



ACP2022 SYDNEY

20 - 23 MAY 2022
CROWNE PLAZA, COOGEE

**22ND ANNUAL SCIENTIFIC MEETING OF
THE AUSTRALASIAN COLLEGE OF PHLEBOLOGY**

CONFERENCE HANDBOOK

THE COLLEGE

The Australasian College of Phlebology (ACP) is a modern and progressive society with a young and energetic governance, a comprehensive training program and a dedicated and passionate membership. The ACP organises annual science-driven, dynamic and innovative congresses, workshops and preceptorships.

We are proud to have introduced modern interventional treatment techniques to Australia and New Zealand in the past 25 years including ultrasound guided sclerotherapy (mid-90s), endovenous laser and radiofrequency ablation (early 2000s) and glue ablation (past 5 years).

The ACP was founded in 1993 as the Sclerotherapy Society of Australia by Dr Paul Thibault. In 1999, the Society officially changed name to the Australasian College of Phlebology to coincide with the introduction of its formal training program. Since then, the ACP has established one of the most comprehensive phlebology training programs in the world. Since 1999, the ACP has graduated dozens of venous specialists who now hold teaching, educational and board positions within the College.

The ACP actively promotes education and research in phlebology and serves the general public, governments, insurance providers, regulatory authorities and the industry as a resource regarding venous disorders. The ACP fellowship represents the multi-disciplinary nature of phlebology and includes a variety of medical specialties such as vascular surgery, dermatology, interventional radiology, haematology, vascular medicine and lymphology. Other members of the college include allied health professionals such as sonographers, scientists and nurses with a shared interest in phlebology.

IMPORTANT REMINDERS

- * Virtual Speakers are required to log in to green room 30 minutes prior to their scheduled talk.
- * In-person delegates choose your table for the Gala Dinner, place your name on the chart until 4pm Saturday 21 May.
- * In-person delegates with dietary requirements make your self known to banquet staff.

The Australasian College of Phlebology
Level 5, 7 Help Street,
Chatswood, NSW 2067
T: + 61 2 9386 1811
E: acpasm@phlebology.com.au

EXECUTIVE BOARD

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Jan Cornay

WELCOME

Dear Colleagues and Friends,

It is truly exciting to say that, after almost 3 years, we get to see each other at a conference face-to-face. I was pleasantly surprised at how well received our virtual meeting was last year, but nothing can beat the face-to-face experience.

In 2020, just six weeks out, we had to cancel our New Zealand conference due to the alpha COVID-19 outbreak. In 2021, just six weeks out, we had to change our meeting in Sydney to a virtual event due to the delta COVID 19 outbreak. We have now passed our six week barrier, and it is now time to see (most of) you in person.

For those unable to travel, we hope you enjoy your virtual experience as much as last year. You will be missed, but there are still plenty of opportunities for you to keep in contact during the meeting.

Please ensure that you take the time to meet with our sponsors and exhibitors. They have waited so patiently to see you in person, with many having booked in 2020 to exhibit. Our meetings could not proceed without their involvement, so please take the time to catch up with each of them individually.

Our trainees have also been patiently waiting for a Conferring Ceremony to receive their Certificates and Fellowships. We look forward to see them rewarded for their dedication and persistence at our ceremony this year. Many have had to deal with changes to the traditional training program and examinations, so please ensure you support them by attending their ceremony. The ceremony will be followed by our "Black and Gold" gala dinner, a night that is always unforgettable.

Finally, thank you to all of you who have come to Sydney. Our last Sydney meeting was 15 years ago, so please take the time to enjoy all that Sydney and it's beaches have to offer. For our dear friends at home, make sure we see you sometime soon, whether at a meeting or just together.

Stay safe, stay well and stay together.



Dr David Connor
Convener, ACP2022
The 22nd Annual Scientific Meeting
of the Australasian College of Phlebology



David Connor
Convener ACP2022

LOCATION

COOGEE BEACH, SYDNEY

Coogee is one of Australia's oldest beachside suburbs and is teeming with charm. You've got the obligatory soft white sand, ocean pools, seaside parks and spectacular views but with a relaxed vibe. You'll find adventure too, from coastal walks to snorkelling or diving in an aquatic sanctuary teeming with marine life. Besides swimming and relaxing on soft sand, Coogee Beach is where you can start, or finish, the Bondi to Coogee Coastal Walk. The 6km trail winds along sandstone cliffs to other pretty beaches, including Bronte and Clovelly. You can spot whales along the coast between May and November during their annual migration.

Coogee boasts a vibrant cafe, bar and restaurant scene. The grand Coogee Bay Hotel has been a seaside retreat since 1873. Coogee Pavilion is a multi-level eatery with rooftop bar, Barzura is a popular local café and Bistro on The Greens is a bright, casual option at South Coogee Bowling Club.

GETTING THERE

Getting to Coogee is easy by public transport, with buses stopping next to Coogee Beach, a popular beach for families with young children. It's about a 20 minute drive from the airport or half hour trip from the hub of Central station.

Taxis are readily available on arrival at the airport and the cost is approx. \$30-\$40. All major car rental companies are located at Sydney airport .

WEATHER

May in Sydney is a popular time to travel as the weather is sunny and pleasant with warm days and mild nights. The average daytime temperatures in Sydney are generally around 16°C and hardly fall below the average low of 12°C. The peak temperature of the month can reach a pleasant 20°C.

Sydney in May is generally sunny and perfect for hitting the beach. The temperature of the sea is cooler than at other times of the year but is still warm enough to swim if you do decide to visit the beach. The waters around the coast of Sydney are 20°C on average in May.



CROWNE PLAZA COOGEE

Charming visitors with its pristine coastline and unspoiled beauty, Crowne Plaza Sydney Coogee Beach has been known as one of Sydney's most iconic beach retreats. Recently reimagined to reflect the coastal locale and just steps from Coogee Bay, breathtaking panoramic sea views and a connection to Sydney's landmarks awaits you.

From the moment you arrive, you'll feel the natural spirit of Coogee. With its clear blue waters, cafés, indigenous roots and picture-perfect sea bath, it is the ideal locale for an inspiring seaside break.

Within its commanding position on Sydney's coastline, the hotel offers a stimulating environment, filled with world famous coastal walks, boutique fashion outlets and access to Sydney's latest super venue, Estate, which sits right on our doorstep!

ACCOMMODATION

Escape to our Sydney beachside hotel. With spacious guestrooms and magnificent ocean views, you'll wake up each morning feeling refreshed and relaxed. Our Coogee Hotel offers 210 modern, well-appointed rooms, deluxe bedding, and premium amenities to ensure an enjoyable stay. Many rooms feature a spacious balcony with views of the ocean. It's hotel accommodation in Coogee Beach at its best.

HOTEL DINING

SHUTTERS RESTAURANT: Taking design inspiration from vibrant Miami, the perfect place to relax and look out onto Coogee Beach.

ESTATE KITCHEN: The most sophisticated of the three Estate venues, Kitchen embraces local seafood among classic favourites for local diners and international guests.

ESTATE TAQUERIA: This cantina is brought to life with eccentric patterns, neon lights and bursts of blue and yellow furniture. With 40 different tequilas behind the bar, soft tortilla tacos on the menu and a DJ on Friday and Saturday nights.

ESTATE TERRACE: Drawing inspiration from northern California, channelling beach club vibes with an open-air entertainment area.





XIX WORLD CONGRESS OF THE INTERNATIONAL UNION OF PHLEBOLOGY

12th - 16th September, 2022

**Lütfi Kırdar Convention and Exhibition Center - ICEC
Istanbul, Turkey**

www.uip2022.org



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ORGANISATION SECRETARIAT

SOLO EVENT

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E-mail: uip2022@soloevent.net

VIRTUAL DELEGATE INFORMATION

DELEGATES

All delegates will receive a link to access the conference virtual platform. It will be sent to the email address you registered with. The link will also be available from the conference website. You will be required to log in with the same credentials used when registering for ACP2022. The log in details are NOT the same as the ACP website log in details.

Scan QR below to be taken to website link.



Compatible Browser

All presenters and attendees are required to connect to the platform using the latest version of Google Chrome or Microsoft Edge.

Delegate Troubleshooting

Please go to the conference website to view the troubleshooting guide should you encounter any issues accessing the virtual platform.

Make sure you have the correct log in details you registered with, if you do not remember them you can use the forgotten password link on the virtual platform homepage.

Recordings

Delegates will be able to access the conference recordings from the virtual platform approximately one week after the conference has finished.

SPEAKERS

All speakers are required to log in 30 minutes prior to their scheduled talk to run through the equipment check with our AV technicians Congress Rentals.

Please make sure you are in a quiet space and let those around you know that you are unavailable to avoid sudden interruptions.

Speaker Troubleshooting

If you are having any problems accessing the green room let us know immediately on 0493 043 419.

Internet

High quality internet connection, preferably a wired Ethernet connection is most suitable for presenters. Both download and upload speeds are important. Recommended 5mbps Download/Upload.

Audio Device

It is strongly recommended that an external microphone is used. This can be a USB microphone, headset, or pair of headphones with an inline microphone.

SPEAKERS MUST LOG IN TO THE SPEAKERS GREEN ROOM 30 MINUTES PRIOR TO YOUR SCHEDULED TALK!

medi

COMPRESSION for chronic venous disease and PAD / Diabetes ?

Merino-Plush in the entire foot

Solid ribbed structure

Yes, certainly!

Unique, soft padding from above the ankles down to the tip of the toes

mediven® angio – Safety down to the toes



Extra long, flat seam

to the tip of the toes

mediven® angio

The first and only medical compression stocking whose safety was scientifically evaluated and proven in patients with chronic venous disease and concomitant PAD and / or diabetes mellitus.*

Visit us at booth #3

* Product safety proven by clinical trial: The use of the medical compression stocking mediven angio in patients with chronic venous diseases and concomitant mild to moderate peripheral artery disease (PAD) and / or diabetes mellitus is safe.¹

¹ Rother U et al. Safety of medical compression stockings in patients with diabetes mellitus or peripheral arterial disease. BMJ Open Diab Res Care 2020;8:e001316.

IN-PERSON DELEGATE INFORMATION

SOCIAL EVENTS

Delegates with a full registration receive a complimentary ticket to the Welcome Reception also the Conferring Ceremony and Gala Dinner. Additional tickets for guests are available for purchase pending availability of seating.

If you did not notify us at the time of registration whether you will be attending any of the included functions it will be assumed that you are not attending and you will not have any tickets in your registration pack. If this has changed and you wish to attend a function please notify the conference staff no later than the day prior to the function.

MEALS

Meals are included in the registration fee and will be served in the Experience Gallery for workshop delegates on Friday 20 May and throughout the exhibition area during the session breaks from Saturday 21 to Monday 23 May. All buffet foods are labelled to identify dietary requirements. If you have noted a dietary requirement in your registration, please make yourself known to the banquets team and they will assist you further.

NAME BADGES

Name badges must be visible and worn at all times within the conference venue for access to the meeting. Event tickets will be issued for delegates who have registered to attend the social functions and must be presented if requested to gain access to the event.

MOBILE PHONES

Delegates are kindly requested to keep their mobile phones on silent in the rooms where scientific and educational sessions are being held, as well as during poster sessions.

INTERNET ACCESS

Conference Delegates can access free wi-fi internet in the conference areas of the hotel. Access is gained via the password below.

Password: ACP2022

INSURANCE

The Organising Committee of the conference is unable to accept responsibility for accidents or damage to the private property of delegates. Please ensure that you do not leave portable and valuable pieces of equipment unattended anywhere, and that you make your own arrangements for health, travel, general and other insurance.

CPD

Members of the ACP

All members of the college will be eligible for CPD Points as per the Q & A CPD Program on the college website. All members must retain copies of their Certificate of Attendance as you may be required to produce this during our random yearly audits.

Members of Other Colleges

You will be provided with a Certificate of Attendance. Each college has individual requirements on what can be claimed. CPD with other colleges is generally recorded as a self directed activity.

SPEAKERS PREPARATION ROOM

Speakers are asked to bring their formatted PowerPoint presentations to the Speakers Preparation Room the day prior or at least two sessions before their scheduled presentation. Files from thumb drives can be transferred to the servers at that time.

The speakers preparation room is located in the Bronte room close to the registration desk and will be open as follows:

Saturday 21 May	8:00 AM - 4:00 PM
Sunday 22 May	8:00 AM - 4:00 PM
Monday 23 May	8:30 AM - 3:00 PM

REGISTRATION DESK HOURS

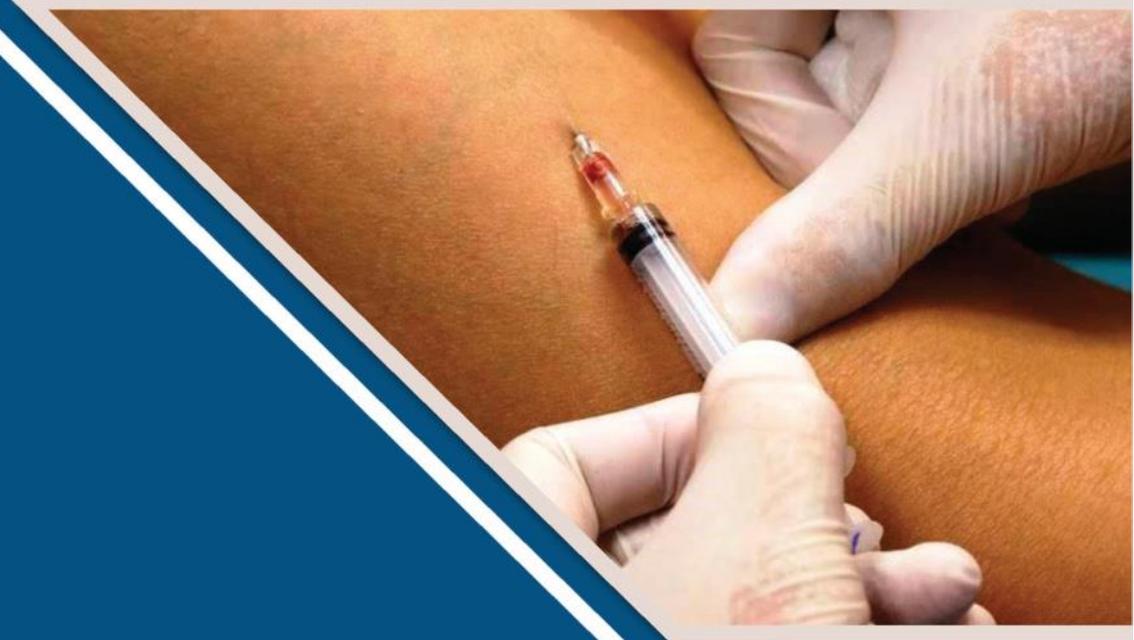
The registration desk will be located in the Experience Gallery for the duration of the conference.

Friday 20 May	8:00 AM - 4:00 PM
Saturday 21 May	8:00 AM - 4:00 PM
Sunday 22 May	8:00 AM - 4:00 PM
Monday 23 May	8:30 AM - 2:00 PM



THE AUSTRALASIAN
COLLEGE OF
PHLEBOLOGY

MANUAL OF VENOUS AND LYMPHATIC DISEASES



Edited by
**Kenneth Myers and
Paul Hannah**



The **Manual of Venous and Lymphatic Diseases** constitutes a concise but comprehensive and contemporary description of the nature and management of venous and lymphatic diseases. This innovative book instructs the post-graduate trainee in phlebology and is also valuable to undergraduate students wishing to gain a broader knowledge than is available in general surgical texts. Additionally, it is a useful reference for practising phlebologists, vascular surgeons and imaging specialists. The text covers basic principles, diagnosis and treatment of chronic venous disease, venous thrombo-embolism, lymphoedema and vascular malformations.

Order online at www.phlebology.com.au

VIRTUAL ACCESS & APP

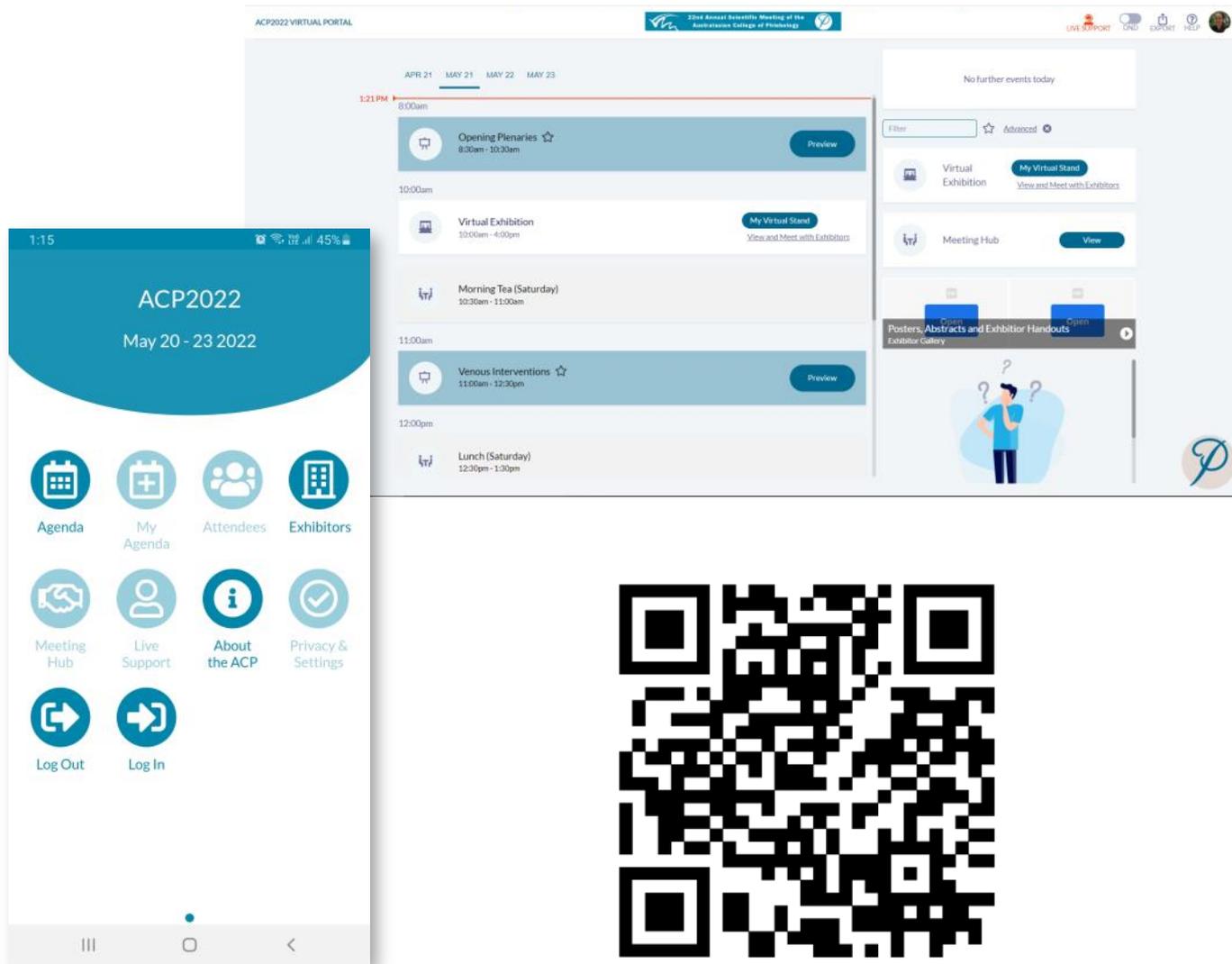
Delegates are encouraged to download the conference app which includes the program and other information.

All delegates will also have access to the Virtual Portal to watch the streams live or at a later date.

For further information on gaining access scan the QR code below or go to <http://www.phlebology.com.au/acp2022/app>

When accessing the app, use the event code ACP2022 and be sure to log in using the details you registered with through EventsAIR.

When logging in to the Virtual Portal use the conference registration details for EventsAIR.



THINGS TO DO IN SYDNEY



Coastal Walk

Perhaps one of most iconic and popular attractions in Sydney is the Bondi to Coogee coastal walk. This is one of the top coastal walks Sydney has to offer, taking in the best of the city's beaches, clifftops and uninterrupted views of the ocean. The Bondi to Coogee walk is just one of many spectacular harbour walks you can enjoy.



Climb the Iconic Sydney Harbour Bridge

The largest steel arch bridge in the world, the Sydney Harbour Bridge is an iconic landmark spanning one of the finest natural harbours known to mankind. Opened in 1932, the bridge is fondly nicknamed the Coathanger by Sydneysiders. You can walk and cycle across the bridge or climb to the top for stunning views.



The Sydney Opera House

The Sydney Opera House constitutes a masterpiece of 20th century architecture. Its significance is based on its unparalleled design and construction; its exceptional engineering achievements and technological innovation and its position as a world-famous icon of architecture.



Camp out in the middle of the harbour

Check in to Cockatoo Island's waterfront campground for unbeatable views of Sydney Harbour as well as access to scenic picnic spots, Barbecue facilities and licensed cafés. A camping experience like no other.



Water Sports

With its incredible harbour, kilometres of coastline and numerous creeks, rivers and waterways, Sydney is an aquatic playground. From wakeboarding on the Hawkesbury River to white-water rafting on an Olympic course, Sydney has an extensive assortment of water sports on offer. Snorkel and dive in one of Sydney's marine reserves, home to blue gropers, yellowtail and more than 160 other species of fish. Zoom across the harbour in a jet boat, take a deep sea fishing charter out into the ocean, or learn how to surf on the iconic Bondi Beach.



Play a round of Golf

It's not hard to find a fabulous golf course in Sydney. There are a number in close proximity to the city centre, perfectly positioned next to the ocean so you can enjoy fantastic views as you tee off. Further afield, you'll discover courses set amongst the tranquil settings of the majestic Hawkesbury River.



Adventure in the City

Sydney's CBD is more than just a place to work, it's a buzzing hub where people want to hang out. Not only are there hip small bars, acclaimed restaurants and buzzing cafes, you've also got marvellous attractions, including UNESCO World Heritage sites, dazzling shows, wonderful galleries, intriguing museums and excellent shopping.



Discover Art and Culture

Sydney's rich and exciting arts scene takes influence from its multicultural heritage and diverse culture. Discover beautiful theatres, galleries, public artworks and fantastic annual events, as well as ancient Aboriginal sites in the NSW capital.



Adventure and Sport

Whether you're a rugby fan, diving enthusiast, avid sailor or expert surfer, you'll find outdoor activities, adventurous challenges and plenty of sport to suit all tastes in Sydney. Battle rapids on an Olympic white-water rafting course, kayak on Sydney Harbour or defy gravity with indoor skydiving.



Aboriginal Culture in Sydney

The importance of Aboriginal culture on Sydney, and the rest of Australia, cannot be understated. The First People of Australia are the oldest continuing living culture on the planet – a storied history cultivated over thousands of years. The impact of Aboriginal heritage can be found all around the NSW capital. Incredible rock carvings share stories from centuries past and Aboriginal tours and galleries give fascinating insight into traditions and beliefs. Events and festivals feature dancing and music performances as well Aboriginal crafts and tools.

INVITED SPEAKERS



Dr Fedor Lurie
Vascular Surgeon, USA

Dr Fedor Lurie MD started his career as an academic vascular surgeon in 1980. He served as the faculty at the Urals Medical Academy (Russia), University of California Davis, and the University of Hawaii. He is

currently the Associate Director of the Jobst Vascular Institute and Adjunct Research Professor at the University of Michigan Ann Arbor.

Dr Lurie's main clinical and research interests are venous and lymphatic diseases, venous physiology, and clinical imaging. He serves as the Director of the ABVLM, Director of the IAC Vein Center Accreditation Board, and member of the Medicare Evidence Development & Coverage Advisory Committee.

Dr Lurie is the Past President of the AVF and the AVF Foundation, member of several committees of the Society for Vascular Surgery, an Honorary Member of the EVF, and several vascular surgery societies.

He served as the principle investigator on multiple clinical trials, published more than 200 original papers, multiple commentaries and review articles, and 19 book chapters. He is also an accomplished speaker with more than 300 presentations worldwide.



A/Prof. Laurencia Villalba
Vascular Surgeon, NSW

Associate Professor Villalba is Wollongong's only female vascular surgeon. Laurencia is the Head of the Vascular department at Wollongong Hospital and founder of the Vascular Care Centre.

A/Prof Villalba is a member of the Court of Examiners for the Australasian College of Surgery

She became an Associate Professor of Vascular Surgery at the University of Wollongong in 2017 where she has been teaching since 2008.

She is the founder and current clinical lead of the Venous Thromboembolism service for the Illawarra/ Shoalhaven Local Health District.



A/Prof. Nuttawut Sermsathanasawadi
Vascular Surgeon, Thailand

Nuttawut Sermsathanasawadi is an Associate Professor in Vascular Surgery with the Department of Surgery at Siriraj Hospital, Mahidol University in Bangkok, Thailand. He graduated medicine from Mahidol University in 1998 and completed a PhD in Vascular and Applied Surgery in Tokyo, Japan in 2010. He is the currently the Chair of the Thai Venous Forum/Thai Vascular Association and has a particular research interest in vascular surgery, venous disease and therapeutic angiogenesis.



Prof. John Devereux
Professor of Common Law, QLD

John Devereux is Professor of Common Law at the University of Queensland. A Rhodes Scholar, Professor Devereux has worked as a lawyer in a variety of contexts including as a Barrister, as a consultant to a multi-national law firm, a Law Reform Commissioner for Queensland, a legal member of the Social Security Appeals Tribunal and the legal member of the Health Quality and Complaints Commission.

He currently serves as a member of the Administrative Appeals Tribunal. John has served with the Australian Defence Force in the Australian Army (infantry) and in the Air Force (legal category). He has seen active service in Iraq and Afghanistan. Professor Devereux was awarded a Bronze Star by the United States of America.



Prof. Vaughan Keeley
Consultant Physician, UK

Vaughan Keeley is a Consultant Physician who specialises in lymphoedema/lymphatic diseases. He leads the lymphoedema service in Derby, Nottingham and

Mansfield, in the East Midlands of the UK.

The service treats all types of lymphoedema/chronic oedema in adults and children. It is one of the two centres in the UK specializing in paediatric and primary lymphoedema, which until the UK left the EU were part of the European Reference Network for Rare Diseases. It is a member of 2 recently established NHS England Rare Disease Collaborative Networks for paediatric and primary lymphoedema (PPL) and somatic overgrowth and vascular malformations (SOVM). In 2020, the service was designated as a Comprehensive Centre of Excellence for Lymphatic Diseases by the Lymphatic Education and Research Network (LERN).

His research interests include the early detection and possible prevention of lymphoedema in breast cancer and quality of life in lymphoedema. He is an Honorary Professor at the University of Nottingham.



Dr Vani Prasad Atluri
Specialist Plastic Surgeon, SA

Vani Prasad is a Plastic and Reconstructive surgeon with expertise in lymphoedema surgery. Vani Prasad undertook specialist surgical training in Plastic and Reconstructive Surgery in Australia and New Zealand and became a Fellow of the Royal Australasian College of Surgeons

(FRACS). He then completed Craniofacial training program for two and a half years in three countries. This included one year at the internationally acclaimed Australian Craniofacial Unit (Adelaide), Wellington (NZ) and in Rotterdam (Netherlands). Vani Prasad undertook further fellowship training in Microsurgery in Winnipeg, Canada and Lymphoedema Supermicrosurgery fellowship with hands-on experience at the National Centre for Global Health and Medicine in Tokyo, Japan.

Vani splits time between Craniofacial Surgery (Public system) and Lymphoedema Surgery (Private Practice). He works as a Visiting Medical Specialist at the Australian Craniofacial Unit at the Women's and Children's Hospital and Royal Adelaide Hospital in Adelaide. Vani offers Lymphoedema surgery in private practice in Adelaide and Melbourne.

Vani is actively involved in Surgical volunteer work in East Timor and Indonesia through Overseas Specialist Surgical Association of Australia (OSSAA). Vani is a member of the Australian Society of Plastic Surgeons, the Australian Lymphology Association and the Plastic Surgery Research Council USA. Vani is an invited speaker at numerous state, national and international conferences to talk about his experience on ICG Lymphatic Mapping and Lymphoedema Surgery.

FACULTY

Prof. Francesco Artale

Ms Evelyn Collier

Dr David Connor

Prof. John Devereux

Dr Paul Dinnen

Dr Joseph Grace

Dr Natasha Harvey

Dr Roland Hilling-Smith

Dr Elizabeth Ibanez

Prof. Fred Joshua

Prof. Adel Kamhway

Dr Mina Kang

Prof. Vaughan Keeley

Dr Alex Lapenga

Dr Gilles Laur

Dr Chris Lekich

Dr Adrian Lim

Prof. Fedor Lurie

Ms Brooke Maitland

Dr Lisa Marks

Dr Sanjay Nadkarni

Prof. Kurosh Parsi

Prof. Neil Piller

Dr Vani Prasad

Dr David Pratt

Dr Stefania Roberts

Prof. Naoki Sakakibara

Dr Nuttawut Sermsathanaswadi

Dr Maya Steeper

Dr Andrew Stirling

Dr Nicolas Teo

Dr Simon Thibault

Dr Paul Thibault

Dr Simon Thibault

Prof. Andre van Rij

A/Prof. Laurencia Villalba

Dr Yunyi Wang



PROGRAM AT A GLANCE

	Friday 20 May	Saturday 21 May	Sunday 22 May	Monday 23 May
0830	Phlebology Training Course	Opening Plenaries	Informed Consent and Treatment Planning	Venous Obstruction, Compression and Thromboembolism
0900				
0930				
1000				
1030	Morning Tea			
1100	Phlebology Training Course	Venous Interventions	Cyanoacrylate Closure	Venous Interventions
1130				
1200				
1230				
1300	Lunch			
1330	Phlebology Training Course: Ultrasound Theory and Practical	Lymphoedema and Lipoedema	Sponsored Session	Challenging Cases and Closing
1400			Venous Interventions	
1430				
1500				
1530	Afternoon Tea			
1600		Trainee and Student Reviews	Poster Session (online)	
1630				
1700		Masterclass		
1730				
1800	Welcome Reception		Conferring Ceremony and Gala Dinner	
Registration	0800-1600	0800-1600	0800-1600	0830-1400
Exhibition		1000-1600	1000-1600	1000-1330
Speaker Room		0800-1600	0800-1600	0830-1500

* Program subject to change

Welcome

Reception

Friday

20 May 2022

6pm – 8pm

Experience Gallery

Join us in the Experience Gallery to enjoy a long awaited catch up with friends and colleagues. Canapes and drinks will be enjoyed in a relaxed atmosphere.

One ticket is included with full registration. Additional tickets are available for purchase.

FRIDAY 20 MAY 2022

PHLEBOLOGY TRAINING COURSE I

Chair: Lisa Marks

- 830** Clinical Diagnosis, Morphology and Classification
Lisa Marks
- 850** Diseases with Telangiectatic Manifestations
Adrian Lim
- 910** Principles of Compression Therapy
Andrew Stirling
- 930** Laser Physics and Vascular Lasers
Adrian Lim
- 950** Clinical Assessment for Lipoedema
Chris Lekich
- 1010** Ultrasound Guided Sclerotherapy
Simon Thibault

1030 Morning Tea

PHLEBOLOGY TRAINING COURSE II

Chair: Andrew Stirling

- 1100** Adverse Effects and Complications of Sclerotherapy
Simon Thibault
- 1120** Endovenous Non-thermal Ablation
Stefania Roberts
- 1140** Endovenous Thermal Ablation
Stuart McMaster
- 1200** Ambulatory Phlebectomy
Paul Dinnen
- 1220** Deep Vein Surgery / Deep Vein Obstruction
David Huber
- 1240** Venous blood flow of the spinal column and Ultrasound assessment
Paul Thibault

1300 Lunch

PROGRAM

PHLEBOLOGY TRAINING COURSE III (ULTRASOUND)

Facilitator: Rachel George-Duif

1330 Theoretical Teaching and Demonstrations
Rachel George-Duif

1430 Practical Teaching
Including Individual Student Practice

Instructors:
Andrew Stirling
Adrian Lim
Joseph Grace

Sonographers:
Rachael George-Duif
Yana Parsi
Michael Cuzzilla

1700 Close

1800

Welcome Reception
Experience Gallery, Crowne Plaza Coogee

2000



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DURING BREAKS
FROM OUR
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SATURDAY 21 MAY 2022

OPENING PLENARIES

Chair: Simon Thibault
Moderator: David Huber

- 830** Introduction and Welcome to ACP2022
Simon Thibault, President of the Australasian College of Phlebology
- 840** The New European Guidelines for CVD
Andre van Rij
- 900** Pelvic Venous Disorders: How to make sense of the new SVP classification
Laurencia Villalba
- 920** Pulmonary Hypertension causing leg swelling: causes and new treatments
Fred Joshua
- 940** The American Venous Forum, American Vein and Lymphatic Society and the Society for Vascular Medicine Expert Opinion
Consensus on Lymphedema Diagnosis and Treatment
Fedor Lurie
- 1000** Panel Discussion

1030 Morning Tea

VENOUS INTERVENTIONS I

Chair: Adrian Lim
Moderator: Kurosh Parsi

- 1100** Pulsatile Perforators
Andre van Rij
- 1120** Immunotherapy Related Rheumatic Disease and Implications for Phlebology
Fred Joshua
- 1140** Cutaneous Necrosis Following Sclerotherapy : Part 1 Review of Mechanisms and Differential Diagnoses
Mina Kang
- 1150** Cutaneous Necrosis Following Sclerotherapy: Part 2 Risk minimisation and management strategies
Mina Kang
- 1200** Panel Discussion

1230 Lunch

* Program subject to change

Gala Dinner

SUNDAY 22 MAY 2022, 5:30PM

Join us in the Oceanic ballroom where guests will enjoy an evening of fine food and great entertainment. The theme of the evening is Black & Gold so dress as dark as the night sky or glitter like the finest gold.

*One ticket is included with full registration, indicate attendance during registration. Additional tickets are available for purchase.

Proudly sponsored by  **oedema institute**
by SIGVARIS GROUP

PROGRAM

LYMPHOEDEMA AND LIPOEDEMA

Chair: Chris Lekich
Moderator: Gilles Laur

- 1330** Renaming Lipoedema: Results of the Australasian Survey
Neil Piller
- 1350** The Adelaide Lipoedema Project: Investigating the genetic basis of lipoedema
Kelly Betterman
- 1410** Indocyanine Green Imaging - Patient, surgeon and therapist benefits
Vani Prasad
- 1430** Surgical Interventions
Vani Prasad
- 1450** Veins and Lymphoedema
Vaughan Keeley

1510 Panel Discussion

1530 Afternoon Tea

TRAINEE AND STUDENT REVIEWS

Chair: Lisa Marks
Moderator: Mina Kang

- 1600** Neuropathic differential causes of leg pain in Phlebology
Nicholas Teo
- 1610** A Review of Reticulate Eruptions
Mina Kang
- 1620** Heparin Induced Thrombocytopenia
Alex Lapenga
- 1630** Lipoedema and Panniculopathy
Gilles Laur

1640 Panel Discussion

MASTERCLASS

Chair: Lisa Marks
Moderator: Mina Kang

- 1700** Masterclass
Kurosh Parsi

PROGRAM

SUNDAY 22 MAY 2022

INFORMED CONSENT AND TREATMENT PLANNING

Chair: Kurosh Parsi
Moderator: Chris Lekich

- 830** Introduction to Session
Kurosh Parsi
- 835** Consent and Informed Consent
John Devereux
- 905** Treatment Planning and Treatment Outcomes
Kurosh Parsi
- 935** Cases arising from informed consent/lack of planning
Alison Rowe
- 955** Round table discussion
Kurosh Parsi - President, International Union of Phlebology
John Devereux - School of Law, The University of Queensland
Alison Rowe - Advocacy and Legal Services, MIGA
Chris Lekich - Phlebologist and Barrister

1030 Morning Tea

CYANOACRYLATE CLOSURE

Chair: Stefania Roberts
Moderator: David Connor

- 1100** Drug Device Delineation- Should the classification of n-BCA endovenous glue as a "Medical Device" be changed?
Kurosh Parsi
- 1120** Cyanoacrylate Granuloma After Cyanoacrylate Closure of Incompetent Saphenous Veins
Nuttawut Sermsathanasawadi
- 1130** Factors Affecting Cyanoacrylate Polymerisation
Joseph Grace
- 1140** EVLA vs Cyanoacrylate Closure - 5 year data from a single centre
Stefania Roberts
- 1150** Segmental Cyanoacrylate Adhesive Closure for Highly Selected Patients: Preliminary Experience
Naoki Sakakibara

1200 Panel Discussion

1230 Lunch

SPONSORED SESSION

- 1330** The Role of a Lymphoedema Therapist in Wound Management
 Susan Butcher
 Session sponsored by SIGVARIS



VENOUS INTERVENTIONS II

Chair: Andre van Rij
Moderator: Stuart McMaster

- 1400** How do we make diagnoses and where does it go right and wrong?
 Fred Joshua
- 1420** The whole truth of the hole in the heart
 Gilles Laur
- 1440** Structural Insights of PFOs
 Roland Hilling-Smith
- 1500** Panel Discussion

- 1530** Afternoon Tea

POSTER SESSION

Chair: Joseph Grace
Virtual Session

- 1600** A 21 year old male presents with 'heavy' legs. An early case of Lipoedema?
 David Pratt
- 1610** Management of Venous Incompetence and Athletic Performance in the Sporting Individual
 David Pratt
- 1620** Challenges of venous ulcer management in the very elderly
 Maya Steeper
- 1630** Endovenous radiofrequency ablation (RF) of accessory saphenous vein (ASV) in an outpatient setting for a complete result: our experience
 Francesco Artale

- 1730** Ceremony Gowning for ACP Academic Procession and Fellowship Recipients
 Pre Ceremony Drinks

- 1800** Conferring Ceremony
 and
 Gala Dinner
 Oceanic Ballroom

PROGRAM

MONDAY 23 MAY 2022

VENOUS OBSTRUCTION, COMPRESSION AND THROMBOEMBOLISM

Chair: Paul Dinnen
Moderator: Sanjay Nadkarni

- 900** Post Thrombotic Syndrome: Novel therapeutic options
Laurencia Villalba
- 920** Popliteal Vein Compression
Andre van Rij
- 940** Venous Compression Syndromes - an update on diagnosis and management
Sanjay Nadkarni
- 1000** Portal Hypertension and Portal Vein Thrombosis
Gilles Laur
- 1010** Panel Discussion

1030 Morning Tea

VENOUS INTERVENTIONS III

Chair: Joseph Grace
Moderator: Paul Thibault

- 1100** Chronic venous disease, platelet and haemostatic abnormalities contribute to the pathogenesis of pigmented purpuric dermatoses
David Connor
- 1110** Usage of Venous Medicare Item Numbers
Joseph Grace
- 1120** Ketogenic diet and its role in Phlebology
Simon Thibault
- 1130** Varicose vein surgery and outcomes amidst the global COVID-19 pandemic
Yunyi Wang
- 1140** The COVID-19 pandemic has resulted in greater disparities in treatment of venous incompetency
Yunyi Wang
- 1150** Perspectives on the Cannulation Experience: A Survey of Clinicians and Patients
Evelyn Collier and Brooke Maitland
- 1200** Panel Discussion

1230 Lunch

CHALLENGING CASES

Chair: Simon Thibault
Moderator: David Connor

- 1330** Effective treatment of Tumescant Assisted Sclerotherapy in hypertrophic facial capillary malformations
Mina Kang

- 1340** Pulsatile bleeds from lower limb vein in 96 year old patient
Stefania Roberts

- 1350** Cerebrospinal Venous Obstruction in CFS: Response to Disulfiram
Paul Thibault

- 1400** Management of Acute Bleeding Varicose Veins
Adel Kamhawy

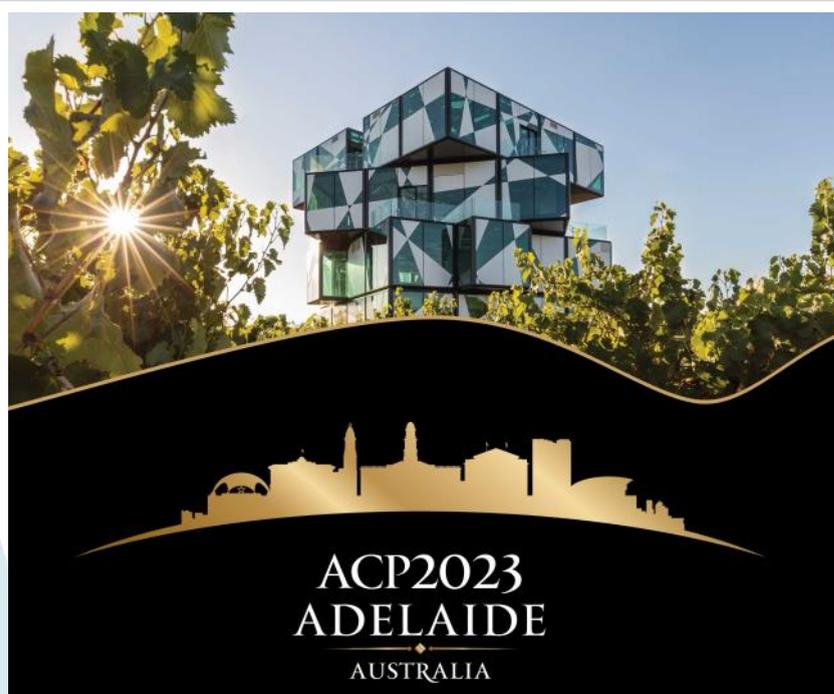
- 1410** Ablation of the Affected Vessels in Livedo Vasculopathy to Prevent Recurrent Ulcerations
Mina Kang

- 1420** Non-touch infrared guided sclerotherapy for chronic venous leg ulcers and bleeding scrotal angiokeratoma
Adel Kamhawy

- 1430** A Wandering Left Ovarian Vein and Pelvic Congestion Syndrome
Farshid Niknam

- 1440** Panel Discussion

- 1500** ACP 2022 Closing



FLOORPLAN

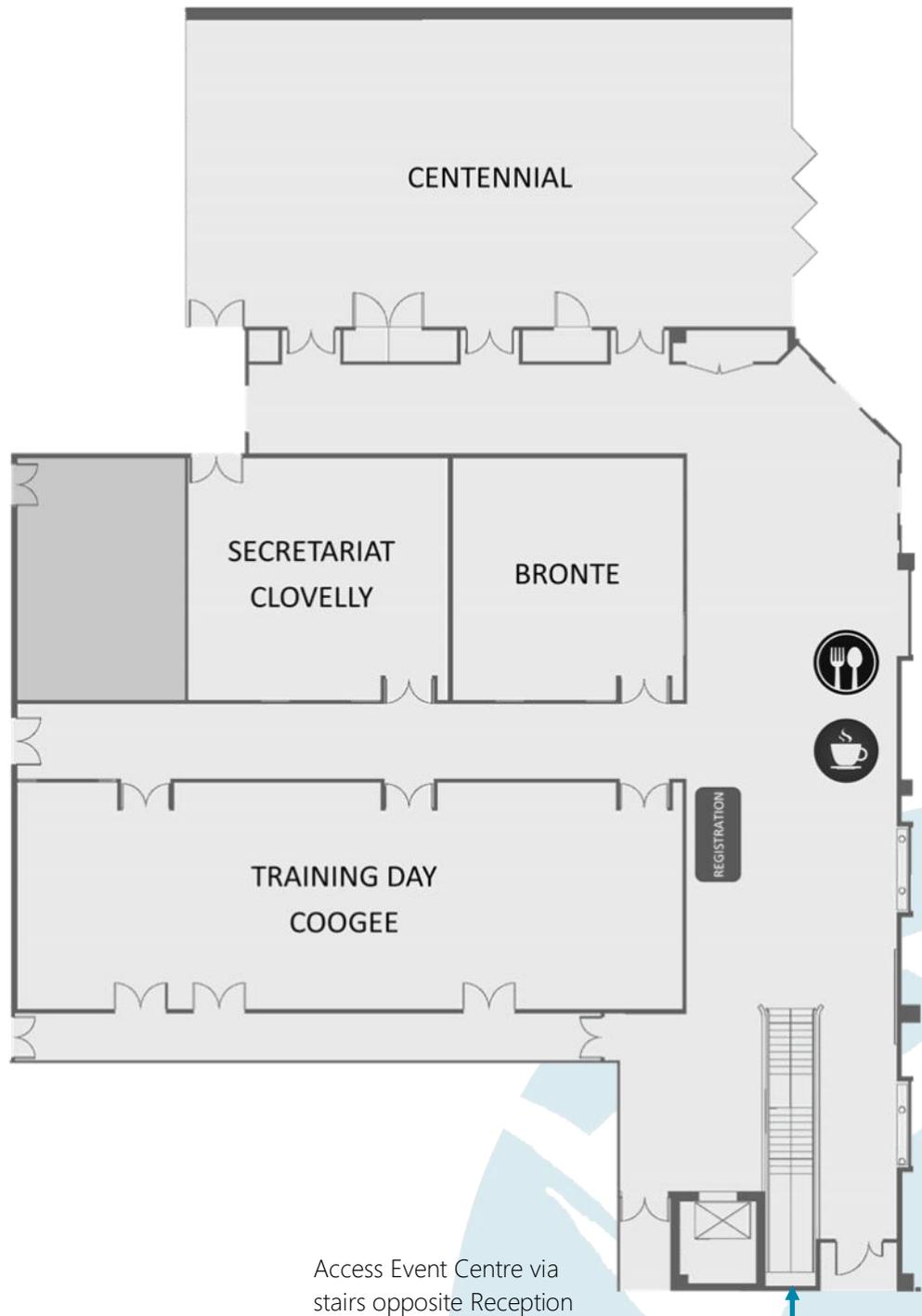
FRIDAY 20TH MAY

Key Events

Phlebology Training Day
Coogee Room

Catering
Experience Gallery

Welcome Reception
Experience Gallery



SATURDAY 21ST TO MONDAY 23RD MAY

Key Events

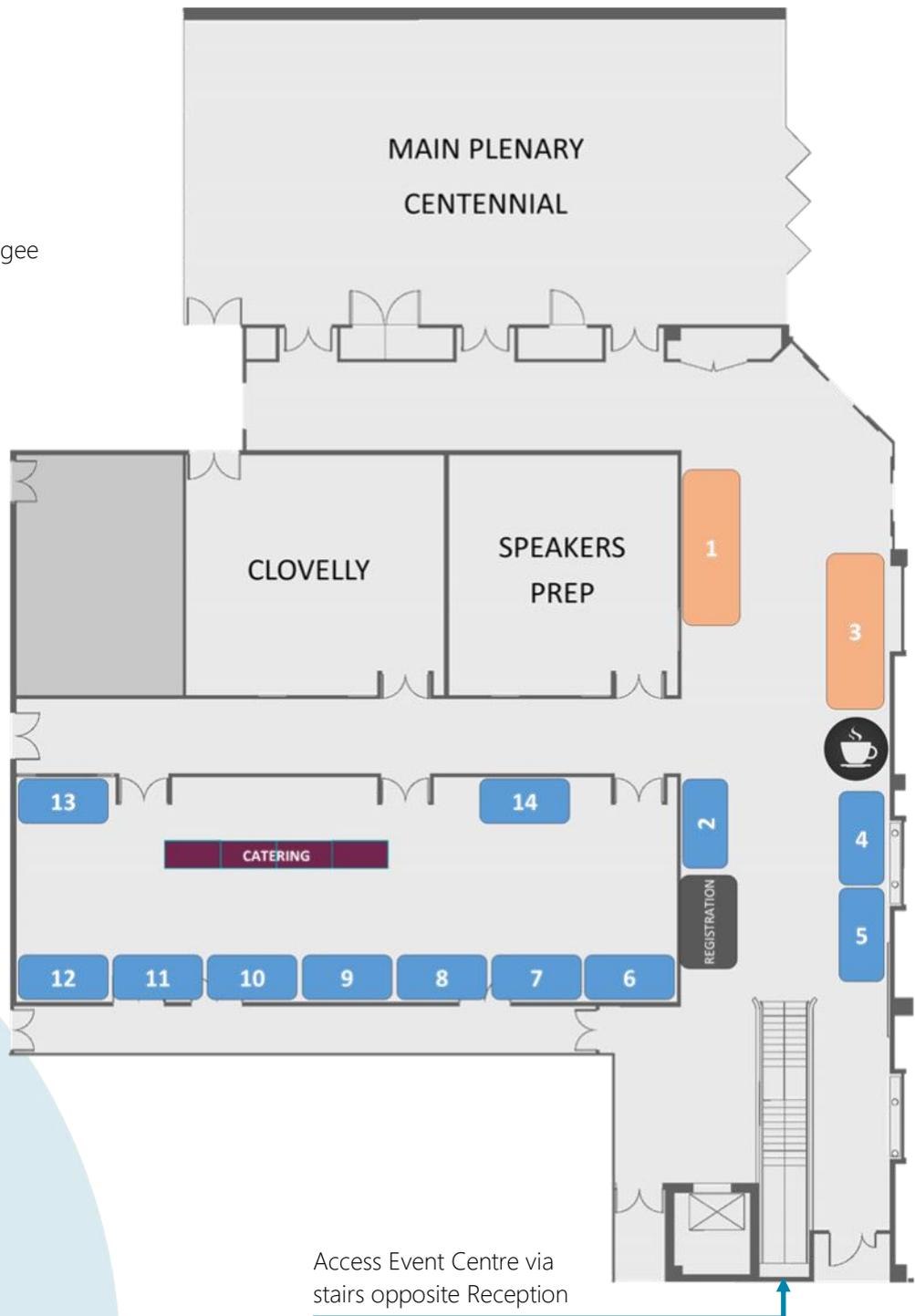
Scientific Sessions
Centennial

Exhibition and Catering
Experience Gallery and Coogee

Speakers Prep
Bronte

VIP Robing
Clovelly

Ceremony and Gala Dinner
Oceanic Ballroom
Reception level



*Floorplan is subject to change

EXHIBITION

EXHIBITOR	BOOTH	EXHIBITOR	BOOTH
AMSL Regenerative Medicine	4	Medical Concepts Australia	13
Concept Health Pharma	12	Medisol	5
Cutera ANZ	10	Medtronic	7
Endotherapeutics	9	Sigvaris Group	1
GE Healthcare	11	Vein Doctors Group	2
Getz Healthcare/Venetix	8	Venosan	6
medi Australia	3		



The Australasian College of Phlebology would like to extend its appreciation to all of our sponsors and exhibitors. Without their continued support we would not be able to bring our meetings to you year after year.

Our exhibitors will be attending in-person but will also have a virtual presence. We encourage all of our delegates to visit our virtual exhibition and have a chat or organise an appointment via the meeting hub. If you are on site be sure to visit our exhibitors during all meal breaks, they are eager to touch base after such a long time.

AMSL Regenerative Medicine Booth 4

Australasian Medical & Scientific Limited (AMSL), subsidiary of Dexcom, Regenerative Medicine Division distributes devices used by Vascular Surgeons, Phlebologists and Cosmetic Physicians for over 25 years. We are exclusive distributors in Australia and New Zealand of Fibro Vein by Merit.

The Regenerative Medicine division also brings an autologous Platelet Rich Plasma (PRP) harvesting device into Australia for use in aesthetic medicine, sports medicine, MSK, and plastic surgery.

 Suzi Chadwick/Courtenay Gray
0499 077 309/02 9882 3999
 events@amsl.com.au
 www.amsl.com.au



Concept Health Pharma (Bruise-eze®) Booth 12

Concept Health Pharma is a wholesale distributor of specialised medication and had become a medical supplies destination for Doctors, Day Surgeries and Medical Centres. As a company passionate about supplying innovative products to health professionals, the addition of the Bruise-eze® range of products to our portfolio provides a new treatment option for CVI.

 Sonia Gibson
0450 262 668
 sonia@concepthealth.com.au
 www.bruise-eze.com.au



EXHIBITORS

Cutera ANZ Booth 10

At Cutera, we develop new solutions that give medical aesthetic professionals the power to adapt, evolve, and stay at the forefront of the field so that they can deliver true patient satisfaction. Ideating, exploring, designing, testing, and developing new solutions is the foundation of our process that has created truly one-of-a-kind devices.



Helen Tudehope

0417 359 820



htudehope@cutera.com



www.cutera.com.au



Endotherapeutics Booth 9

Endotherapeutics was founded in 1999 by Ivan Srejber with a small team, with a focus on innovative, specialised medical technologies that provided access to life-improving solutions to healthcare professionals and their patients. With its mission of "Improving Healthcare" and a strong focus on its values, Endotherapeutics is proud of its strong reputation and relationships with customers and partnering with leading international healthcare companies. Over 20 years of experience has allowed Endotherapeutics to develop extensive knowledge of the Australian and New Zealand healthcare systems. This includes the registration and reimbursement of new medical technologies and their successful sales and marketing. Today Endotherapeutics is a leading Australian healthcare technologies company that operates across both Australia and New Zealand.



Mario Castro

0452 502 713



mcastro@endotherapeutics.com.au



www.endotherapeutics.com.au



Endotherapeutics

Forme Medical

Forme Medical is a privately owned Australian company that was founded in Melbourne in 1985. We have been refining our products with leading Australian medical professionals over the past 35 years to design and develop premium, functional examination couches and treatment tables that meet the exacting standards required by medical practitioners and specialists. Forme Medical has sold thousands of treatment tables and examination couches across Australia and internationally, including into public and private hospitals, medical service networks and private clinics and practitioners. In 2021 Forme Medical was acquired by Alevo Pty Ltd and became part of the Alevo family which also includes Athlegen Treatment tables, Centurion Treatment tables and Azima, adding to the rich history of development and service provided by Forme Medical.



Jen Gander

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www.formemedical.com.au



GE Healthcare

Booth 11

As a leading global medical technology, diagnostics and digital solutions innovator, GE Healthcare enables clinicians to make faster, more informed decisions through intelligent devices, data analytics, applications and services, supported by its Edison intelligence platform.

With over 100 years of healthcare industry experience and around 50,000 employees globally, the company operates at the centre of an ecosystem working toward precision health, digitizing healthcare, helping drive productivity and improve outcomes for patients, providers, health systems and researchers around the world.



Hashim Behdasht

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Hashim.Behdasht@ge.com



www.gehealthcare.com.au



Getz Healthcare/Venetix

Booth 8

Getz Healthcare is a supplier of high-end products and services across Australia and New Zealand since 1965. We currently represent over 45 leading brands providing access to over 200 healthcare solutions for clinicians and patients across the region. Our extensive range of innovative, high quality products and integrated solutions work together to create an efficient and effective working environment and enhanced patient experience.

Our venous health division covers a full range of products for Phlebology including sclerotherapy, radiofrequency ablation, and compression stockings. Visit our friendly staff in booth #8 to learn more about our complete solutions for Venous Health.



Karen Barclay

0434 692 757



karenbarclay@getzhealthcare.com



<http://venetix.getzhealthcare.com>



medi Australia

Booth 3

medi continues to be a leader compression with innovative technology. Come and experience medi vision. With medi vision, your legs are scanned with a 3D camera, generating an exact 3D model with all relevant measurements – contactless – with a perfect fit. medi vision is flexible and mobile – can be used in hospitals, clinics or during home visits.

Our motto “medi, I feel better”, worldwide helps people increase their quality of life: Whether it’s varicose veins, or chronic wounds – medi’s products and treatments contribute to treatment success for many diseases and ailments.



Alex Carver

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www.mediaustralia.com.au



EXHIBITORS

Medical Concepts Australia Booth 13

Medical Concepts Australia has manufactured drapes, gowns & surgical kits in Melbourne since 1986.

We offer the ability to custom make surgical drapes to suit individual needs. We also offer a complete range of products that are required for Phlebology and related procedures – from gowns to probe cover sets, split sheets, single sterile drapes.

With over 30 years of expertise & experience Medical Concepts is proud to be recognised as one of Australia's leading manufacturers.



Kate Williamson

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www.medconcepts.com.au



Medisol Booth 5

MEDISOL was founded in 2018 in Sydney, Australia with the aim of supplying high quality, reliable and cost-effective medical devices and consumables to the public and private health institutions by utilizing the experience gained in the sector since 2003

MEDISOL currently supplies fibre beam guides (radial and bare tip), Radio Frequency Ablation systems and also in the process of getting approval for cyanoacrylate glue. All products have EC, ISO and some of them FDA certificates.

MEDISOL aims to reach the target audience with most suitable price, high quality and continuous service with solutions of clinically proven, high-tech devices and consumables.



Huseyin Yontar

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www.medisol.com.au



Medtronic Booth 7

Medtronic is a global leader in medical technology, services, and solutions. We collaborate with others to take on healthcare's greatest challenges.

Our Australasian headquarters are in Macquarie Park, in the northwest of Sydney, Australia. We have hubs in Melbourne, Brisbane, Adelaide, Perth and Auckland.

Medtronic Australasia now employs more than 800 staff across Australia and New Zealand. All are passionate about providing access to medical technology that changes the face of chronic disease.



James Chiou

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James.chiou@medtronic.com



www.medtronic.com



Sigvaris Group

Booth 1

At Sigvaris, we care about people. Our history and experience with compression products goes back more than 150 years.

For almost 60 years, Sigvaris medical compression solutions have offered effective and reliable support for vascular conditions. Anywhere, anytime. For everyone.

Ultimately, we are dedicated to helping people feel their best. Everyday!



Viktoriiia Korolova
0429 609 075



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www.sigvaris.com



Vein Doctors Group

Booth 2

Vein Doctors Group is a leading phlebology group with seven doctors providing venous services in Gold Coast, Brisbane, Ballina, Cairns, Mackay, Sydney and Melbourne. Vein Doctors Group is proud to provide career pathways to trainee phlebologists, as well as succession pathways to senior doctors. As a growing group, we are currently seeking clinic locations with a high demand for venous services as well as trainee phlebologists to work alongside our supervisors to meet this demand. Careers with Vein Doctors Group offer training by our experienced supervisors and medical director, collaboration with other Phlebologists and trainees within the group, rewarding mentorships, as well as provision of the full range of marketing, administration, governance, IT, accounting, patient and practice management services.



Sarah Pickup

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spickup@miamiprivatohospital.com.au



www.veinclinic.com.au



Venosan

Booth 6

VENOSAN Compression Stockings are manufactured by Lohmann & Rauscher (L&R), a leading global manufacturer of high-quality, innovative wound management, compression products as well as operating room consumables & apparel. L&R has over 170 years' experience around the world, focusing on providing solutions that meet clinician and patient needs. In Australia, L&R has created a dedicated Sales and Support team focused on Compression, to service clinicians, and in turn ensure positive outcomes for patients. With brands such as VENOSAN® (including Flat Knit & Made to Measure), ReadyWrap™ and Rosidal®, L&R are uniquely placed to provide compression solutions throughout the entire patient journey, from the acute to maintenance phase.



Robyn Wight

0416 773 288



Robyn.Wight@au.LRMed.com



www.lohmann-rauscher.com/en/products/compression-support-retention/compression-therapy/compression-stockings/venosan/



Oedema Institute

PATIENT JOURNEY



01

PATIENT RECOVERING POST SURGERY

Stephanie is recovering from vascular surgery



02

REFERRAL FROM SURGEON

Stephanie has been referred to the Oedema Institute as a part of managing her post surgery pains and oedematous legs

Specialising in treatment pre & post surgery



LASER THERAPY

Especially effective for those suffering from lipoedema



LYMPHATIC MASSAGE

Directing Lymphatic fluid out of tissue and encouraging improved lymphatic flow

COMPRESSION GARMENT ADVICE

Education on the importance of garment types and self management!



06

PAIN FREE - READY TO MOVE

Stephanie is now feeling better after surgery, following treatment at The Oedema Institute

Call us

Ph: 03 9641 9988

Fax: 03 9923 6689





oedema institute
by SIGVARIS GROUP

03 CONSULTATION WITH THERAPIST

Stephanie has been assessed by a Specialised Lymphoedema Therapist, and discussed her treatment options



04 PUMP THERAPY AND LYMPHATIC MASSAGE

Stephanie has agreed to multiple treatments of pump therapy and lymphatic massage



05 LIAISE WITH REFERRER

The therapist has written reports to the surgeon and patient's GP



Suite 4, M City
Medical 2107
Dandenong Road,
Clayton VIC 3168



ABSTRACTS



Pelvic Venous Disorders: How to make sense of the new SVP classification

Associate Professor Laurencia Villalba

Opening Plenaries, May 21, 2022, 8:30 AM - 10:30 AM

Syndromic terminology for pelvic venous disorders such as May-Thurner, nutcracker or pelvic Congestion syndromes should be abandoned and the new symptoms-varices-pathophysiology (SVP) classification embraced to avoid confusion and allow clinicians to categorise these diverse patient populations into more homogenous groups, which will allow for better comparisons, data analysis and treatment guidelines.

Over the past decade, there has been increasing research and knowledge gained on the pelvic veins, which has improved our understanding of how they relate to acute and chronic venous disease. Our ability to treat these veins with minimally invasive techniques has also grown exponentially. However, traditional syndromic terminology has made it difficult to have consistent reporting standards and outcome measures, which in turn has affected the interpretation of the available literature. The lack of uniformity in definition and diagnostic criteria has had a negative effect on the credibility of the existence of these syndromes, which has potentially resulted in patients remaining underdiagnosed and undertreated.

Symptoms and signs associated with pelvic venous disorders relate to venous hypertension and depending on where that happens, will determine the symptoms that the patient will present with. The most common presentations are: • chronic pelvic pain • venous claudication • lower limb varices (typical or atypical) • flank pain and haematuria. It is important to note that different symptoms can come from the same vein lesions and different lesions can cause similar symptoms.

The symptoms-varices-pathophysiology (SVP) classification is meant to complement the widely accepted Clinical Etiologic Anatomic Physiologic (CEAP) classification, it is patient centred, as in 'S' for symptoms, guides towards the anatomical location of the varices 'V' and facilitates addressing the best way to manage the issue by including the pathology 'P' (reflux or obstruction, thrombotic or non-thrombotic).



SATURDAY

OPENING PLENARIES

Pulmonary Hypertension causing leg swelling: causes and new treatments

[A/Prof Fredrick Joshua](#)

Opening Plenaries, May 21, 2022, 8:30 AM - 10:30 AM

Pulmonary Hypertension is a problem that is often unrecognised resulting in substantial morbidity and mortality. Once identified treatment is through specialised clinics of which "The Sydney Pulmonary Hypertension Specialists Clinic" is the largest private pulmonary hypertension clinic in Australia. This presentation will explain the relevance and how pulmonary hypertension can be recognised, the causes and the new treatments that are available as well as the cross section of patients seen at our clinic.



The American Venous Forum, American Vein and Lymphatic Society and the Society for Vascular Medicine Expert Opinion Consensus on Lymphedema Diagnosis and Treatment

Dr Fedor Lurie

Opening Plenaries, May 21, 2022, 8:30 AM - 10:30 AM

Background

Lymphedema imposes a significant economic and social burden in modern societies. Controversies about its risk factors, diagnosis, and treatment permeate the literature. The goal of this study was to assess experts' opinions on the available literature on lymphedema while following the Delphi methodology.

Methods

In December of 2019, the American Venous Forum created a working group tasked to develop a consensus statement regarding current practices for the diagnosis and treatment of lymphedema. A panel of experts was identified by the working group. The working group then compiled a list of clinical questions, risk factors, diagnosis and evaluation, and treatment of lymphedema. Fifteen questions that met the criteria for consensus were included in the list. Using a modified Delphi methodology, six questions that received between 60% and 80% of the votes were included in the list for the second round of analysis. Consensus was reached whenever >70% agreement was achieved.

Results

The panel of experts reached consensus that cancer, infection, chronic venous disease, and surgery are risk factors for secondary lymphedema. Consensus was also reached that clinical examination is adequate for diagnosing lymphedema and that all patients with chronic venous insufficiency (C3-C6) should be treated as lymphedema patients. No consensus was reached regarding routine clinical practice use of radionuclide lymphoscintigraphy as a mandatory diagnostic tool. However, the panel came to consensus regarding the importance of quantifying edema in all patients (93.6% in favor). In terms of treatment, consensus was reached favoring the regular use of compression garments to reduce lymphedema progression (89.4% in favor, 10.6% against; mean score of 79), but the use of Velcro devices as the first line of compression therapy did not reach consensus (59.6% in favor vs 40.4% against; total score of 15). There was agreement that sequential pneumatic compression should be considered as adjuvant therapy in the maintenance phase of treatment (91.5% in favor vs. 8.5% against; mean score of 85), but less so in its initial phases (61.7% in favor vs. 38.3% against; mean score of 27). Most of the panel agreed that manual lymphatic drainage should be a mandatory treatment modality (70.2% in favor), but the panel was split in half regarding the proposal that reductive surgery should be considered for patients with failed conservative treatment.

Conclusion

This consensus process demonstrated that lymphedema experts agree on the majority of the statements related to risk factors for lymphedema, and the diagnostic workup for lymphedema patients. Less agreement was demonstrated on statements related to treatment of lymphedema. This consensus suggests that variability in lymphedema care is high even among the experts. Developers of future practice guidelines for lymphedema should consider this information, especially in cases of low-level evidence that supports practice patterns with which the majority of experts disagree.

SATURDAY

VENOUS INTERVENTIONS

Immunotherapy Related Rheumatic Disease and Implications for Phlebology

A/Prof Fredrick Joshua

Venous Interventions, Centennial Room, May 21, 2022, 11:00 AM - 12:30 PM

Metastatic melanoma is increasingly treated with checkpoint inhibitors; "immunotherapy". This has resulted in stimulation of the immune system and marked improvements in metastatic melanoma survival. It is however associated with a number of side effects including rheumatic disease presentations. The importance of immunotherapy and its increasing use in cancer management as well as rheumatic disease side effects will be discussed in this presentation.



Cutaneous Necrosis Following Sclerotherapy: Part 1 - Review of Mechanisms and Differential Diagnoses

Dr Mina Kang

Venous Interventions, Centennial Room, May 21, 2022, 11:00 AM - 12:30 PM

Introduction

Though uncommon, post-sclerotherapy cutaneous necrosis is a potentially debilitating complication. However, its pathogenic mechanisms are poorly understood in the literature and accurate diagnosis of the implicated mechanism remains a challenge for most clinicians. To classify the pathogenic mechanisms, we propose a morphological approach based on the clinical pattern of necrosis as round or stellate patterns.

Method

A comprehensive literature review was conducted to investigate the pathogenic mechanisms implicated in cutaneous necrosis post sclerotherapy. Based on this, a morphological classification approach was proposed depending on the clinical pattern of necrosis as round versus stellate patterns.

Results

Extravasation of sclerosants, in particular irritant or osmotic types, result in round pattern necrosis which has smooth and non-geographic borders. Historically, extravasation has been cited as the main cause of sclerotherapy-related necrosis, it is far less likely with the use of detergent agents particularly in the foam format. Stellate (star-like) pattern of necrosis represents arteriolar occlusion, that results from either inadvertent intra-arterial injection or a correctly executed intravenous, or intra-telangiectatic injection, with the former resulting in much more extensive and larger area of stellate necrosis than the latter. Intravenous injections can follow necrosis secondary to the veno-arteriolar reflex vasospasm (VAR-VAS) or intravenous injection in the vicinity of persistently open arterio-venous anastomoses (AVAs). The VAR-VAS may follow a high-pressure injection causing an acute rise in intravenous pressures. It involves reflex spasm of the pre-capillary sphincters, entry of sclerosant into the arteriolar side of the circulation most likely via AVAs resulting in arteriolar occlusion.

Conclusions

Morphological classification system based on the round vs stellate pattern of necrosis improves the understanding of the implicated pathogenic pathway, and enables more accurate diagnosis of the complication.

Cutaneous necrosis following sclerotherapy: Part 2- Risk minimisation and management strategies

Dr Mina Kang

Venous Interventions, Centennial Room, May 21, 2022, 11:00 AM - 12:30 PM

Introduction

Tissue necrosis is a serious but rare complication of sclerotherapy. Prompt detection and targeted management are essential to prevent progression and minimise serious complications.

Methods

A comprehensive literature review was conducted to examine the risk factors and management strategies of tissue necrosis following sclerotherapy

Results

Risk factors must be optimised to reduce the chance of necrosis following sclerotherapy. These may be treatment-related including poor choice of sclerosant type, concentration, volume or format, poor injection technique, suboptimal ultrasound visualisation and treatment of vessels in high-risk anatomical areas. Risk factors specific to individual patients should be identified and optimised pre-operatively. Tissue necrosis is more likely to occur with extravasation of irritant sclerosants such as absolute alcohol, sodium iodide, bleomycin and hypertonic saline whereas extravasation of foam detergent sclerosants rarely results in tissue loss. Proposed treatments for extravasation of irritant sclerosants include infiltration of an isotonic fluid and hyaluronidase. Management of inadvertent intra-arterial injections may require admission for neurovascular observation and monitoring for ischaemia, intravenous systemic steroids, anticoagulation, thrombolysis and prostanooids infusion when required. Treatment of veno-arteriolar reflex vasospasm (VAR-VAS) necrosis follows the same protocol involving systemic steroids but rarely requires hospital admission and may not require anticoagulation. In general, treatment of post-sclerotherapy necrosis is challenging and most proposed treatment measures are not evidence-based and only supported by anecdotal personal experience of clinicians. Mid to long-term measures include addressing exacerbating factors, management of medical and psychosocial comorbidities, treatment of secondary infections and referrals to relevant specialists. All ulcers should be managed with compression and prescribed dressing regimes in line with the healing stage of the ulcer.

Conclusions

Ultimately, management to post-sclerotherapy necrosis remains challenging. Thus, prevention of necrosis through careful ultrasound imaging, selection of sclerosants and consideration of anatomical and patient-specific risk factors remains paramount.

Renaming Lipoedema: Results of the Australasian Survey

Professor Neil Piller¹, Dr Gilles Laur²

¹Lymphoedema Clinical Research Unit, Flinders Centre for Innovation in Cancer, Bedford Park, Australia, ²Ocean Shores Medical Centre, Australia

Lymphoedema and Lipoedema, Centennial Room, May 21, 2022, 1:30 PM - 3:30 PM

Introduction

The UIP and the Deutsche Gesellschaft für Phlebologie have initiated a project regarding the re-naming of Lipoedema. This is the first step in a wider process which will consider a raft of possible changes regarding aetiology, assessment, treatment, and management of lipoedema related to a consensus document initially published in the Journal Wound Care 1 led by Tobias Bertsch.

Why the need for a new name? The name "lipoedema" is seen to be misleading since "it suggests a central role of extracellular oedema in the pathogenesis of this condition and because it suggests that this condition should be treated similar to other oedemas such as lymphoedema, oedema in acute and chronic venous diseases and cardiogenic oedema" There were some "recommendations" we had to consider which were 1) The names uniqueness (not used for other conditions), 2) its relevance (reflecting manifestations or biology or path of the disorder) 3) the practicality of the name (clear meaning /easy to use) and had to adhere to acceptable language and expression internationally and be culturally neutral. Of course, if we did not want a name change then the reasons for this needed to be presented for consideration.

Methods

As part of this renaming process, we sought the views of the ACP membership using Survey Monkey administered by Zivka Nicholls.

Results

35 responses were received with views evenly spread as to why the name should change and why it should not. Among the suggestions for name change were lipodynia, lipophyma and lipohypertrophy. The reasons for maintaining the name included, that it's a name well known by patients and practitioners. Further details will be presented at our meeting.

Discussion

There have been many myths about many aspects of lipoedema which continue to appear in the literature. Some of these myths have been seen as facts by many. This may have resulted in sub-optimal treatment for lipoedema patients. The search for a new name from professional groups around the world is first step to correct these problems and aimed at better patient outcomes.

1 Bertsch, T et al Lipoedema: A paradigm shift and consensus. Journal of Wound Care, 2020, 29, Suppl 2, 11, 2-51

The Adelaide Lipoedema Project: Investigating the genetic basis of lipoedema.

Dr Kelly Betterman¹, Michelle Parsons^{2,3}, Marielle Esplin^{2,3}, Milena Babic^{1,4}, Julia Dobbins^{1,4}, Simon Khoury⁵, Leila Eshraghi^{6,7}, Luis Arriola-Martinez^{1,4,8}, Peer Arts^{1,4,8}, Jinghua Feng^{8,9}, Rob King⁸, Rosalie Kenyon⁸, Alan McGovern⁸, Ming Lin⁸, Eric Haan¹⁰, Professor Neil Piller^{2,3*}, Hamish Scott^{1,4,8,10*}, Natasha Harvey^{1,10*}

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Lymphoedema and Lipoedema, Centennial Room, May 21, 2022, 1:30 PM - 3:30 PM

Lipoedema, first described in 1940 by Allen and Hines, is a chronic, progressive, incurable condition that occurs almost exclusively in women presenting as bilateral, symmetric enlargement of the buttocks, thighs and lower legs. The prevalence of lipoedema remains enigmatic due to the lack of consistent diagnostic criteria, combined with its frequent misdiagnosis with other similarly presenting diseases, including lymphoedema and obesity. The precise mechanism and genetic basis of lipoedema are also currently unknown, although evidence exists for both hormonal and hereditary influences. Furthermore, lymphatic dysfunction has also been suggested to play a role in the pathogenesis of lipoedema.

The hereditary nature of lipoedema prompted us to investigate whether there was a genetic event that might be responsible. To address this question, we recruited 166 individuals to the Adelaide Lipoedema Project; 98 women affected with lipoedema and 66 family members. By undertaking whole exome sequencing of this cohort, we seek to identify the genetic basis of lipoedema in these families. Understanding the genetic basis and deregulated molecular pathways that lead to lipoedema will provide new tools for diagnosis and pave the way for the design of novel therapeutics to aid treatment of this debilitating condition, ultimately improving quality of life for affected individuals.

* these authors contributed equally

Veins and Lymphoedema

Prof Vaughan Keeley

Lymphoedema and Lipoedema, Centennial Room, May 21, 2022, 1:30 PM - 3:30 PM

Traditionally, chronic oedema due to venous disease has been considered to be a separate entity from that due to lymphatic disease (lymphoedema). It is increasingly recognised that many patients have oedema with both venous and lymphatic components eg in lymphoedema distichiasis, breast cancer treatment related lymphoedema of the arm and any condition where there is venous hypertension.

Whenever there is venous hypertension, capillary filtration into the interstitial space increases. This leads to an increase in lymphatic drainage and if the two are balanced, no oedema will develop. However, if the raised capillary filtration exceeds the maximum transport capacity of the lymphatic system to drain the extra fluid, then oedema will develop (high output failure). It seems that persistent high flow through the lymphatic system, causes damage to lymphatics in the long term and therefore reduced lymphatic flow, making the oedema worse. Thus, lymphatic failure is responsible for the oedema of venous disease, both in the short and long term.

This mechanism raises the issue about whether early intervention to reduce venous hypertension, before lymphatic damage occurs, may improve the oedema before it becomes irreversible.

Generally it is felt that early intervention with compression after deep vein thrombosis reduces the risk of long term post thrombotic oedema and the above mechanism may be important in this effect.

Early intervention for superficial venous incompetence may, therefore, also reduce the risk of chronic swelling but in some countries, such as the UK, guidelines recommend surgical intervention only when there are established complications of venous incompetence such as lipodermatosclerosis, ulceration and oedema.

The same argument may apply when there is there is venous hypertension in other conditions such as obesity, immobility and chronic heart failure.

Neuropathic differential causes of leg pain in Phlebology

Dr Nicholas Teo¹
¹Vein Doctors, Miami, Australia

Trainee and Student Reviews, Centennial Room, May 21, 2022, 4:00 PM - 5:00 PM

Introduction

Chronic neuropathic pain is an easily missed, yet important differential diagnosis for leg pain. Neuropathic pain can have features that mimic venous insufficiency pain and is important to differentiate prior to treatment. Neuropathic pain can co-exist with and complicate venous pain by impairing the veno-arteriolar reflex. Identifying neuropathic pain early in diagnosis and prior to planning management for venous disease will be useful for the Phlebologist. I performed a literature review to identify which neuropathic syndromes of the leg in particular had these mimicry features, and how to differentiate these syndromes from venous pathology.

Methods

I analyzed vascular surgical textbooks, neurosurgical textbooks and neurosurgical journal articles to identify neuropathic syndromes that could mimic venous symptoms that would be useful for Phlebologists to know.

Results

I identified two lower limb neuropathy syndromes in particular with features which can be confused for venous symptoms. These syndromes are saphenous neuropathy and tarsal tunnel syndrome.

Conclusions

Neuropathic leg pain and its syndromes are useful for the Phlebologist to know and differentiate from venous symptoms. Two such syndromes are saphenous neuropathy and tarsal tunnel syndrome. While other neuropathic syndromes such as sciatica and peroneal neuropathy also have features which can mimic venous symptoms, they are more readily identified and differentiated from pain from venous insufficiency. These syndromes are further discussed with most common areas of compression, symptoms and identifying features which help to differentiate these symptoms from venous insufficiency.

A Review of Reticulate Eruptions

Dr Mina Kang

Trainee and Student Reviews, Centennial Room, May 21, 2022, 4:00 PM - 5:00 PM

Introduction

Reticulate eruptions (RE) refer to a group of dermatoses that exhibit a net-like, branched or stellate (star-like) configuration. However the classification, clinical manifestations, and terminology surrounding reticulate eruptions are confusing and conflicting.

Methods

A comprehensive literature review was conducted to propose a classification according to the underlying vascular pathology.

Results

Reticulate eruptions can be classified into the following three groups. These include: i) functional (non-inflammatory/non-occlusive, NON-RE), ii) inflammatory (I-RE) and iii) occlusive (O-RE) reticulate eruptions. Livedo reticularis (LR) is the classic example of NON-RE that presents with a diffuse, symmetric and generalised distribution. LR may be classified into two sub-types of vasospastic and venocongestive based on the underlying microvascular haemodynamics. Vasospastic LR is commonly seen in young females as a 'physiologic' finding and is due to an oestrogen-driven increase in vasomotor tone. It may also be caused by catecholamine-releasing tumours such as pheochromocytoma or drugs such as catecholamines, amantadine and quinidine. Venocongestive LR is a pathological finding due to sluggish drainage of the sub-dermal reticular venous plexus. This sub-type may be a manifestation of an underlying hyperviscosity syndrome found in conditions such as polycythaemias or multiple myelomas. LR should be differentiated from livedo racemosa which presents with a 'broken', branched or focal presentation and is caused by an inflammatory process such as vasculitis of medium-sized vessels or thrombo-occlusive processes as seen in livedo vasculopathy.

Conclusions

A clear understanding of the pathophysiologic mechanism behind the manifestations of reticulate eruptions are necessary to better differentiate between the various types of reticulate eruptions and improve treatment approach for the underlying disease.



Heparin-induced thrombocytopenia

Dr Alex Lapenga¹

1Cairns Skin Centre, 161 Pease Street, Manoora, Australia

Trainee and Student Reviews, Centennial Room, May 21, 2022, 4:00 PM - 5:00 PM

Objectives

To update Phlebologists on the history and current knowledge of Heparin Induced Thrombocytopenia (HIT).

Methods

A literature search was conducted using Google Scholar and 'UpToDate'.

Results

Multiple studies were identified that described HIT from a historical perspective to current day practice.

Discussion

HIT is a relatively common condition that has only been well understood for the last 30 years. It is essential to have a working knowledge of its management.

HEPARIN INDUCED THROMBOCYTOPENIA AND THROMBOSIS: Heparin-induced thrombocytopenia (HIT) is a life-threatening complication of exposure to heparin that occurs in a small percentage of patients exposed, regardless of the dose or schedule. HIT results from an autoantibody directed against endogenous platelet factor 4 (PF4) in complex with heparin. This antibody activates platelets and can cause catastrophic arterial and venous thrombosis. Untreated HIT has a mortality rate as high as 20 percent⁽¹⁾.

Historical Perspective: Heparin was discovered 90 years ago and over a period of 2 decades it was being widely used as an anticoagulant⁽²⁾. Heparin has numerous advantages including its immediate onset of action, short half-life, simple laboratory monitoring (aPTT), ability to be reversed (using protamine), and low cost ⁽²⁾. Rodger E. Weismann in 1957, at the Fifth Scientific Meeting of the International Society of Angiology in New York described multiple thromboemboli in 9 of the 10 patients reported during systemic heparin therapy⁽³⁾. Six patients died as a result of the thromboembolism, and 2 survivors underwent above-knee amputation⁽³⁾. The arterial emboli began on average 10 days after commencing heparin⁽³⁾.

Reference

1. Crowther M. Clinical presentation and diagnosis of heparin-induced thrombocytopenia. 2014.
2. Kelton JG, Warkentin TE. Heparin-induced thrombocytopenia: a historical perspective. *Blood, The Journal of the American Society of Hematology*. 2008;112(7):2607-16.
3. Weismann RE, Tobin RW. Arterial embolism occurring during systemic heparin therapy. *AMA archives of surgery*. 1958;76(2):219-27.

Lipoedema and Panniculopathy

Dr Gilles Laur1
1Venus vein centre, Miami, Australia

Trainee and Student Reviews, Centennial Room, May 21, 2022, 4:00 PM - 5:00 PM

The subcutaneous tissue, also known as panniculus adiposus is divided by connective tissue septa into lobules. Its thickness is dependent on multiple factors such as age, sex, genetic factors, endocrine and metabolic conditions.

The inflammatory diseases of the subcutaneous tissue called panniculitis are often very similar in aetiology, pathogenesis and clinical profile.

While there has been several attempts to classify this inflammation anatomically from the septa (septal panniculitis) or within lobules (lobular panniculitis), and to determine the nature of the inflammation; all classifications of panniculitis have tried to consider mainly cutaneous/subcutaneous nodules with or without ulceration from an etiology point of view. For decades the classification of inflammatory disorders of the subcutaneous tissue has been confusing for dermatologists, due to the overlapping clinical and histologic features, and the lack of specific treatments. Often septal panniculitis with no vasculitis are the consequence of dermal inflammatory processes extending to the subcutaneous fat, such as necrobiosis lipoidica. In other cases, the inflammatory process is primarily a septal panniculitis, such as erythema nodosum. Many diseases of various organs can cause pathological changes in the fat. Lipoedema, or adiposis dolorosa, is a type of subcutaneous adipose tissue disorder that affects mainly women. It is a disease of adipose tissue caused by abnormal fat accumulation in subcutaneous tissue. Despite growing interest among patients and medical professionals, lipoedema is still often misdiagnosed, misunderstood, and mistreated. In lipoedema, both inflammation and hypoxia influence the expansion and differentiation of adipose tissue-derived stem cells, resulting in hypertrophic adipocytes and deposition of collagen, a primary component of the extracellular matrix. It creates a form of edematofibrosclerotic panniculitis. The aim of this presentation is to provide insights into the pathophysiology of lipoedema, based on the available data and outcomes from anatomical and interventional clinical studies, as a form of panniculopathy.

Cyanoacrylate Granuloma After Cyanoacrylate Closure of Incompetent Saphenous Veins

Dr Nuttawut Sermsathanasawadi

Cyanoacrylate Closure, Centennial Room, May 22, 2022, 11:00 AM - 12:30 PM

Background

Cyanoacrylate closure (CAC) is a minimally invasive surgery to treat incompetent saphenous veins.

Objective

To evaluate the incidence, the risk factors for, and the management of cyanoacrylate granuloma (CAG) after CAC of incompetent saphenous veins in patients with chronic venous disease.

Methods

Data specific to incompetent saphenous veins, including great saphenous veins, anterior accessory saphenous veins, and small saphenous veins, that were treated with CAC were retrospectively evaluated.

Results

A total of 126 saphenous veins from 101 patients were included. Recapture of the delivery catheter before withdrawal was not performed in all patients. Cyanoacrylate granuloma occurred in 3 of 101 (2.9%) patients, and in 3 of 126 (2.3%) treated saphenous veins. All patients with CAG presented with granuloma and abscess at the puncture site 3 to 5 months after CAC. All patients were treated with incision, drainage, and removal of the glue foreign body. No recurrent granuloma was observed during the study period. No patient or procedural predictive factor for CAG was identified.

Conclusion

Cyanoacrylate granuloma is not a rare complication after CAC when recapture of the delivery catheter is not performed. Patients should be advised of the possibility of CAG after CAC.

Segmental Cyanoacrylate Adhesive Closure for Highly Selected Patients: Preliminary Experience

Dr Naoki Sakakibara¹, Dr. Rie Yagi², Dr. Tomohiro Imai³, Prof. Minoru Tabata²

¹Edogawa Hospital, Edogawa Ward, Japan, ²Juntendo University, Bunkyo Ward, Japan, ³Tokyo Vascular and Vein Clinic, Bunkyo Ward, Japan

Cyanoacrylate Closure, Centennial Room, May 22, 2022, 11:00 AM - 12:30 PM

Introduction

Saphenous vein sparing surgery, so-called ASVAL and CHIVA, has been evaluated for decades and has shown more effectiveness than stripping with experienced surgeons. Although patients were highly selected, widely variable recurrences have been observed, and the European Society for Vascular Surgery 2022 clinical practice guideline downgraded ASVAL to Class IIb (Level C). However, some patient populations need equivalent asymptomatic/cosmetic outcomes with preserving the saphenous vein. Hence, a new segmental cyanoacrylate adhesive closure (sCAC) concept is postulated. The objective is to investigate the preliminary feasibility of sCAC.

Methods

Symptomatic patients with GSV reflux underwent sCAC. Thigh GSVs were preserved, and segmental GSVs and branch origins of tributaries in the calf were only treated with low-dose CAC by transcatheter or percutaneous techniques. Inclusion criteria were GSVs located in the compartment, competent terminal vein valve, truncal reflux with a diameter less than 6 mm, and patients who cannot tolerate the compression bandage or stocking due to contact dermatitis.

Results

In a total of 576 patients (710 procedures), seven patients were selected for sCAC. An average age of 61, all females, a mean CEAP clinical score of 2.8, VCSS of 3.8, and a mean GSV truncal diameter of 5.9 mm were recorded. 6 patients underwent transcatheter CAC, and one patient underwent percutaneous CAC. Treated GSVs and tributaries were occluded segmentally, for up to one year, and a vein diameter was narrowed in all patients. Thigh GSV reflux was abolished but open, and all patients were asymptomatic.

Conclusions

New concept of sCAC is likely to CHIVA/ASVAL, but segmental GSV closure is allowed. The advantages of sCAC were mostly sparing GSV, volume reduction of cyanoacrylate, no incisions, and no necessity of compression garment. Although sCAC is indicated for highly selected patients, recurrence of symptoms is unknown in the mid-term, and careful follow-up is still necessary.

The Role of a Lymphoedema Therapist in Wound Management

Susan Butcher

Sponsored Session, May 22, 2022, 1:30 PM - 1:50 PM

Objective

Presenting the data to highlighting the challenges faced in treating and managing chronic wounds and ulcers. Provide case studies on how this model of care approach can promote healing times Demonstrate the benefits of a lymphoedema therapist to be apart of a care team.

Method

Utilizing the skill set of Lymphoedema therapists within the clinic environment. By Presenting a model of care approach Highlighting the lymphoedema therapist training skills How this fits into the model of care approach

Summary

To provide a clear picture of the benefits and justification for a lymphoedema therapist to be apart of a care team for the treatment and management of people living with chronic venous disease and oedema related issues. To demonstrate the need to treat and manage both oedema and wound related issues together to achieve the best outcomes for patients.

How do we make diagnoses and where does it go right and wrong?

[A/Prof Fredrick Joshua](#)

Venous Interventions II, Centennial Room, May 22, 2022, 2:00 PM - 3:30 PM

Medicine is a complex discipline of which diagnosis is central to treatment strategies. Our diagnostic pathways and algorithms help us to determine the correct diagnosis. This presentation will explore diagnostic methods and examine why it can fail but also evaluate strategies that can be employed when unable to make a diagnosis. Treatment decisions and the extrapolation from clinical trials to the individual patient will also be discussed.



The whole truth of the hole in the heart

Dr Gilles Laur

Venous Interventions II, Centennial Room, May 22, 2022, 2:00 PM - 3:30 PM

Introduction

Fat embolism syndrome with cerebral fat embolism is a disabling complication that has an array of presentations varying from mild light headedness to respiratory failure, neurocognitive deficit and death. Its pathogenesis is poorly understood but can be associated with an undiagnosed perforated foramen ovale also known as patent foramen ovale (PFO). Current consensus is that PFO screening should not be done routinely except after cryptogenic stroke. There are no current guidelines for screening regarding surgery types to prevent stroke or death. the prevalence of PFO is about 25 percent in the general population, which increases the risk of cryptogenic stroke by 40 to 50 percent in patients. Doctors are faced with a fiduciary responsibility towards patients to ensure a safe surgery in a possible undiagnosed Patient with PFO. The primum non nocere, which is a key component of the care provided by doctors, means given the risk of PFO; it might be better no to do a surgery than to risk more harm than good.

Case details

Review of several patients presenting clinically symptomatic and asymptomatic PFOs prior to have lipoedema surgery.

Conclusion

An interdisciplinary and personalised approach to define high risk patients is required for the management of PFO especially when the risk of fat embolism syndrome is at stake. The association of PFO and the true risk of morbidity and mortality as well as the benefit of screening surgical patients requires further research. Zaman et al. wrote a provocative paper illustrating how making overdiagnosis a priority can result in medical nihilism that is detrimental to patients. In high-risk procedures, deferring PFO detection could imply a significant risk that is not addressed in the consenting process. Carefully evaluating the benefits and risks of PFO detection and then ultimately closure of a PFO if found can provide a more robust medicolegal position where the patient understands fully all risks associated with their elective procedures

Post Thrombotic Syndrome: Novel Therapeutic Options

Associate Professor Laurencia Villalba

Venous Obstructions, Compression & Thromboembolism, Centennial Room,
May 23, 2022, 9:00 AM - 10:30 AM

Venous thromboembolism is the third most common vascular disease globally, it affects 1-2/1000 people. Iliofemoral DVT only recanalizes in about 20% and its chronic sequela Post Thrombotic Syndrome (PTS) affects around 50% of those individuals.

Post-thrombotic venous obstruction, and deep vein valve dysfunction, have a high rate of venous claudication and venous ulceration and more rapid progression of disease.

Technology currently available to treat ilio-femoral DVT prevents PTS. However, there is still a considerable proportion of patients that are never offered this therapeutic option and end up developing severe PTS. Venous hypertension is the source of signs and symptoms of venous insufficiency, whether is primary or secondary the mechanism is the same and we know that the chances of developing advanced disease features is higher with a combination of obstruction and reflux

The economic burden of venous ulcers has been estimated to be at least U\$5527 per person per year. Historically, all we had to offer to these patients was anticoagulation and compression stockings but in the last decade a range of endovascular tools to treat the deep veins has become available, aimed at treating the underlying condition and not just the symptoms.

A range of dedicated venous stents continues to grow to treat obstruction in the ilio-femoral system with constant improvements in design for flexibility and durability. Deep venous reflux is also getting attention from industry and endovascular options to create new valves within the vessel wall are being evaluated in select patient populations. Overall, this is a new era for venous enthusiasts with plenty of exciting new options to help fight this terrible disease.



Portal Hypertension and Portal Vein Thrombosis

Dr Gilles Laur1

1Venus vein centre, Miami, Australia

Venous Obstructions, Compression and Thromboembolism, Centennial Room,
May 23, 2022, 9:00 AM - 10:30 AM

Besides recognising phlegmasia, the phlebologist should have a working knowledge of the pharmacomechanical thrombolysis and stenting which may take place after referral. Likewise the phlebologist may find themselves in the position to diagnose cutaneous melanoma or perhaps pancreatic cancer presenting with thrombophlebitis. I wish to present a summary of portal vein thrombosis and the myeloproliferative syndromes which lie on the periphery of the world of phlebology.

Case presentation

Healthy 40yo ED nurse confides that she has melaena. She is asymptomatic, no relevant history, no iron intake. Routine blood tests unremarkable, FOB test positive. Endoscopy the next day shows esophageal varices and gastric congestion. Contrast CT finds portal vein thrombosis but no other abnormalities such as malignancy or bowel infarction. Endoscopic ultrasound confirms portal vein thrombosis and Prothrombotic screen negative, JAK2 mutation present

Conclusion

Portal hypertension is often asymptomatic until complications develop. It often develops in the setting of schistosomiasis in the third world, but in western countries cirrhosis is responsible for 90% of cases. The remaining 10% may be due to intrahepatic, prehepatic (eg portal vein thrombosis) or post hepatic (eg Budd-Chiari hepatic vein thrombosis) in origin.



Ketogenic diet and its role in Phlebology

Dr Simon Thibault

Venous Interventions III, Centennial Room, May 23, 2022, 11:00 AM - 12:30 PM

Being overweight has been well established as a risk factor for the development of varicose veins and is associated with the severity of venous disease. It is also possible that there is a role played by excessive daily carbohydrate intake in the pathophysiology of venous disease.

A ketogenic diet is one that forces the body to use ketone bodies as its primary fuel rather than glucose. This is achieved by carbohydrate restriction. Regarding its potential use in Phlebology, there are some advantages of a ketogenic diet that may have benefit. Firstly, as part of a weight loss program. Additionally, there is early evidence that a ketogenic diet provides benefit to patients with lipedema and its anti-inflammatory effects may have some benefit in patients where inflammation is a presenting feature.



Varicose vein surgery and outcomes amidst the global COVID-19 pandemic

Dr Yunyi Wang¹, Dr Sarah Aitken¹
¹Sydney Local Health District, Sydney, Australia

Venous Interventions III, Centennial Room, May 23, 2022, 11:00 AM - 12:30 PM

Introduction

Varicose vein surgery is common procedure performed in Australian hospitals with the aim to prevent symptomatic burden and complications. Due to the COVID-19 pandemic, delays in elective surgery have exacerbated waitlist times in public hospitals with an associated 30% reduction in varicose vein surgery from 2018-2019. We present the NSW varicose vein outcomes and associated costs attributed to performing varicose vein surgery during the pandemic.

Methods

We performed a retrospective review using data from the NSW Varicose Vein Registry in 2018. Adults who underwent surgical intervention were included and divided into gender and two age cohorts, those <75 years and 75 years or older based on ASA scores. Outcome variable were compared with Chi-square analyses. Cost-effectiveness analysis was conducted using the disability-associated life year metrics.

Results

There was a total of 3970 patients that met the study criteria. Of these patients, 62% were female (2447/3970), 94% under the age of 75 (3745/3970) and 38% with an ASA score of 2 (1504/3970). The median length of stay was 1 day with older patients more likely to remain for >1 day ($p < 0.0001$). The most common complications involved wound, bleeding, cardiac and venous thromboembolism ($p < 0.05$) of which a total of 60 patients required re-admission. The cost per DALY for varicose vein surgery in public hospitals in our model is approximately \$8000 which is considered cost effective in Australia.

Conclusions

There are long-term favourable outcomes from surgical intervention however this has been decreased in recent years. Potential reasons include delays to elective surgery and increased hospital rationing based on clinical severity. The cost-effectiveness of varicose vein surgery depends on public health, hospital and patient factors and long-term planning may alleviate this. A better understanding of treatment outcomes and associated costs globally may provide further insight into the surgical management of varicose vein disease.

The COVID-19 pandemic has resulted in greater disparities in treatment of venous incompetency

Dr Yunyi Wang¹, Dr Sarah Aitken¹
¹Sydney Local Health District, Sydney, Australia

Venous Interventions III, Centennial Room, May 23, 2022, 11:00 AM - 12:30 PM

Introduction

Varicose vein surgery provides an important public health intervention, aimed at reducing long-term venous complications. The COVID-19 pandemic has limited capacity to maintain normal venous elective surgery. This study aims to quantify the reduction in venous surgery during the first wave of the COVID-19 pandemic, and explore disparities in access to care.

Methods

This study uses Australian Institute of Health and Welfare elective surgery activity data from 1 July 2018 – 31 June 2019 compared to 1 July 2019 – 31 June 2020. Elective varicose vein activity and waiting times are compared between periods and for different jurisdictions and patient groups.

Results

Public hospital activity for varicose vein surgery decreased to 2732 procedures (29.9%) in 2019-2020 compared to 3873 procedures in 2018-2019, the largest activity decrease for all surgical procedures. Overall, waitlist additions decreased by 4.6% compared to the previous year. Victoria had 41% activity reduction, NSW 31%, with smaller reductions or no change in other states. Disparities in venous surgery accessibility were exacerbated by the pandemic for patients living in outer regional areas, with an increase in median time to surgery of 58 days, compared to 15 days for patients living in major cities. In 2019-2020, patients who identified as Indigenous Australians waited more than twice as long for surgery as other Australians, compared to no difference in 2018-2019. Socioeconomic status did not change waiting times.

Conclusions

There has been a considerable decrease in varicose vein surgery activity during the COVID-19 pandemic, equating to almost one third of previous activity volumes. The resultant increase in waiting times is not equitable, with Indigenous Australians and patients from outer regional areas experiencing considerably longer waiting times than previously. When planning health resources to address the shortfall in varicose vein treatment, these health inequities require priority.



Perspectives on the Cannulation Experience: A Survey of Clinicians and Patients

Ms Brooke Maitland^{1,2}, Ms Evelyn Collier^{1,2}, Dr Katherine Arenson³, Mr Nicholas Buckley^{4,5}, Mr Nikhilesh Bappoo^{1,2}
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Venous Interventions III, Centennial Room, May 23, 2022, 11:00 AM - 12:30 PM

Introduction

Cannulation is the common invasive medical procedure (70-90% of inpatients), yet it presents high insertion failure rates (40-70%) due to difficulties in locating the vein. The pain and cost of multiple failed cannulations presents a significant burden on patients and the healthcare system. The aim of this study is to compare patients', junior (≤ 5 years experience) and senior (> 5 years) clinicians' perception of cannulations to evaluate the need of a new approach to locate veins when performing cannulations.

Methods

Patients (n=23), junior (n=21) and senior (n=33) clinicians consented to participate in an online survey, consisting of questions pertaining to their cannulation experience. Clinicians self-reported the percentage of their cannulations which were successful on the first attempt. Patients were asked to report on their experience of being cannulated, where a negative experience was categorized as feeling emotions synonymous to fear, pain and/or frustration. Unless otherwise stated, data was analyzed via one-way ANOVA and pairwise t-tests. Results were deemed significant at $p < .05$.

Results

Nearly half of clinicians (46.3%) felt very confident when performing cannulations, however there was no significant relationship between confidence in performing cannulations and self-reported rate of successful cannulations ($p=.89$). Significantly more senior clinicians (75.8%) reported a cannulation success rate $\geq 80\%$, compared to junior clinicians (39.1%), (Chi-square, $p < .05$). Despite this, 72% of all clinicians indicated they would use a device that improved cannulation success rate, with 37% using it when there is no palpable vein. On the contrary, only 45.8% of patients reported that their first cannulation attempt was usually successful and 56.5% of patients described their cannulation experience negatively.

Conclusions

There is a discrepancy between self-reported cannulation success rates by clinicians and patients. However, most participants expressed interest in a device to assist in improving cannulation success rate.

Effective treatment of Tumescant Assisted Sclerotherapy in hypertrophic facial capillary malformations

Dr Mina Kang

Challenging Cases and Closing, Centennial Room, May 23, 2022, 1:30 PM - 3:30 PM

Introduction

Capillary malformations (CMs) are the most common type of congenital vascular malformations. The lesions most commonly affect the head and neck, in particular the V1 and V2 dermatomes. The clinical course varies depending on the anatomical location of the lesion but the lesions generally darken and thicken over time. Hypertrophic facial CMs (HFCMs) remain a therapeutic challenge, often failing conventional therapies including surgical excision, dermabrasion, radiotherapy, electrocautery, cryotherapy, photodynamic therapy (PDT), intense pulsed light (IPL) and various laser modalities. Here, we describe the novel technique and assess the efficacy of tumescant assisted sclerotherapy (TAS) in conjunction with yellow vascular laser (577nm) for the treatment of HFCMs.

Method

Three patients who underwent TAS for treatment of facial nodular and hypertrophic CMs were included in the case series.

Results

Significant lightening in colour was achieved in two out of three patients with the use of yellow vascular laser. Complete resolution in nodularity was achieved in all patients with TAS. No significant complications such as skin necrosis, distal embolization, blindness, neurological adverse events occurred in any patients. Mild complications included scab formation at the site of injection in two patients which resolved within 14 days.

Conclusion

TAS is effective in reducing nodularity and hypertrophy of facial CMs. Yellow vascular laser, similar to other vascular lasers, is limited in achieving colour lightening of the lesions.



Cerebrospinal Venous Obstruction in CFS: Response to Disulfiram

Dr Paul Thibault

Challenging Cases and Closing, Centennial Room, May 23, 2022, 1:30 PM - 3:30 PM

Introduction

Cerebrospinal venous obstruction (CSVO) refers to venous obstructions in the major extracranial veins of the head, neck and vertebral column which affects the CSVS but may also involve the IJVs. The predominant pathology is chronic and constant obstruction of the major veins of the neck and vertebral column with resultant development of collateral flow and new pathways. The veins involved include the IJVs, VVs, external and internal vertebral venous plexuses and azygous veins. CSVO may be associated with a wide range of chronic vascular and inflammatory diseases, with manifestations in the head, neck, and chest. These include multiple sclerosis, rosacea, disfiguring dilated superficial veins in the head, neck, and chest, as well as chronic cough, chronic sinusitis, and chronic fatigue syndrome. The vague neurological symptoms of brain fog, poor cognition, headaches, and fatigue are common presenting symptoms of the syndrome.

Thibault has suggested that these venous obstructions are due to a chronic persistent venulitis caused by the obligate, intracellular parasite, *Chlamydia pneumoniae* (Cpn).

Cpn has been shown to persist in the vascular system by resisting attacks from both the immune system and various antibiotic therapies.

Case Details

34-year-old male with 10-year history of ankylosing spondylitis and CFS, and 6-month history of severe constant headaches and confirmed CSVO, was initially treated with a combined antibiotic protocol directed at chronic persistent Cpn with the addition of simvastation to treat dyslipidaemia after 6 months, then a 4-month treatment with disulfiram, minocycline and simvastation. There appeared to be a dramatic improvement in both symptoms and objective measurements with the introduction of Disulfiram.

Conclusion

CSVO is a common condition encountered in a number of chronic diseases of unknown aetiology. For patients that fail to respond to the recommended therapeutic suggestions, the use of Disulfiram should be considered. Disulfiram forms disulfides with thiol-bearing substances that can modify bacterial thiol-disulfide exchange to evoke antimicrobial effects. For the treatment of chronic Cpn infection, disulfiram can be used at a dose of 4mg/kg/day combined with either minocycline or a macrolide for a period of 2 – 4 months.

Management of Acute Bleeding Varicose Veins

Prof. Adel Kamhawy1
1Tanta University, Egypt

Challenging Cases and Closing, Centennial Room, May 23, 2022, 1:30 PM - 3:30 PM

Introduction and Aim

To assess the safety and efficacy of combined surgical and Polidocanol foam sclerotherapy for management of acute bleeding reticular varicose veins of the lower limb suggesting that proximal venous reflux is not the only precipitating cause.

Patients & Methods

A prospective clinical study including 125 patients with mean age 43 years, were diagnosed as having acute bleeding reticular varicose veins. Blood tests for bleeding tendency was done Elastic bandage local compression as the first line of treatment to give time for stable crust and skin creeping ,then Duplex Scanning to detect patency and competency of deep , perforators and superficial venous system. Sapheno-Femoral disconnection(SFD)was done in incompetent group and peroperative Polidocanol (POL) foam sclerotherapy 0.5 to 1 % using easy foam syringes ,Accuvein AV400, magnification and following patients clinically and with Duplex at one week, 1, 3, 6, months for complications, recurrence and incidence of DVT was reported.

Results

75 males and 50 females with acute perforative and ulcerative bleeding .Superficial Thrombophlebitis (STP) was noted distally in 35 cases . Seventeen patients without SFJ reflux with bleeding from medial aspect of the ankle, 34 patients had previous SFD with bleeding from ankle area and chin of the tibia , and 74 with SFJ reflux with bleeding from ankle area and medial side of the leg. In these 74 cases surgery was don under spinal anesthesia plus intraoperative foam sclerotherapy of bleeding reticular v. v .Maximum dose of foam was 10 ml. No recurrence of bleeding and no DVT.

Conclusion

There is no correlation between the size of V.V and complications. 51/125 =40% of cases had no proximal reflux. In parallel to management of portal hypertension, terminal interruption of reflux source by injection sclerotherapy is the current therapy which is simple, safe and effective.



Ablation of the Affected Vessels in Livedo Vasculopathy to Prevent Recurrent Ulcerations

Dr Mina Kang

Challenging Cases and Closing, Centennial Room, May 23, 2022, 1:30 PM - 3:30 PM

Introduction

Livedo vasculopathy (LV) is a rare painful cutaneous thrombotic microangiopathy that almost always presents in the lower legs. Its characteristic features include recurrent painful ulcers that scar with atrophie blanche, and reticulate pigmentation, in particular in the reticulate racemose pattern. The pathophysiology of LV remains unclear, but it is known to be associated with venous thromboembolism, hypercoagulable states, antiphospholipid syndrome, factor V Leiden mutation and lipoprotein A. Treatment is attempted with anticoagulation and compression, neither of which are effective in preventing recurrent ulcerations.

Methods

Retrospective follow-up case series was performed over a 12-year period on seven patients with LV, presenting with recurrent ulcerations. Routine clinical work-up included skin biopsy, hypercoagulable state blood work-up and duplex ultrasound (DUS) venous mapping. Concurrent chronic venous disease was treated with endovenous ablative interventions. In addition, vessels deemed to be involved in the process of vasculopathy was identified on DUS and treated with endovenous laser ablation (EVLA) and/or sclerotherapy.

Results

Of the seven patients, five patients underwent endovenous interventions and two patients were conservatively managed with compression, due to contraindications and comorbidities. The mean length of disease at the time of presentation was 13.1 years. Range of follow-up duration was 1-12 years. On long-term follow-up, group that underwent venous interventions achieved complete ulcer healing, with no recurrence in ulcerations. Four patients achieved complete resolution in pain. Two patients who were managed conservatively had ongoing recurrence of ulcerations and little to no resolution in pain in the follow-up period.

Discussion

Ablative venous interventions in treating the underlying affected vessels and concurrent venous hypertension in patients with livedo vasculopathy is useful in ulcer healing and prevention of recurrent ulcerations.

Foam Sclerotherapy guided by non-touch laser for management of Bleeding Scrotal Angiokeratoma.

Prof. Adel Kamhawy1
Tanta University, Egypt

Challenging Cases and Closing, Centennial Room, May 23, 2022, 1:30 PM - 3:30 PM

Introduction and Aim

To present a method of Control of emergency spontaneous scrotal angiokeratoma bleeding in a sensitive area from multiple Lesions, superficial blood Vessels, no tissue support and difficult compression using sclerotherapy and good visualization of bleeding source.

Materials & Methods:

Twenty male Patients(age ranged between 38 – 60 years) with previously mentioned lesions. 0.5-1% foam polidocanol using easy foam kit and AccuVein AV400 infrared Laser for accurate injection and clinical follow up.

Results

All patients were successfully treated with foam Sclerotherapy in three sessions of the lesions without any further recurrence over one year of follow-up.

Conclusion

Foam sclerotherapy with Polidocanol by help of Nontouch infrared laser(AccuVein AV400) to visualize reticular veins in dark scrotal skin is an effective, simple, convenient, economical and safe modality for the treatment of bleeding angiokeratoma of scrotum allowing the material to treat large surface area of bleeding and potentially bleeding.

A Wandering Left Ovarian Vein and Pelvic Congestion Syndrome

Dr Farshid Niknam
1Vein Surgery Clinic, Perth, Australia

Challenging Cases and Closing, Centennial Room, May 23, 2022, 1:30 PM - 3:30 PM

23 year old woman with chronic abdominal and pelvic pain on a background of a complex medical history. She has a history of significant longstanding dysmenorrhea that is different to her other abdominal pain. It is a heavy feeling into the vagina or dragging sensation accompanied by cramps in the pelvis and can change in intensity. She also has a history of anxiety and depression partly because of chronic intense pain.

She has been seen by Gynaecologist, Gastroenterologist, and psychologist. She has had a multitude of tests including an endoscopy and laparoscopy that all of which have been normal. All common causes such as endometriosis and inflammatory bowel disease and IBS has been excluded.

A tertiary level pelvic ultrasound for ovarian pathology was unremarkable. A CT of the abdomen and pelvis done after trauma that showed prominent pelvic veins in the adnexal and left ovarian region as an incidental finding. She recently referred to a vascular surgeon for investigation and management.

Her CT venography scan showed that her left ovarian vein, rather than tracking directly up across the psoas and into the left renal vein from below, tracks laterally across the lateral abdomen underneath the spleen, arches underneath the diaphragm and then dives downwards and enters the left renal vein from above. On the CT venography scan, there is significant Nutcracker Syndrome and it is apparent that this infra-renal segment does not exist. The left ovarian vein opacifies early on CTV which suggests direct outflow from the renal vein with contrast even extending across the pelvis and presumably draining via the right ovarian vein. She may have evidence of May-Thurner syndrome although has not clearly seen on CTV or duplex US.

There are no significant lower limb varicose veins, but we did note retrograde flow in a pelvic escape vein in the left groin with Valsalva, which again would confirm that she has high pelvic venous pressures.

She is in a waiting list for intravascular ultrasound for assessment of Left iliac vein for May-Thurner syndrome and management of her significant Nutcracker Syndrome and possible May-Thurner syndrome with intravenous stenting.

POSTERS



Management of Venous Incompetence and Athletic Performance in the Sporting Individual

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Introduction

It is known that varicose veins are troublesome in the sporting individual. The trauma sustained during contact sports and also the nature of the exertion involved in some sports can predispose to issues with venous pathology and sometimes exacerbate this. There are many studies with regard to compression therapy and its possible beneficial effects on athletic performance. It is also known that venous incompetence impacts negatively on venous return and consequently cardiac output.

Methods

A review of the current literature and the advice given by phlebologists to prospective patients online was undertaken. This was performed using Ovid and PubMed for terms relevant to venous incompetence, compression therapy and athletic performance. A review of the literature arising from this was then undertaken by the author.

A review of vein treatment websites was also undertaken.

Results

Currently the consensus is that compression therapy is recommended as the treatment of choice for symptom relief of venous incompetence and that venous insufficiency requires procedural treatment.

In addition to whether compression therapy is effective, there are several manufacturers with different products available.

Conclusion

The evidence with regard to compression therapy and performance enhancement is far from conclusive. There is a lack of information and firm recommendations in regard to compression therapy in athletes with varicose veins and the relative timing with regard to interventions as they have not been included in the majority of the literature. Studies on athletes with varicose veins against controls should be performed with regard to athletic performance before and after the adoption of compression therapy. Additional studies with regard to performance before and after vein treatments would also be welcomed.

A 21 year old male presents with 'heavy' legs. An early case of Lipoedema?

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Case Details

A 21 year old male presents with 'heavy' legs. He reports concern that his legs have always been large and out of proportion to the rest of his body. He has made successful attempts to lose weight and has embarked on aerobic and anaerobic physical training but has noticed no change in their appearance. There is no family history of vascular or lymphatic conditions. On examination he is 184 tall and 82kg (BMI 24.2) Upper body and limbs are well muscled and thin in comparison with his lower limbs.

Lymphoscintigram: Normal peripheral lymphoscintigraphy study. No evidence of lymphatic dysfunction in either lower limb.

Venous Ultrasound: One single incompetent 4mm lower perforator communicating with gastrocnemius vein. He is advised on the situations in which to return and undergoes a trial of compression stockings.

Conclusions

This case hopefully provokes a discussion about the long term prospects of an individual in this position in regard to whether review and observation are the best approaches or whether early consideration of interventions such as liposuction are the most appropriate approaches to treatment.



Challenges of venous ulcer management in the very elderly

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Introduction

Ulcer management can be challenging in the elderly. I will present a case of 93yo man with a venous ulcer that had failed to improve with conservative treatment over 2+ years. I will discuss the overall principles of ulcer management and then elaborate on the specific challenges faced with the elderly.

Case details

93 year old gentleman with a venous ulcer lower leg, present over 2 years and not improved with conservative treatment. Established venous cause. Declined for any treatment in public system due to age. He presents with increasing pain in the ulcer that is affecting his ability to walk and severely impacting his quality of life. Patient goal was improvement in pain rather than ulcer resolution. USS showed incompetent main trunks with refluxing tributaries feeding underneath ulcer.

Challenges included:

- inability to tolerate or independently manage compression
- fragility and condition of surrounding skin.
- high risk VTE event given age with poor mobility. Balancing these risks when deciding on treatment plan.
- balancing risk that treatment with RFA or sclerotherapy could make him quite uncomfortable and take months to settle, further impairing his quality of life when remaining time may be short.

We decided not to treat main trunks due to VTE risk and risk of significant discomfort. We elected to do do limited, focused sclerotherapy, treating only tributaries underlying the ulcer. We took a very slow, conservative approach with minimal foam volume each session to assess inflammation and avoid making him more uncomfortable.

Excellent outcome with pain resolving after focused treatment and ulcer reducing in size.

Conclusions

Treatment of underlying venous incompetence to improve venous ulcers in the very elderly requires careful balancing of the risks but made a substantial difference to quality of life in our case with only minimal targeted sclerotherapy.

Endovenous radiofrequency ablation (RF) of accessory saphenous vein (ASV) in an outpatient setting for a completely result: our experience.

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Introduction

Thermal ablation of the saphenous vein is an endovascular surgical technique recognized, in all international scientific contexts, better than traditional surgery, both for the reduction of relapses and for the lower frequency of side effects.

A prospective non-randomized study was carried out on the treatment of incontinent accessory saphenous vein (ASV) by Endovenous radiofrequency ablation (RF)

Methods

40 patients with accessory saphenous vein (ASV) incontinence et internal saphenous vein continence, were divided into two groups. The first one of 20 patients was treated with radiofrequency in the deep subfascial part of ASV and subsequent phlebectomy of the superficial part; the second one of 20 patients was treated with high ligation, usually 10 cm from the groin, and subsequent phlebectomy.

The procedure of thermal ablation was performed in outpatient setting with VNUS ClosureFAST Procedure. All patients were controlled after 1 month, 6 month, 1 year, 2 years.

Results

In all of patients treated by radiofrequency, complete elimination of venous reflux was recorded after 1 month; this result was stable after 6 months, 1 year and two years. In the group of patients treated with high ASV ligation, there were 8 cases (40%) of relapse of varicose veins 6 months after the treatment. Patients with relapse were treated with subsequent phlebectomy. No skin damage or secondary effects were detected.

Conclusions: A combined treatment of radiofrequency ablation (RFA) of ASV and phlebectomy brings about a more complete and definitive result ($P < 0,001$).





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