

Physician turned patient with varicose veins

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I became interested in varicose veins as a junior surgical trainee, when I noticed that my vascular teachers of the mid-late 1970s tended to neglect varicose veins and to give them low priority. Since then, I have authored many studies of varicose veins; written a book for patients about them; and continue to write about their treatment, and to contribute to national guidelines.^{1–6}

Then I developed varicose veins myself, about seven years ago - just some modest varicosities on my left lower leg, but I hated them. I approached a vascular colleague suggesting appropriate ligations/s and phlebectomies, but he produced a duplex scanner, pronounced my small saphenous vein incompetent, and injected sclerosant foam.

I have always warned patients about discomfort after foam sclerotherapy; and about the risks of tenderness, prolonged hardness, and brown staining. Of course, I developed all of these. More disturbing still, two weeks after treatment, I got thrombophlebitis ascending my great saphenous trunk. Happily, a duplex scan showed no deep vein involvement. This experience of foam sclerotherapy (which I still use frequently) emphasised my prejudice that while it is simple and inexpensive treatment, the recovery can be quite disagreeable.

Recurrence is more common after foam sclerotherapy than after other treatments. That seems to trouble many patients little – but not me.⁷ After about five years varicose veins reappeared - a modest cluster medially on my lower leg. They started to ache, so I had another scan. My small saphenous vein had re-cannalised and was highly incompetent - wide and regular in my upper calf but irregular in the mid-calf, probably as a result of the previous foam.

The veins became more symptomatic and I considered how I wanted them treated. I did not want foam sclerotherapy again, nor mechanicochemical ablation, which I see as a way improving the efficacy of foam – but foam nevertheless. As for endothermal ablation, I have used both radiofrequency and laser ablation but always disliked injecting patients with the necessary volume of tumescent anaesthesia. This is, in part,

because I strongly favour concomitant and thorough phlebectomies, with ligations, aimed at no residual varicosities, and minimal postoperative discomfort: such phlebectomies are the focus for my use of local anaesthetic.

So, when cyanoacrylate glue became readily available I adopted it: that was the treatment I wanted (with careful phlebectomies), but it was not available locally. I asked a respected colleague, over 200 miles away, and we agreed on a consultation in spring 2020 and the procedure in summer 2020.

Then came COVID – just as my veins became more symptomatic and started to cause some mild skin discoloration on my lower shin. The symptoms were as fascinating as they were disturbing: they included discomfort at night, odd sharp pains on getting up in the morning, and occasional feelings of water dripping down my leg. Patients often describe such symptoms, which are not readily explicable, and which may be regarded with scepticism by vascular specialists.⁴

With the onset of skin change I started to apply moisturiser lavishly and regularly: and to wear a compression stocking (23–32 mmHg), learning quickly the importance of ensuring no tension whatever over the area of the heel, which I now think is probably a significant factor in poor compliance. I was surprised that wearing below knee compression each day became almost unnoticeable; and that a closed toe stocking was marginally preferable to open toe.

Worse was to come. In late 2020 very troublesome tenderness and quite gross induration developed in the area of the varicosities. Concerned about possible thrombophlebitis, I had another duplex scan, which showed that the subcutaneous tissues were twice as thick as those of my right leg. There was no obvious oedema fluid. I concluded that I had acute

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inflammatory liposclerosis, but without any typical overlying skin redness, or any discolouration characteristic of lipodermatosclerosis. I feared deterioration and chronicity.

COVID had worsened, and treatment as originally planned had become impossible, so I arranged to see a local vascular colleague. Astonishingly, two days before doing so, the pain and considerable induration started to improve quite dramatically. My surgeon attributed this to the fact that I had been taking ibuprofen (albeit irregularly).

The induration and pain resolved completely: none remained when I had radiofrequency ablation of my small saphenous vein three weeks later, and none persists. This condition - transient acute inflammatory liposclerosis without any rubor or other skin change - is recognised by some experienced colleagues, but not in the published literature: descriptions of acute or inflammatory liposclerosis consistently include erythema or other skin discolouration.⁸⁻¹⁰ It probably represents a variant of inflammatory lipodermatosclerosis, in the context of good prophylactic skin care.

Having endothermal ablation, with tumescent injection to my calf, was less painful than I had expected (although subsequently there was tenderness at 1 – 6 weeks). Cannulation was awkward and was done in two sections because the small saphenous trunk was scarred in my mid-calf. A duplex scan at four weeks showed that my proximal (quite large) small saphenous vein had not been ablated and was still a direct source of high pressure into the varicose veins.

I had gone full circle – back to a surgical solution. After detailed discussion, my surgeon performed a saphenopopliteal ligation (a procedure he had not done before under local anaesthetic) and ligation of the tributary connecting the small saphenous with my varicose veins. Interestingly, the procedure was less uncomfortable than having endothermal ablation.

This has been an unwelcome but fascinating personal journey through most of the treatment options available for varicose veins. The latter part concurs with my own practice, which is shifting increasingly towards surgery under local anaesthesia, guided by duplex marking, in addition to the range of more modern ablative techniques.

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