Vulvar varicose veins after pregnancy. Do we have to embolize the leak points?

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I do not have any potential conflict of interest

➢ Vulvar varicose veins: general considerations

- ✓ varices on the labia majora and/or minora
- ✓ seen in 4% of the women population
- ✓ After the second pregnancy

- ✓ Most often, asymptomatic (but women are embarrassed to talk about them)

- ✓ When symptomatic:
  - *Feelings of fullness or pressure in the vulvar area*
  - *Swelling and discomfort*
  - *Pain in the vulva area*
  - *Pruritus and dyspareunia*

- ✓ Aggavated by long periods of standing, exercise and sex

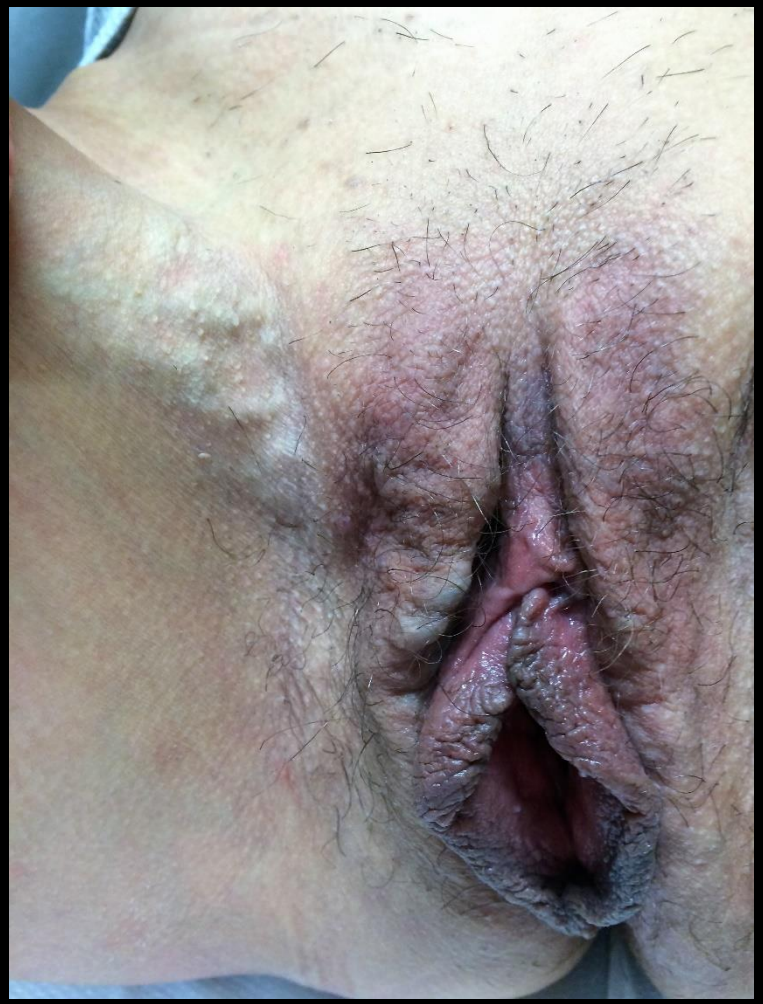
- ✓ can be isolated or associated with perineal varices, varices of the lower limbs
- ✓ may occur as part of pelvic congestion syndrome (PCS).

➢ Three clinical cases

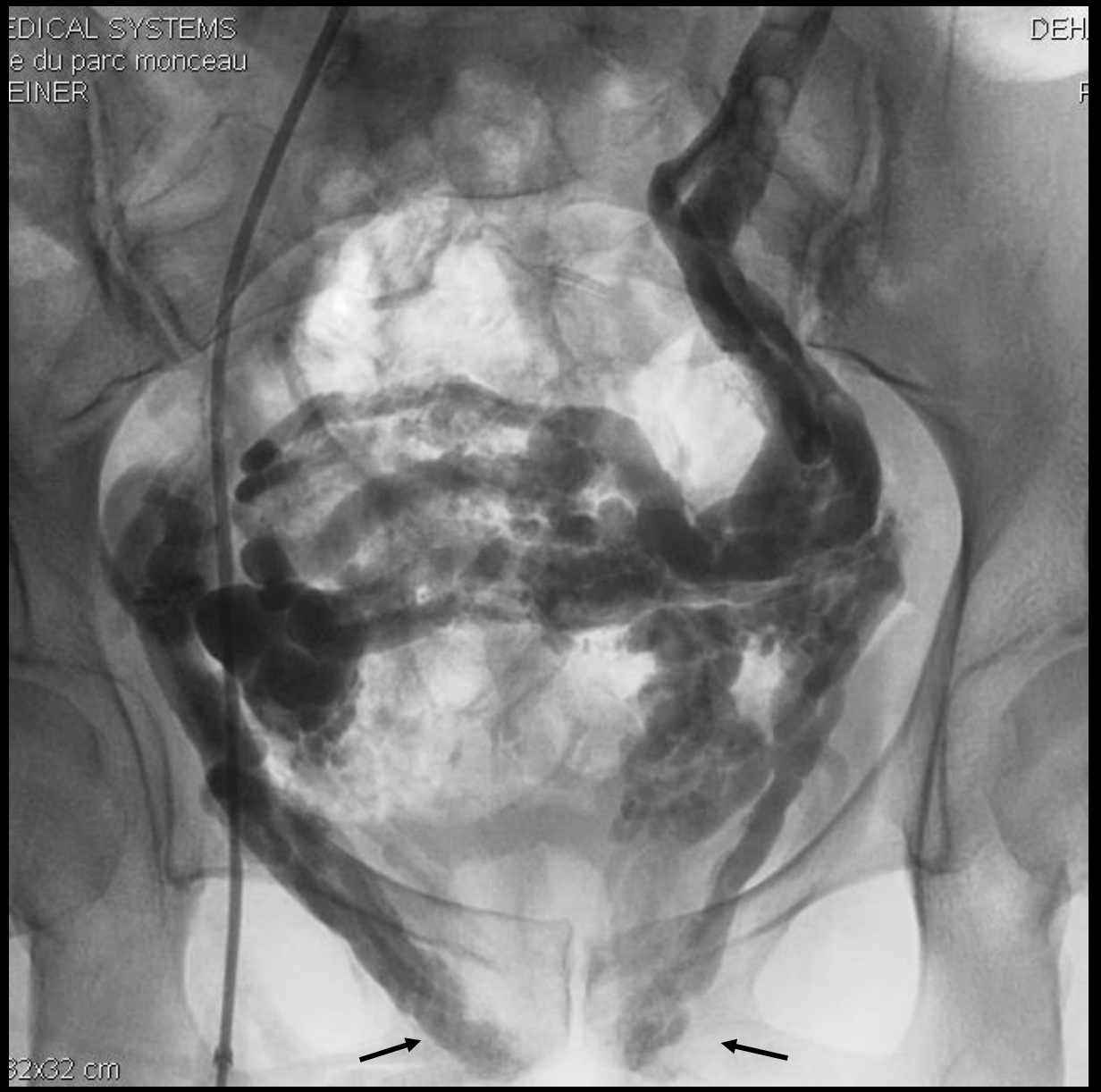
Clinical summary of the three cases:

- Symptomatic vulvar varices
- Absence of pelvic congestion syndrome (PCS)
- Vulvar varices associated with perineal varices and atypical varices of lower limbs

First Patient

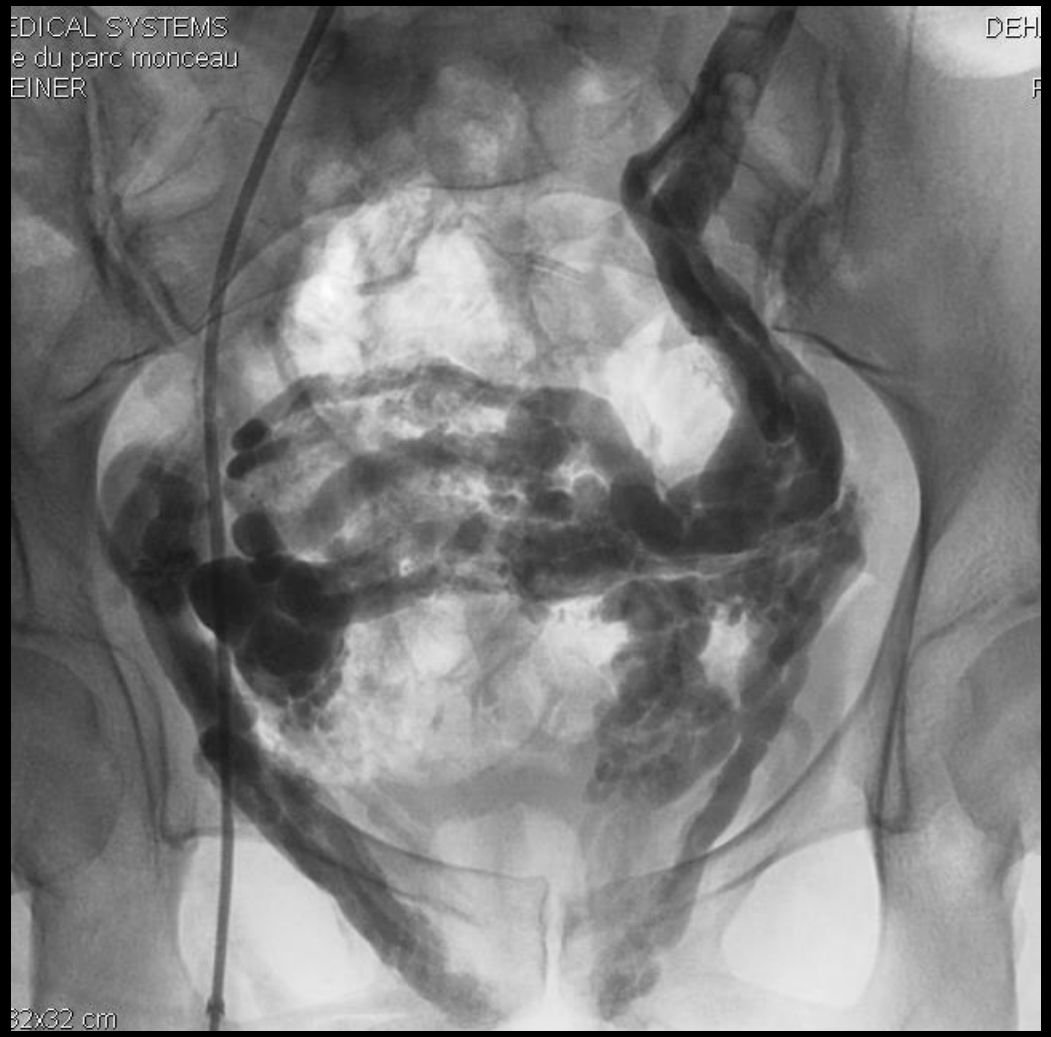


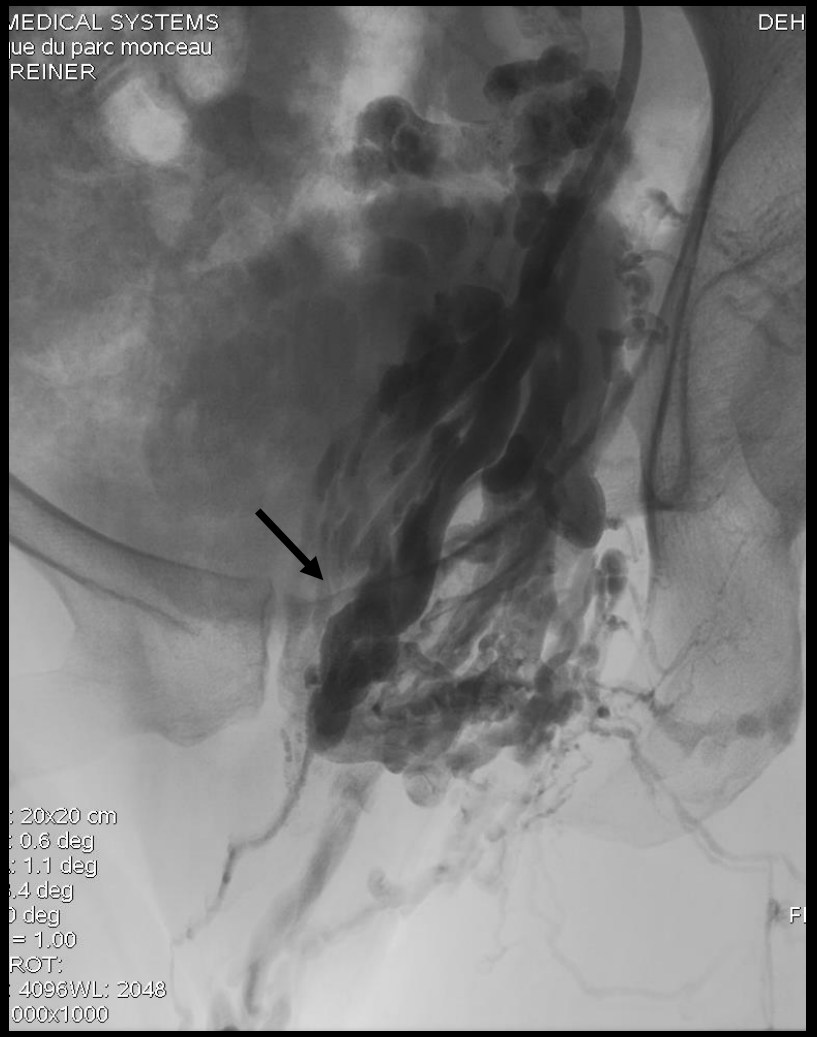
Genital and perineal varicose veins (lying position)



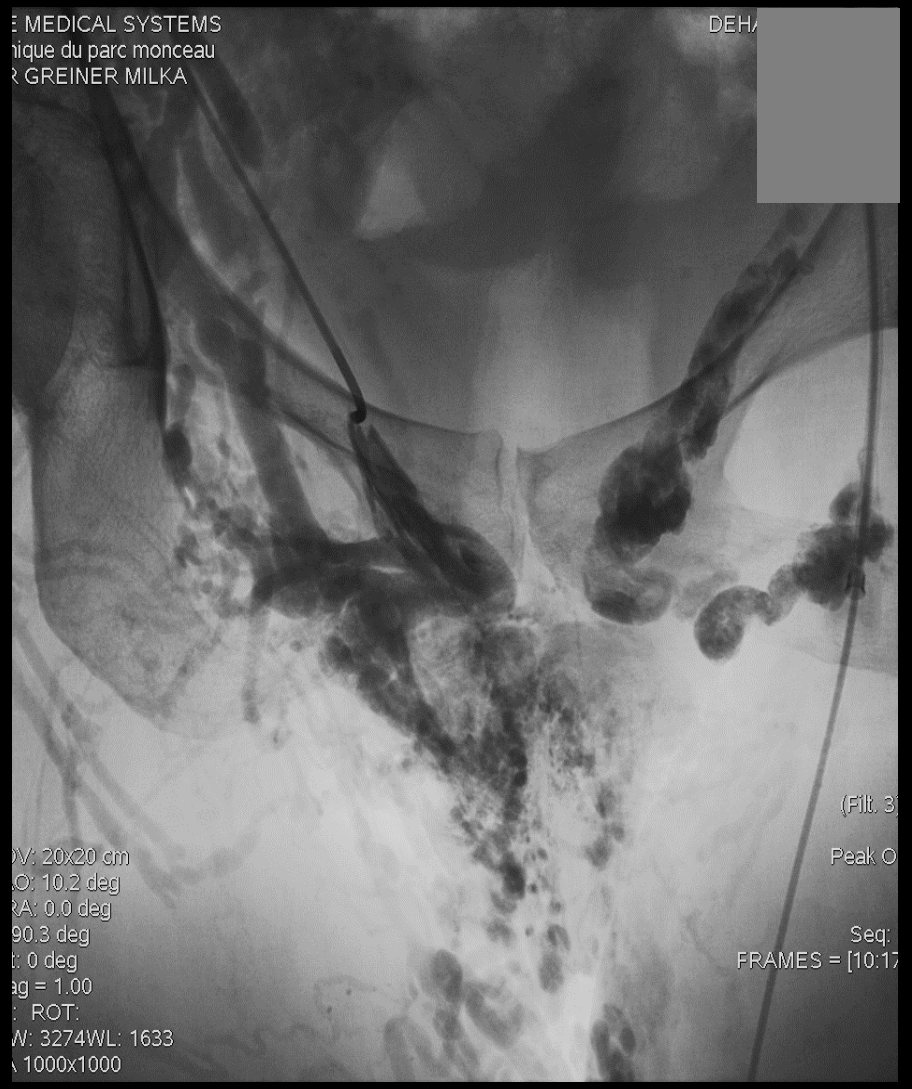
Pelvic phlebography: left ovarian vein catheterization
Black arrows: medial pudendal venous leaks

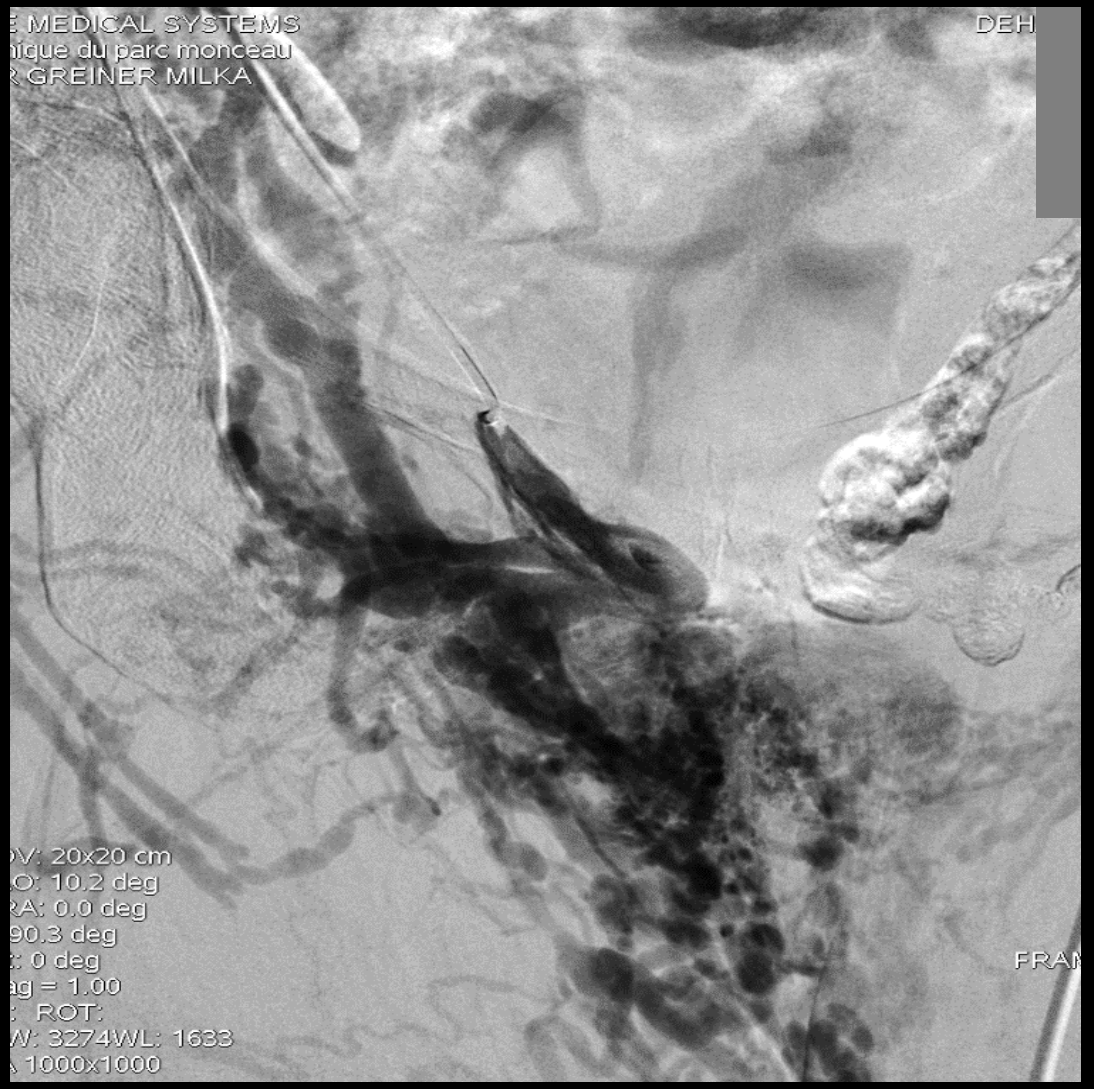
First Patient



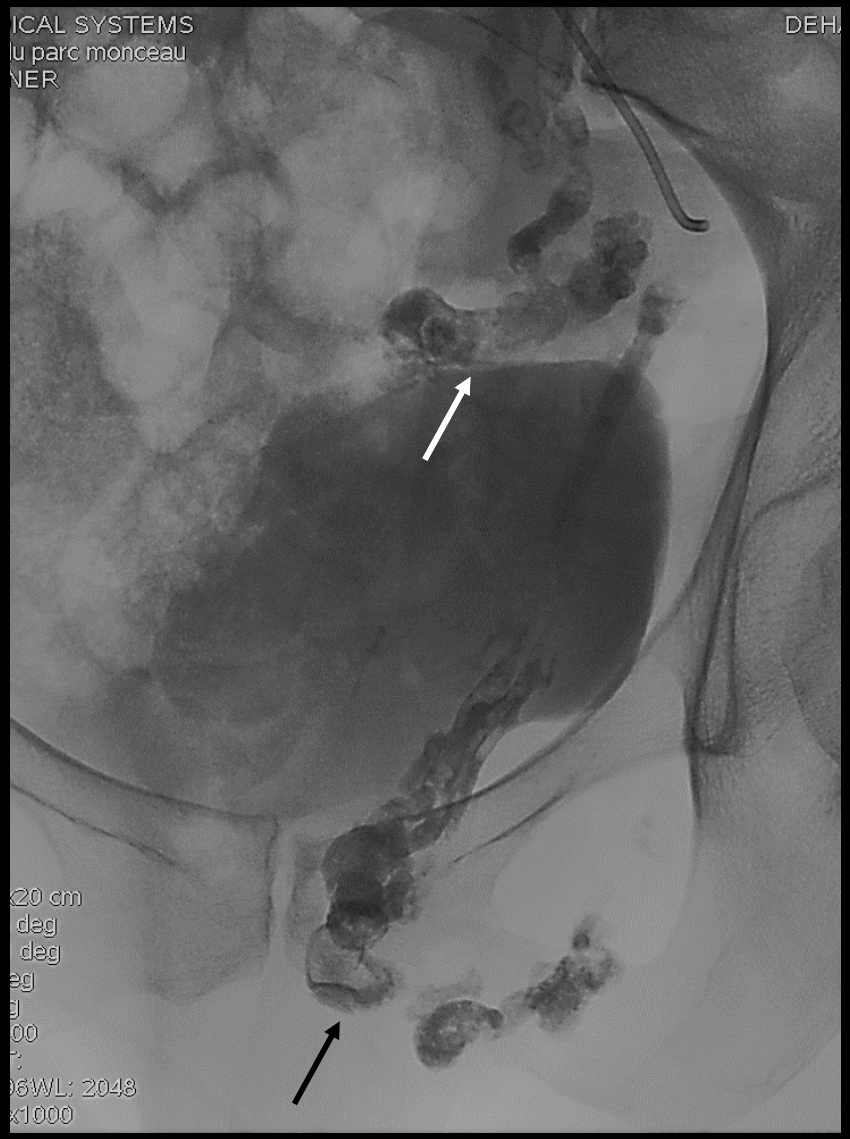


Selective catheterization of left medial pudendal vein

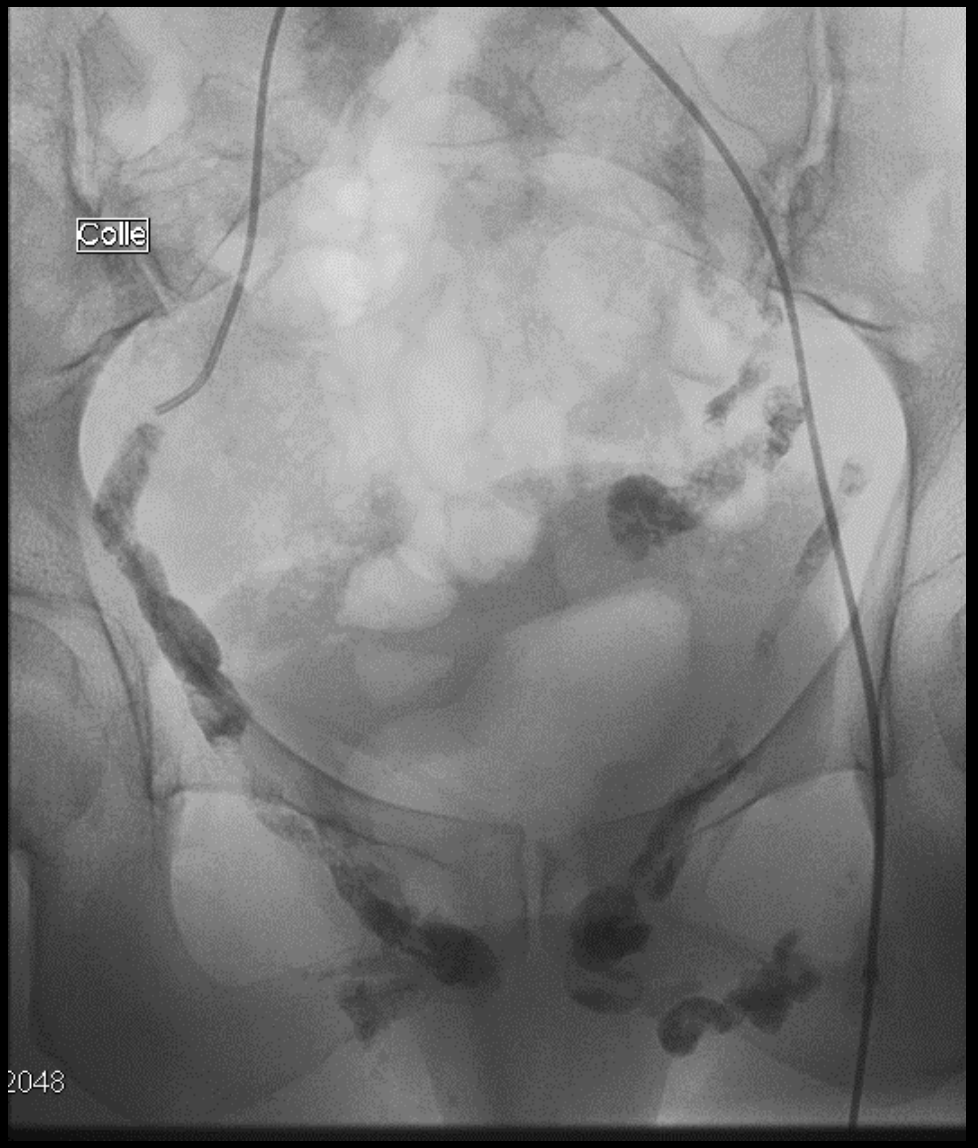




Same patient: selective catheterization of right medial pudendal vein and injection of contrast product: massive opacification of vulvar varicose veins

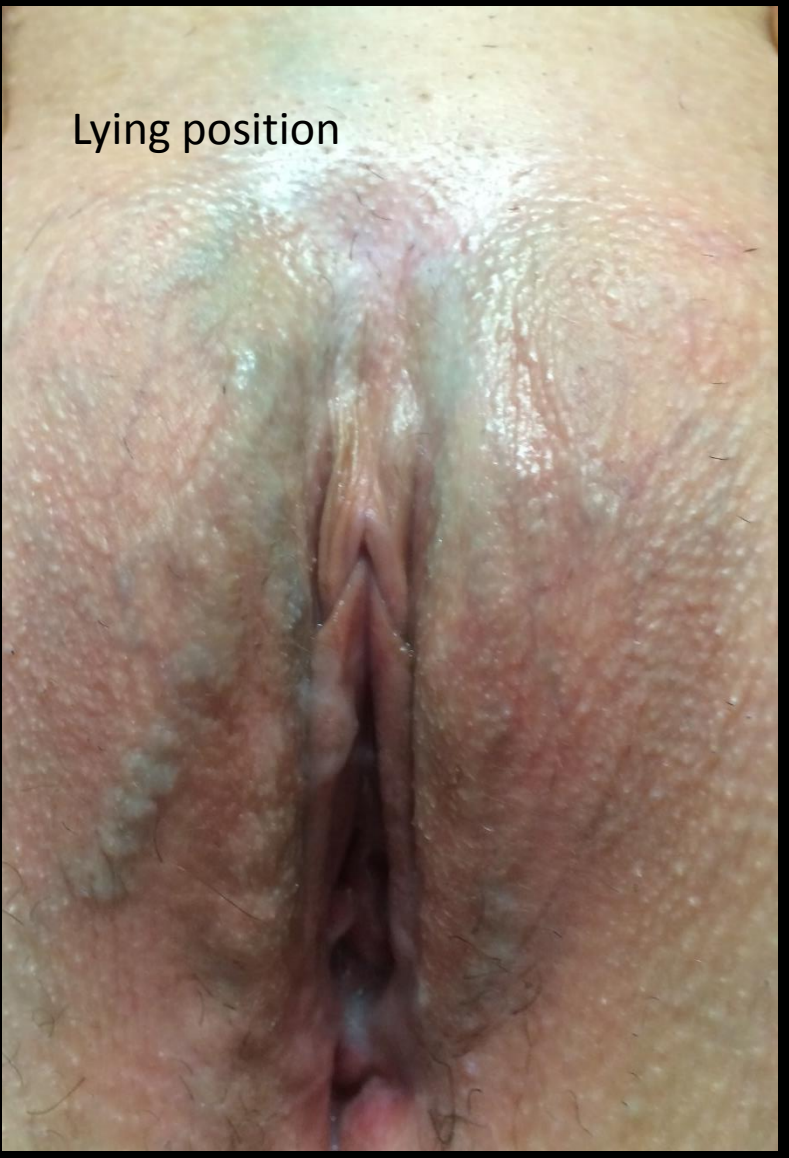


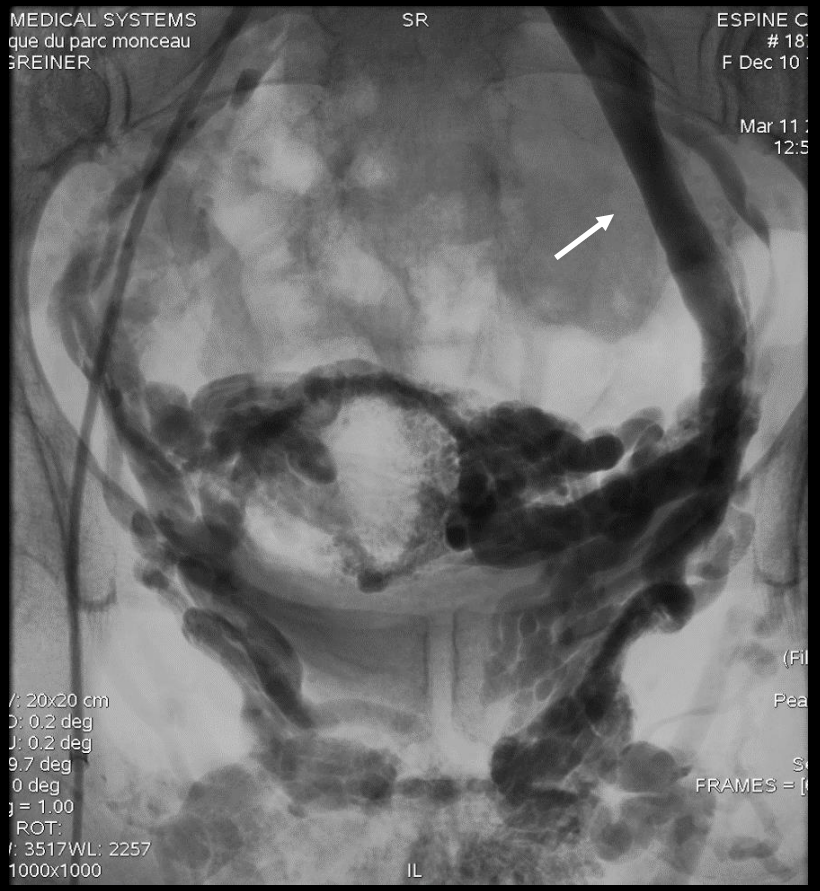
Left ovarian reflux *(white arrow)* and medial pudendal leak *(black arrow)* treated by glue



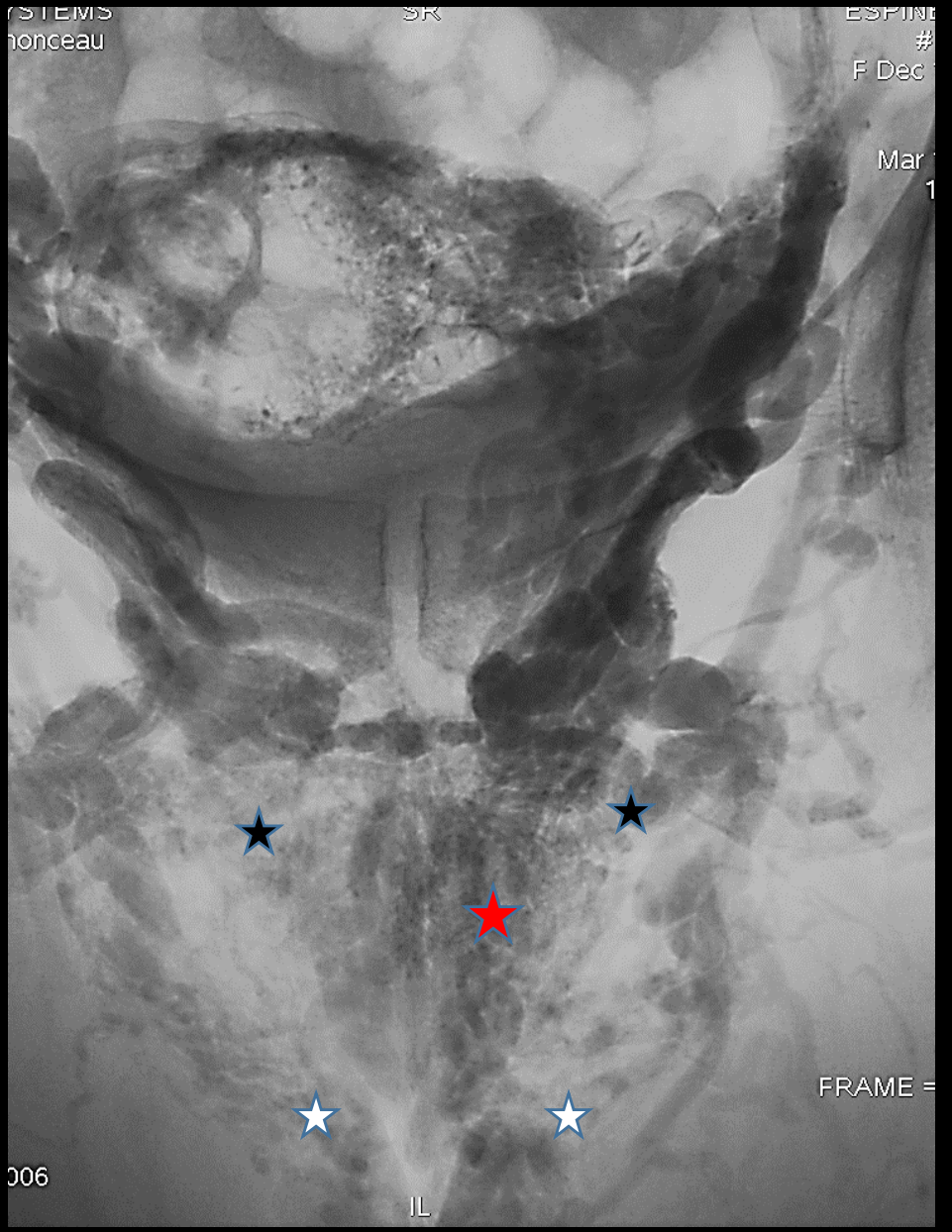
Right medial pudendal vein treated by glue

Second patient

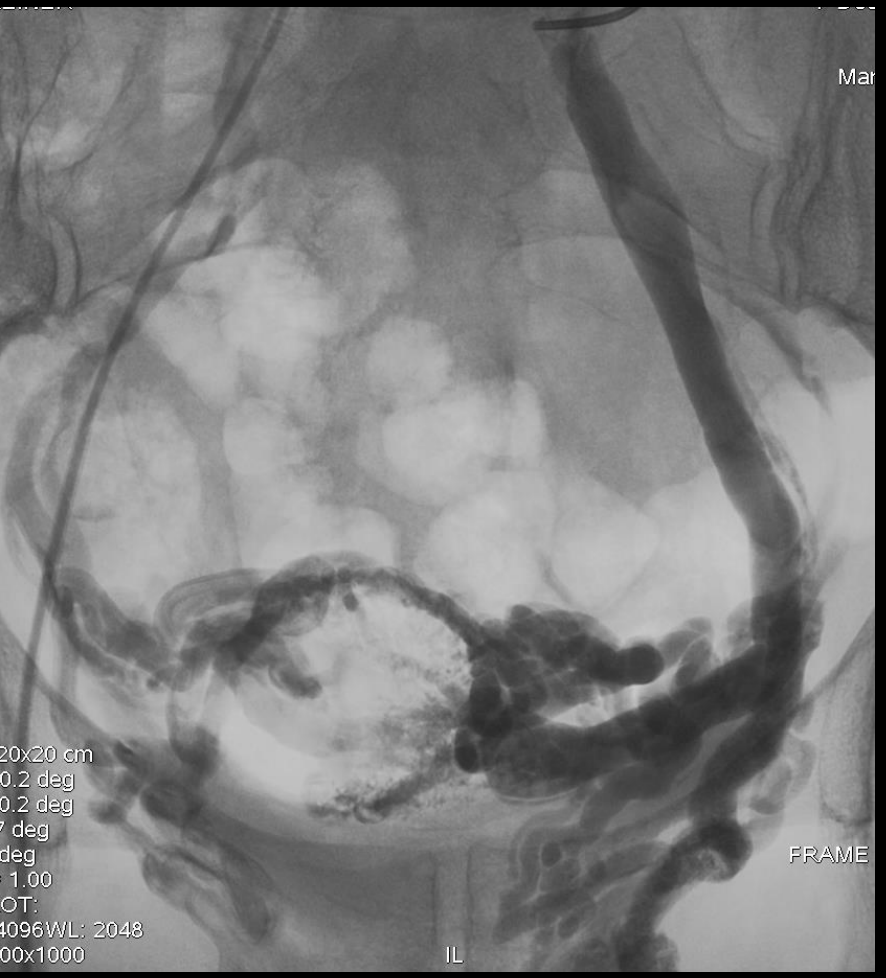


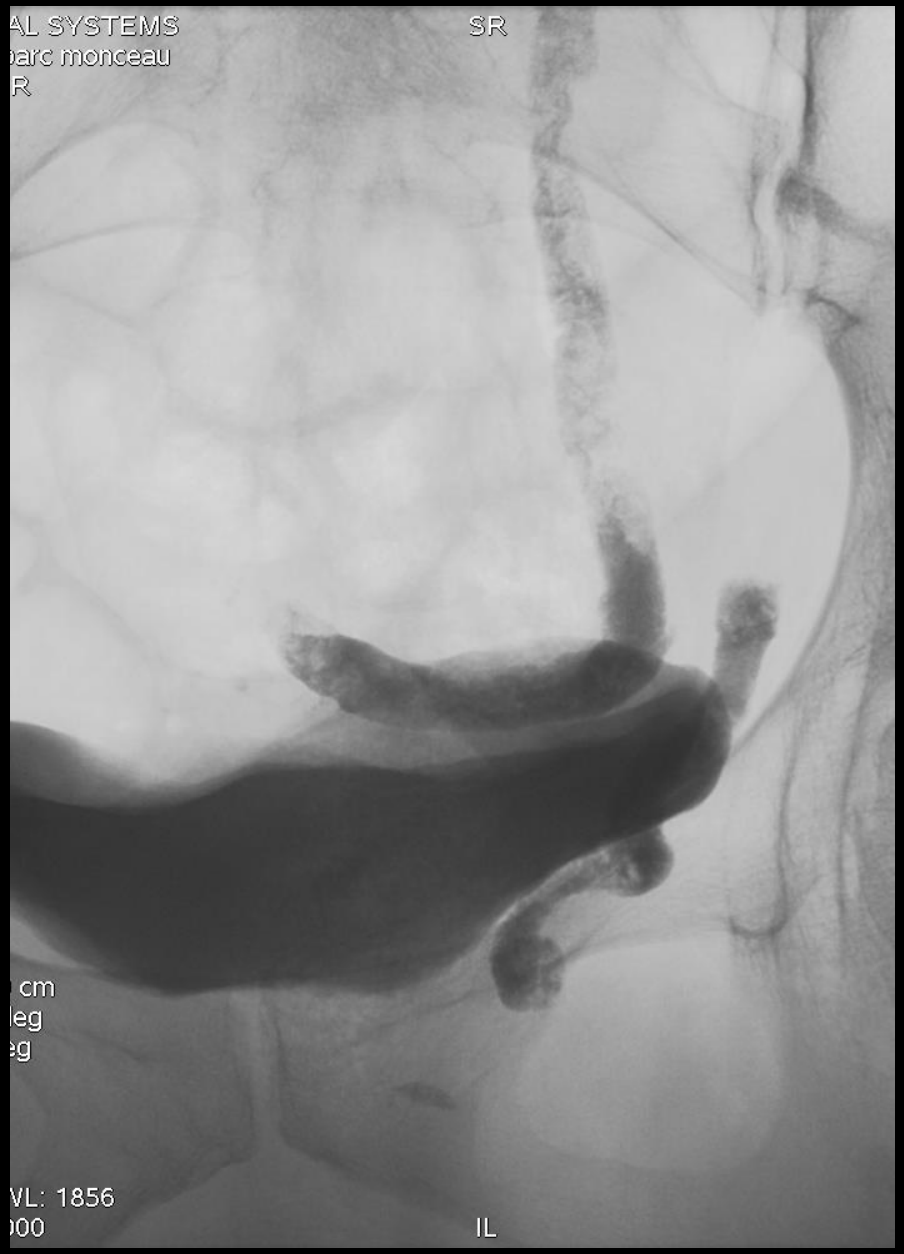


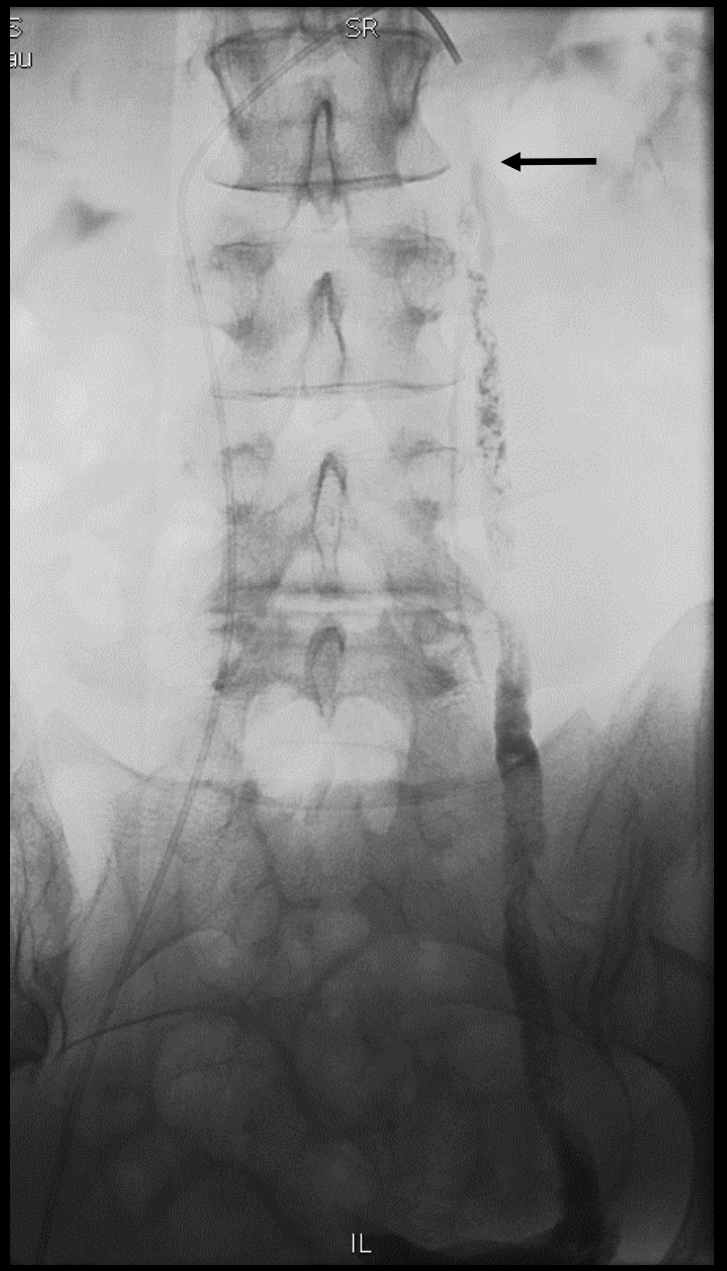
Phlebography: diffuse varicose veins (vv) linked to massive left ovarian reflux (white arrow); vv of external genital organs (red star); perineal vv (black star); atypical vv of thighs (white stars)



Second patient

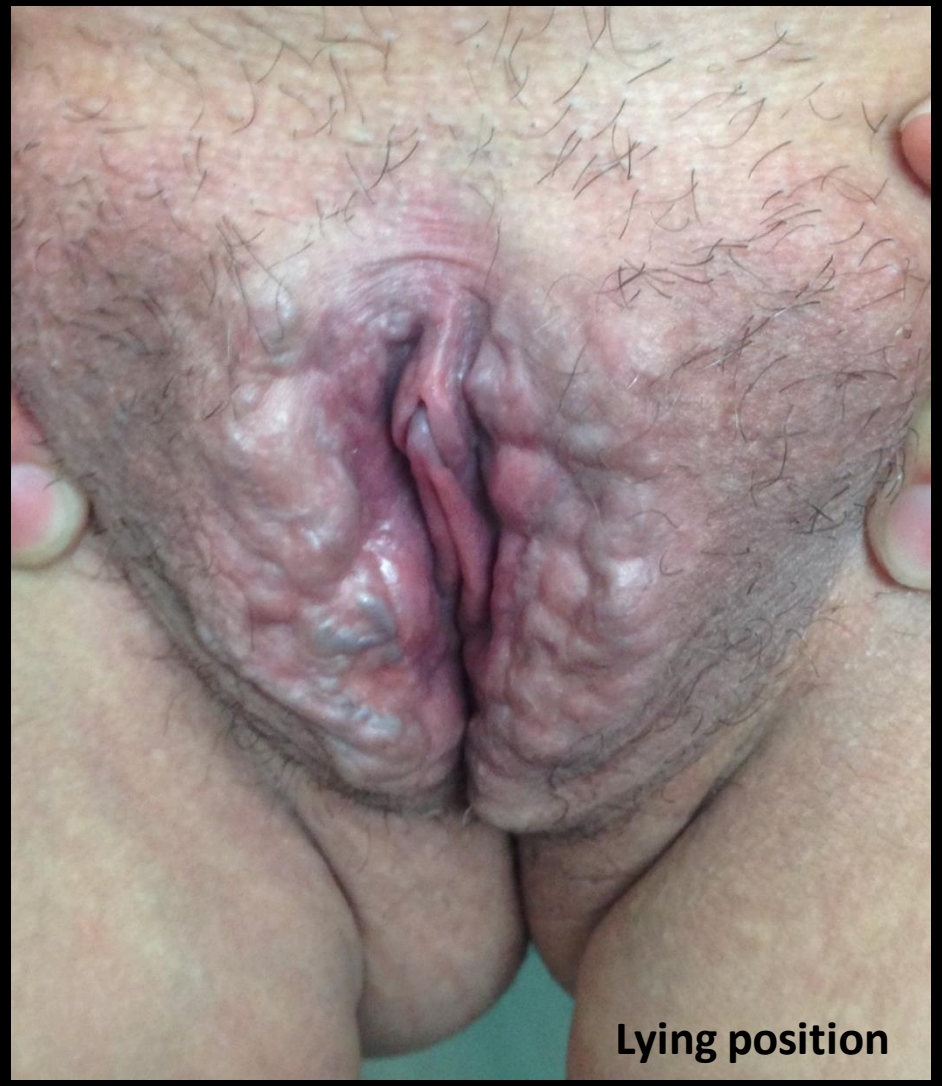


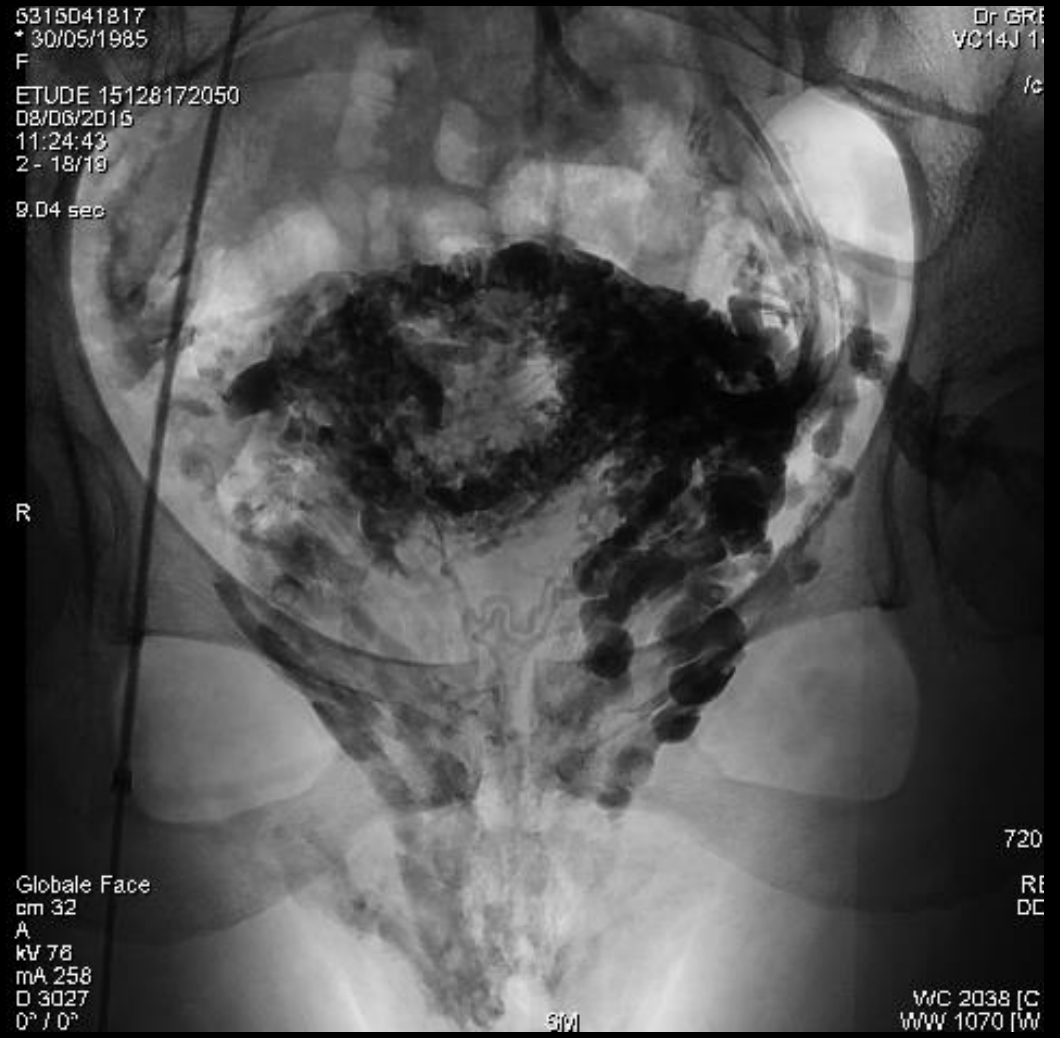




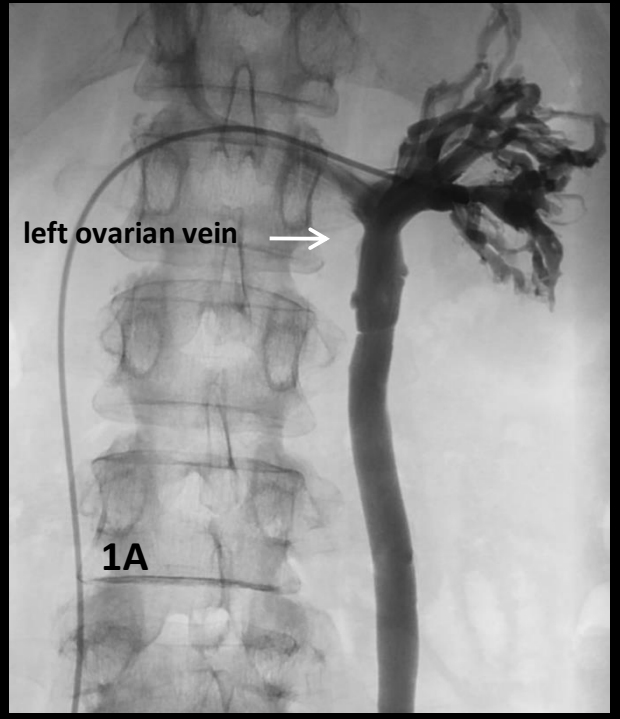
Treatment by glue

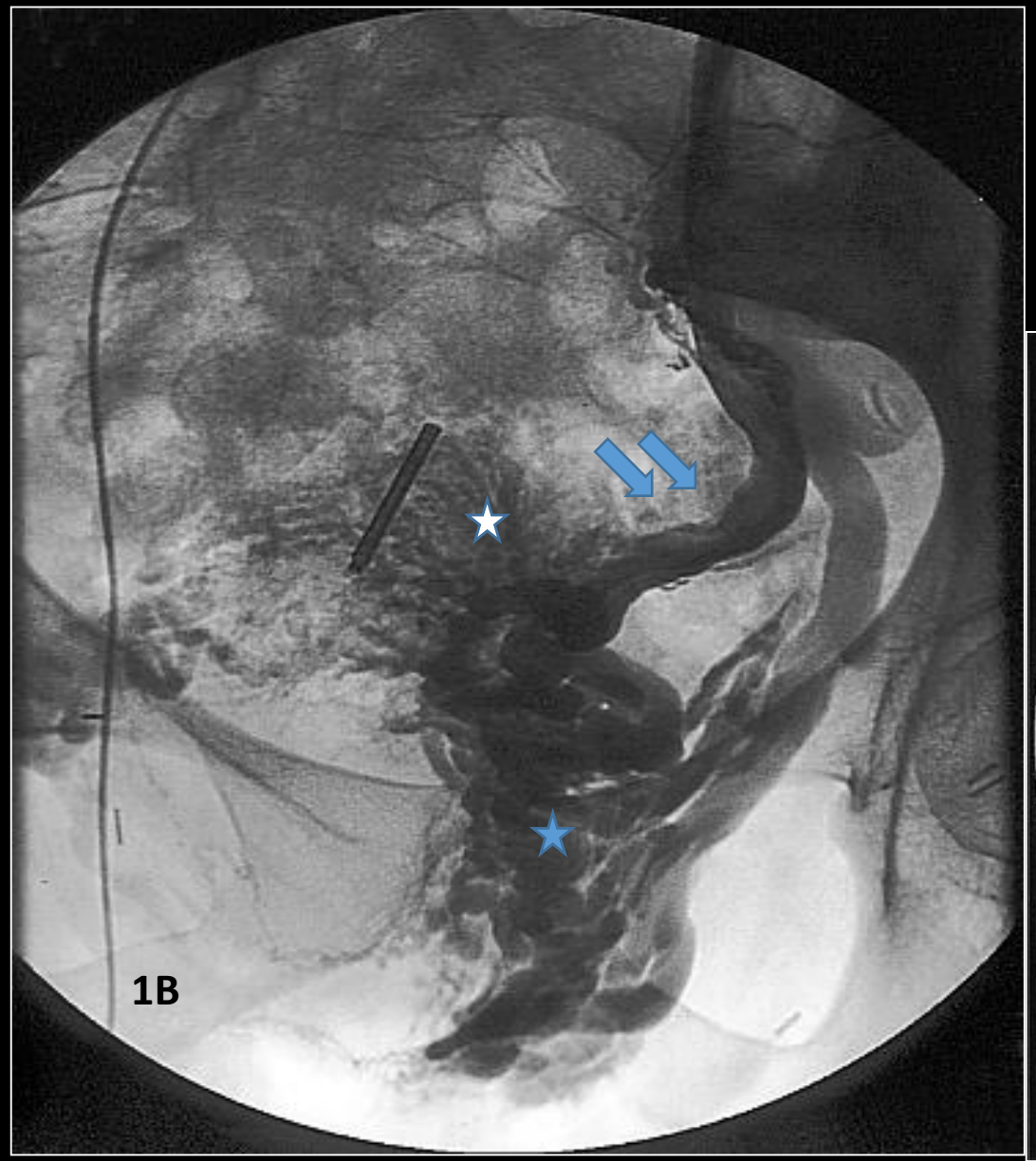
Third patient

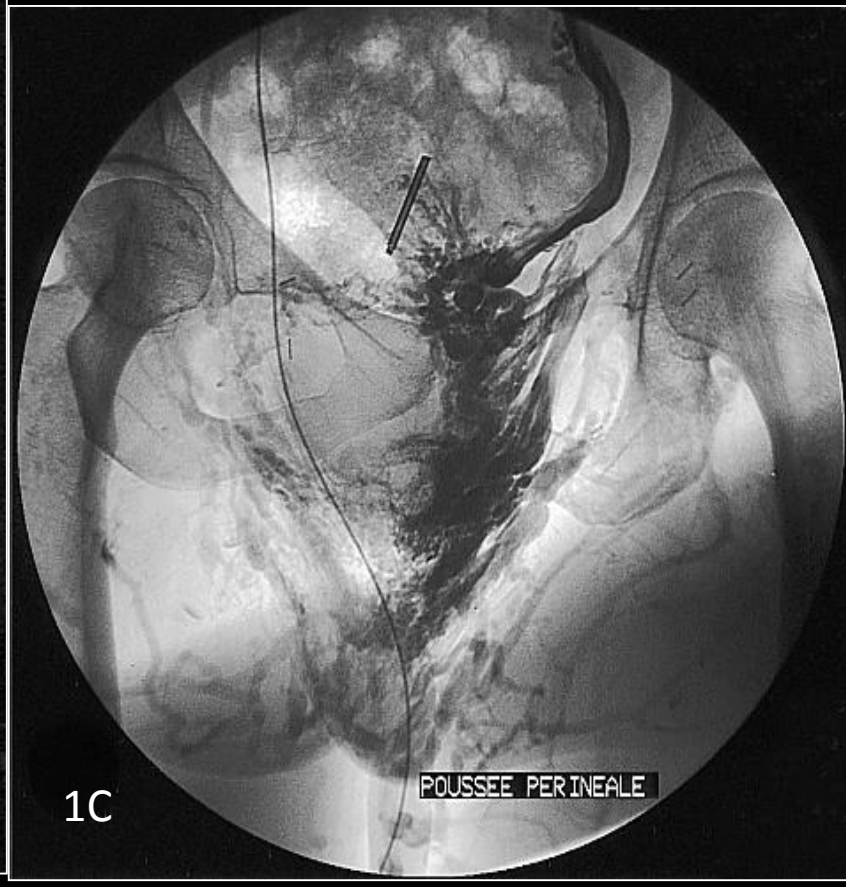




Phlebography: Multiple, large and bilateral medial pudendal leaks







Patient hospitalized in emergency after the second sclerotherapy session *(for pelvic pain and high temperature)*

Phlebography six months after hospitalization

1A: left reno-ovarian reflux

1B: pelvic level: no varicocele (blue arrows); repermeabilized of thrombosed myometrial veins (★); perineal varices (★)

1C: Valsalva maneuver; buttock varices

Conclusion 1: constatations in clinical practice

- ***The Persistence of protruding vulvar varices in lying position is a sign of pelvic venous hyper pressure***
- ***The larger the leak points calibre, the lesser the pelvic congestion syndrome; the absence of PCS is not unusual when vulvar varices and pelvic leaks towards lower limbs are voluminous***
- ***The larger the pelvic leak points calibre, the more essential the treatment of pelvic varicose veins and pelvic refluxes***

Conclusion 2: in our practice, the decision-making process is based on the medical history and the clinical signs

Conclusion 2: decisional algorithm in our clinical practice

Small vulvar varices without PCS

⇓⇓

sclerotherapy (± pelvic US)

Vulvar varices with PCS

Large vulvar varices with or without PCS

⇓⇓

Doppler Us of LRV, ovarian veins, iliac veins and IVC, search of leak points

(± cross-sectional imaging (if suspicion of compression of the left renal vein, iliac veins))

↙ ↘

absence of pelvic varices and leak points

⇓⇓

sclerotherapy

Pelvic varices and/or leak point(s) > 3mm

Number of leak points > 3

⇓⇓

Phlebography + treatment (pelvic varices, reflux, leak points)

sclerotherapy of residual genital varices ***if necessary***

leak point ligation : ***exceptional //***