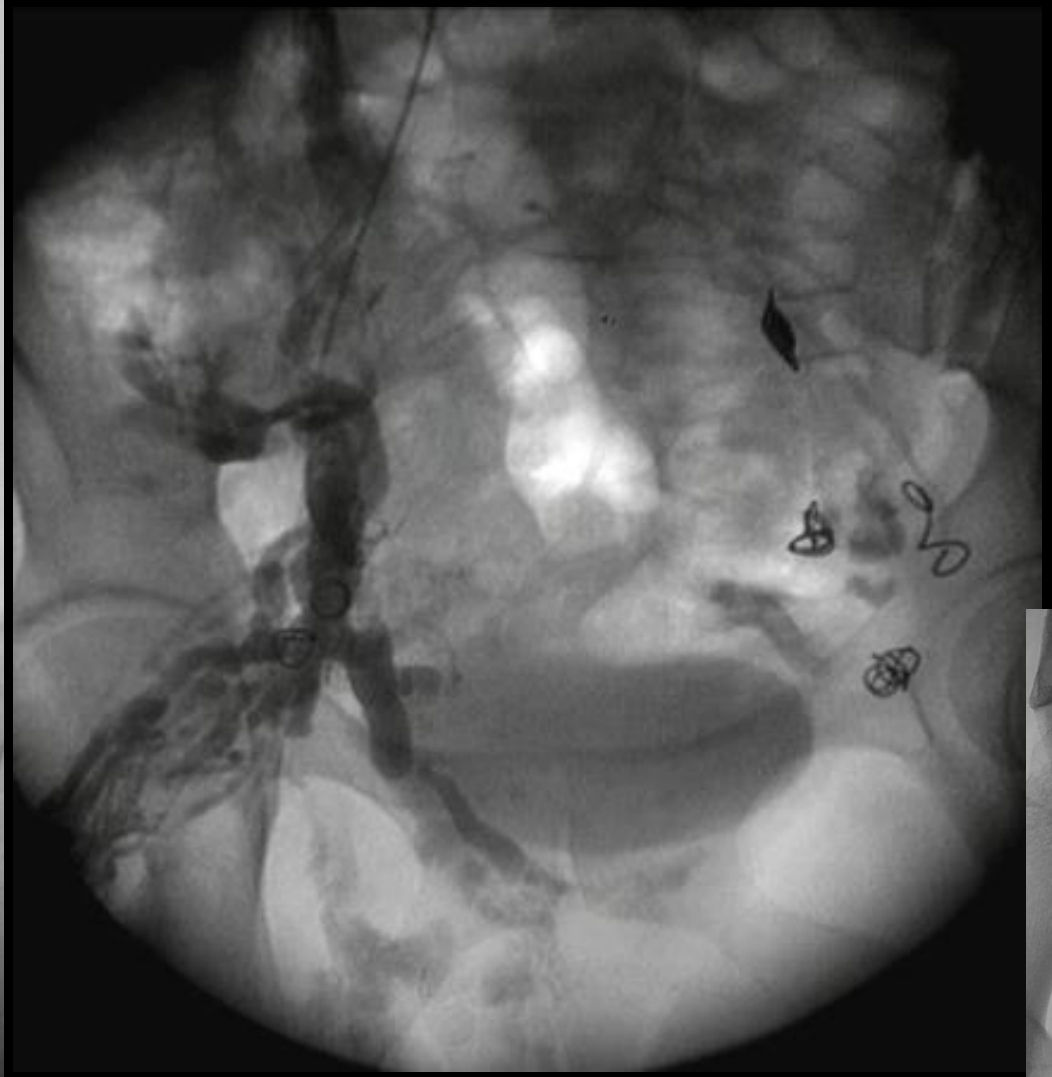

Glue (ovarian vein)
Glue
Uterine
vein
Glue
(Pudendal vein)

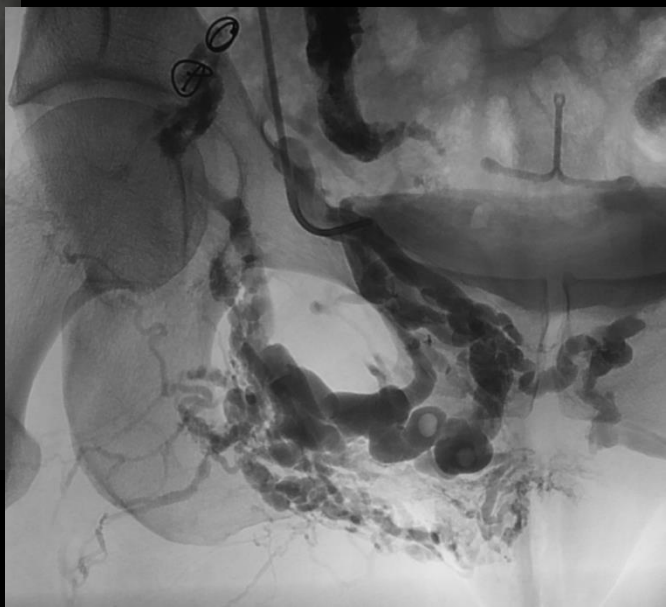
Rule 10

- Use of instantly occlusive materials (glue, coils± sclerosing agents…) in sufficient quantities (coils) to obtain a reliable result.

Same patient!







Proper long-term outcome of the pelvic congestion syndrome treatment is directly linked to the respect of these rules

THANK YOU