Edition 6 - November 2008

THE AUSTRALASIAN COLLEGE OF PHLEBOLOGY

VEINEWS

Message from the College President

As we are fast approaching the festive season, I can confidently say that this year has been a very busy and successful year indeed for the Australasian College of Phlebology. I would like to thank the members of the Executive Board for their hard work and meeting on such a regular basis. In 2008, our Board consisted of David Jenkins (Vice President), Louis Loizou (Hon. Secretary), Paul Thibault (Treasurer), John Barrett, Lourens Bester, Jacqui Chirgwin, Mark Elvy, and Gabrielle McMullin. John has since resigned due to multiple other commitments and we thank John for his years of service to the Board. John will remain in charge of the Standards Committee of the College.

Since the previous edition of Veinews in July 2008, the College has seen the launch of two more state faculties, that of Victoria and Queensland. The Victorian Faculty Launch was held on Thursday 7th August at the beautiful Como House in South Yarra, Melbourne. The Governor of Victoria, the Honourable Professor David de Kretser AC attended and graciously acknowledged the launch of the Faculty in his inspirational speech. He also unveiled the commissioned portrait of our College Chancellor, Professor Kenneth Myers, as painted by artist Daryl Carnahan. Many thanks to the organisers Stefania Roberts and Lou Loizou for their meticulous planning and execution. I wish the Interim Faculty Chairperson Dr Stefania Roberts all the best with this role.

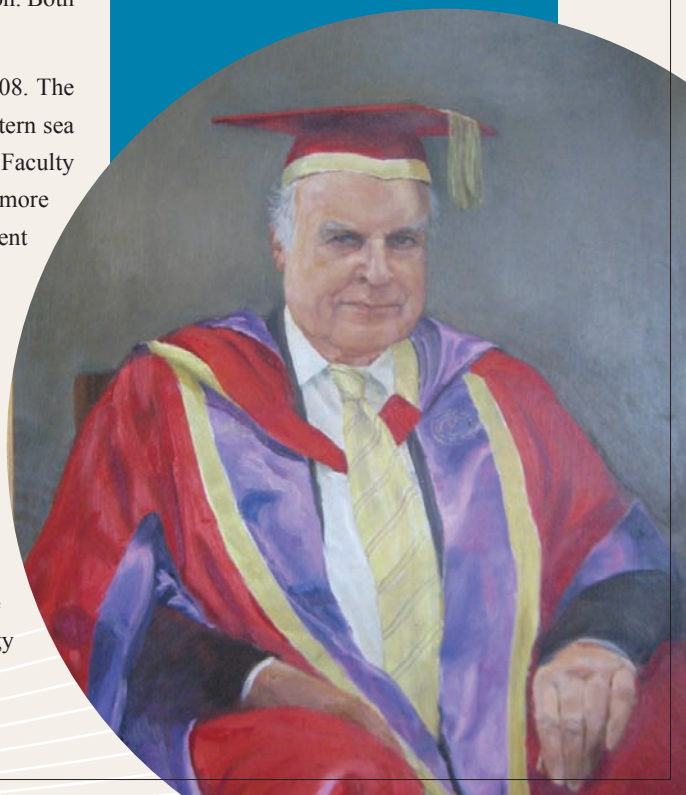
Of course, Victoria was not the only state to see the launch of its very own College Faculty in 2008. The Queensland Faculty was launched at Customs House in Brisbane on 9th September, an evening attended by the Chancellor of the University of Queensland, Sir Llewellyn Roy Edwards, AC. Dr Paul Dinnen, the Interim Chairman of this Faculty, received the commemorative plaque from Professor Myers to recognise the occasion. Both faculties are expected to be operational from January 2009.

The NSW Faculty conducted its regular meetings 8 times across the space of 2008. The consistent attendance of College members and trainees from up and down the eastern sea board is a testament to the time and effort put in by David Jenkins, our NSW Faculty Chairman. I thank David very much for his tireless input and we all look forward to more meetings of the same calibre in 2009. We also would like to recognise the consistent support shown by Focus Medical, our NSW Meetings sponsor.

In August, the Standards Committee met in Melbourne to discuss standards in microsclerotherapy. It was a very fruitful meeting with strong deliberation given to the topic. Once again, I would like to take this opportunity to thank Dr John Barrett for his efforts as the Chairman of this committee.

Though there were many highlights to the College year in 2008, the Annual Scientific Meeting (ASM) was the pinnacle of both the social and educational calender for me. The conference was held at the Crowne Plaza, Surfers Paradise on the Gold Coast, Queensland from 6th – 11th September and we were honoured with the attendance of some true luminaries of the Phlebology

in this edition...



world including Professor Byung-Buong Lee, Professor Philip Coleridge Smith and Professor Eberhard Rabe (President of the UIP). Each was presented with the Award of Excellence for their internationally recognised contributions in the realm of Phlebology. Other notable international speakers attending our meeting this year included Dr Stephan Guggenbichler (Germany) and Dr John Kingsley (USA). We would like to extend our thanks to you all for your impressive input and for sharing your knowledge with not only our Collegiate but other interested delegates. Our next ASM will be held in March 2010 (13th-17th March) in Auckland. Over the years, we have received numerous requests to hold the meeting outside of the heavier business months of the year. Also with the UIP holding its World Congress in early September, the Board decided against conducting a meeting in 2009. Leon Olsen from Conference Matters, NZ did a great job in organising this year's conference and we look forward to working with Leon towards a much bigger Auckland meeting.

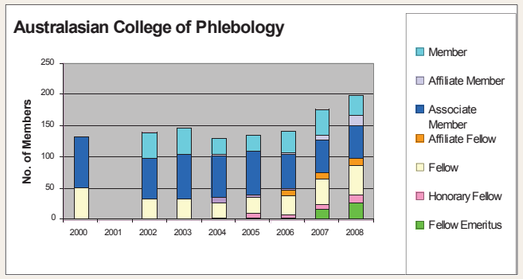
The Conferring Ceremony has been the highlight of the meeting for me personally. Congratulations must go to Dr Owen Roberts for receiving the President's Medal for his results in the Part I examinations. To receive the President's Medal, one must achieve a minimum of 85% in the Part I examinations, certainly not an easy task. Congratulations also to our successful graduands, Drs Stefania Roberts and Andrew Stirling (Fellowship) and Dr Keh Kor, Alister Lilleyman and Owen Roberts (Sclerotherapy Certificate). We were honoured that Sir Llewellyn Roy Edwards, the Chancellor of University of Queensland, accepted our invitation to give the second Ken Myers Oration, a truly moving speech. Graduands of this year's examinations can look forward to receiving their certificates at the next Conferring Ceremony.

This year, both the Basic and Advanced Courses were changed slightly so that they ran concurrently across two days instead of just the one.We felt that this was a more efficient use of our trainees' time, allowing for far more focused tuition. Both courses attracted strong numbers of newly interested delegates. I would like to thank Lou Loizou, Annie Silkman and Fiona Bye for coordinating these courses, and Chris Lekich and Paul Varcoe for their local support and providing patients for the workshops. Special thanks must go to our sonographers who organised the Diagnostic Imaging Workshops held on the last day of the conference, and in partcular to Annie Morgan for chairing and running the sessions on the day. Also, I would like to extend my appreciation to Yana Parsi and Annie Silkman again for organising these Workshops and to Philips, Toshiba, Sonosite, and Terason for supporting these Workshops.

The ACP has worked hard in recent months to develop more specifically crafted preceptorships. We now offer five different packages in the areas of Introductory, Advanced, Ultrasound, Emergency Crisis Management as well as the Comprehensive 6-day package. These different modules will allow medical practitioners of all levels of training to be able to obtain further more taylor-made exposure to this specialty.

Speaking of training, the College is pleased to announce the completion of the Written and Clinical exams for 2008. Congratulations must go to Lisa Marks and Christopher Lekich for successfully passing these Examinations. Many thanks to the members of the Board of Censors and invited examiners. We strive to maintain high standards with the pass mark at these examinations remaining at 75%. I encourage those who did not get through to re-sit the examinations next year.

It would seem that not only College training numbers but College membership numbers are steadily on the increase (see insert). We are pleased to announce that the Collegiate has grown by more than 10% in the past year alone, and has increased by 1/3 in the past 3-4 years. These are impressive statistics which I feel are indicative of the increasing attention Phlebology is commanding as a specialty interest group.



CATEGORY		
Fellow Emeritus	27	98
Honorary Fellows	15	
Fellows	45	
Affiliate Fellows	11	
Associate Members	87	102
Affiliate Members	15	
TOTAL:	200	

As you can see, the College now has 200 members. There is an interesting cross-section of specialists within our fellowship as demonstrated in the table below:

COMPOSITION OF FELLOWSHIP	98
Surgeons	**35**
▪ Vascular Surgeons	30
▪ General/Venous Surgeons	5
Dermatologists	**15**
Interventional Radiologists	**6**
Vascular Physicians and Angiologists	**7**
Haematologists	**4**
Others:	
▪ College Graduates	6
▪ Invited International Fellows	3
▪ Grandfathered Fellows	22

Please keep in mind over the New Year that 2009 holds in store for us the first journal publication in conjunction with the Royal Society of Medicine Phlebology (UK). The amalgamation of ANZJP and Phlebology is for the best interest of the specialty and the authors. Phlebology is indexed by index medicine and hence articles appearing in that Journal will appear in Medline. This will increase the number of submissions to this Journal.

We do hope that you enjoy this publication of Veinews. This is our second edition for the year with the first being released in May. In the May edition, we were very lucky to be able to publish the fascinating feature article by Nick Morrison and Attilio Cavezzi about Phlebology at work in Guayaquil, Ecuador. A lot of work goes into collating all the information that you find between these pages, and I am very grateful for our Newsletter Editorial Chairperson, Jacqui Chirgwin, for the marvellous work she does for each edition.

Last but not least, I would like to thank the College staff and in particular Fiona Bye (College Administrator), and Annie Silkman, Kylie Holmes and Match Hu for helping Fiona ease into her role.

As this is our last Veinews publication for the year, I would like to take this opportunity to wish our members, sponsors, supporters and interested readers all the best over the holiday break. May it be a safe and enjoyable time for you all.

Warmest Regards,

Kurosh Parsi
President
Australasian College of Phlebology

Conference Report

After the spectacular event that was the 2007 conference in Double Bay, notably including the inauguration ceremony at The Great Hall of The University of Sydney, I was expecting a less flamboyant meeting in 2008. In the end, I think it was only marginally so.

With the momentary passing of another year, the annual ACP conference for 2008 was held in the Gold Coast. Famous phlebologists from around the globe once again converged on Australia. There were phlebologists from the USA, UK, Latvia and Germany, the President of the UIP, Prof Rabe, and Dr Kingsley with a whole legion of staff from Alabama. The welcome cocktail party was well attended and a festive start and thankfully, there were no bag-pipes played.

An intensive program commenced the following day, with some very interesting (and some very controversial) talks on foam sclerotherapy. Prof Coleridge-Smith informed us of his experiences treating primary and recurrent varicose veins with foam UGS, noting its effectiveness and safety compared with surgical techniques. It does seem that our enthusiasm for treating varicose veins with foam UGS is shared by many in both mainland Europe and now the UK. We are also now learning a lot more about bubbles and enjoyed a spirited discussion on appropriate volumes and concentrations of sclerosant foam.

Prof Myers was able to give us more excellent data from his long-running study of foam sclerotherapy, if only he would inject veins in the right direction. In an elegantly executed but essentially flawed study, it was perhaps not surprising to find that a low concentration of aethoxysklerol resulted in fewer side-effects than an extremely high concentration of Fibrovein in the treatment of telangiectasia. Dr Denekamp and others were equally surprised.

After lunch, Dr Parsi got to use his new audience assessment device, and some of us were reassured that at least there were others in the audience that were equally misguided about the treatment of calf vein thrombosis. We heard about unusual clots, common clots, spontaneous clots and provoked clots. And the day ended with drinks in the appropriately named Bar Thrombus.

The second morning of the conference saw Dr Kingsley reporting on the 4600 patients he has treated with the 1320nm laser. In those patients that he had followed up for 6 months or more, he found over 99% treatment success, amazing numbers for any form of medical treatment for any condition, let alone for varicose veins. We also heard reports on the latest laser, the 1470nm diode, and learnt that it also works.

Dr Stirling made a suggestion that we have a laser physicist talk to us at some stage, which may be a reasonable idea considering the large variations in power delivered through the different laser systems with differing wavelengths. Dr Chapman Smith discussed his experience with, and showed us some advanced techniques, in treating extra-fascial veins with endovenous laser. After morning tea, we heard about the history of phlebology in Germany from Prof Rabe, and that salty sea-dog of phlebology Dr Paul Thibault gave a surprisingly interesting talk on Australian and New Zealand phlebology. After a brief run-down on the training scheme in Australasia, Dr Parsi kindly gave us all some time to prepare for the evening's festivities.

As I mentioned earlier, the Conferring Ceremony and Queensland Faculty launch had a mammoth task to live up to after the spectacular events of last year. I don't know if it was quite as big, but it certainly was impressive. The venue, that being Customs House in Brisbane, was a beautiful site for such an event and the string quartet made for a lovely entrance. My only gripe was the bag-pipes used for the national anthems. I really don't like bag-pipes. The only thing that annoys me more than bag-pipes is belly dancing. And don't even think of it Dr Loizou!

Wednesday morning's talks covered the range of treatments available for varicose veins as well as Dr Kingsley's report on treating restless leg syndrome with endovenous laser. Prof Coleridge-Smith and Dr Frydman told of their approaches to treatment of varicose veins and Dr Guggenbichler informed us some more about the European approach to foam sclerotherapy. Sea Dog reported on his latest attempts to further improve his beloved ultrasound guided sclerotherapy technique with the use of post-injection tumescent compression.

After lunch, we heard about some of the latest techniques of management of lymphoedema from Prof BB Lee and Dr Moseley, as well as some science on the capillary barrier. In a very full afternoon, there were talks on dermatological vascular lasers, foam sclerotherapy, nerve blocks for EVLA, leg swelling from a pelvic sarcoma, and vibrating needles.

All in all, it was a very rewarding conference, with some interesting talks and some controversy. Full credits to the organisers for a good job done, and next year, please, no bag-pipes.

Simon Thibault

Launch of Victorian Faculty of ACP

Como House, South Yarra, Melbourne

Thursday, 7th August 2008

The launch of the Victorian Faculty of the Australasian College of Phlebology was held on Thursday August 7th at historic Como house which, typical of Melbourne, was a wet and cold night. The launch was well attended with eminent Victorian doctors who will provide the foundation upon which the Victorian chapter can grow. The Victorian Faculty will follow the concept of the extremely successful model that has been operating in Sydney and chaired by Dr David Jenkins. " Vein School" has proved popular amongst training doctors of the college as well as established phlebologists from not only within NSW but also QLD, Victoria and Tasmania. "Vein School" provides a forum for the presentation of clinical cases with actual patients while the "Journal Club" includes the presentation of relevant topics by invited speakers as well as the discussion of interesting journal articles. As another milestone in the history of our College, the Victorian Faculty launch was presided over by the Governor of Victoria, Professor David De Kretser AC and his wife Mrs Jan De Kretser. The Australasian College of Phlebology is very grateful to the Governor and Mrs De Kretser for making themselves available to preside over the event, given their extremely busy schedule. The honorary secretary Dr Louis Loizou commenced the proceedings with an introduction but concluded with a provocative challenge directed towards the College President Dr Kurosh Parsi. Dr Parsi laid down the challenge to the Victorians to present and maintain, and even exceed, the standards set by the NSW Faculty. Dr Parsi then introduced the Governor of Victoria Prof David De Kretser AC who presented an inspirational speech formally launching the Victorian Faculty.

The Governor was kind enough to allow the ACP to reprint his speech below, so that those who could not attend can share his inspirational words of encouragement.

The Victorian Launch was then followed by the unveiling of an oil portrait that was commissioned by the ACP. The portrait was painted by acclaimed artist Daryl Carnahan and the subject is Professor Ken Myers, the first Chancellor of the ACP. This was a proud moment in the history of our college as it begins a tradition of acknowledging individuals who have had an important role in establishing the college into the internationally recognized body it has now become. Professor Myers, our first chancellor, has been instrumental in guiding the college towards this recognition and this portrait will provide a symbolic watchful eye over our college as we advance towards specialty accreditation.

Special thanks must be given to the sponsors of the evening who without their continued and generous support many of the ACP initiatives could not proceed.

Milivoj Boltuzic of Device Consulting.
Paul Neilson and Jean-Pierre de Mezieres of Sole Health.
Hayden Rice from Biomet Australia.

Louis Loizou

Speech by Governor of Victoria Prof David De Kretser AC

Launch of Victorian Faculty of ACP

Thursday, 7th August 2008

Acknowledgements:

Professor Kenneth Myers
Chancellor of The Australasian College of Phlebology

Dr Kurosh Parsi
President of The Australasian College of Phlebology

Dr Louis Loizou
Honorary Secretary of The Australasian College of Phlebology

Distinguished guests, ladies and gentlemen

I would like to begin by acknowledging the traditional owners of this land, the Kulin Nations, and pay my respects to their elders both past and present.

Jan and I are honoured to be here this evening for the launch of the Victorian Faculty of The Australasian College of Phlebology.

This is a significant and exciting milestone in Victorian medical history. The inauguration of the Victorian Faculty also marks a very special day in the College's history.

Of course, one may ask, why do we need a college? A college brings together people with high standards of academic and clinical expertise and provides peer group inspiration, debate and challenge. A college reflects the broad interests of professionals and includes contemporary clinical, ethical and policy issues. A college can only result in ensuring better medical practice and training on both a local and international level. All of these aims benefit the community in which we live. I know that the Australasian College of Phlebology is already highly regarded on a global scale as a leading medical training environment, and I'm sure that the addition of the new Victorian Faculty will contribute further to this success.

Progress in developing diagnostic and clinical approaches requires multidisciplinary teams as the rapid rate of scientific knowledge and technology development can no longer be found in a single scientist or specialist. It is simply impossible to keep abreast of all of the developments germane to a particular medical field.

The formation of this Faculty is critical in responding to the compounding technological development and the growth of our scientific knowledge.

Such developments have increased the need for clear communication between medical practitioners. As leaders in your field, you need to ensure that other scientists, in different disciplines, can understand you. The external interface of your college is also critical in enabling public understanding of the implications of your work.

An example of this is the development of Endovenous Laser Ablation (ELA). ELA promises dramatic improvements in the treatment of varicose veins, a condition that causes significant pain and suffering to a considerable percentage of our population. This will no doubt pose an even greater challenge as our society continues to age. The development of a therapeutic procedure requiring only local anaesthesia, having highly effective results, lower recurrence rate, shorter recovery period, lower costs and no scarring is a significant advancement.

Having had first hand experience starting a medical institute from scratch, I know that it is not an easy process or task. It requires stamina, consultation, commitment and passion, all of which have been demonstrated by the Founders of this College.

I wish you all the best for the future of the College and look forward to hearing of the many success stories over the coming years.

Congratulations on this auspicious day in your history.

Thank you.

IVC Filtration

Introduction to IVC Filters

Although systemic anticoagulation remains the cornerstone of venous thromboembolism treatment, not all patients are candidates for this therapy, some fail the therapy, and some patients on anticoagulation suffer complications from the treatment. Fortunately, inferior vena cava (IVC) filtration is available for these selected patients as an adjunctive treatment for venous thromboembolism, or as an effective prophylactic measure in selected high-risk patients.

Indications for Infrarenal IVC Filtration

The three classic indications for IVC filtration include the presence of venous thromboembolic disease (pulmonary embolus or IVC, iliac, or femoropopliteal deep venous thrombosis) combined with one of the following:

(a) contraindication to anticoagulation

(b) complication of anticoagulation

(c) failure of anticoagulation (including recurrent PE despite adequate anticoagulation and inability to achieve therapeutic systemic anticoagulation).

The contraindications to anticoagulation have been cited as a bleeding complication of anticoagulation, known recent hemorrhage, recent major trauma or surgery, hemorrhagic stroke, thrombocytopenia, heparin-associated thrombocythemia thrombosis syndrome, and a known central nervous system neoplasm, aneurysm, or vascular malformation.

Additional well-accepted indications include:

A. massive pulmonary embolism with residual deep venous thrombus (DVT) in a patient at risk for further PE; free floating iliofemoral or IVC thrombus.

B. Severe cardiopulmonary disease and deep venous thrombosis (e.g. cor pulmonale with pulmonary hypertension); and poor compliance with anticoagulant medications.

"Extended" indications include prophylactic IVC filter placement in selected, high-risk patients without documented PE or deep venous thrombosis.

A. Severe trauma victims with closed head injury, spinal cord injury, and/or multiple long bone or pelvic fractures.

Cook Select Retrievable Filter

B. Other high-risk patients include those that are immobilized or subjected to prolonged intensive care.

C. Prophylactic filters preoperatively in patients who have multiple risk factors for venous thromboembolism.

D. Filtration for protection during iliofemoral DVT thrombolysis for prevention of significant PE.

Indications for Suprarenal IVC Filtration

A. Renal vein thrombosis.

B. IVC thrombosis extending up to or above the level of the renal veins, renal cell carcinoma with renal vein or IVC involvement, thrombus extending above a previously placed infrarenal filter.

C. Pulmonary embolism after gonadal vein thrombosis.

D Anatomic variants, such as a duplicated IVC and low insertion of the renal veins.

E. Pregnant women.

Contraindications to IVC Filtration

Absolute contraindications:

Complete thrombosis of the IVC.

Uncorrectable Coagulopathy.

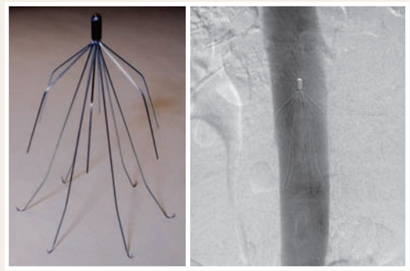
Bacteremia/Sepsis are relative contraindications, and clinical judgement must be used.

Success and Efficacy of IVC Filtration

The technical success for IVC filter placement should be equal to or exceed 97% in experienced hands.

The primary indicator of efficacy of an IVC filter is the recurrent PE rate. Generally speaking, all available IVC filters have comparable recurrent symptomatic PE rates, which range roughly between 2 and 5%. However, it is important to understand that the true incidence of recurrent PE following IVC filtration is probably higher, since most asymptomatic PE remain undiagnosed.

Decousus et al. compared IVC filters to a control group. This study showed a significant benefit of filters at 12-day follow-up, with the control group experiencing a more than four-fold increase in PE rate compared to the filter group (4.8% without filter vs. 1.1% with filter). This difference was even greater when only patients with PE at enrollment were considered



Bart Retrievable Filter

(8.6% without filter vs. 1.1% with filter). However, there was no significant difference in mortality between these two groups. In addition, at 2-year follow-up, there was no significant difference between the two groups with respect to PE rate, but the filter group did experience more recurrent deep venous thrombosis than the control group (20.8% and 11.6%, respectively). These findings persisted in a subsequent paper reporting on 8-year follow-up of these patients. There was a significantly lower rate of symptomatic PE in the filter group compared with the no filter group (6.2% vs. 15.1%, p=0.008) while there was a slightly higher rate of DVT (35.7% vs. 27.5%, p=0.042).

General IVC Filter Placement Procedure

Prior to placement of an IVC filter, objective documentation of venous thromboembolism is essentially best performed with either ultrasonography, radionuclide scintigraphy, contrast enhanced computed tomography.

The procedure may be performed via a jugular, femoral, subclavian, or sometimes an upper extremity peripheral vein route.

Inferior vena cavography is performed to analyse the status of the IVC with regard to patency and the presence or absence of thrombus, to include measurements of the diameter of the IVC and the location of the renal veins, and to exclude the presence of a venous anomaly such as a megacava, duplicated IVC, and circumaortic or retroaortic left renal vein.

Complications of IVC Filtration

Complications of IVC filter placement vary among the specific filters, but for simplicity, they can be considered collectively for all filters as a group.

Thromboembolic events following IVC filter placement, such as recurrent PE.

IVC thrombosis

Recurrent deep venous thrombosis at the access site are not uncommon, with occurrence rates reported to be, 0.5-6%, 2-30%, 20.8%, and 2-28%, respectively. Most partial IVC thrombosis complications, often diagnosed incidentally on ultrasound or CT examinations, remain asymptomatic, and might be better interpreted as evidence of efficient embolus trapping by the filter. Complete IVC thrombosis can result in phlegmasia cerulea dolens, which can sometimes be treated with venous thrombolysis. Filter migration (0-18%) and embolisation to the right heart or pulmonary arteries (2-5%) occasionally occur spontaneously, but may be precipitated by entrapped exchange guide-wires used during bed-side central venous catheter placement procedures. Both guide-wire entrapment and filter embolisation have been successfully treated using Interventional Radiology transcatheter techniques.

continued...

IVC penetration, which may or may not cause a retroperitoneal hematoma or perforation into the aorta or gastrointestinal tract, has been documented to be as high as 41% in one series, but clinically significant penetration is believed to be a rare event. Filter fracture, which can be a late occurring event, can be detected on plain radiographs, and has been reported to occur with a rate of 2-10%.

Retrievable Filters

Because of the risk of the above-mentioned long-term complications of IVC filtration, retrievable filters have been introduced. Currently available temporary or retrievable filters might be better classified as "optional" filters, since they can function as permanent or temporary filters. An IVC filter that gives the option for use as a permanent or temporary filter is an attractive alternative for patients with a time-limited need for IVC filtration. This would include patients such as severely injured trauma patients at high risk for pulmonary thromboembolism and patients with venous thromboembolism and a temporary contraindication for anticoagulation, who subsequently can undergo anticoagulation. These patients may only require a filter for the short term, and could benefit by having the filter removed percutaneously at a later time.

The Günther Tulip Retrievable Filter has been used in Europe since 1992, and was introduced in the U.S. in 2000. It is manufactured from conichrome, a non-ferromagnetic alloy and thus it is MRI compatible up to 1.5 T.

The Recovery Retrievable Filter received FDA clearance as a permanent filter in 2002 and was redesigned in 2005 and renamed G2. Since there is no indicated retrieval time limit, extended implantations have occurred, with some filters successfully removed up to six months post insertion. Both of these filters are MRI-compatible and MRI-safe, and do not cause an artifact on MRI.

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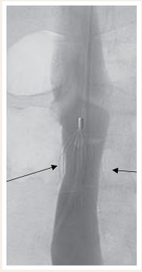
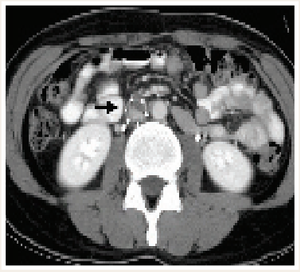
A/Prof Lourens Bester
St. Vincent's Hospital,
Sydney



Penetration and this normal and should not be called perforation



CT with Thrombus in Filter

Continuing Professional Development Program

The Board is committed to ensuring that fellows of the Australasian College of Phlebology maintain high standards and high levels of professional development through the Continuing Professional Development Program. This program has been running from January 2007 and the triennium concludes on December 31st, 2009.

The aim of the program is to assist Australasian Phlebologists in a range of ongoing educational activities, which maintain clinical standards once Fellowship of the ACP has been attained; so that they maintain and improve the quality of care they give to patients and promote the highest possible standards of care to the community.

Fellows are required to gain 160 points in accredited activities over **a three-year** period.

Electronic data collection and automatic points allocation is available on the college's website at **www.phlebology.com.au**.

Log in and click **QA** and **CPD**.

The above table is represented on the web page and data can be entered retrospectively.

Dr Mark Elvy

Area	Activity	Points	Maximum points per activity	Points per triennium
Medical Education Group 1	Meetings and Conferences	2 / hour	50 / meeting	120
	Workshops and Seminars	2 / hour	50 / workshop	
	Learning Projects	2 / hour	50 / project	
	Practice-related CME	0.5 / hour	50 / triennium	
Teaching, Research, Presentation and Publications Group 2	Teaching	1 / hour	N / A	20
	Presentation	5 / presentation	N / A	
	Publication	10 / publication	N / A	
	Examination questions - Part I & II	2.5 / question	20 / annum	
Quality assurance and Practice assessment Group3	Collaborative outcome projects		10 / per project	20
	Patient satisfaction studies			
	Evaluation projects			
	Clinical Incident reporting			

Incorporation of ANZ Journal of Phlebology into the Journal

"Phlebology"

From 2009, the ANZ Journal of Phlebology will be incorporated into *Phlebology* published by the Royal Society of Medicine Press Ltd. The Board of the College decided on this action for a number of positive reasons. First, *Phlebology* has recently been indexed by Index Medicus and articles published will be available on Medline. This is the only dedicated phlebology journal to achieve this privilege. This overcomes a major deterrent for authors to publish in our journal, a deterrent that had become a significant obstacle to producing a quality Phlebology Journal annually in our region. *ANZJ Phlebology* will retain its own branding and the College will have editorial control of that section, including selection of the editor. Secondly, *Phlebology* will be produced 6 times a year and will be available to all of our members. Because of the high cost of producing our own journal, this will effectively give a better service to members and Fellows without an increase in cost to the College.

However, to make this new collaboration work, we need members to fully support the Journal by making quality contributions on a regular basis. The following information is provided to prospective authors on how to contribute to the Journal.

1. Aims and scope

The aim of this journal is to report the results of high quality studies and reviews on any factor that may influence the outcome of patients with venous disease. The journal is intended to appeal not only to medical practitioners (dermatologists, vascular surgeons and radiologists) but also to nursing staff and allied professionals as well as basic scientists. Published contributions include editorials, reviews, full original papers, short reports, and letters to the Editor. Previously unpublished contributions on all aspects of the investigation and treatment of venous disease will be considered for publication.

2. Editorial policy

Covering letter - The covering letter is important. To help the Editors in their preliminary evaluation, please indicate why you think the paper is suitable for publication. If your paper should be considered for fast-track publication, please explain why.

Peer review - All papers will be reviewed by independent referees, and authors may be requested to amend their contribution. The final decision about acceptance or rejection remains with the Editor.

Ethical approval - All research submitted for publication must be approved by an ethics committee.

Patient consent - Any article containing identifiable patient information must be accompanied by a statement of consent to publication. If there is any doubt about whether or not information is identifiable, the Editors are happy to discuss this before an article is submitted. Reviewers will also be asked to take careful account of issues relating to patient confidentiality when reviewing articles. Not only should submissions be accompanied by a statement of consent, but the Editors also expect to be informed about the measures that have been taken to anonymise the details that could have led to parties being identified. They also reserve the right to work with the authors to make additional anonymising changes as they or the reviewers see fit. The Editors may also ask authors to remove personal information that, whilst interesting and colourful, does not add to the substance of an article, but does increase the likelihood of parties being identified. The exception to this will be where the patient has indicated in writing that she/he wants to be identified, has read the material, has discussed the consequences of being identified, and has agreed to the disclosure of all the personal information contained in the article. In order to ensure that valuable and novel issues are aired, the Editors will sometimes consider publishing cases studies that contain potentially identifiable information where it has been impossible or clearly undesirable to seek consent from relevant parties. However, given the strong preference for consent having been sought and obtained the reasons for not seeking consent must be compelling, and the public interest arguments for publishing the case must be powerful. In cases where consent has not been obtained, the authors must provide a statement from a Medical Director or equivalent that the hospital or medical centre is happy for the case to be published.

Competing interests and other declarations - All authors are required to declare any conflicts of interest when submitting papers for publication. Declarations of funding sources, a guarantor and a statement of contributorship are also required.

Permissions - All previously published material must be accompanied by the written consent to reproduction of the copyright holder. An acknowledgement of permission should be included at the relevant point in the paper, and a full reference to the original place of publication should be included in the reference list.

Copyright - Authors of accepted manuscripts will be required to allocate copyright to the publisher prior to publication.

Acknowledgements - Only the help of those who have made substantial contributions to the study and/or the preparation of the paper should be acknowledged.

3. Types of articles

Editorials - Short pieces on topical subjects, usually commissioned by the Editor, of no more than 1000 words plus up to 10 references.

Original Articles - Original articles should be 2000–3000 words and should carry a structured abstract (of about 150 words), which states the main purposes of the study (Objectives), the basic procedures used (Methods), the findings (Results) and the most important conclusions drawn (Conclusions). The rest of the paper should be structured in conventional style: Introduction, Methods, Results, Discussion, Acknowledgements and References.

Short Reports - Short reports should be 500–800 words, and should include an abstract and no more than 5 references.

Review Articles - Review articles should be 4000–6000 words and also require an abstract, indicating the scope of the review, the methods used to retrieve the relevant literature, the principal findings and conclusions drawn. Subheadings should be used within the article to highlight the content of different sections.

Letters - Comments on articles previously published in the journal, or communication on topics that are newsworthy but not appropriate for consideration as a paper.

4. How to submit a manuscript

Only manuscripts submitted via the online manuscript submission and peer review site, which can be found at **http://mc.manuscriptcentral.com/phleb** will be considered for publication.

An author proforma should accompany all submissions and should be signed by all authors. A copy of the form is available at **www.rsmpress.co.uk/phleb_statements.pdf**, as well as in the 'Instructions and Forms' section of the online submission website. Please print out this form, and scan and upload a completed copy of it with your manuscript as a supplementary file.

All submissions must be in English.

Tables and figures may be submitted as separate files, in which case the files should be uploaded in the following order: (1) main text, including title page, abstract and references; (2) tables; (3) figures; (4) supplementary files; and (5) author proforma.

File formats - Text files must be saved in .doc or .rtf format. Other suitable formats include .tif for photographic images, .xls for graphs produced in Excel, and .eps for other line drawings.

5. How to prepare a manuscript

Formatting - Manuscripts must be submitted using double line-spaced, unjustified text throughout, with headings and subheadings in bold case. Press 'Enter' only at the end of a paragraph, list entry or heading.

Title page - The first page should contain the full title of the manuscript, a short title, the author(s) name(s) and affiliation(s), and the name, postal and email addresses of the author for correspondence, as well as a full list of declarations. Please also include a list of up to five keywords. The title should be concise and informative, accurately indicating the content of the article. The short title should be no more than six words long.

continued...

Abstract - An abstract of no more than 150 words must accompany all Original Articles, Research Articles and Short Reports. The abstract should follow the following format: Objectives, Method, Results and Conclusions.

Tables - Tables must be prepared using the Table feature of the word processor. Tables should not duplicate information given in the text, should be numbered in the order in which they are mentioned in the text, and should be given a brief title.

Figures - All figures should be numbered in the order in which they are mentioned in the text. All figures must be accompanied by a figure legend. If figures are supplied in separate files, the figure legends must all be listed at the end of the main text file.

Line drawings should be produced electronically and clearly labelled using a sans serif font such as Arial. Graphs may be supplied as Excel spreadsheets (one per sheet). Other line drawings should be supplied in a suitable vector graphic file format (e.g. .eps)

All photographic images should be submitted in camera-ready form (i.e. with all extraneous areas removed), and where necessary, magnification should be shown using a scale marker. Photographic images must be supplied at high resolution, preferably 600 dpi. Images supplied at less than 300 dpi are unsuitable for print and will delay publication. The preferred file format is .tif.

References - Only essential references should be included. Authors are responsible for verifying them against the original source material. RSM Press uses the Vancouver referencing system: references should be identified in the text by superscript Arabic numerals after any punctuation, and numbered and listed at the end of the paper in the order in which they are first cited in the text. Automatic numbering should be avoided. References should include the names and initials of up to six authors. If there are more than six authors, only the first three should be named, followed by et al. Publications for which no author is apparent may be attributed to the organisation from which they originate. Simply omit the name of the author for anonymous journal articles - avoid using 'Anonymous'. Punctuation in references should be kept to a minimum, as shown in the following examples:

Malan E. Vascular Malformations (Angiodysplasisas). Milan: Carlo Erba, 1974

Belov St. Classification of congenital vascular defects. Int Angiol 1990;9:141-6

Abbreviations - Symbols and abbreviations should be those currently in use. Authors should not create new abbreviations and acronyms. The RSM's book Units, Symbols and Abbreviations provides lists of approved abbreviations.

Units - All measurements should be expressed in SI units.

Statistics - If preparing statistical data for publication, please read the statistical guidelines.

6. Proofs and eprints

Proofs will be sent by email to the designated corresponding author as a PDF file attachment and should be corrected and returned promptly; corrections should be kept to a minimum.

A PDF eprint of each published article will be supplied free of charge to the author for correspondence; hardcopy offprints may be ordered from the publisher when the proofs are returned.

Paul Thibault

ACP 2008 Gold Coast

Gold Coast – Australia’s favourite conference destination – was home to the 2008 Australasian College of Phlebology Annual Conference. Visitors came from across Australia and beyond. Once again, there was the familiar feel of an international meeting. We welcomed back some familiar faces and a few new ones. The weather was perfect and there was a level of camaraderie among delegates that made the meeting exceptionally friendly and relaxing, which perfectly complemented the action-packed scientific program.

Conferring Ceremony and Dinner

All the delegates were chauffeured from The Crowne Plaza Surfers Paradise to the sistoric Customs House in Brisbane. Some of the german contingent almost missed the bus after a leisurely afternoon stroll along the beach. But all was well and the bus made up for lost time and arrived just on time for champagne cocktails by the river, set alight by the sunset.

The team from the Australasian College of Phlebology and hardworking beavers from the Sydney Skin and Vein Clinic greeted all the guests enthusiastically and escorted them to their various meeting places to begin the formalities of the evening. The Ceremonial speaker **Sir Llewellyn Edwards**, **The Chancellor of the University of Queensland**, worked the preparatory room like a seasoned politician that befits an ex-Health Minister. That is not to detract in any way from his excellent Ken Myers Oration, delivered with great passion. As an ex-GP-turned Health Minister, Sir Edwards offered an insightful reflection on the unique privileges and responsibilities that come with being a doctor. Many felt flushed and favoured as Sir Llewellyn engaged the delegates one-on-one.

As well, the conferring ceremony heard inspirational speeches from our International guests: **Professor BB Lee, Professor Phillip Coleridge Smith and Professor Eberhard Rabe** during the course of the night as awards were presented. These vignettes are always welcome especially when so succinctly and sweetly delivered! **Hon Justice Margaret White, Vice Chancellor of the University of Queensland and Justice of the Supreme Court of QLD**, gave an entertaining and lively speech that was extremely well received. Congratulations to **Dr Keh Khor, Dr Alister Lilleyman** and **Dr Owen Roberts** for the Part 1 certification and **Dr Owen Roberts** for the President’s medal. We especially welcome **Dr Stefania Roberts** and **Dr Andrew** Stirling for attaining Fellowship – well done!

The ceremonial dinner was elegant but had a measure of restraint compared to the giddy opulence of the preceding Sydney University Great Hall gastronoganza. The menu showcased the very best of our Australian produce including an array of seafood and the very best of Australian beef served in all its Australiana gusto! We were all well entertained by the band Savvy who played a wide range of songs. Then came Mamma Mia, or was it Dancing Queen, signalling that it’s party-time!

And the dance floor erupted….. The guests squeezed themselves on the dance floor to show off their awesome dance moves. Whether it was inspiration from ‘Dancing with The Stars’ or ‘So You Think You Can Dance’ or simply delusion under the stars – it did not matter – as everyone had the best time! **Dr John Kingsley** and his entourage from Alabama stole the show with their rousing version of ‘Sweet Home Alabama’. Dr Kingsley donned his cool dancing shades and the dance floor was smokin’. Corey Hart meets Robert Palmer. *Hmmm…* hot, or not – you be the judge! The verdict of a ‘mega-good-time’ was delivered by the collective dancing feet, doing their thing through the night!

Septemberfest - Oom-pah Fun @ Bar Thrombus

Another highlight was the Bavarian night at Bar Thrombus, to the sounds of our very own *Oom-pah Band*. **Dr Stirling** and his wife Christine were impressively dressed in their collective Lederhosen and Bavarian best. Dr Stirling showed off a strong pair of legs and looked a very Germanic sight indeed when dancing the chicken dance with **Yana Parsi**. Yana was dressed in her original Bavarian Fraulein outfit, comprising of a white blouse and a cherry empire line dress and there’s no stopping her! **Professor Philip Coleridge Smith** “upped the ante” during the German hat dance dexterously moving the hat around from contestant to contestant without even breaking a bead of sweat!

All good things must come to an end! So we thank all the conference committee members and volunteers who have worked so hard to make the conference the success that we have now come to expect! But we certainly do not take this labour of love for granted. We especially commend our College President **Dr Kurosh Parsi**, and his team of conveners and meeting coordinators, especially the SSVC angels, for their tireless and perfectionist spirit. We hope to see all of you again at the 2009 College meeting!

Conferring Ceremony

Customs House, University of Queensland
Tuesday, 9th September 2008

Ceremony Opening Speeches

Welcome and Introduction of the Members of the Academic Procession	Dr Kurosh Parsi, President Australasian College of Phlebology
A Message from the International Union of Phlebology	Professor Eberhard Rabe, President Union Internationale de Phlebologie

Conferring of Awards

Presentation of Awards of Excellence

Sir Llewellyn Edwards, Chancellor
University of Queensland

Professor Philip Coleridge Smith
Promotion of Research and Scientific Standards in Phlebology

Professor Byung-Boong Lee
Clinical Research and Post-Graduation Teaching of Vascular Anomalies and Lymphology

Professor Eberhard Rabe
Promotion of Phlebology on an International Level

Presentation of Emeritus Fellowship

Professor Ken Myers, Chancellor
Australasian College of Phlebology

Professor Byung-Boong Lee
Professor Peter Woodruff
Dr Thomas Karplus (in absentia)
Professor Hatem Salem (in absentia)

Presentation of Honorary Fellowship

Dr Peter Blombery
Professor Harry Gibbs

Presentation of Invited Fellowship

Dr William Clark
Dr Vikram Puttaswamy (in absentia)

Presentation of Affiliate Fellowship

Dr Philip Bekhor (in absentia)
Dr Scott Dunkley (in absentia)

Presentation of Fellowship Certificate to Advanced Phlebology Training Program Graduands

Dr Stefania Roberts
Dr Andrew Stirling

Presentation of the President's Medal for Sclerotherapy

Dr Owen Roberts

Presentation of Sclerotherapy Certificate

Dr Keh Khor
Dr Alister Lilleyman
Dr Owen Roberts

Congratulatory Speech

Justice Margaret White, Deputy Chancellor
University of Queensland

Launch of the Queensland Faculty

Official Announcement	Dr Kurosh Parsi, President Australasian College of Phlebology
Official Launch	Professor Eberhard Rabe, President Union Internationale de Phlebologie
Acceptance of Speech	Dr Paul Dinnen, Interim Chairman of Queensland Faculty

Ken Myers Oration

Sir Llewellyn Edwards, Chancellor
University of Queensland

Closing Remarks

Dr Louis Loizou, Honorary Secretary
Australasian College of Phlebology

2009 Ken Myers Oration
Sir Llewellyn Edwards AC
Chancellor, The University of Queensland

Conferring Ceremony
Tuesday, 9 September 2008

Acknowledgements:

I begin by acknowledging the traditional owners of the land where we gather, and I pay my respects to elders past and present.

I also acknowledge:

- The Honourable Justice Margaret White
- Professor Ken Myers
- Professor Andre van Rij
- Dr Kurosh Parsi
- Professor Eberhard Rabe
- Members of the Academic Procession and Executive Board of the Australasian College of Phlebology
- international guests
- college members, partners and friends

I am delighted to have the opportunity to address you this evening. It is indeed an honour to deliver an address in the name of a person as distinguished as Professor Ken Myers.

I'm advised that my speech is not supposed to be 'medical' – and that is a great relief, because my own expertise in medicine would pale pitifully beside that of every other person with medical qualifications in this room – including the most 'junior'. I am still proud to be a member of the profession.

You might be aware that medicine has not been my only calling. After a school education in Ipswich (a wonderful city, far removed from the stereotype crafted by Pauline Hanson) I followed the urging of my father, who felt the sting of the Depression and told me to get a trade. I dutifully went into the family electrician business.

I've also been a politician (Member for Ipswich, Health Minister, Deputy Premier and Treasurer), a director on many corporate boards, and have had the exclusive privilege of Chairing Expo '88 - the celebration that is often credited as Brisbane's 'coming of age'. I've been a member of the University of Queensland Senate since 1984 and the Chancellor for almost 15 years.

I would not trade any of these experiences (with the possible exception of some encounters in politics) for a mound of gold. Expo, for instance, enabled me to work with a marvellous team that made Brisbane the happiest place on Earth during 1988.

But if there is one period that stands out as the most rewarding, the most privileged – indeed the happiest - it is my years as a general practitioner in Ipswich. Even as a young boy, I wanted to be a doctor. In those days you did as you were told by your father – so I became an electrician.

Graduating from medicine, some years later, was a dream come true. Formally, my education at The University of Queensland had prepared me for the profession.

But in reality, I learned more from the people I worked with, my patients and their families. One person who stands out was a young woman stricken by polio. She spent 13 years in an iron lung, and I was part of a team that treated her throughout that period. The younger people in this room have perhaps never witnessed the ravages of polio: this young woman could not live without that contraption, could barely move a muscle or speak. Yet she communicated to everyone around her in the most powerful of ways. She inspired us, brought us joy, made us strong. Her spirit sustained her – and us – for 13 years. For me, this memory evokes a time when medicine was not nearly as sophisticated or clever as it is today - but it was at least as rewarding.

As a GP, I was taken into the lives of individuals and families. I shared their triumphs and their sorrows. My colleagues and I did not feel constrained by the threat of litigation or heavy-handed bureaucracy. As doctors, I believe that we cannot avoid being inspired by our patients.

My only advice to you is: don't try to avoid it. Let your patients inspire and teach you, and you will be both a better doctor and a better person.

EVENTS TO REMEMBER

College Calendar – Key Dates

Saturday 6 December 2008		
Board of Censors Meeting	0900-1130	College
Interviews for Advanced Trainee Selection	1200-1300	College
Saturday 24 January 2009		
Basic Trainee Interviews	0900-1200	College
Monday 26 January 2009		
Start of the Training Year 2009		
Saturday 7 February 2009		
Vein School, Journal Club & Trainee Orientation Day	1400-1700	East Sub Div
Saturday 21 February 2009		
Board Meeting and AGM	0900-1300	College
Saturday 7 March 2009		
NSW Case Studies & Clinical Meeting	0900-1200	East Sub Div
Saturday 14 – Sunday 15 March 2009		
Board of Censors	0900-1600	TBA
Tuesday 17 March 2009		
Phlebology Emergency Crisis Management Preceptorship	0800-1700	Royal North Shore Hospital
Saturday 4 April 2009		
Vein School & Journal Club	1400-1700	East Sub Div
Saturday 2 May 2009		
NSW Case Studies & Clinical Meeting	1400-1700	East Sub Div
TBA May 2009		
Ambulatory Phlebectomy Workshop	TBA	East Sub Div
Friday 29 – Saturday 30 May 2009		
Training Courses: Part I and Part II	TBA	Melbourne
Saturday 13 June 2009		
Vein School & Journal Club	1400-1700	East Sub Div
Saturday 4 July 2009		
NSW Case Studies & Clinical Meeting	1400-1700	East Sub Div
Saturday 1 August 2009		
Vein School & Journal Club	1400-1700	East Sub Div
Monday 31 August – Friday 4 September 2009		
UIP World Congress		Monaco
Saturday 12 September 2009		
Vein School & Journal Club	1400-1700	East Sub Div
Monday 21 – Friday 25 September 2009		
22nd International Congress on Lymphology		Sydney
Saturday 26 – Monday 28 September 2009		
Post-congress Satellite		Uluru
Friday 9 October 2009		
Part II Written Exams	0900-1600	TBC
Saturday 10 October 2009		
Part I & Part II Written Exams	0900-1100	TBC
Saturday 17 October 2009		
Exam Preparation	1400-1700	East Sub Div
Saturday 7 November 2009		
Vein School & Journal Club	1400-1700	East Sub Div
Friday 13 November 2009		
Part II Clinical Exams	0900-1600	East Sub Div
Saturday 14 November 2009		
Part II Clinical Exams	0900-1200	East Sub Div
Part I Clinical Exams	1400-1800	East Sub Div
Friday 4 December 2009		
Interviews for Trainee Selection	1300-1500	East Sub Div
Saturday 5 December 2009		
Board of Censors Meeting	0900-1130	College
AGM	1130-1200	College
Monday 18 January 2010		
Start of the Training Year 2010		

CONTACT

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