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

Milka GREINER MD
American Hospital of Paris
Pitié-Salpêtrière University Hospital – Paris

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

- Aggravated 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
Genital and perineal varicose veins (lying position)

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

Lying position

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

Lying position

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 hyperpressure

• 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*