

CONTROVERSES ET ACTUALITÉS EN CHIRURGIE VASCULAIRE
CONTROVERSIES & UPDATES IN VASCULAR SURGERY

JANUARY 19-21 2017

MARRIOTT RIVE GAUCHE & CONFERENCE CENTER
PARIS, FRANCE



AASV

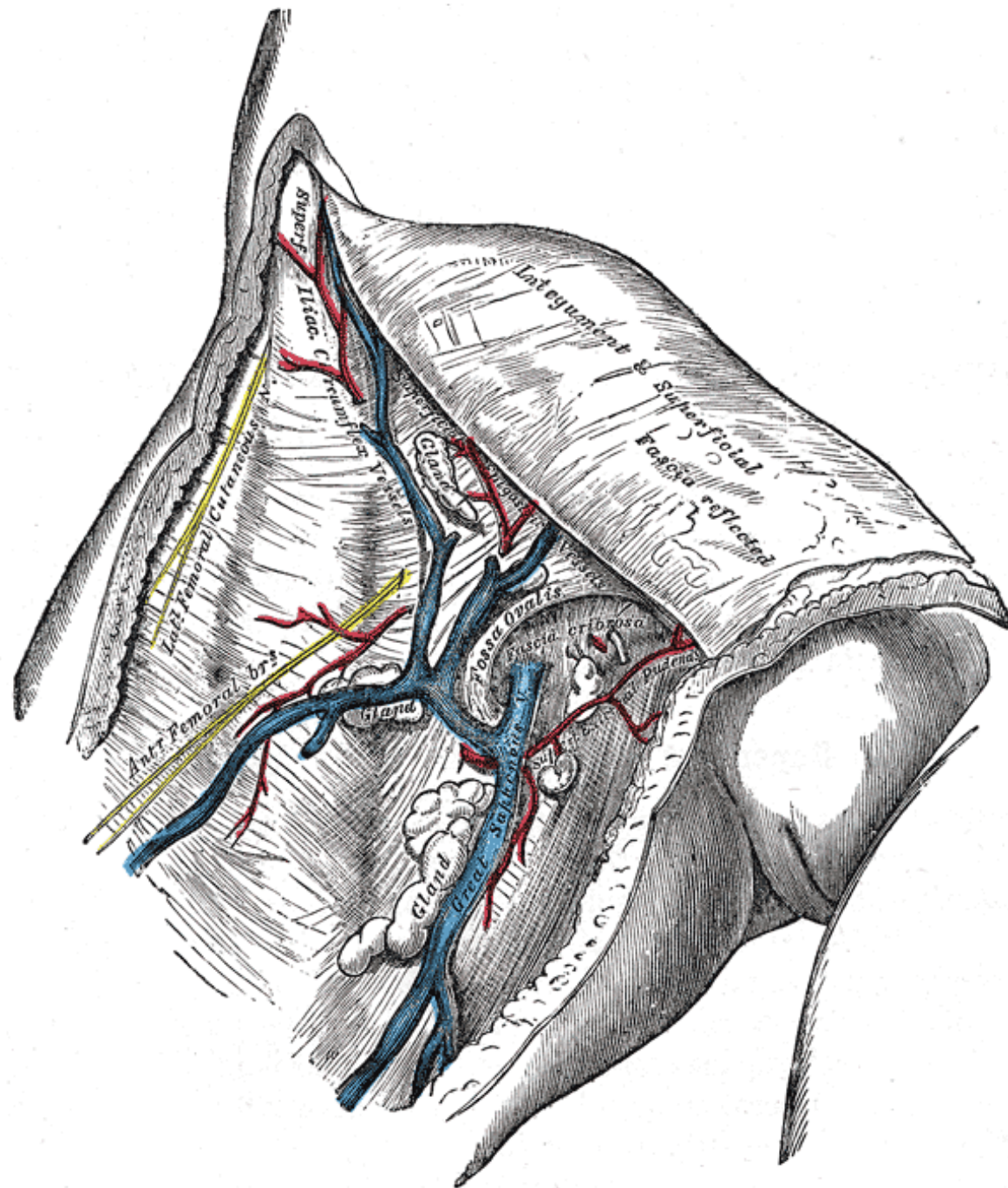
*After thermal ablation of the GSV,
do we have to treat systematically AASV in
the same time
(different anatomic variations of SFJ)?*

Olivier Pichot, Grenoble

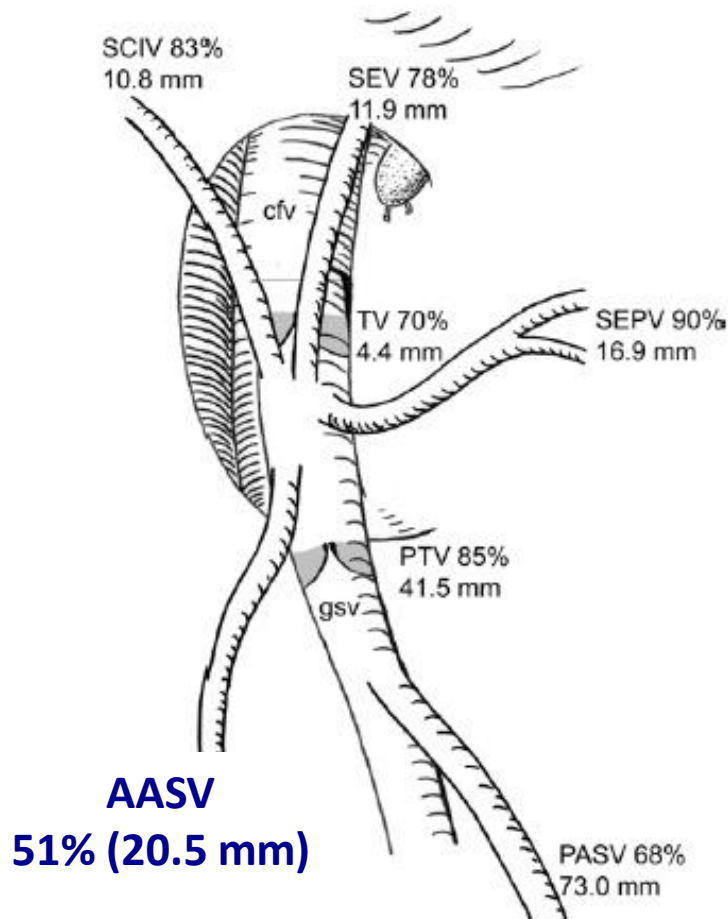
Disclosure

I do not have any potential conflict of interest for this presentation

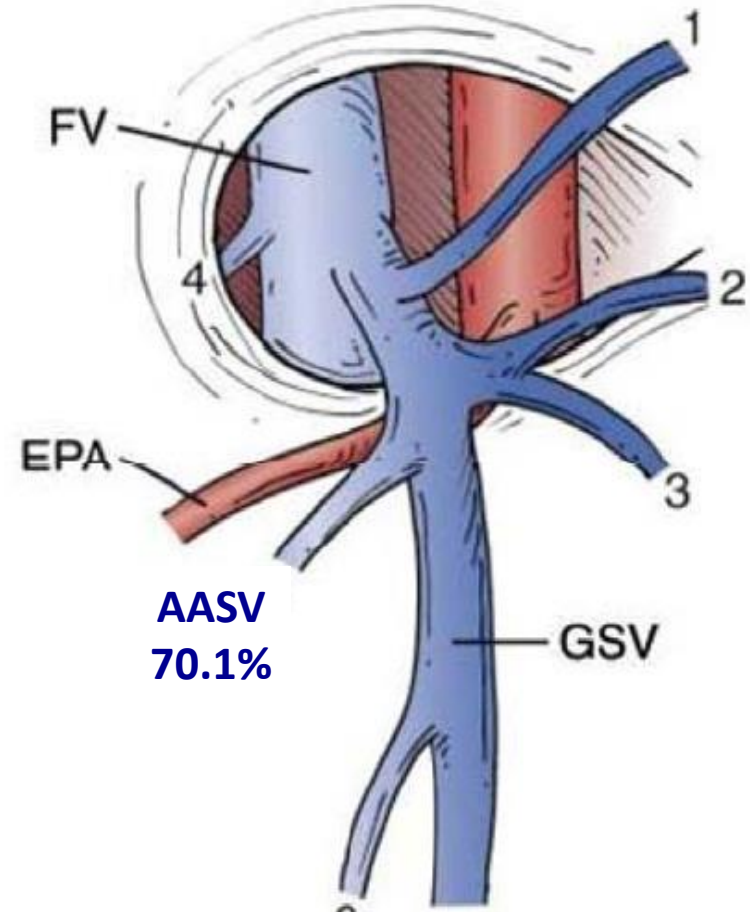
Anatomy



Anatomy

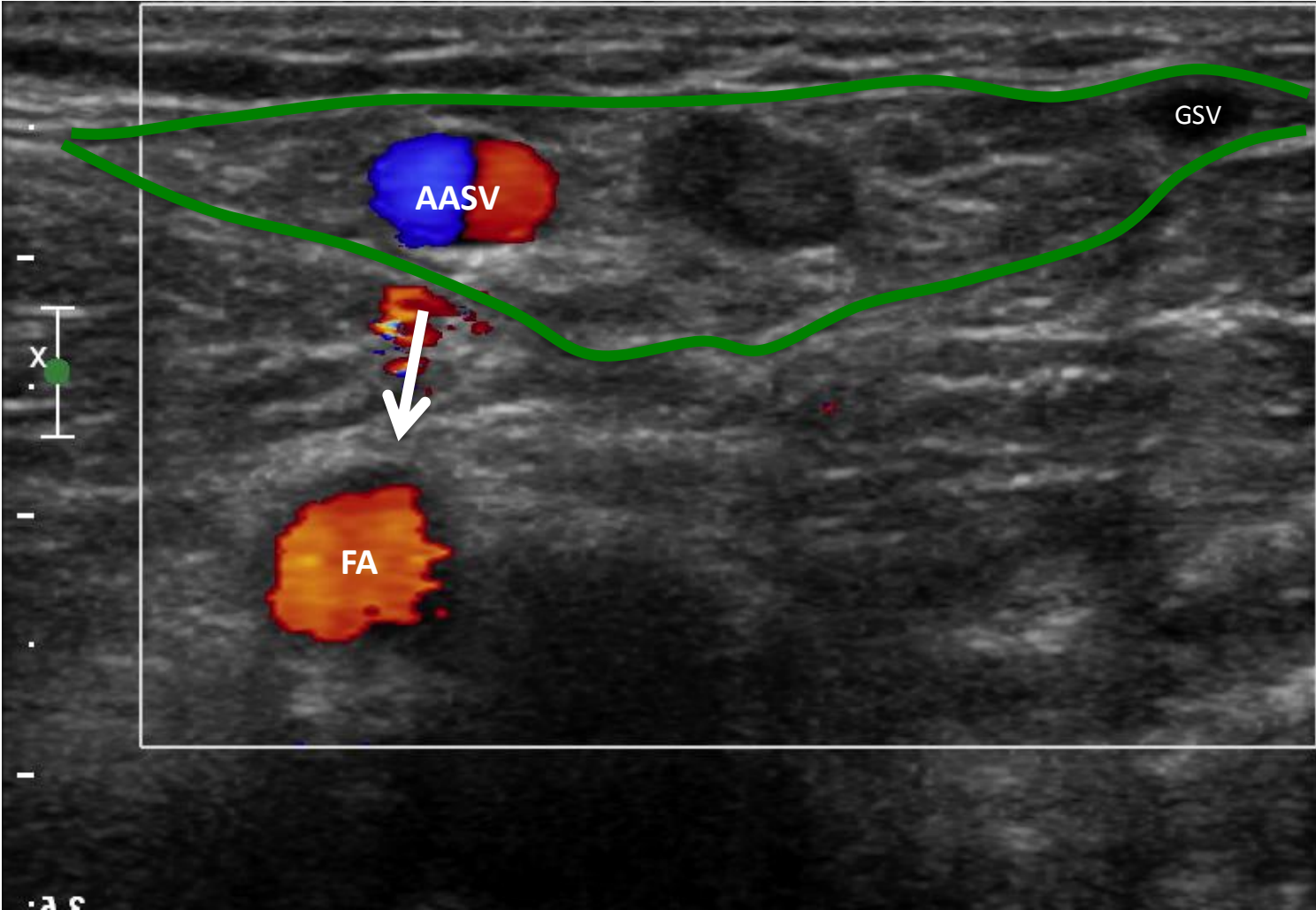


Mühlberger 2009

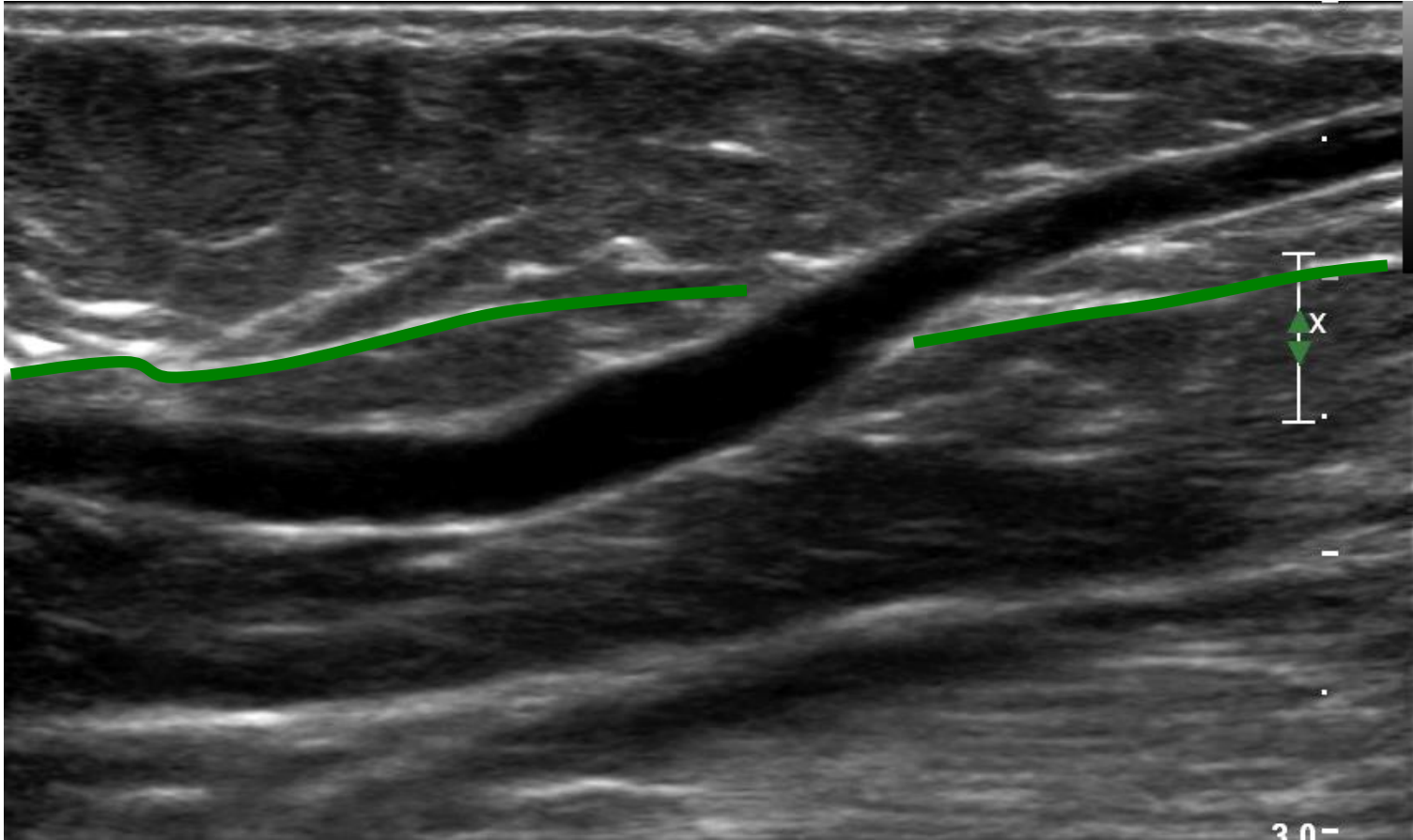


Hemmati 2012

Duplex anatomy



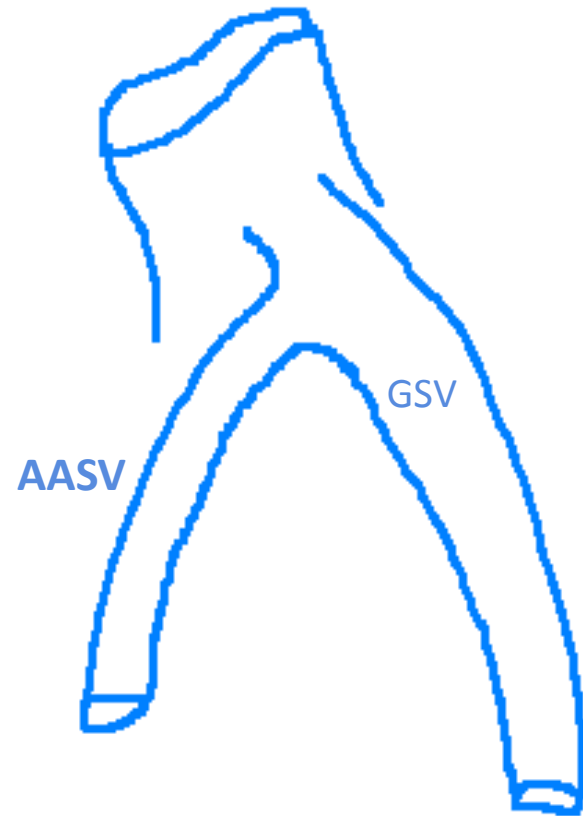
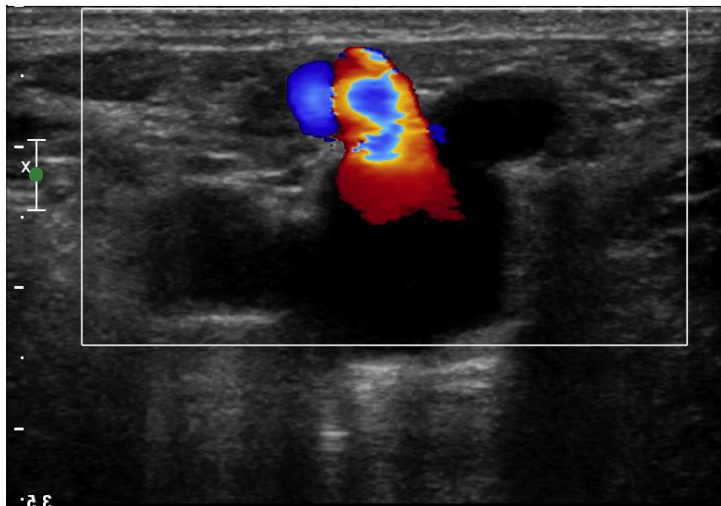
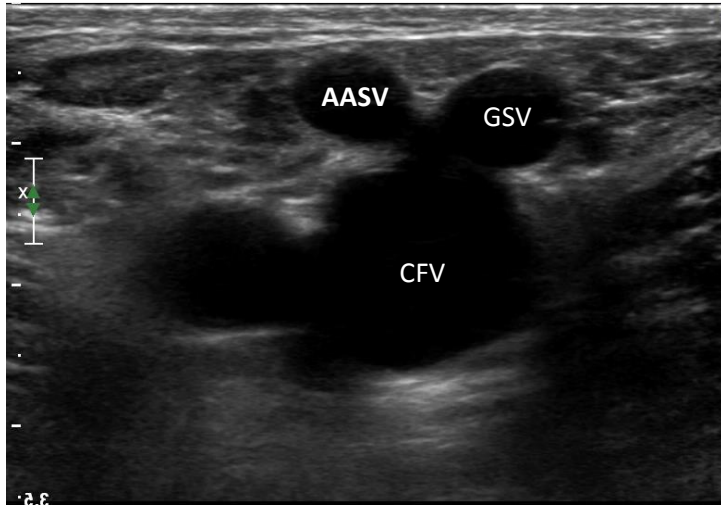
AASV trunk

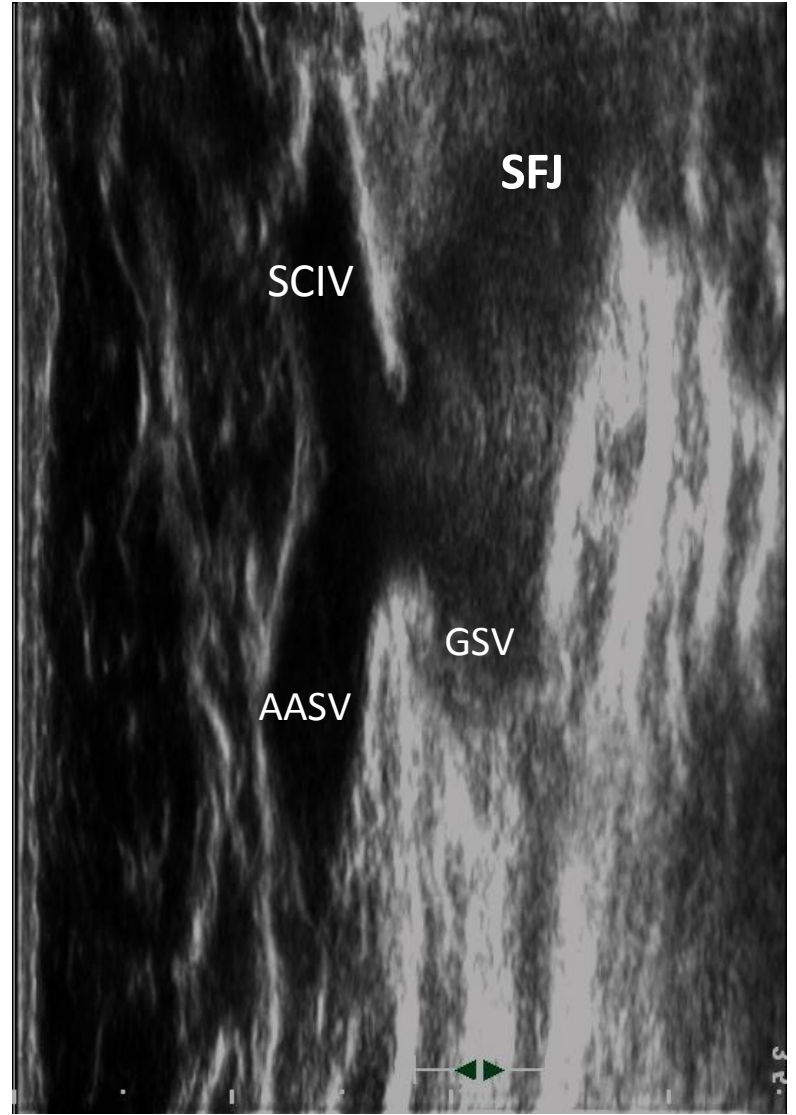
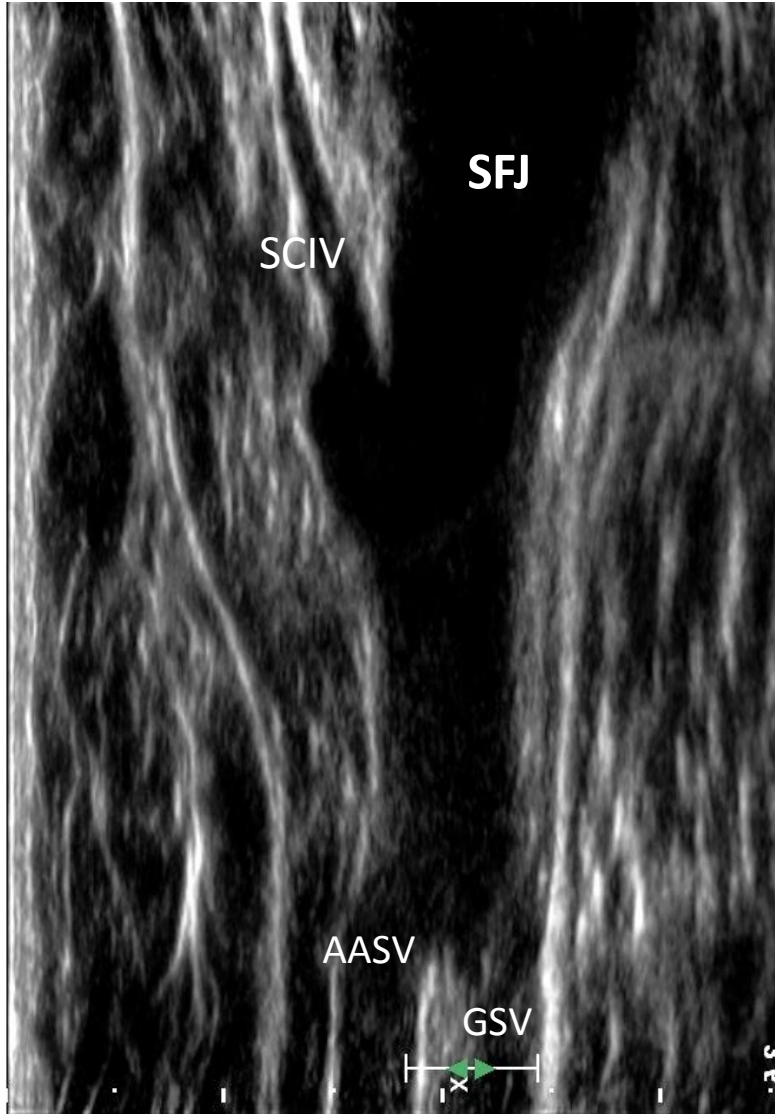


AASV trunk

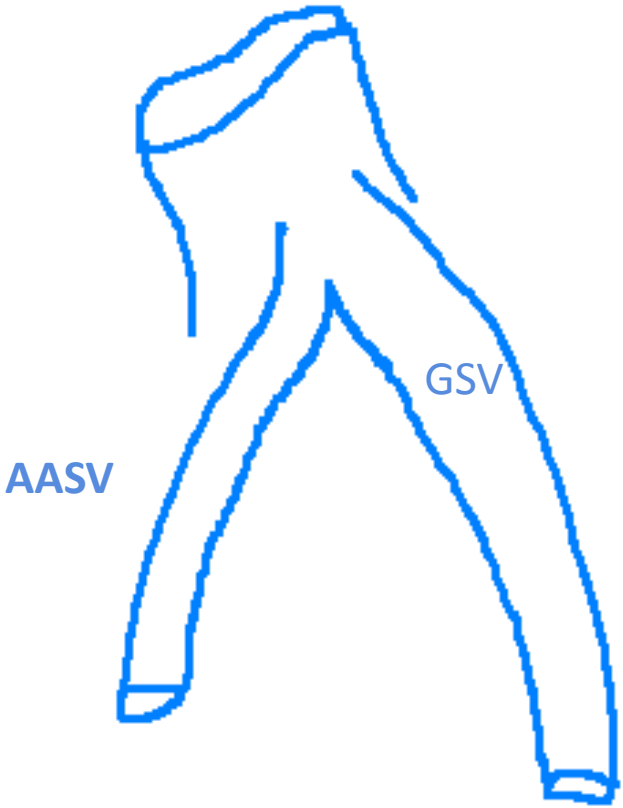
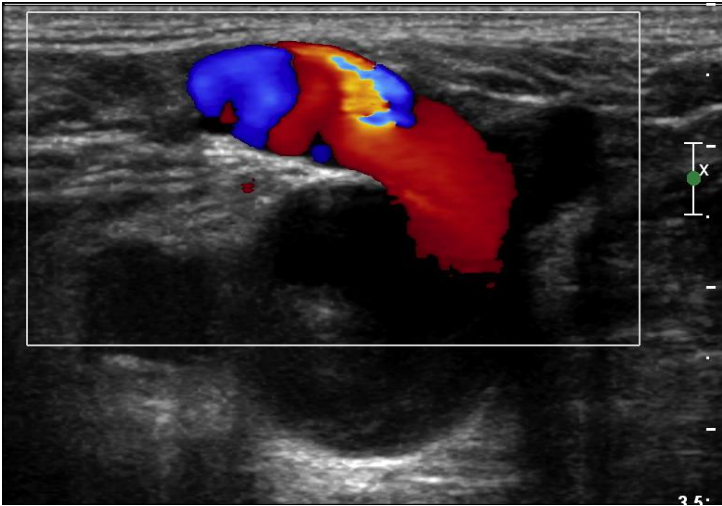
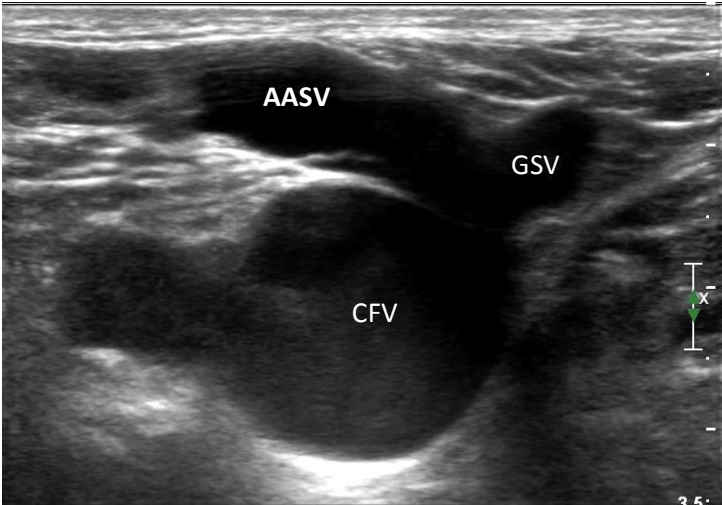


AASV termination: into the GSV

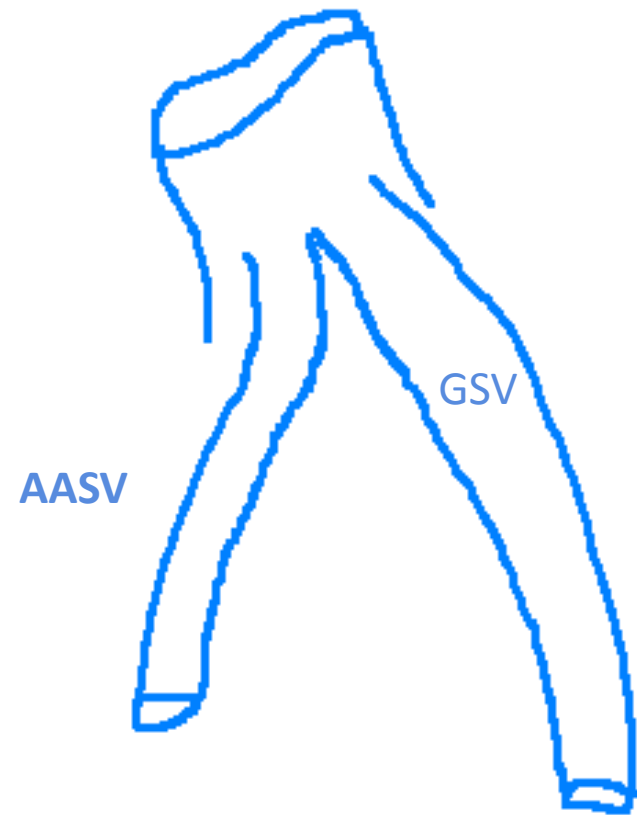
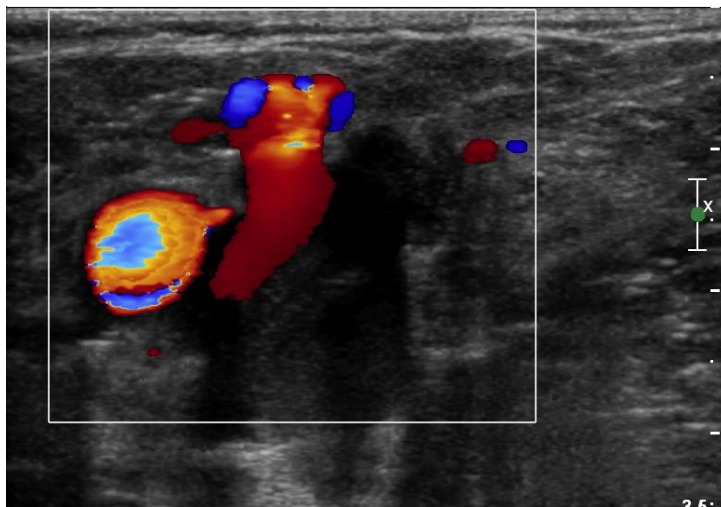
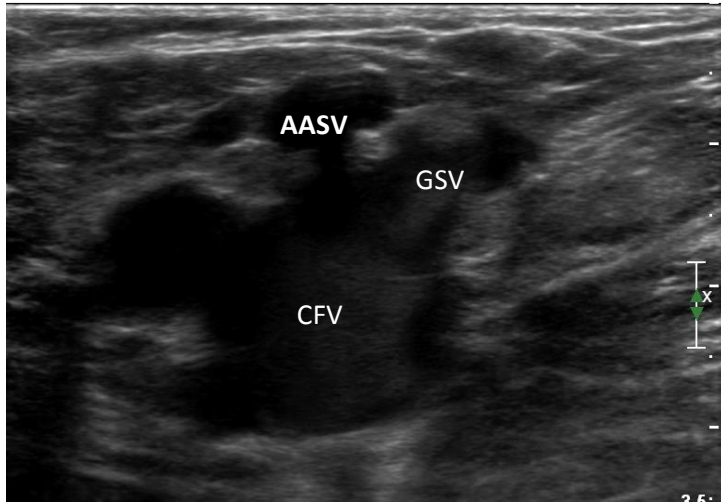




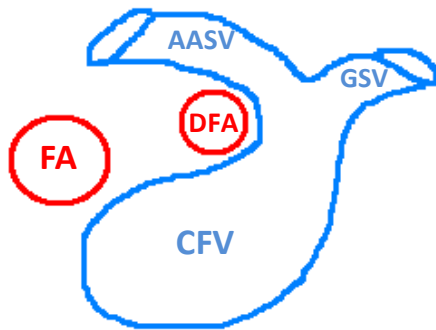
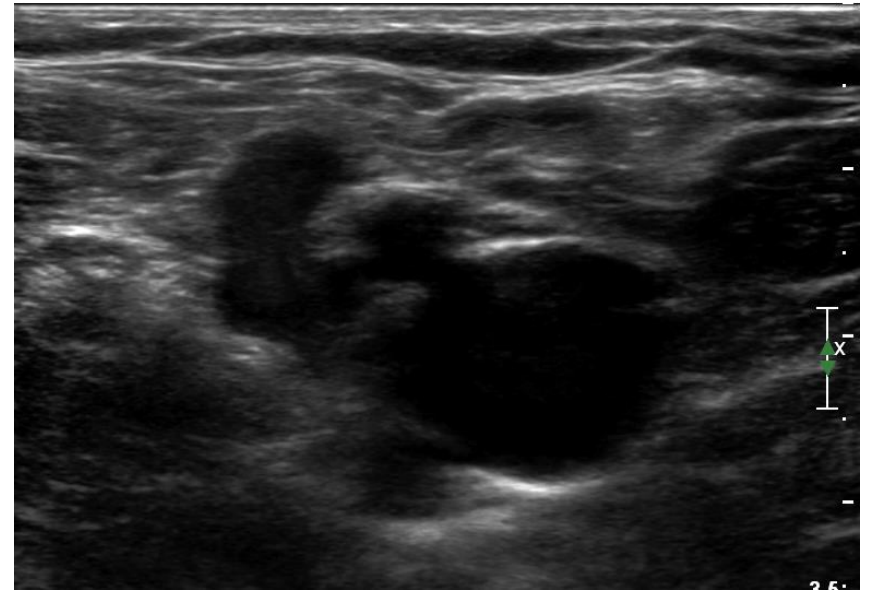
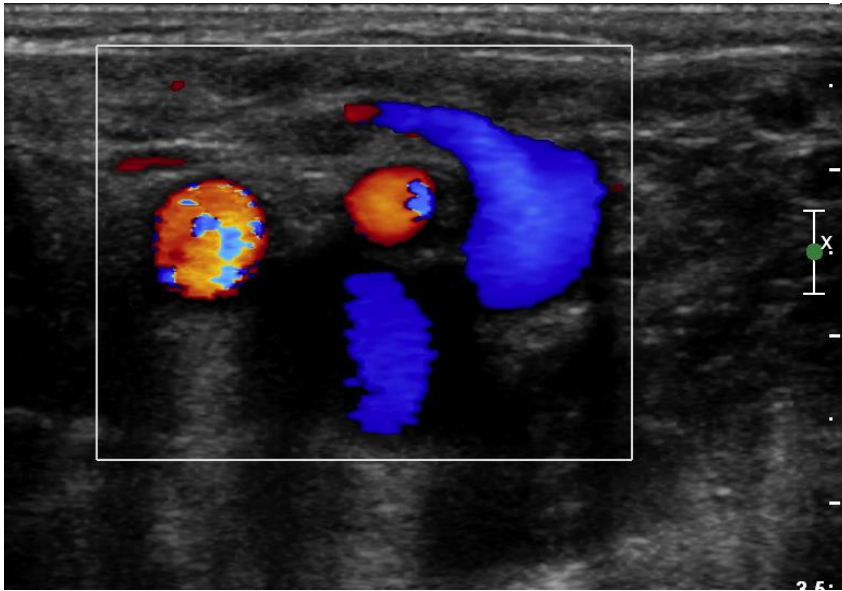
Common termination with GSV



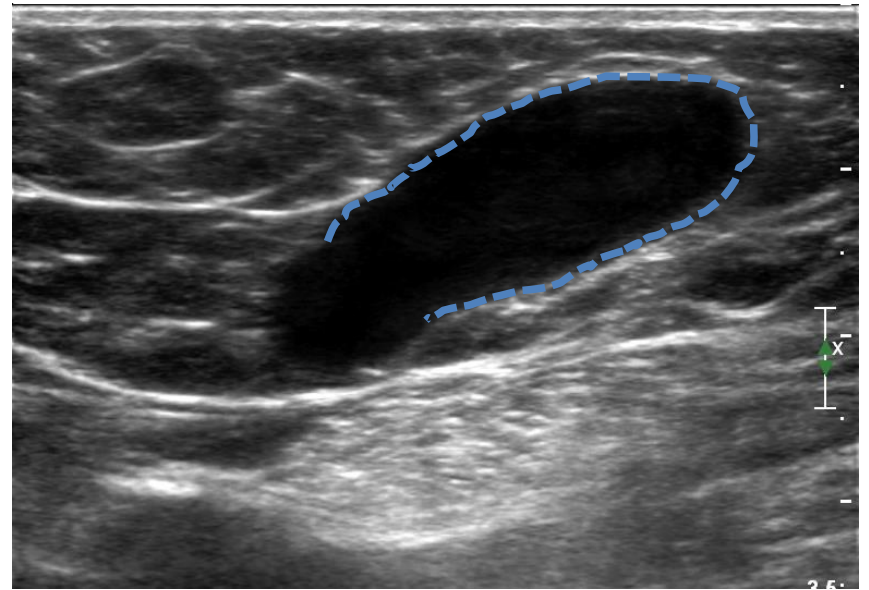
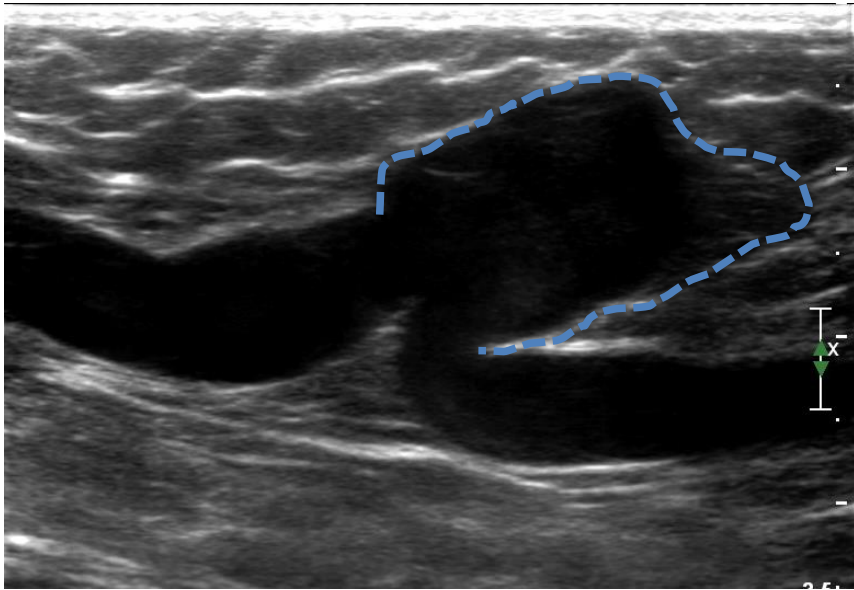
AASV termination: into the CFV



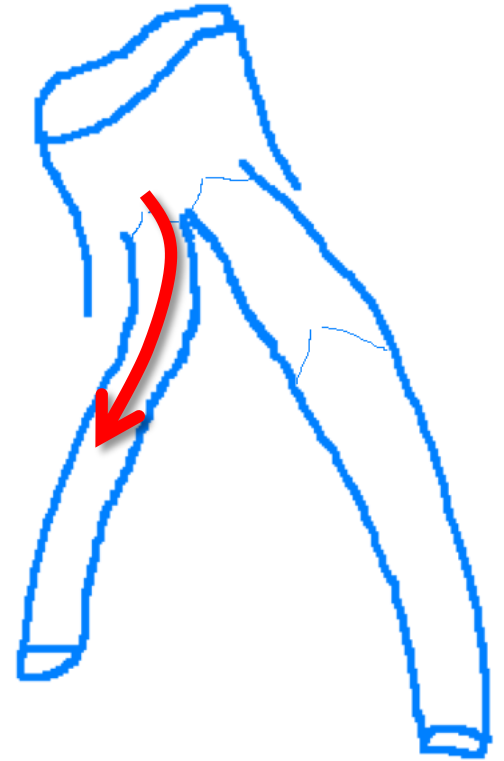
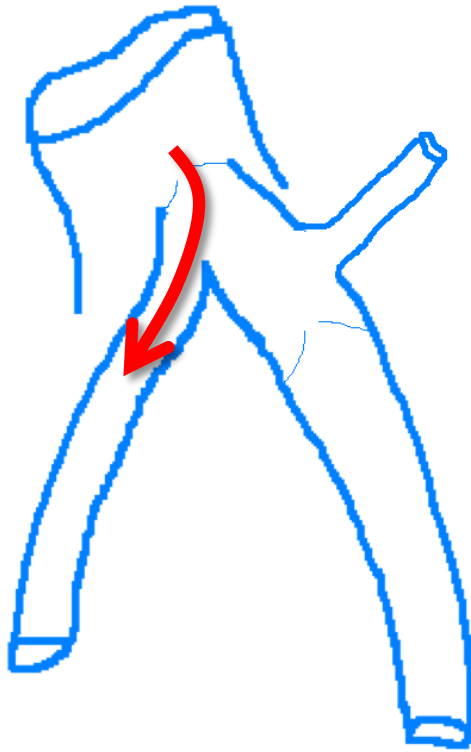
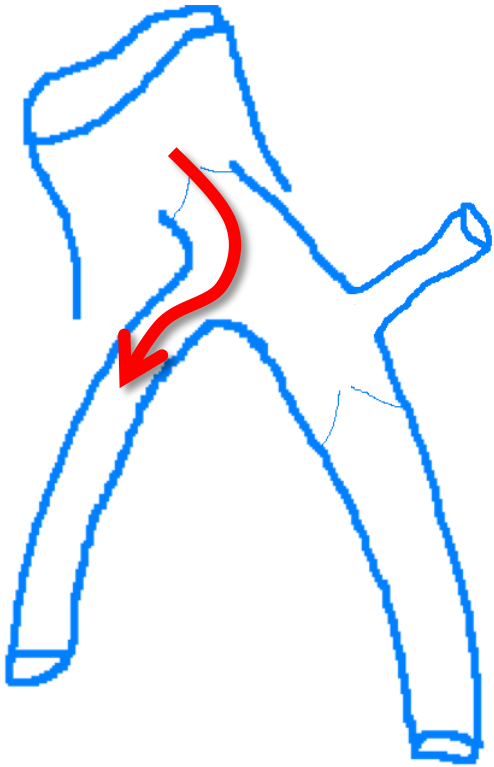
Anatomical variations: AASV termination



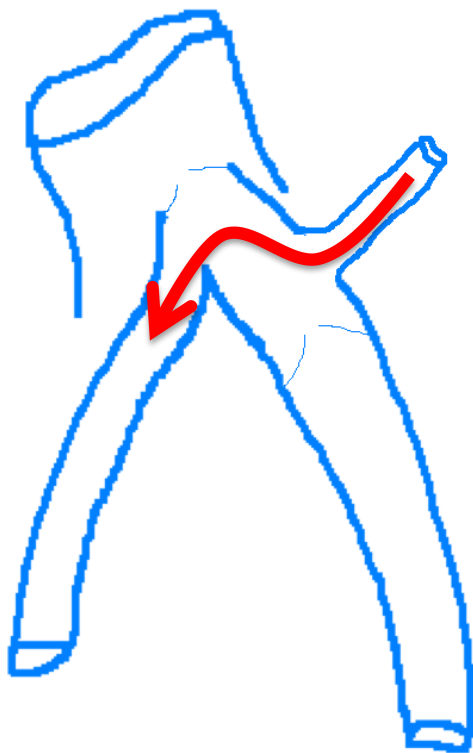
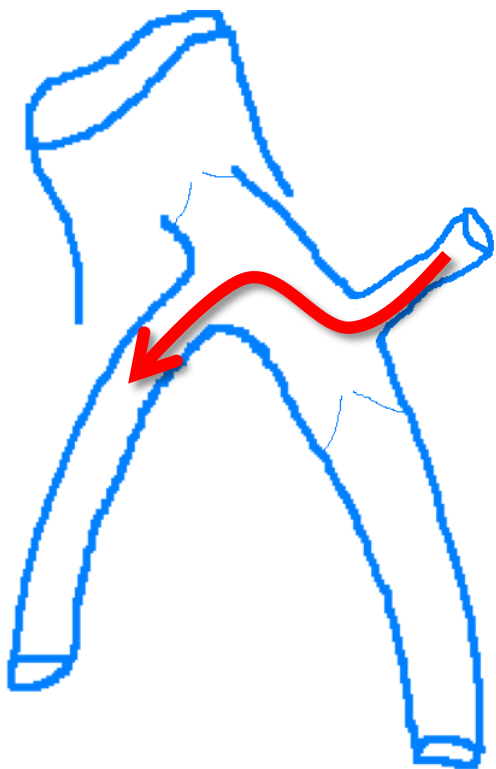
Anatomical variations: AASV trunk



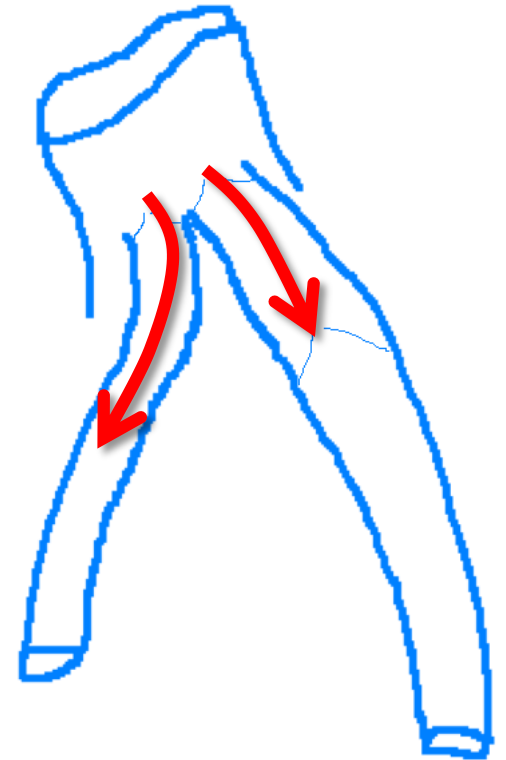
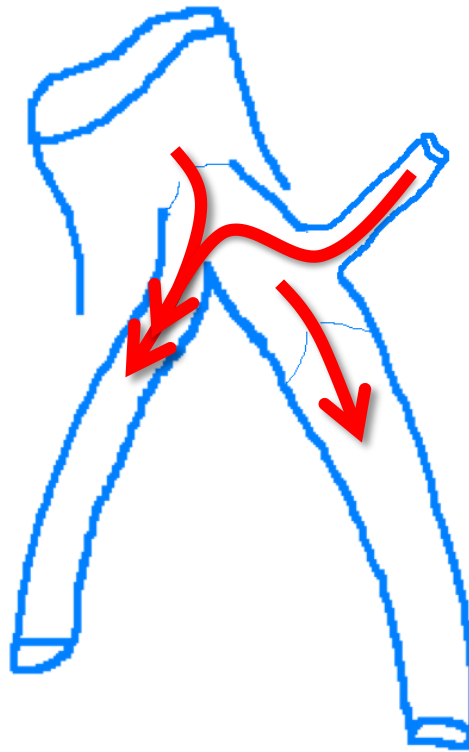
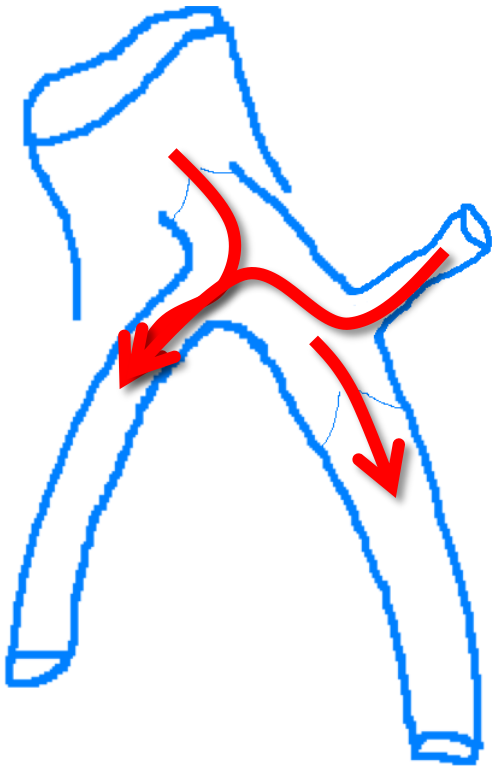
Hemodynamic



Hemodynamic



Hemodynamic



Incidence of AASV reflux

	Limbs (n)	Isolated AASV reflux (%)	Combined AASV & GSV reflux (%)
Labropoulos EJVES 1999	612	4.9	-
Garcia Gimeno JVS 2009	2036	10.9	-
Laredo Endovascular today 2010	313	10	1.6

American College of Phlebology Guidelines – Treatment of refluxing accessory saphenous veins

Kathleen Gibson¹, Neil Khilnani², Marlin Schul³ and
Mark Meissner⁴; on behalf of the American College
of Phlebology Guidelines Committee

Phlebology

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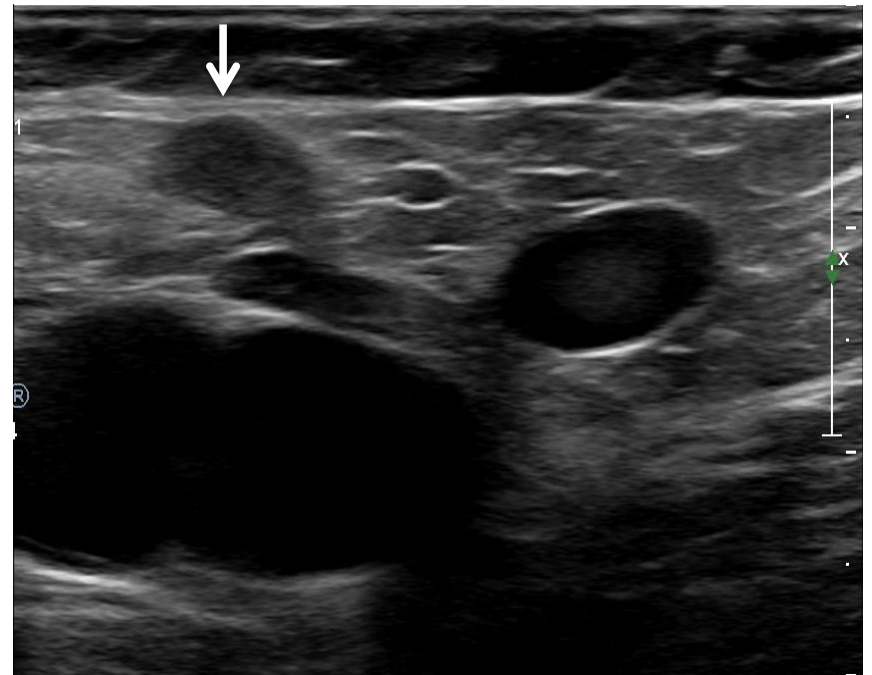
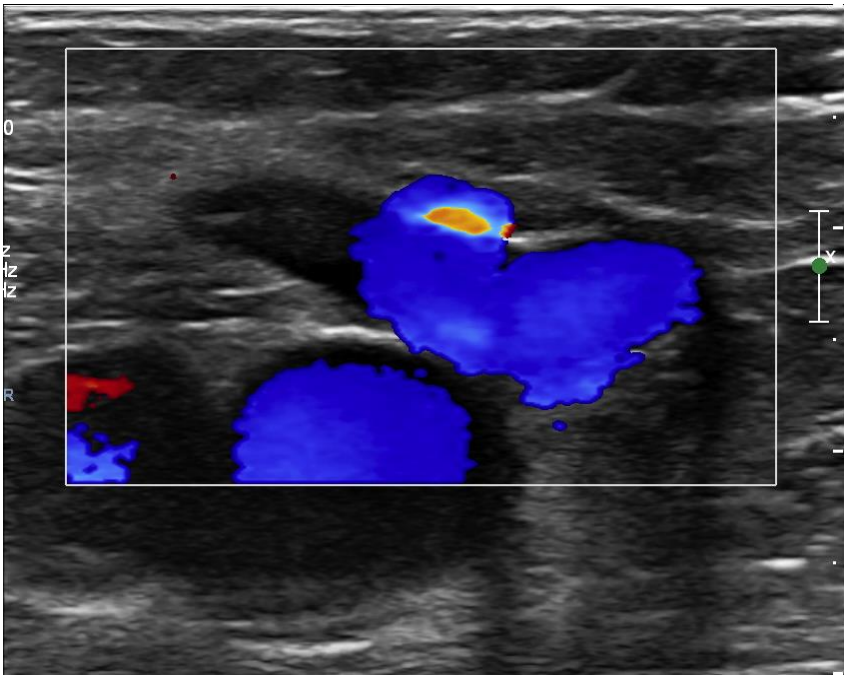
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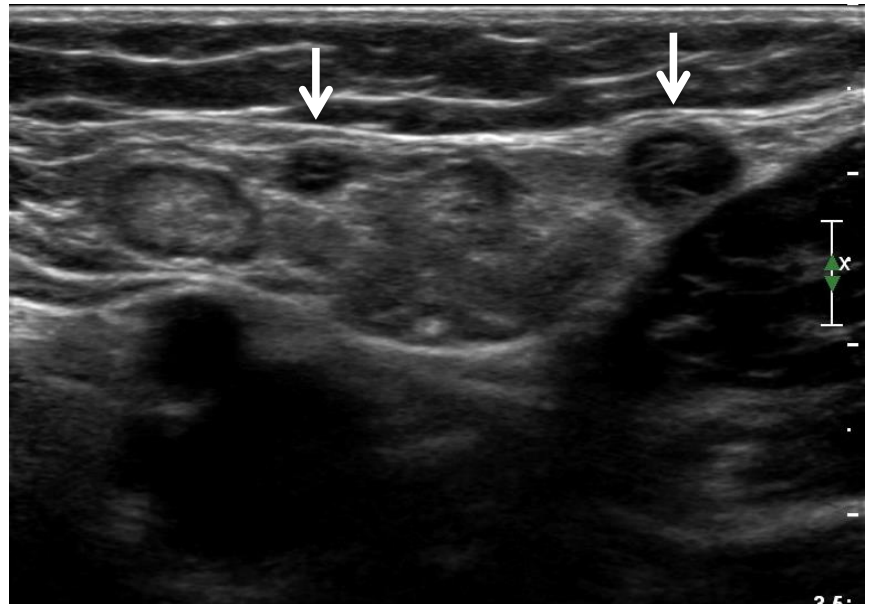
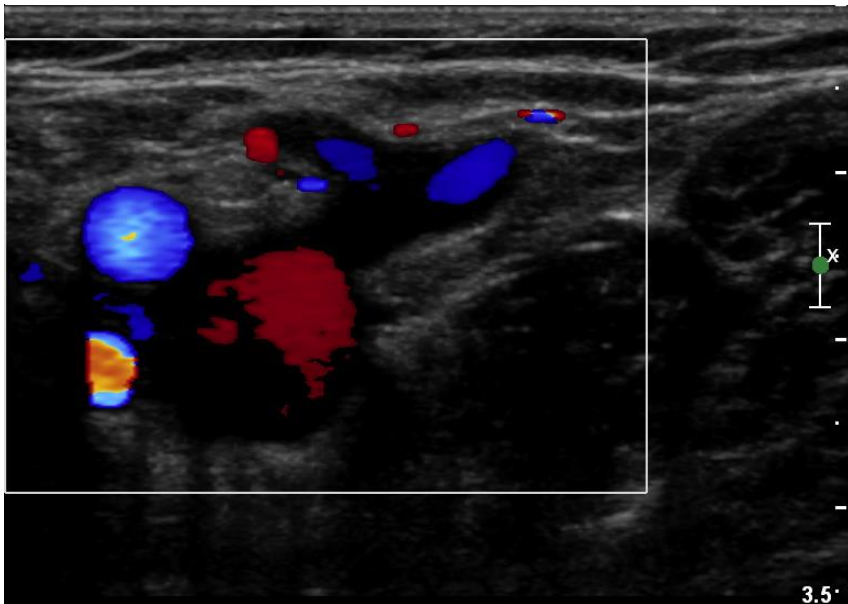
Recommendation

We recommend that patients with symptomatic incompetence of the accessory GSVs (AAGSV and PAGSV) be treated with endovenous thermal ablation (laser or radiofrequency) or UGFS to reduce symptomatology (strength of recommendation Grade 1, Level of evidence C).

Single TA of the AASV



TA of both GSV and AASV



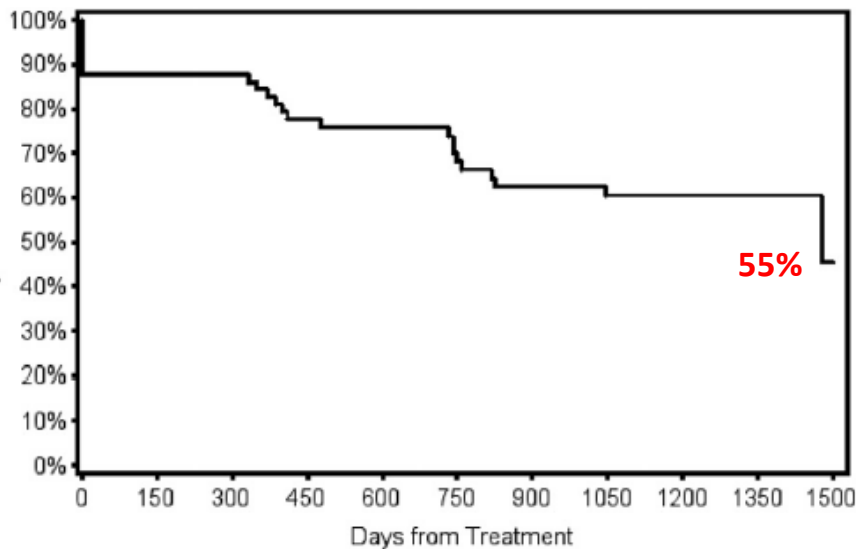
REVATA Study

- **Prevail in 164/2380 patients after EVL or RF**
 - 159 GSV TA: 97% (+ adjunctive SSV TA in 43 patients)
 - 2 isolated SSV and 3 AASV ablations
- **Mean time of VV recurrence: 3 years**
- **Origin of recurrence:**
 - Total or partial GSV recanalization: 29%
 - New VV in unablated GVS territory: 14%
 - AASV reflux: 24%
 - New SSV reflux: 16%
 - Perforator pathology: 64%

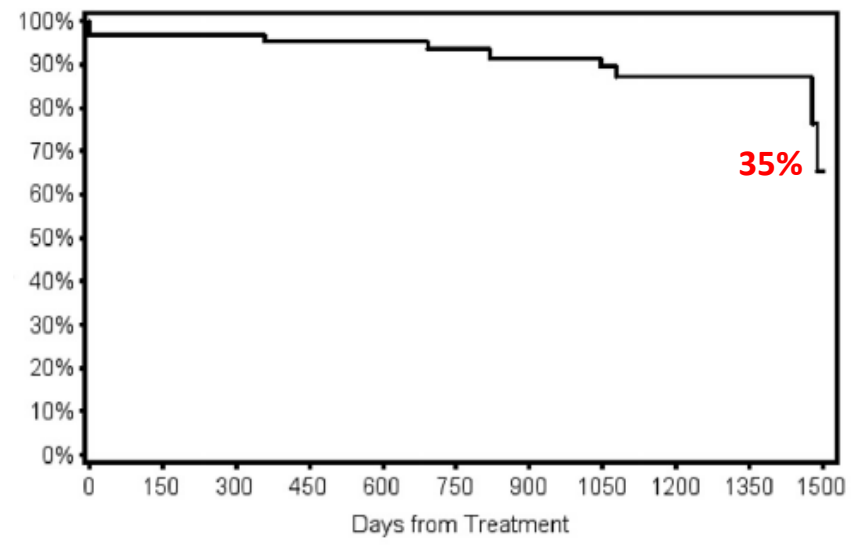
AASV evolution after GSV TA

- 93 limbs in 76 patients
- AASV detectable in 46% refluxing in 2%

(No) AASV reflux probability



(No) AASV axial reflux probability

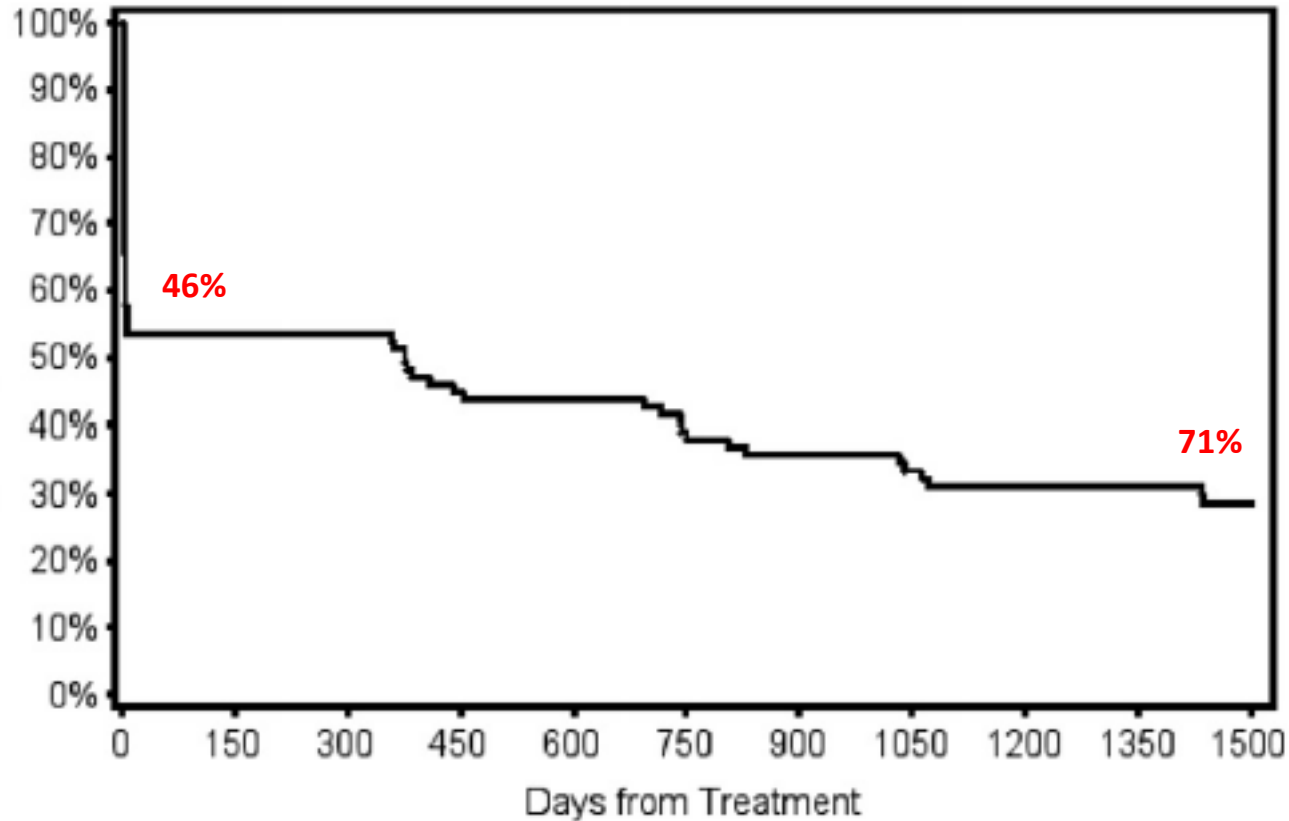


Days	0	150	300	450	600	750	900	1050	1200	1350	1500
At Risk	65	54	54	43	41	36	33	30	25	24	1

Days	0	150	300	450	600	750	900	1050	1200	1350	1500
At Risk	65	60	60	54	52	48	47	44	35	33	3

AASV evolution after GSV TA

Probability of (no) present AASV



Days	0	150	300	450	600	750	900	1050	1200	1350	1500
At Risk	93	49	49	41	40	34	31	29	25	25	4



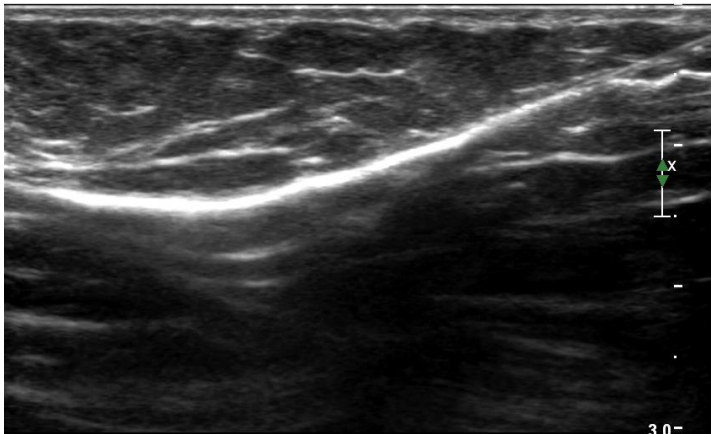
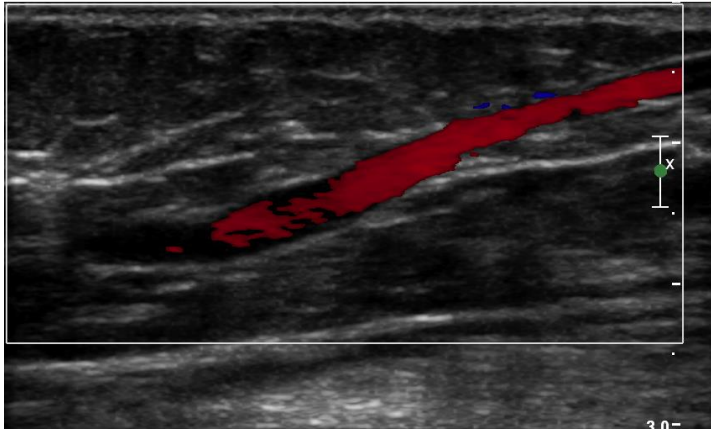
- Is there a place for treating non-refluxing accessory vein in a prophylactic fashion at the time of GSV ablation?

PREVAIT after TA

- 8 comparisons TA vs L&S in 7 RCTs \geq 2Y FU
 - RFA n=3
 - EVL n=5
- Overall recurrent VV
 - after L&S: 22%
 - after TA: 22%
- Different mechanisms
 - L&S:
 - Neovascularization: 18%
 - TA:
 - Recanalization: 32%
 - AASV reflux: 19%

PREVAIT after TA
resulting of AASV
reflux:
4,2%

Secondary UGFS

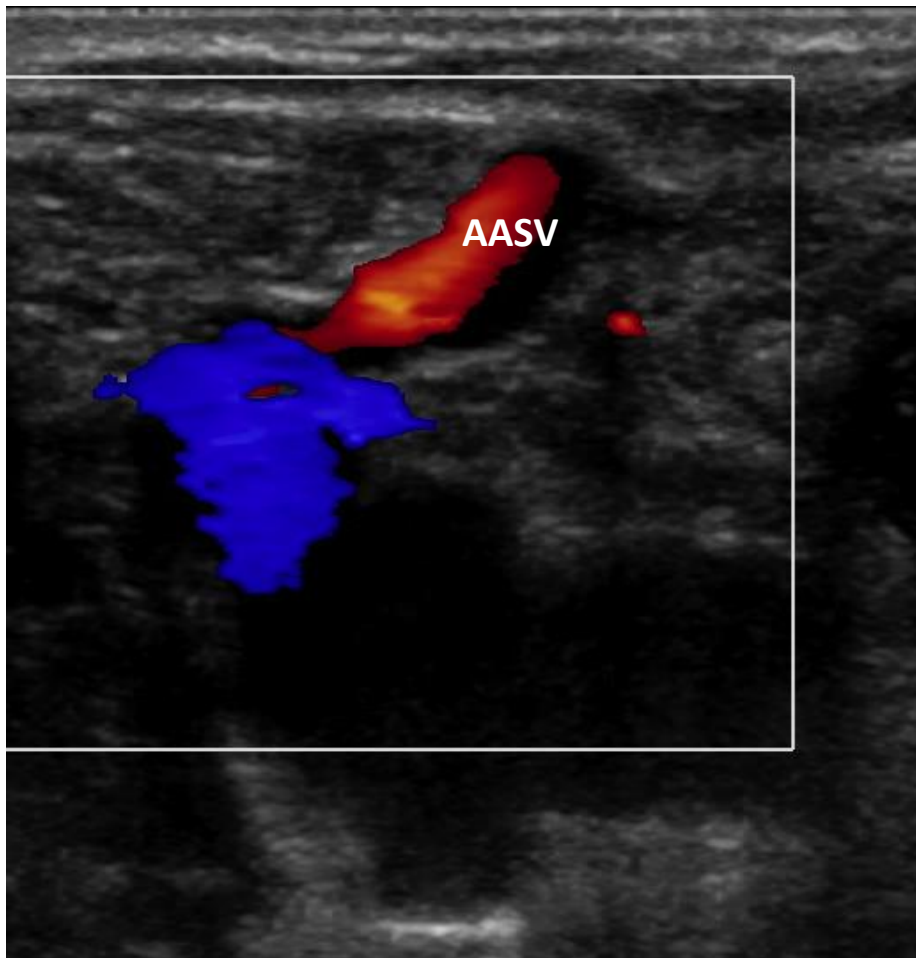


UGFS in primary AASV (n 93) and recurrent AASV (n 46)

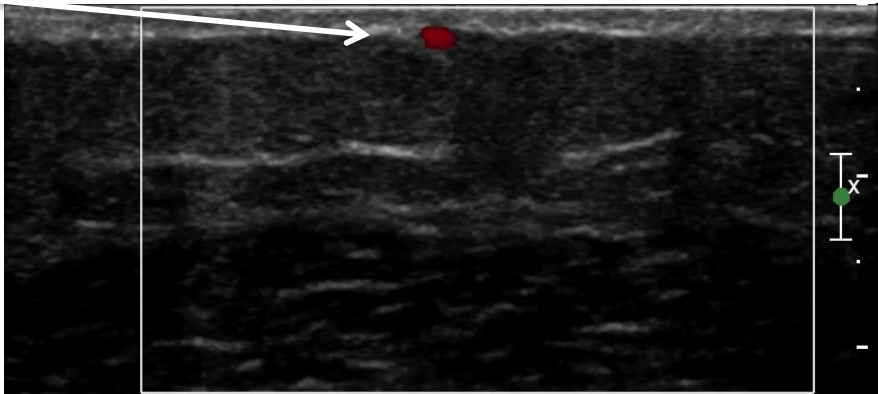
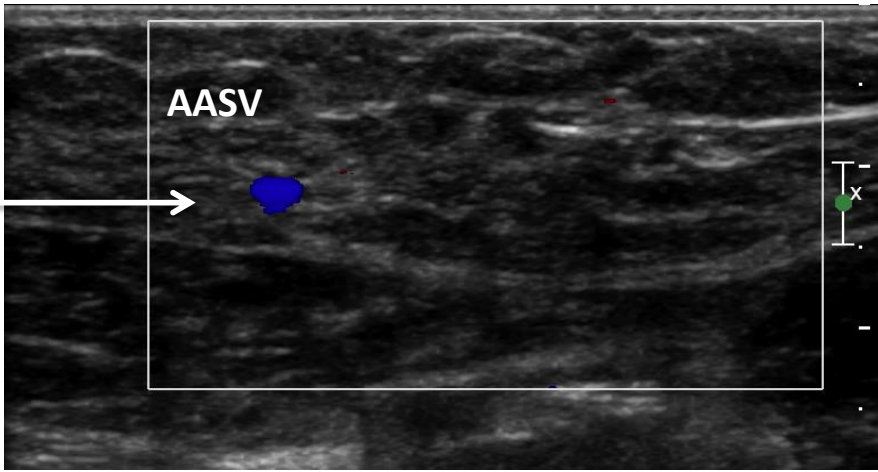
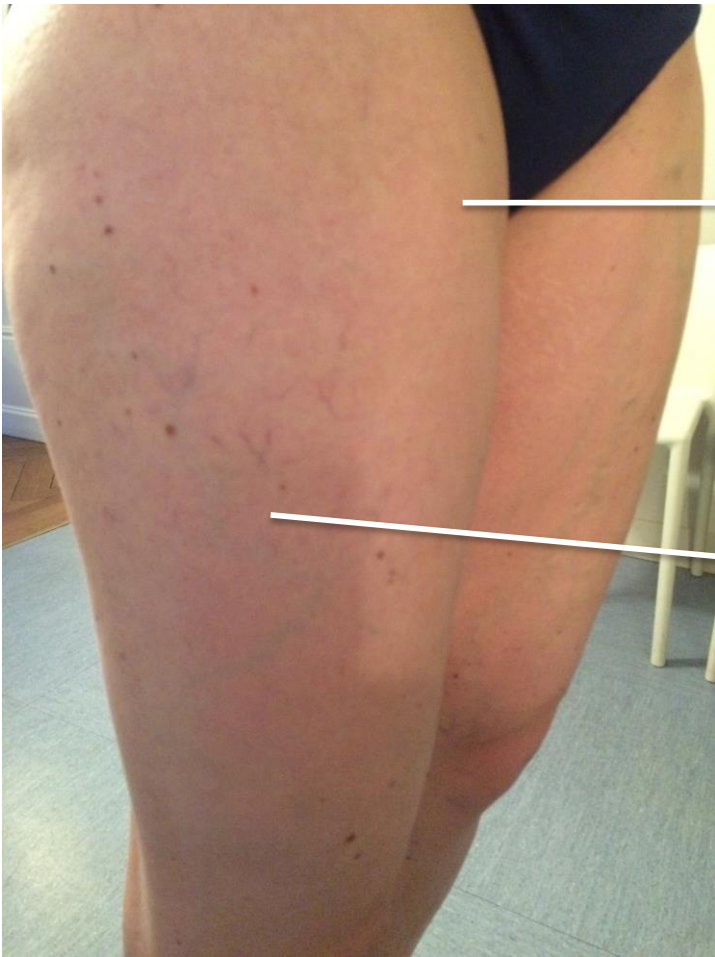
Table II. Second UGFS treatments for recurrent (recanalization) and new reflux

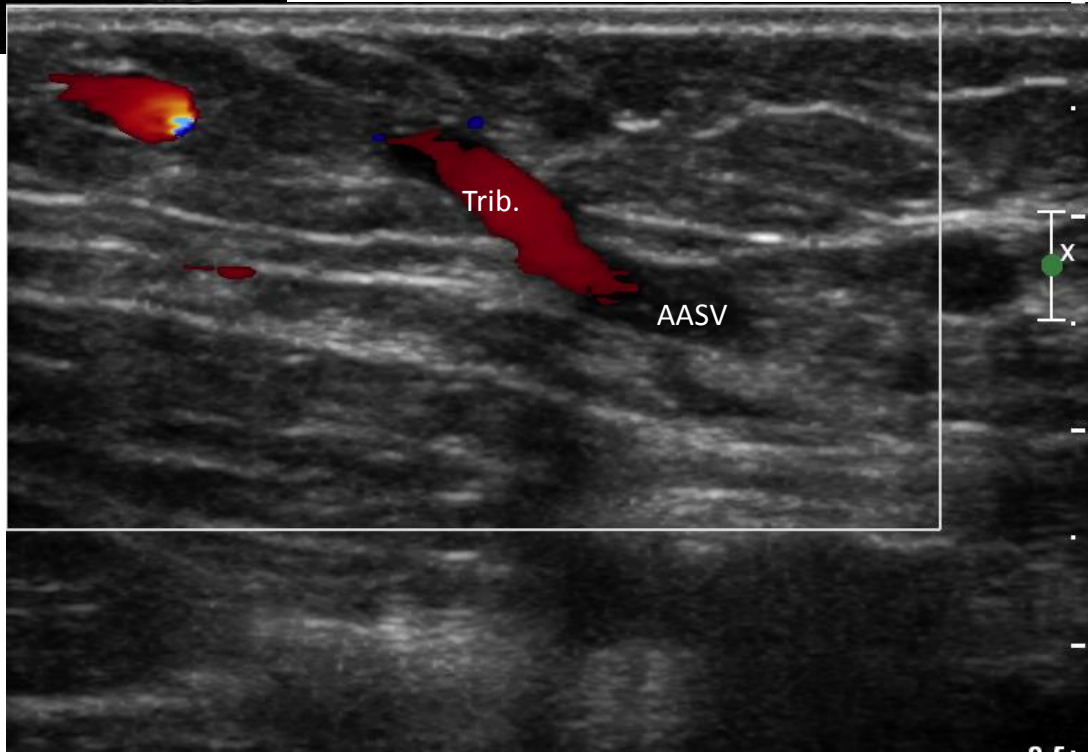
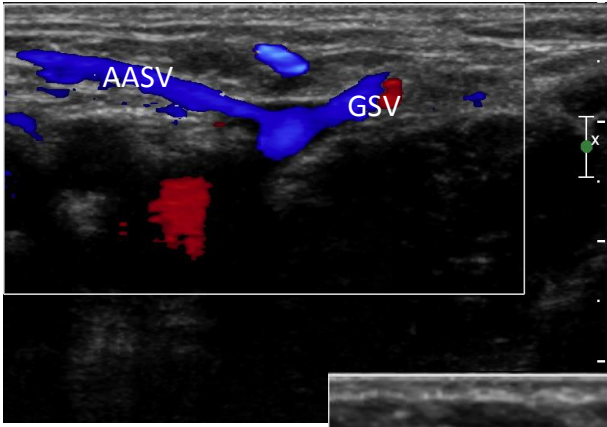
<i>First treatment</i>	<i>GSV reflux</i> N = 1031	<i>AASV reflux</i> N = 139	<i>SSV reflux</i> N = 239
Legs (%) requiring second UGFS	122 (11.8)	14 (10.1)	25 (10.5)
Mean (range) follow-up (months)	41 (6-68)	35 (8-64)	32 (9-66)
Recurrent reflux (n = 109)			
GSV ^a	87	—	—
AASV	—	5	—
SSV	—	—	17
Recanalization rate	8.4%	3.6%	7.1%

Descending or ascending progression?

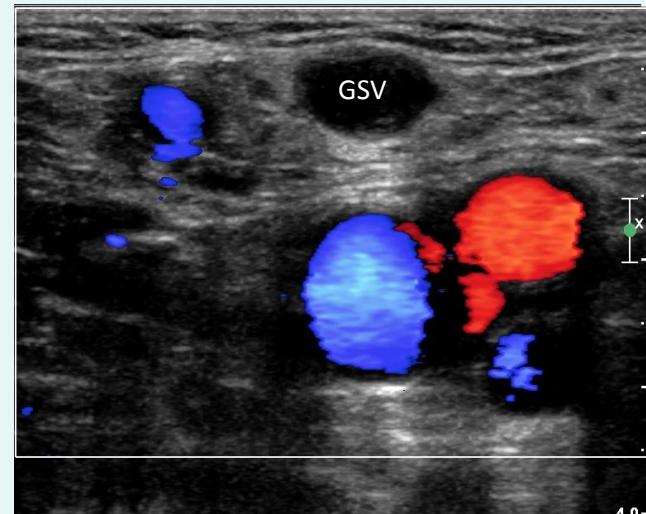


Descending or ascending progression?





Single TA of the GSV if the AASV is competent

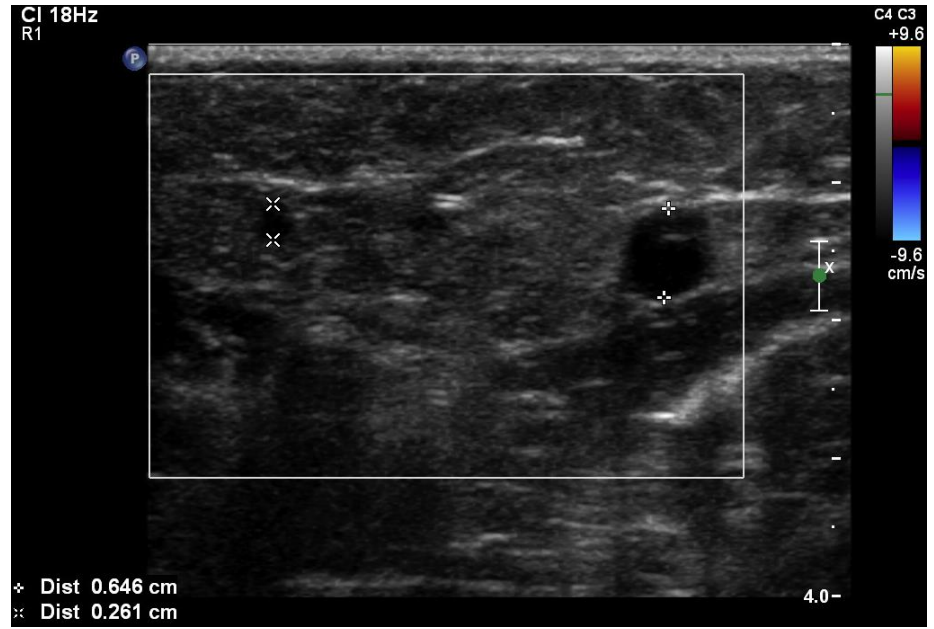
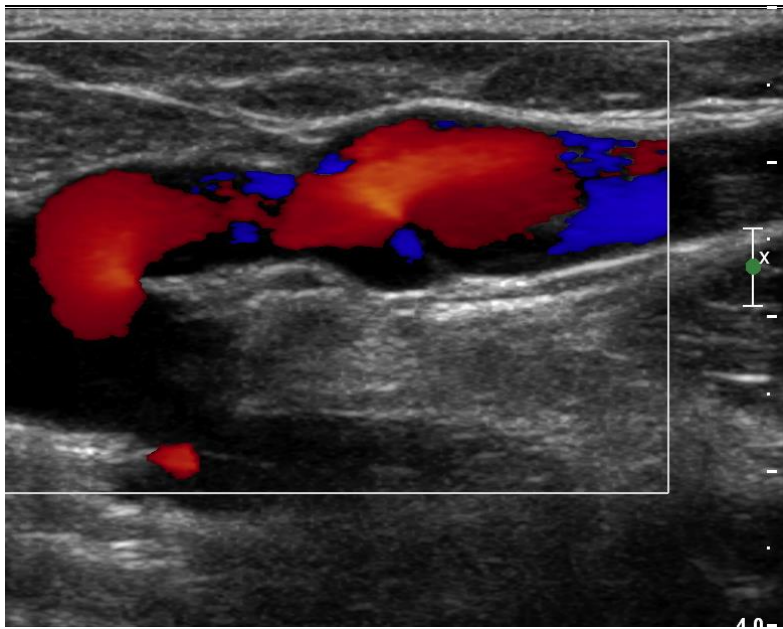


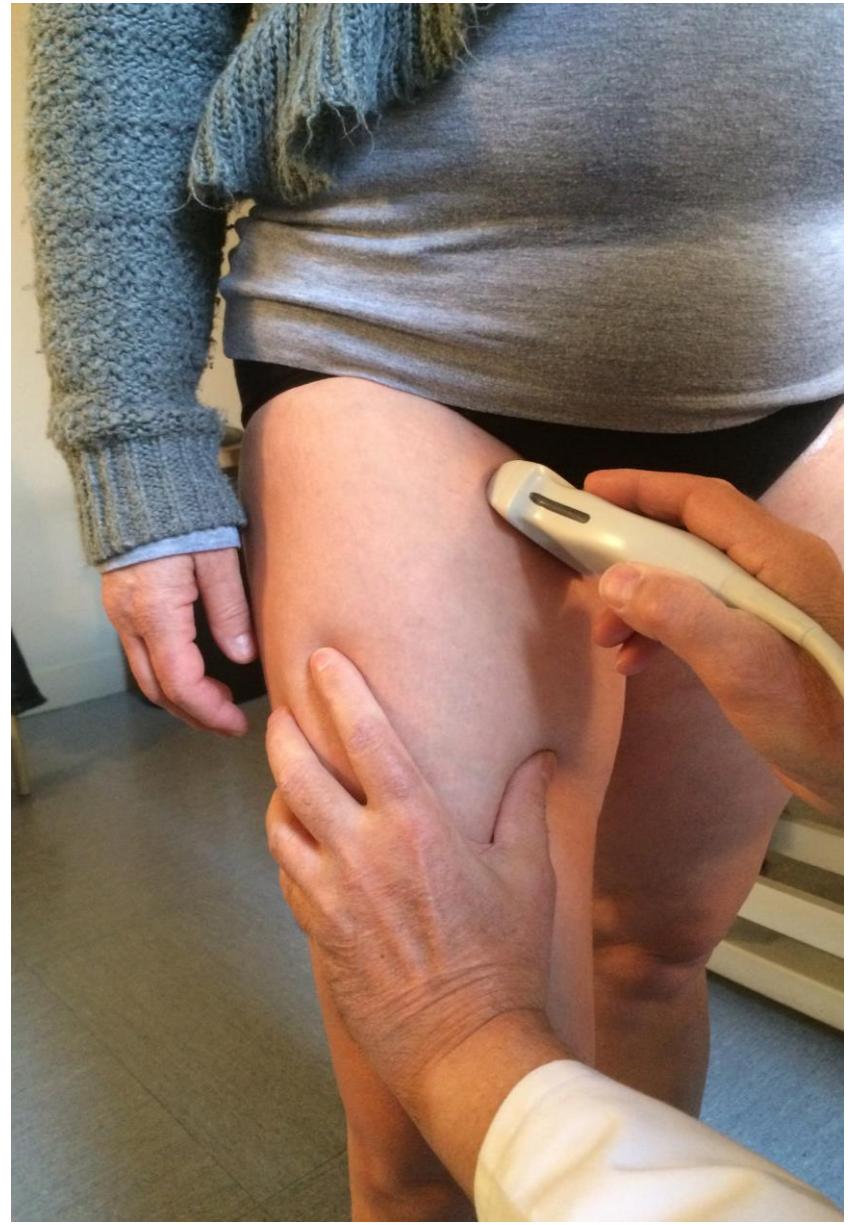
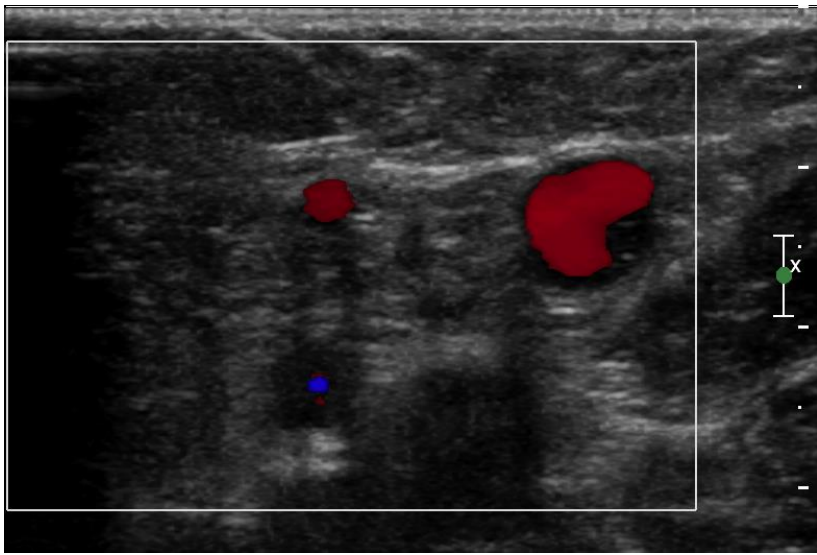
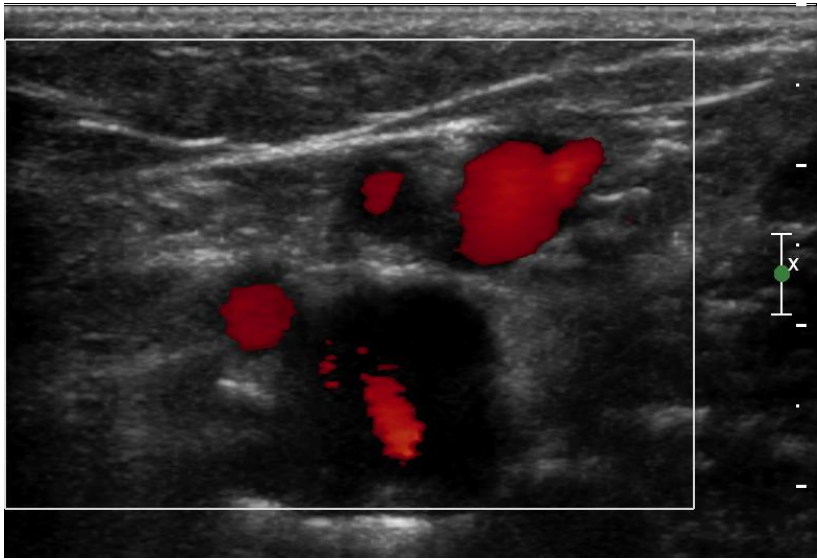
ACP Recommendation

We recommend that patients with symptomatic incompetence of the accessory GSVs (AAGSV and PAGSV) be treated with endovenous thermal ablation (laser or radiofrequency) or UGFS to reduce symptomatology.

There are no data, however, to demonstrate that treating non-refluxing accessory vein in a prophylactic fashion at the time of GSV ablation improves patient outcomes or reduces the incidence of varicose vein recurrence.

Don't miss any AASV reflux!







Thanks for attention!