

AGENTS OF CHANGE

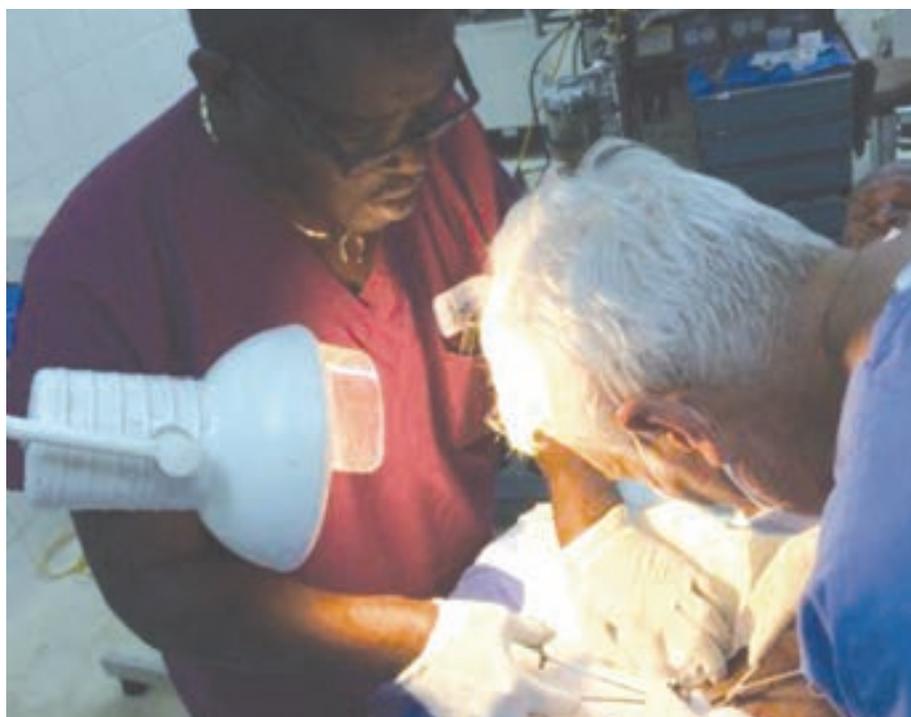
Vein Experts use low cost foam sclerotherapy technique to treat patients in Haiti

By Larry Storer

Ron and Peggy Bush have returned from a June mission trip to Haiti, now officially the poorest place on earth, where they taught local health care providers how to effectively treat patients with venous disease for as little as \$5 per patient and still obtain results comparable to conventional treatment at a much higher cost in the United States.

Ronald Bush, MD, FACS, and his wife, Peggy, APN, have been going to Haiti since 2007, working with various organizations including United Methodist Missions, Friends of the Children of Haiti and Life's Path, which also supports a school in Cyvadier, Haiti.

"Our goal at this time is to provide treatment



Dr. Joseph Leon Paul, a Haitian orthopedic surgeon, and Dr. Ron Bush provide venous surgery at Complexe Medico-Chirurgical Rose.

not only for patients with venous disease, but to educate health providers in Haiti on how to effectively treat venous disease for as little as \$5 per patient," Dr. Bush said.

Peggy Bush said that they also plan to provide this same low-cost treatment to patients in Florida who do not have insurance and have limited ability to pay. "They deserve care as well

and cannot afford a thermal ablation."

By making venous treatment available to even the poorest patients in Haiti, Dr. and Mrs. Bush have created a huge shift in terms of patients they can help and the cost of helping. The poverty and destruction from the 2010 catastrophe

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'Cost controls' breaking backs of practitioners

By Deborah Manjoney,
MD, FACS, RPVI

The media and government agencies keep announcing that medical costs need to be controlled, but they fail to recognize that much of the cost escalation is from government regulations that are being forced on physicians and hospitals. In addition, delays in implementation of regulations, while giving a reprieve when the timelines have been unreasonable, continue to strain every aspect of the healthcare industry.

These governmental mandates are, without doubt, some of the main reasons why so many physicians are allowing their practices to be purchased by hospital systems or larger healthcare organizations. Implementation of the rules requires too much money, too much time and too little reason to continue in private practice. Staying independent means that the physician must absorb the costs within the practice.

Do any of these rules lead to better patient care? Will physicians ever revolt? Because many phlebology practices are single physician or small group oriented, it is appropriate to reflect on the demands being made by governmental agencies.

MEANINGFUL USE

In 2009, The American Recovery and Reinvestment Act amended portions of the Social Security Act to "authorize incentive

COST CONTROLS
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Jacmel patient with saphenous insufficiency and multiple varicosities left leg.

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CASE STUDY

Patient presents with pulsatile varicosities

By Emma Stout, MD

A 75-year-old male presented to the American Vein & Vascular Institute for an evaluation of bilateral lower extremity edema.

For a few years, the patient complained of bilateral lower extremity edema and itching of the skin around the ankles and calves. As of late it appeared to be worsening.

The patient was taking Hydrochlorothiazide for the swelling and it appeared to be helpful. On examination, the patient had severe stasis dermatitis associated with skin thickening on the right anterior lower leg; the left leg had mild discoloration from the ankle to the calf.

In addition, the patient had pronounced varicosities in the great saphenous distribution of both legs, on the right more so than on the left. The varicosities located on the medial distal thigh appeared to pulsate when the patient was sitting down.

He said that he had family history of varicose veins and he had not been wearing graduated compression stockings because of discomfort. He had no prior evaluation for lower extremity venous insufficiency.

His past medical history was positive for chronic rate controlled atrial fibrillation, HTN, DM, facial skin cancer and dyslipidemia.

The social history was negative for any alcohol intake; he was a former smoker and exercised occasionally. His medications included bisoprolol, lisinopril, warfarin, HCTZ, metformin, digoxin, niacin, pravastatin and losartan.

A physical exam revealed a well-developed, well-nourished white male who was not in

distress, and his pulse was regular with no JVD. There were no apparent skin temperature changes in the legs.

The bilateral pitting edema and stasis dermatitis was worse in the right leg. Bilateral moderate to severe varicosities presented in the medial thigh and distal calf on the right leg.

A duplex ultrasound showed no DVT and severe reflux in the common femoral veins. The rest of the deep system was normal. There was severe axial reflux in the great and small saphenous veins bilaterally. Right GSV= 13mm; Right SSV= 7mm; Left GSV = 8mm; Left SSV = 4mm.

The patient was consented for bilateral GSV and SSV ablations. The right GSV was treated in the usual manner with two treatment cycles at the SFJ and a single cycle in the remainder of the thigh and upper calf. The treatment was complicated by difficulty compressing the vein despite manual sonographic pressure and liberal tumescent anesthetic. Duplex interrogation of the GSV following ablation showed it to be patent.

Three-day post-op duplex ultrasound showed closure of the GSV just at the knee. The remainder of the vein was patent with no change in size or venous reflux. Ultrasound confirmed no evidence of arteriovenous malformation or AV fistula, and pulsatile flow was noted in the veins of both lower extremities.

A repeat right GSV RFA was performed on the patient after two weeks. Subsequent ambulatory phlebectomy on the large varicosities had to be aborted after the first incision because of brisk bleeding. The patient was wrapped with a three-layer short stretch bandage.

He returned two days later for follow up and reported that he was doing fine but needed to keep the bandages on all the time to control the bleeding. Duplex ultrasound showed the right GSV to now be patent with severe axial reflux and persistent pulsatility.

The patient was then referred for cardiology consultation where he was diagnosed with severe tricuspid valve regurgitation, confirmed by echocardiogram. The severe tricuspid regurgitation was the cause of the central hypertension and the symmetric pulsatile venous flow in the lower extremities.

After the full workup, the patient underwent tricuspid valve repair with post-op echo, demonstrating mild tricuspid valve regurgitation and normal CVP. Following surgical valve correction, the pulsatility in the patient's superficial veins resolved completely and the distension of his varicosities also improved.

Subsequent ablations and sclerotherapy were uneventful and resulted in complete closure of the refluxing segments. Our clinic recommends a cardiac workup and treatment of underlying abnormalities prior to endovenous ablation in patients with suspected tricuspid regurgitation, as this likely would have prevented early treatment failure in our patient.

Tricuspid regurgitation (TR) has occasionally been known to lead to marked pulsation of the varicose veins. Pulsatile lower limb spectral Doppler waveform correlates well with right-sided heart failure, and right atrial pressures of more than 8mm Hg. In our patient, the right atrial pressure was 15mm Hg. We don't recommend using venous duplex imaging of the lower extremities as a screening tool for right

side heart failure because of its low sensitivity.

Typical symptoms of tricuspid regurgitation:

- Active pulsating JV
- Pulsatile varicosity
- Pulsatile deep and superficial venous system of the lower extremities
- Lower extremities edema
- Shortness of breath **VTN**



Dr. Emma Stout recently became a Diplomate of the American College of Lymphatic and Venous Medicine. With this board certification, she joins an elite group of highly trained and specialized physicians focused on the

diagnosis and treatment of vein disease (phlebology). She is the 5th double board certified physician at American Vein, the only vein organization in the state of Colorado with all board certified physicians. Dr. Stout finished her phlebology fellowship under the direction of Dr. Gordon Gibbs, founder and chief medical executive. Dr. Stout is from Novara, Italy, and attended medical school at Sapienza University in Rome. Dr. Stout performed her residency at St. Mary Corwin Regional Medical Center in Pueblo.

How will you use Glass in your practice?

How will you use Google Glass? Not, will you, but, how will you.

A recent *New York Times* profile of Dr. Selene Parekh, an orthopedic surgeon at Duke Medical Center in Durham, N.C., who has been using the wearable, Internet-connected, optical display technology since the company started distributing them on a very limited basis more than a year ago.

Dr. Parekh uses his set, which cost him and other so-called explorers \$1,500, to

record his surgeries. Soon, he told *The New York Times*, he hopes to stream live feeds of his operations to India to help train other orthopedic surgeons.

"In India, foot and ankle surgery is about 40 years behind where we are in the U.S.," he said in the *Times* article. "So to be able to use Glass to broadcast this and have orthopedic surgeons around the world watch and learn from expert surgeons in the U.S. would be tremendous."

Google Glass is being used to stream operations online, and doctors can float medical images in their field of view while performing surgery. They can even hold video conferences with colleagues during a surgical procedure. Software developers have

begun to create new programs that project a patient's vital signs, lab results, medical histories and surgical checklists onto the glasses.

Not everyone is onboard. Dr. Matthew Katz, a radiation oncologist at Lowell General Hospital in Massachusetts, said recently on his blog: "Until the FDA or research confirms its safety, Google Glass is banned from my clinic as a privacy and medical practice hazard." His primary worries about Glass-wearing doctors are patient security and physician distraction.

No doctor wants to get on the wrong side of HIPAA laws. The *San Francisco Chronicle* reported in January that employees of Google's secretive X research group met with FDA staffers. At the time, the *Chronicle*

reported that the FDA confirmed but did not comment on the visit, calling it a "meet and greet."

Bakul Patel, the senior policy adviser for the agency, told the *Times* the FDA would regulate only Glass software programs that function as medical devices just as it does for hand-held devices.

Still, Dr. Oliver Muensterer, a pediatric surgeon and the first to publish a peer-review study on the use of Google Glass in clinical medicine, has no doubts about the product's eventual widespread acceptance. "Not the current version," he told the *Times*. "But a version in the future that is specially made for healthcare with all the privacy, hardware and software issues worked out." **VTN**