What is the Ideal Treatment for Varicose Veins?

The ideal treatment should treat the symptoms and prevent the complications of venous hypertension due to superficial reflux, improve cosmesis, be minimally invasive, and be associated with low morbidity. It should also have a low recurrence rate and short recovery time, be acceptable to the operator and acceptable to the patient.

Endovenous techniques are revolutionizing arterial vascular surgery and there are a number of techniques in venous surgery that are beginning to challenge the role of open surgery. These include radiofrequency ablation, endovenous laser, and foam injection sclerotherapy.

Endovenous laser treatment is performed by inserting a flexible wire into the vein and applying energy to the vein wall to heat it up to 85°C. The heat causes the vein wall to collapse and thrombose. Complications include cutaneous nerve injury (5-7%), hematoma accounting for 17% of settled claims in general/vascular surgery. It should also have a low recurrence rate and short recovery time, be acceptable to the operator and acceptable to the patient.

Radiofrequency and laser ablation are alternatives to stripping of the GSV. Peripheral varicosities still need treatment with either hook phlebectomy or injection sclerotherapy. Foam injection sclerotherapy can be used to treat truncal incompetence as well as peripheral varicosities. These procedures have the advantages of being minimally invasive, and can be done under local anesthesia as an outpatient or in the consulting rooms with similar, if not better overall outcomes compared to surgery.

Diabetic Foot Ulcers

Why are Diabetic Foot Ulcers Difficult to Heal?

One of the most common complications of diabetes in the lower extremity is the diabetic foot ulcer. An estimated 15% of patients with diabetes will develop a foot ulcer during their lifetime. The annual cumulative incidence of diabetic foot ulcer is 0.6% to 3%, rising to 3% per year in neuropathic patients. The prevalence of foot ulcers ranges from 2% to 10%. Neuropathy, deformity, high plantar pressure, poor glucose control, duration of diabetes, and male gender are all contributory factors for foot ulceration.

7% to 20% of patients with foot ulcers will subsequently require an amputation. In diabetes, nerve damage results from interacting metabolic abnormalities, worsened by disease of the vasculo nervous system. The damage affects peripheral sensory nerves and afferent nerve fibers to the foot, and fine vasomotor control of the pedal circulation.

In sensory neuropathy, loss of protective sensation leads to a lack of awareness of incipient or actual ulceration. Motor neuropathy affects the muscles responsible for foot motion and sensation, leading to the potential consequences of micro-embolization of the small muscles of the foot, and fine vasomotor control of the pedal circulation.

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In patients with diabetes, foot ulceration is the precipitator of approximately 85% of lower extremity amputations.

Diabetes is common cause of non-traumatic lower extremity amputation and accounts for more than 60% of lower extremity amputations in the USA.

Diabetic peripheral neuropathy allows abnormal forces to be applied to the foot without appreciable discomfort to the patient and a related change in the plantar pressure under normal conditions, which in turn can lead to ulceration. Foot tissues can become ischaemic because of macrovascular disease, both structural (thickened basement membrane), and functional (cholesterol deposition with defective microcirculation and abnormal endothelial function) which in turn can lead to ulceration. Foot tissues can become ischaemic because of macrovascular disease, both structural (thickened basement membrane), and functional (cholesterol deposition with defective microcirculation and abnormal endothelial function) which in turn can lead to ulceration.

In the chronic phase, foot ulcers may be accompanied by a chronic inflammatory reaction and a non-viable, non-permeable, non-vascular granulation tissue, which in turn can lead to ulceration. Once healed prevention of ulcer recurrence is critical.

When should a specialist be sought?

In the acute phase:
- callus formation
- ulceration
- ischaemic change
- acute local sepsis
- non healing

In the chronic phase:
- recurrent callus/ulceration
- worsening deformity
- worsening neuropathy
- deteriorating sugar control
- onset of ischaemia
In August 2002 the Kingsbury hospital opened the first private multi-disciplinary peripheral vascular unit in this country. This has not only provided a comprehensive vascular service to the local community but has become a major tertiary referral centre for vascular patients across Southern Africa.

The unit comprises four vascular surgeons supported by an experienced team of ancillary and para-medical staff including specialist nursing staff, physiotherapists, orthotists, physicists, anaesthesiologists, clinical psychologist, biokinetists and dieticians.

The focal point of the unit is the endovascular suite. This comprises a fully equipped ceiling-mounted cath-lab with state-of-the-art digital vascular radiology within a large operating theatre enabling the entire range of both open and percutaneous vascular interventions to be performed in one facility. The theatre staff have developed considerable expertise with these procedures.

Patients are managed in a dedicated 22-bed vascular and neurology ward led by a unit manager and a clinical nurse specialist who has received specialist training at the St George’s Hospital vascular unit in London.

In modern vascular units most investigations are non-invasive and are based on duplex ultrasound. The unit boasts two full-time vascular ultrasound specialists who offer a full range of non-invasive vascular investigations.

The unit has taken a lead in new vascular innovations in South Africa including stenting of complex aortic aneurysms, carotid stenting and peripheral sub-intimal angioplasty. Endovascular training has become a key focus area.

Several members of the team have been travelling widely providing education and support for other surgeons who are learning these techniques.

This common benign vascular cutaneous syndrome caused by exposure to cold, humid conditions is poorly understood. Acute chilblains appear as extremely painful and often symmetrical erythematous or erythrocyanotic plaques or papules with shiny tense chilblains appearing as extremely painful and often symmetrical erythematous or erythrocyanotic plaques or papules with shiny tense epithematous or erythrocyanotic plaques or papules with shiny tense...

WINTER CHILBLAINS

Erythematous Plaque

Chilblains on the toes

Did you know?

- Diabetes is the commonest cause of non-trauma induced lower limb amputation.
- Foot complications are common in diabetics
- Foot ulcers exceed 8% of lower limb amputation
- Ulcers are caused by poor circulation and damage to nerves in the feet

Who should attend?

- All newly diagnosed type 2 diabetics
- All type 1 diabetics > 5 years duration
- Diabetic patients with ulcers, foot infection, callus (corns) dry skin, abnormal feeling and poor circulation.

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Superficial thrombophlebitis is a common problem in general practice. It is estimated that 123 000 Americans develop it annually. Lumps more than 50% occur in varicose veins and recurrence rates vary from 5-50%. It is notoriously persistent with more than 55% persisting beyond 30 days and many cases taking up to 3 months to resolve.

Ascer in a study in 1995 demonstrated that in patients with superficial thrombophlebitis involving the greater saphenous vein in the thigh or approaching the sapheno-femoral junction can, with colour flow duplex, be shown to have associated deep vein thrombosis in 40%.

This may be either contiguous (an extension of clot through the sapheno-femoral junction) or non-contiguous. High ligation of the saphenous vein has traditionally been recommended when the process extends to within 5cm of the SFJ but this may actually result in pulmonary embolism if the clot has already extended deeply.

Treatment usually consists of rest, analgesia, aspirin and careful reassessment. Topical anticoagulant gel and elastic support are helpful. Extensive thigh involvement demands anticoagulation and a colour duplex scan of the deep veins becomes very important in such cases. High ligation is seldom required. A proportion of cases are associated with underlying hyper-coagulable states (especially malignancy) and appropriate investigation is required in recurrent cases or when several areas of the body are affected (thrombophlebitis migrans).

Peripheral pulses are usually easily palpable and laboratory tests are helpful only in excluding other systemic diseases. The differential diagnosis includes systemic vasculitis and the “blue toe syndrome” from athero-embolism or malignancy.

Apart from the avoidance of cold and the application of vaseline the mainstay of treatment is nifedipine (Adalat) which appears to be actively involved in clinical research and the training of Surgeons from Groote Schuur Hospital.

He was appointed as Senior Specialist Surgeon at 2 Military Hospital in Wynberg in 1999 and was later appointed Chief Specialist and Head of Surgery in 2002. At 2 Military Hospital he headed a very busy surgical department gaining broad experience in all aspects of general surgery. He had the opportunity to be actively involved in clinical research and the training of Surgical Registrars from Groote Schuur Hospital.

He has been author and co-author of six papers in peer review journals and has presented at 12 national and international meetings. His other interests are information technology and painting.