The Australasian College of Phlebology
13th Annual Scientific Meeting & Workshops

06-11 February 2010 | The Langham Auckland | New Zealand | www.phlebology.com.au

Conference Proceedings
VENUE AND CONTACTS

Venue
The Langham Auckland
83 Symonds Street, Auckland 1140
New Zealand
Tel: (64)(9)379 5132
Fax: (64)(9)377 9367
www.langhamhotels.co.nz

The Langham Auckland is a 30 minute drive from Auckland International Airport. The average taxi fare from airport to hotel is NZ$75.00 depending on traffic. For those wishing to travel in style one of The Langham’s limousines can be booked to meet you at the airport.

Contacts
General College Information
Requests for information about the ACP and its mission may be directed to:
Zivka Curkoski
College Administrator
Australasian College of Phlebology Inc.
P.O. Box 549
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Bondi Junction NSW 2022
Phone: +61 2 9386 1811
Fax: +61 2 9386 1822
Email: info@phlebology.com.au
Web: www.phlebology.com.au

ACP 2010 Conference Organisers
Conference Matters, the official 2010 Meeting Organiser, will process registrations and abstracts. Information about the commercial exhibition as well as the organization and sponsorship of special events may also be obtained from the Organizing Secretariat.

For further information contact:
ACP 2010 Meeting Organiser
Conference Matters
PO Box 1661
Whangarei 0140
New Zealand
Phone: +64 21 164 3815
Fax: +64 9 437 4089
Email: info@conferencematters.co.nz
Website: www.conferencematters.co.nz/index_acp.php

Registration and Hotel Accommodation
Phone: +64 21 164 3815
Fax: +64 9 437 4089
Email: info@conferencematters.co.nz

Exhibition and Sponsorship
Requests about sales opportunities or questions by industry partners should be directed to:
Leon Olsen
Conference Matters
Phone: +64 21 164 3815
Fax: +64 9 437 4089
Email: leon@conferencematters.co.nz

TABLE OF CONTENTS

Venue & Contacts ................. 2
Welcome from the College President .................. 3
Keynote Speakers ..................... 4-5
About the ACP .......................... 6
Organising Committee & Speakers ..................... 8-9
Program Overview ...................... 11
Exhibition Layout ....................... 12
Hotel Layout ............................ 13
Program
Saturday ....................... 14
Sunday ......................... 15
Monday ....................... 17
Tuesday ....................... 18-19
Wednesday .......... 20-21
Thursday ....................... 23
Special Events ..................... 22
General Information ............ 24
Index of Speakers ........... 26-27
Abstracts ....................... 28-88
Exhibitor Contacts .......... 90-93
ACP 2011 ........................... 95
Kia ora Dear Colleagues and Friends,

On behalf of the Organising Committee, it is my great privilege and pleasure to welcome you to the ‘City of Sails’ (Auckland, New Zealand), hosting the 13th Annual Scientific Meeting (ASM) and Workshops of the Australasian College of Phlebology. This conference celebrates the 10th anniversary of the formation of the Australasian College of Phlebology.

We have put together a stimulating scientific program that will highlight the latest scientific advances in our field along with high quality keynote and symposium lectures. The invited international keynote speakers include:

- Prof. Imre Bihari, Phlebologist, Vascular Surgeon, Hungary
- Dr Attilio Cavezzi, Phlebologist, Vascular Surgeon, Italy
- Prof. Philip Caleridge-Smith, Phlebologist, Vascular Surgeon, UK
- Prof. JJ Guex, UIP Treasurer, Phlebologist, Vascular Physician, France
- Dr Ted King, Phlebologist, USA
- Dr Nick Morrison, President American College of Phlebology, Vascular Surgeon, USA
- Assoc. Prof. Toshio Nakayama, Prof of Biomedical Engineering and Fluid Mechanics, Japan
- Assoc. Prof. Makoto Ohta, Prof of Biomedical Engineering and Fluid Mechanics, Japan
- Dr Michel Schadeck, Phlebologist, Vascular Physician, France
- Dr Marc Vuylsteke, Vascular Surgeon, Belgium

The 3 day ASM includes keynote lectures, original papers, panel discussions, and the popular ‘Controversies in Phlebology’ keypad interactive debates. As usual, the Program’s emphasis is on good science and evidence-based medicine.

Pre-conference courses include a 2-day Basic Phlebology Course covering all aspects of sclerotherapy, and a concurrent 2-day Advanced Phlebology Course covering interventional techniques, coagulation, dermatology and rheology workshops. The format of these courses emphasise a tutorial type sessions providing interaction with the participants.

The popular one-day Diagnostic Imaging Ultrasound Workshop will run on the last day of the meeting for ultrasound enthusiasts.

The Scanmedics Conference Welcome Party, The ‘Last Drink’, on Waiheke Island will be unforgettable…ensure you have your tickets!

The Conferring Ceremony and the Conference Dinner will be again a highlight of this year’s meeting. The gothic Auckland Town Hall will host our Conferring Ceremony promising entertainment and glamour enjoyed by the delegates in our previous events.

I look forward to seeing you during the meeting!

Ka kite ano,

Kurosh Parsi
President, Australasian College of Phlebology
2010 KEN MYERS ORATOR

**Professor Earl Owen**

Professor Earl Owen, known as the Father of Microsurgery designed micro instruments, microscopes and new operations to save congenitally abnormal babies from dying at birth in the 1960s. He was the co-leader of that team and the same group that also performed the world’s first double hand transplantation.

**Professor Masud Behnia**

Masud Behnia has worked in experimental and numerical fluid mechanics and heat transfer for over 25 years. He has, in particular, extensively studied two-phase flow systems using experiments and CFD simulations. He has substantial experience in validating numerical results by comparison with experimental data. Results of his research have been widely published in journals and conferences and his career total publications include more than 350 refereed papers.

**Professor Imre Bihari**

Imre Bihari studied at the Medical Faculty of Semmelweis University in Budapest. He spent 29 years working for the National Medical Center, Medical University, and became University Associate Professor, Department of Cardiac and Vascular Surgery.

**Dr Atillio Cavezzi**

Dr Atillio Cavezzi is a vascular surgeon from S. Benedetto del Tronto, Italy. Atillio has undoubtedly been instrumental in promotion of foam, ultrasound guided sclerotherapy as a legitimate alternative to surgery in many countries and in particular in Australia and New Zealand. Atillio is an international teacher of phlebology and lymphology, has hundreds of publications and is the author or co-author of a number of books in Phlebology and lymphology.

**Professor Philip Coleridge Smith**

Professor Coleridge Smith is a Reader in Surgery at UCL Medical School, London UK. He pioneered the introduction of duplex ultrasonography in the clinical investigation of venous disease in the UK. Professor Coleridge Smith has pioneered the introduction of ultrasound guided foam sclerotherapy for the treatment of varicose veins into the UK and keeps series of over one thousand patients under review.

**Dr Jean Jerome Guex**

Jean Jerome Guex, MD, FACPh is coauthor of the definitive book on sclerotherapy, Treatment of Varicose and Telangiectatic Leg Veins, 4th Edition. He is Past President of la Societe Francaise de Phlebologie and Treasurer of the Union Internationale de Phlebologie. He is a Member of the American Venous Forum and is a Fellow and Honorary Member of the American College of Phlebology. Emeritus Fellow of the Australasian College of Phlebology and Member of the Board of Directors of the American College of Phlebology.

**Dr Ted King**

Dr. King is a clinical assistant professor at the Medical School of the University of Illinois in Chicago. Dr. King has expertise in ultrasound venous mapping, endovenous thermal and chemical ablation, ultrasound-guided foam sclerotherapy, and visually guided liquid and foam sclerotherapy. His research interests include all endovenous treatment modalities. Clinically, Dr. King’s clinical interests include the non-surgical treatment of symptomatic vulvar and labial varices, Klippel-Trenaunay Syndrome, Restless Legs Syndrome secondary to varicose vein disease, recurrent varicose veins after previous treatment, venous stasis ulcers, and the cosmetic treatment of hand and facial veins.
Dr Nick Morrison
Nick Morrison, MD, FACS, FACPh is a world-renowned leader in the field of phlebology who has dedicated his medical practice to veins. He is a fellow with the American College of Surgeons and American College of Phlebology and President-elect of the American College of Phlebology. He established the Morrison Vein Institute in Scottsdale, AZ and is a partner in the Morrison Training Institute for physicians, nurses, and ultrasound technologists.

Professor Ken Myers
Prof Ken Myers has had a major interest in venous disease for more than 25 years. Professor Myers is the Chancellor of the Australasian College of Phlebology and has participated in or organised many international phlebology meetings. He has been at the forefront of developing new techniques such as echosclerotherapy and endovenous laser therapy.

Associate Professor Makoto Ohta
Makoto Ohta is Associate Professor, Institute of Fluid Science, Tohoku University, Sendai, Japan. Assoc. Prof Ohta’s has a particular interest in fluid mechanics, blood flow, biomaterials and the role of engineering in the medical field. He holds a heuristic perspective on health treatment, with a belief that not only doctors and pharmacologists hold the key for future treatments, but that engineers will also help to create new procedures.

Professor Neil Piller
Professor Neil Piller is the Director of the Lymphoedema Assessment Clinic, Department of Centre. He is Australasian Editor of Lymphatic Research and Biology and on the Editorial Board of US and Chinese Journals of Lymphology. Neil has released a DVD on “The Vital Essence - Understanding the lymphatic system in Health and Disease” and is the main Author of “The Lymphoedema Handbook” published in 2006. He was the Chair of the 2009 International Society of Lymphology meeting in Australia.

Dr Michel Schadeck
Dr Michel Schadeck is a phlebologist and angiologist and a Past President of French Society of Phlebology practicing in Paris. He has been credited with the development of ultrasound guided sclerotherapy in 1985 and has been instrumental in the globalisation of this treatment modality. Dr Shadeck was the co-founder of the European School of Phlebology (1989) and a founding member of the European Venous Forum (1999). He has published two books and more than 45 scientific papers in the fields of sclerotherapy, ultrasound guided sclerotherapy, superficial venous investigations, varicose disease and treatment in childhood, mercury bath-pressotherapy, lymphology and epidemiology.

Professor André van Rij
André M van Rij is Professor of Surgery at the Dunedin School of Medicine University of Otago where he directs the Vascular Research Unit. His research has focused on venous disease and the biology of varicose vein recurrence and venous thrombosis. His translational research bridges new basic research into the venous clinic. Professor van Rij is a vascular surgeon and President of the NZ Association of General Surgeons. Professor van Rij is the Deputy Chancellor of the Australasian College of Phlebology.

Dr Marc Vuylsteke
Dr Marc Vuylsteke is a vascular surgeon at St-Andries Hospital, Tielt, Belgium. Marc has published many articles on endovenous laser treatment. He is a member of the Benelux Society of Phlebology and is on the organising committee for the 11th meeting of the European Venous Forum in Antwerp, June 2010.
ABOUT THE ACP

The Australasian College of Phlebology (ACP) is a multi-specialty organization dedicated to promotion of phlebology research, teaching and training in Australasia.

Our membership includes medical practitioners and other health professionals such as scientists and sonographers dedicated to education and research in the field of phlebology. Our members have a shared interest in phlebology, but represent a variety of medical specialties, including vascular surgery and medicine, dermatology, haematology, interventional radiology, general surgery, and family medicine.

Since its inception in 1993, the ACP has been active in promoting education and research in phlebology and serves the general public as a resource regarding vein disorders. Public educational initiatives such as patient education seminars, GP education workshops and media interviews are undertaken by College Fellows on a regular basis. Our mission is to improve the standards of practice and patient care as it relates to venous disorders.

The ACP is a member of the Union International Phlebologie (UIP), a multi-national organization that has member phlebology organizations from 35 countries from Europe, North America, Latin America, and Asia.

Annual Scientific Meetings and Workshops of ACP were initiated in 1994. These meetings have been instrumental in disseminating knowledge and experience among specialists from many medical disciplines.

Academic Board

Chancellor
Prof. Kenneth A. Myers
Dep. Chancellor
Prof. Andre van Rij

Executive Board

President
Dr Kurosh Parsi
Vice President
Dr David Jenkins
Honorary Secretary
Dr Louis Loizou
Honorary Treasurer
Dr Ivor Berman
Committee Members
Prof Lourens Bester
Dr Jacqui Chirgwin
Dr Paul Dinnen
Dr Gabrielle McMullin

Regional Faculties

State
NSW
QLD
VIC
Chairman
Dr David Jenkins
Dr Paul Dinnen
Dr Stefania Roberts

Committees & Divisions

Committee
AMC Accreditation Taskforce
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Board of Censors
Dr Kurosh Parsi
Conferring Ceremony
Dr Louis Loizou
Continuing Professional Development
Dr Mark Elvy
Finance and Fundraising
Dr Louis Loizou
Information Technology
Dr Kurosh Parsi
Diagnostic Imaging Taskforce
Dr Gary Frydman
Ethics and Professional Standards
Dr Louis Loizou
Research and Scientific Committee
Prof Ken Myers
Scientific Meetings
Dr Kurosh Parsi
Standards Committee
Dr John Barrett
Training
Dr David Jenkins
Newsletter Editor
Dr Jacqui Chirgwin
Preceptorships
Dr Louis Loizou
Public Education
Dr Louis Loizou
Workshops
Dr Gabrielle McMullin

Interest Groups

Interest Group
Ambulatory Phlebectomy
Dr Mark Elvy
Interventional Phlebology
Prof Lourens Bester
Lymphology
Prof. Neil Piller
Thrombosis and Haemostasis
Dr Kurosh Parsi
Ulcer Management
Dr Mark Elvy
Ultrasound in Phlebology
Ms. Darryl Queenin
Vascular Malformations
Dr Kurosh Parsi

Administration

College Administrator
Zivka Curkoski
Education Officer
Shoshana Dannon
Accounts
Match Wu
The ideal alternative to classic surgical stripping of the great and small saphenous veins!

- Less painful
- Less bruising
- Less expensive fibers

The Endo laser 1500nm delivers the optimal wavelength for the endoluminal treatment of varicose veins. The 1500 nm is 1000 times more absorbent in water than 810 nm with this greater specificity requiring less power, implying less heat diffusion in surrounding tissue and no undesirable side effects. Only a minimum of local anesthesia is needed, delivered through a sole puncture with patients being able to walk within 15 minutes of the treatment.

Key features:
- Wavelength: 1500 nm
- Procedure power: 6W
- Maximum laser output power: 12 W
- Red aiming beam (630 nm) enables visibility of fiber tip throughout procedure
- Small, portable, weighing approx 10kg
- Synchronized pull back device available
- Fiber tester incorporated

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ORGANISING COMMITTEE

Program Chair:
Dr Kurosh Parsi

Basic Phlebology Course Coordinator:
Dr Louis Loizou

Advanced Phlebology Course Coordinator:
Dr Kurosh Parsi

Conference Organising Committee:
Dr Kurosh Parsi, Dr David Jenkins, Dr Louis Loizou, Dr Paul Thibault

Confering Ceremony Organising Committee:
Dr Louis Loizou, Dr Kurosh Parsi, Ms. Annie Silkman

Conference Welcome Party Organising Committee:
Dr Louis Loizou, Dr Paul Dinnen, Dr Stefania Roberts, Ms. Annie Silkman, Ms Yana Parsi

Diagnostic Imaging Workshops Coordinator:
Ms Annie Morgan

Diagnostic Imaging Workshops Organising Committee:
Ms. Bronwen Allen, Dr Oswaldo Cooley Andrade, Ms Yana Parsi, Ms. Daryl Queenin

Auckland Local Support Committee:
Dr John Barrett, Ms. Bronwen Allen, Ms. Darryl Queenin

ACP 2010 Speakers

KEN MYERS ORATION
Prof. Earl Owen, Pioneer of Microsurgery, University of Sydney

INVITED INTERNATIONAL SPEAKERS
1. Dr Attilio Cavezzi, Phlebologist, Vascular Surgeon, Italy
2. Prof. Philip Coleridge Smith, Phlebologist, Vascular Surgeon, UK
3. Prof. Jean Jerome Guex, Phlebologist, Vascular Physician, France
4. Dr Ted King, Phlebologist, USA
5. Dr Michel Schadeck, Phlebologist, Vascular Physician, France
6. Dr Nick Morrison, Phlebologist, Vascular Surgeon, USA
7. Assoc. Prof. Toshio Nakayam, Professor of Biomedical Engineering and Fluid Mechanics, Japan
8. Assoc. Prof. Makoto Ohta, Professor of Biomedical Engineering and Fluid Mechanics, Japan
9. Dr Marc Vuylsteke, Phlebologist, Vascular Surgeon, Belgium

KEYNOTE LECTURES
1. Prof. Imre Bihari, Phlebologist, Vascular Surgeon, Hungary
2. Prof. Philip Coleridge Smith, Phlebologist, Vascular Surgeon, UK
3. Dr Nick Morrison, Phlebologist, Vascular Surgeon, USA
4. Prof. Ken Myers, Phlebologist, Vascular Surgeon, Melbourne
5. Prof. Andre van Rij, Phlebologist, Vascular Surgeon, Dunedin

GUEST LECTURES
1. Prof. Masud Behnia, Mechanical Engineering and Fluid Dynamics, Sydney University
2. Ms Katja Beitat, Healthcare Complaints Commission, NSW
3. Dr Attilio Cavezzi, Phlebologist, Vascular Surgeon, Italy
4. Prof. Philip Coleridge Smith, Phlebologist, Vascular Surgeon, UK
5. Dr. Sanjeev Chunilal, Haematologist, Auckland
6. Prof. Jean Jerome Guex, Phlebologist, Vascular Physician, France
7. Prof. Karkenahalli Srinivas (NSW) School of Aerospace, Mechanical and Mechatronic Engineering, University of Sydney
8. Dr Nick Morrison, Phlebologist, Vascular Surgeon, USA
9. Assoc. Prof. Makoto Ohta, Professor of Biomedical Engineering and Fluid Mechanics, Japan
10. Dr Abdullah Omari, Phlebologist, Vascular Physician, Sydney
11. Prof. Neil Piller, Lymphologist, Adelaide
12. Dr Michel Schadeck, Phlebologist, Vascular Physician, France
LOCAL SCIENTIFIC FACULTY

- Dr John Barrett, Phlebologist, Auckland
- Prof. Masud Behnia, Professor of Mechanical Engineering and Fluid Dynamics, University of Sydney
- Dr Ivor Berman, Phlebologist, Interventional Radiologist, Melbourne
- Prof. Lourens Bester, Vascular Anomalies Specialist, Interventional Radiologist, Sydney
- Dr Peter Chapman-Smith, Phlebologist, Whangarei
- Dr Jacqui Chirgwin, Phlebologist, Newcastle
- Dr Sanjeev Chunilal, Haematologist, Auckland
- Dr Paul Dinnen, Phlebologist, Vascular Surgeon, Gold Coast
- Dr Mark Elvy, Phlebologist, Sydney
- Dr Gary Frydman, Phlebologist, Vascular Surgeon, Melbourne
- Dr David Jenkins, Phlebologist, Sydney
- Dr Chris Lekich, Barrister, Phlebology Registrar, Gold Coast
- Dr Louis Loizou, Phlebologist, Melbourne
- Dr Sanjay Nadkarni, Phlebologist, Interventional Radiologist, Perth
- Prof. Ken Myers, Phlebologist, Vascular Surgeon, Melbourne
- Dr Abdullah Omari, Vascular Physician, Sydney
- Dr Kurosh Parsi, Phlebologist, Dermatologist, Sydney
- Dr John Pereira, Vascular Anomalies Specialist, Interventional Radiologist, Sydney
- Prof. Neil Piller, Lymphologist, Adelaide
- Dr Stefania Roberts, Phlebologist, Melbourne
- Dr George Somjen, Phlebologist, Vascular Surgeon, Melbourne
- Dr Paul Thibault, Phlebologist, Newcastle
- Prof. Andre van Rij, Phlebologist, Vascular Surgeon, Dunedin

DIAGNOSTIC IMAGING WORKSHOPS

Tutors

- Ms. Bronwen Allen, Vascular Sonographer, Auckland
- Dr Oswaldo Cooley Andrade, Vascular Sonographer, Sydney
- Ms Daryl Queenin, Vascular Sonographer, Auckland
- Ms Annie Morgan, Senior Vascular Sonographer, Sydney
- Ms Yana Parsi, Vascular Sonographer, Sydney
JOBST UltraSheer

JOBST UltraSheer is the sheerest compression stocking in its class – fashion and efficiency all rolled into one whilst offering light weight, comfortable and highly effective leg support.

- Beautifully sheer
- Durable and long lasting
- Available in Knee High, Thigh High, Waist High and Maternity variants

JOBST forMen

JOBST forMen are fine quality dress socks which are long-lasting, lightweight and stylish.

- The use of micro and multifibre yarns result in a soft, skin friendly fabric
- High durability and patient comfort
- Available in Knee High and Thigh High variants

JOBST Relief

JOBST Relief range consists of classical therapeutic stockings that offer durability & comfort.

- Easy to don
- Increased patient comfort
- Available in a wide range of styles; knee high, thigh high, waist high and chaps - open and closed toe variants also available

Sclerosants

Registered and available in Australia

Sclerotherapy Solutions
**PROGRAM AT A GLANCE**

The academic program will cover many aspects of phlebology. Who should attend: vascular surgeons and physicians, dermatologists, coagulation haematologists, interventional radiologists, sclerotherapists, general practitioners, sonographers, vascular biology and coagulation scientists, residents, fellows in training, medical students, nursing staff.

**Program Overview**

<table>
<thead>
<tr>
<th>Saturday 06 Feb</th>
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*Registration Desk open daily from 7:30-5:30pm*
Exhibitors Listing

Covidien .......................... 13-14
Mr Travis Stephenson

Device Consulting ..........18 & 25
Mr Milivoj Boltuzic
Mr Gavin Dimitri
Ms Magalie Terry

GE Healthcare ...................... 21
Christine Rieger

InSight Oceania .................... 11
Mr Greg Clark

Medical Specialties Australia . 19
Jacqui Mitchell
Stephanie Sherlock
Paul Turner

NZMS / AMS / Sole Healthcare . 20
Mr Bill Woodward

OBEX ................................. 12
Mr Jack Johnston
Mrs Jane Young

Regional Health .............23 & 24
Alisa Gray
Amanda Punch

Scanmedics ......................... 16
Mr Shaun Connolly
Mr John Hunter

Smith & Nephew ..............3 & 4
Mr David Blair
Ms Ann Gentry

SonoSite .............................. 17
Mr Richard Scott

Sydmed ............................... 7
Lucy Watson

The Celon Method .............. 5
Mr Damien Rayner

Toshiba .............................. 22
Grant Campbell
Sarah Colley
Beth Knight
John Riley

Total Library Solutions .... 8 & 9
Mr Colin Greenwood

Wagner Medical ................. 1
Mr Sam Wagner
The Langham Auckland Conference Rooms

Room Locations

**Basic Phlebology 2 day Course**
- Saturday 06 February .......... Westhaven
- Sunday 07 February .......... Westhaven

**Advanced Phlebology 2 day Course**
- Saturday 06 February .......... Tamaki
- Sunday 07 February .......... Tamaki

**Basic and Advanced Phlebology Combined Sessions**
- Saturday 06 February .......... Westhaven
- Sunday 07 February .......... Westhaven

**Welcome Cocktail Function**
- Saturday 06 February .......... Greys

**Scanmedics Welcome Cocktail Party**
- Sunday 07 February .......... Cable Bay Vineyard

**Exhibition and Main Conference**
- Monday 08 February .......... The Great Room
- Tuesday 09 February .......... The Great Room
- Wednesday 10 February .......... The Great Room

**Speaker Setup Room**
- Sat 06 – Wed 10 February .......... Aucklander

**Breakfast Sessions**

**Breakfast in Italy**
- Monday 08 February .......... The Paperless Office
- Tuesday 09 February .......... The Paperless Office
- Wednesday 10 February .......... Medicolegal Breakfast

**Diagnostic Imaging Workshops**
- Thurs 11 February .......... Westhaven

General Information

**Parking and Shuttle**

The Langham Hotel
83 Symonds Street, Auckland
P (09) 379 5132

The Langham, Auckland offers Valet Parking at $30.00 per car. Self-parking in a public car park adjacent to the hotel is available. All parking is subject to availability.

The Langham, Auckland provides a complimentary 24 seater Shuttle Bus from the Hotel to Downtown Auckland from 7:00am to 9:30pm each day and return.

**Health Club**

The use of the Health Club and heated pool facilities on the 2nd floor is complimentary.

**Telephone Directory**

- Emergency services ................. 111
- (fire/police/ambulance)
- Registration desk ................. 09 300 2913
- Accommodation
  - Langham Hotel .................. 09 379 5132
- Accident & medical clinic
  - Quay Med 68 Beach Rd .......... 09 919 2555
- Monday – Friday 8.00am – 7.00pm
- Saturday 10.00am – 2.00pm
- After hours pharmacy .......... 09 520 6634
- Auckland visitors centre ....... 09 366 6888

**Taxi services**

- Corporate Cabs ................. 09 377 0773
- Crop Taxis .................. 09 300 3000
- Super Shuttle ................. 09 522 5100

**Airlines Reservations Arrival/Departure Information**

- Air New Zealand ................. 09 357 3000
- 09 306 5560
- Qantas .................. 09 357 8900
- 09 306 5564
# Saturday 06 February

## Basic and Advanced Phlebology Course

<table>
<thead>
<tr>
<th>Time</th>
<th>Basic Phlebology Course</th>
<th>Advanced Phlebology Course</th>
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</thead>
<tbody>
<tr>
<td>0700 - 1730</td>
<td><strong>Combined Sessions - Basic Phlebology Course &amp; Advanced Phlebology Course</strong>&lt;br&gt;Westhaven Room&lt;br&gt;CHAIR: Dr Louis Loizou</td>
<td>Registration</td>
</tr>
<tr>
<td>0700 - 0845</td>
<td>Emergencies in Phlebology - Part 1&lt;br&gt;Advanced Cardiac Life Support for Phlebologists&lt;br&gt;Dr John Vassiliadis (NSW)&lt;br&gt;Emergency Physician</td>
<td><strong>STREAM A</strong>&lt;br&gt;Basic Phlebology Course (Phlebology Part I)&lt;br&gt;Westhaven Room&lt;br&gt;Registration Required&lt;br&gt;CHAIR: Dr Stefania Roberts&lt;br&gt;MODERATOR: Dr Louis Loizou</td>
</tr>
<tr>
<td>0900 - 1030</td>
<td><strong>Introduction to Sclerotherapy</strong>&lt;br&gt;Dr Stefania Roberts (VIC)&lt;br&gt;Phlebologist</td>
<td><strong>Physiology</strong>&lt;br&gt;Basic Concepts &amp; Functional Measures&lt;br&gt;Prof Andre van Rij (NZ)&lt;br&gt;Phlebologist, Vascular Surgeon</td>
</tr>
<tr>
<td>0945 - 1030</td>
<td><strong>Patient Assessment and CEAP Classification</strong>&lt;br&gt;Dr Louis Loizou (VIC)&lt;br&gt;Phlebologist</td>
<td><strong>Physiology</strong>&lt;br&gt;Physiology&lt;br&gt;Lasers&lt;br&gt;Prof. Imre Bilhari (Hungary)</td>
</tr>
<tr>
<td>1030 - 1100</td>
<td>Morning Tea</td>
<td><strong>Lymphology Workshop</strong>&lt;br&gt;Diagnosis &amp; Classification&lt;br&gt;How to Investigate Lymphedema&lt;br&gt;Prof. Neil Piller (SA)</td>
</tr>
<tr>
<td>1100 - 1145</td>
<td><strong>How to Set up a Sclerotherapy Practice</strong>&lt;br&gt;Dr Louis Loizou (VIC)&lt;br&gt;Phlebologist</td>
<td><strong>Informant Consent and Medicolegal Issues</strong>&lt;br&gt;Dr Chris Lekich (QLD)&lt;br&gt;Barrister</td>
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<tr>
<td>1145 - 1230</td>
<td><strong>How I Treat AVMs</strong>&lt;br&gt;Prof. Lourens Bester (NSW)&lt;br&gt;Interventional Radiologist</td>
<td><strong>Panel Discussion</strong></td>
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<tr>
<td>1330 - 1500</td>
<td><strong>Sclerotherapy Contraindications and Complications</strong>&lt;br&gt;Dr Paul Thibault (NSW)&lt;br&gt;Phlebologist</td>
<td><strong>Vascular Anomalies</strong>&lt;br&gt;Dr Kurosh Parsi (NSW)&lt;br&gt;Phlebologist</td>
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<tr>
<td>1500 - 1530</td>
<td><strong>Afternoon Tea</strong></td>
<td><strong>Catheters, Wires, Embolic Agents and Devices</strong>&lt;br&gt;Prof. Lourens Bester (NSW)&lt;br&gt;Interventional Radiologist</td>
</tr>
<tr>
<td>1530 - 1800</td>
<td><strong>CW-Doppler and PPG Hands-on Workshop</strong>&lt;br&gt;Dr Louis Loizou (VIC)&lt;br&gt;Phlebologist&lt;br&gt;Dr David Jenkins (NSW)&lt;br&gt;Phlebologist</td>
<td><strong>How I Treat AVMs</strong>&lt;br&gt;Dr Sanjay Nadkarni (WA)&lt;br&gt;Interventional Radiologist</td>
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<tr>
<td>1900 - 2100</td>
<td><strong>CONFERENCE WELCOME COCKTAILS</strong>&lt;br&gt;Live music, refreshments and cocktails while catching up with colleagues</td>
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<tr>
<td>Time</td>
<td>Basic Phlebology Course</td>
<td>Advanced Phlebology Course</td>
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<tr>
<td>0700 - 0745</td>
<td>Emergencies in Phlebology - Part 2</td>
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<td>0745</td>
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<tr>
<td>0800 - 0930</td>
<td>STREAM A</td>
<td>STREAM B</td>
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<td>Basic Phlebology Course (Phlebology Part I)</td>
<td>Advanced Phlebology Course (Phlebology Part II)</td>
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<td>Westhaven Room</td>
<td>Tamaki Room</td>
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<td>Registration Required</td>
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<td></td>
<td>CHAIR: Dr Louis Loizou</td>
<td>CHAIR: Dr Mark Elvy</td>
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<td>MODERATOR: Dr Stefania Roberts</td>
<td>MODERATOR: Dr Andrew Stirling</td>
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<tr>
<td>0800 - 0825</td>
<td>Sclerotherapy of Reticular and Telangiectic Veins: How I Do It</td>
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<td></td>
<td>Prof Imre Bihari (Hungary) Phlebologist, Vascular Surgeon</td>
<td>Sclerotherapy of Reticular and Telangiectic Veins: How I Do It</td>
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<tr>
<td>0825 - 0850</td>
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<td>Prof. Philip Coleridge Smith (UK) Phlebologist, Vascular Surgeon</td>
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<td>0850 - 0915</td>
<td></td>
<td>Sclerotherapy of Reticular and Telangiectic Veins: How I Do It</td>
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<td>Dr JJ Guex (France) Phlebologist, Angiologist</td>
<td>Dr Michel Schadeck (France) Phlebologist, Angiologist</td>
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<tr>
<td>0915 - 0940</td>
<td></td>
<td>Sclerotherapy of Reticular and Telangiectic Veins: How I Do It</td>
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<td>Dr Michel Schadeck (France) Phlebologist, Angiologist</td>
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<tr>
<td>0940 - 1000</td>
<td>Panel Discussion</td>
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<tr>
<td>1000 - 1030</td>
<td>Morning Tea</td>
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<tr>
<td>1030 - 1145</td>
<td>Sclerosants and the Coagulation</td>
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<td></td>
<td>Dr Kurosh Parsi (NSW) Phlebologist, Dermatologist</td>
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<tr>
<td>1145 - 1200</td>
<td>Short Break</td>
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<tr>
<td>1200 - 1330</td>
<td>Rheology - Fluid Dynamics of Blood Flow - Modelling and Simulation</td>
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<td>Basic Concepts, Movement of Liquids in Liquids &amp; Movement of Foams in Liquids</td>
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<td></td>
<td>Prof. Masud Behnia (NSW) - Prof of Mechanical Engineering, University of Sydney</td>
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<td>Prof. Srinivas Karkenahalli (NSW) - Deputy Head, School of Aerospace, Mechanical and Mechatronic Engineering</td>
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<td>Assoc. Prof. Makato Ohita (Japan) - Prof of Biomedical Engineering and Fluid Mechanics, Tohoku University</td>
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<td></td>
<td>Assoc. Prof. Toshio Nakayama (Japan) - Prof of Biomedical Engineering and Fluid Mechanics, Tohoku University</td>
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<tr>
<td>1330 - 1430</td>
<td>Lunch</td>
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<td>1430 - 1500</td>
<td>Afternoon Free</td>
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<tr>
<td>1500 - 1600</td>
<td>Conference Welcome Party</td>
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<td></td>
<td>‘The Last Drink’ Waiteheke Island, Cable Bay Vineyard</td>
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<td>Maori Welcome - Live Music - Cocktails and Canapes</td>
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<td>1600 - 1730</td>
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<td>1730</td>
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<tr>
<td>1800 - 2200</td>
<td>Conference Welcome Party</td>
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<td></td>
<td>Yes Minister Sir Humphrey addresses the EVLT item number</td>
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<td>Wine Tasting Challenge</td>
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<td>Wineroos vs All Noirs vs Team World</td>
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</tbody>
</table>
Conference Welcome Party
Wine Tasting Competition
& Yes Minister
Cable Bay Vineyard

GRAND JUDGE: Dr Lou Loizou

Wineroos vs All Noirs vs Team World

Representing Australia:
Prof. Masud Behnia (NSW - Mudgee Enthusiast)
Dr Gurnit Dhillon (VIC)
Dr Stefania Roberts (VIC)
Dr Paul Thibault (NSW - Hunter Valley Resident)

Representing NZ:
Dr Peter Chapman Smith (Pinot for breakfast)
Dr Kamal Karl (Pinot for lunch)
Dr John Barrett (Pinot for breakfast & lunch)
Mystery Guest

Representing The World:
Prof. Philip Coleridge Smith (UK)
Dr JJ Guex (France)
Dr Nick Morrison (USA)
Dr Michel Schadeck (France)

Prepare early, YOUR COUNTRY NEEDS YOU!

Features: Maori Welcome • Yes Minister • Wine Tasting Challenge
• Limbo Challenge & More... Includes ferry transfer from hotel

NZD$65.00 per person

Time: 6PM, Sunday 7th February, Cable Bay Vineyard, Waiheke Is.
Dress Code: Island Style
### Scientific Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
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<tbody>
<tr>
<td>0700 - 1730</td>
<td>Registration</td>
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</tbody>
</table>
| 0700 - 0815 | **Breakfast with the Stars**  
**What’s New in Phlebology in Italy and Around the World?**  
*Greys Room*  
Dr Attilio Cavezzi  
Phlebologist, Vascular Surgeon, Italy  
CHAIR: Dr Louis Loizou  
NZD$65.00 per person |
| 0825 - 0830 | **CONFERENCE WELCOME:** Dr Kurosh Parsi - ACP President                     |
| 0830 - 0900 | **ENDOVENOUS SYMPOSIUM 1 - The Great Room**  
CHAIR: Prof Ken Myers  
MODERATOR: Dr John Barrett  
**KEYNOTE LECTURE:** EVLA - Does the Wavelength Matter?  
Prof. Ken Myers (VIC) |
| 0900 - 0930 | **GUEST LECTURE:** The Complementary Roles of Surgery, Endovenous Laser Ablation,  
and Foam Sclerotherapy in the Treatment of Venous Insufficiency - the U.S. Perspective  
Dr Nick Morrison (USA) |
| 0930 - 0945 | Endovenous Laser Treatment: 1500 nm vs. 980 nm - a Comparative Trial  
Dr Mark Vuytsteke (BEL) |
| 0945 - 1000 | The proximal great saphenous vein: Recanalisation, reflux & recurrence after endovenous  
laser treatment  
Dr George Somjen (VIC) |
| 1000 - 1015 | High Energy Endovenous Laser Ablation and Saw-Knife Phlebectomy  
Prof. Imre Bihari (HUN) |
| 1015 - 1030 | Panel Discussion                                                           |
| 1030 - 1100 | **SCLEROTHERAPY SYMPOSIUM 1 - The Great Room**  
CHAIR: Dr Paul Thibault  
MODERATOR: Dr Mark Malouf  
**KEYNOTE LECTURE:** Foam Sclerotherapy - The State of the Art  
Prof P. Coleridge-Smith (UK) |
| 1100 - 1130 | Liquid or Foam - Which is Better?  
Dr Michel Schadeck (FRA) |
| 1145 - 1200 | Catheter Directed Sclerotherapy and Phlebectomy  
Dr Attilio Cavezzi (ITA) |
| 1200 - 1215 | Ultrasound Guided Sclerotherapy - what do we know for sure?  
Prof. Ken Myers (VIC) |
| 1215 - 1230 | Froth Treatment  
Prof. Imre Bihari (HUN) |
| 1230 - 1245 | Experience with concomitant ultrasound-guided foam sclerotherapy and endovenous laser  
treatment in chronic venous disorder and its influence on Health Related Quality of Life (HRQL):  
interim analysis of more than 1000 consecutive procedures.  
Dr Ted King (USA) |
| 1245 - 1300 | Panel Discussion                                                           |
| 1300 - 1400 | **Exhibition & Lunch**                                                      |
| 1400 - 1500 | Afternoon Free                                                              |
| 1730 - 1830 | **Pre-Ceremony Drinks**                                                    |
| 1830 - 1930 | **Conferring Ceremony and Launch of the New Zealand Faculty**  
Australasian College of Phlebology  
Ken Myers Oration:  
Professor Earl Owen, University of Sydney |
| 1930 - 2300 | **Gala Dinner**                                                            |

**Location:** Auckland Town Hall (Transport from Hotel Organised)
<table>
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<tbody>
<tr>
<td>0700 - 1730</td>
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<tr>
<td>0700 - 0745</td>
<td>Complimentary Breakfast Session - Greys Room</td>
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<tr>
<td></td>
<td>Secrets of the Paperless Office</td>
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<tr>
<td></td>
<td>Do you find yourself working in IT rather than medicine at times?</td>
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<td>Mr Rafic Habib - Managing Director - ISN Solutions</td>
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<tr>
<td>0700 - 0745</td>
<td><strong>CONTROVERSIES IN PHLEBOLOGY 1</strong> - Small Veins Symposium - The Great Room</td>
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<td>CHAIR: Dr Kurosh Parsi</td>
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<td>MODERATOR: Dr Stefania Roberts</td>
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<tr>
<td>0800 - 0830</td>
<td><strong>KEYNOTE LECTURE</strong> - Curing the Incurable</td>
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<td>Prof P. Coleridge Smith (UK)</td>
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<tr>
<td>0800 - 0830</td>
<td>Keypad Interactive Session - How would you treat (Sclerosant/concentration/technique) ... ? (1 minute per question)</td>
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<tr>
<td></td>
<td>1. Sporadic telangiectasias of ant. thigh (more reticular veins than telangiectasias)</td>
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<td>2. Widespread spontaneous matting of both legs with no previous treatment</td>
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<td>3. Gets matting every time you treat her</td>
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<td>4. Very fine spider veins which are barely visible</td>
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<td>5. Gets severe pigmentation</td>
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<td>6. Extensive small vein disease with no varicose veins</td>
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<tr>
<td>0830 - 0900</td>
<td>Audience Survey</td>
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<tr>
<td>0900 - 1000</td>
<td>Expert Panel Opinion - Panel members have 6 minutes each to answer the above questions</td>
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<tr>
<td></td>
<td>Prof. Imre Bihari (Hungary)</td>
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<td>Dr Attilio Cavaezzi (Italy)</td>
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<td>Dr Paul Thibault (NSW)</td>
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<td>1000 - 1030</td>
<td>Panel Discussion</td>
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<tr>
<td>1030 - 1100</td>
<td>Exhibition &amp; Morning Tea</td>
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<tr>
<td>1100 - 1115</td>
<td><strong>STREAM A</strong> Basic Science Research</td>
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<td></td>
<td>The Great Room</td>
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<td></td>
<td>CHAIR: Prof. Andre van Rij</td>
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<td>MODERATOR: Dr Michel Schadeck</td>
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<tr>
<td>1100 - 1115</td>
<td>Variables in Foam Sclerotherapy with Tessari Method: Experimental Data</td>
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<td>Dr Attilio Cavaezzi (Italy)</td>
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<tr>
<td>1115 - 1130</td>
<td>Interaction of Detergent Sclerosants with Fibrinolytic Mechanisms</td>
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<td>Dr Kurosh Parsi (NSW)</td>
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<tr>
<td>1130 - 1145</td>
<td>Detergent Sclerosants Interfere with Platelet Activation and Aggregation</td>
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<td>Dr Anne Pilotelle (NSW)</td>
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<td>1145 - 1200</td>
<td>Overall Thrombotic Activity of Detergent Sclerosants: Thromboelastographic Data</td>
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<td>David Du (NSW)</td>
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<tr>
<td>1200 - 1215</td>
<td>Fibrinolytic and Thrombolytic Activity of Detergent Sclerosants</td>
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<td>Dr Kurosh Parsi (NSW)</td>
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<tr>
<td>1215 - 1230</td>
<td>Questions</td>
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<tr>
<td>1230 - 1330</td>
<td>Exhibition &amp; Lunch</td>
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</tbody>
</table>
### VENOUS DISEASE UPDATE - The Great Room

**CHAIR:** Dr Paul Dinnen  
**MODERATOR:** Dr David Jenkins

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1330</td>
<td>KEYNOTE LECTURE - Venoactive Drugs - Gimmick or Medicine?</td>
<td>Prof P. Coleridge Smith (UK)</td>
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<tr>
<td>1400</td>
<td>Multiple Sclerosis and Cerebral Venous Insufficiency</td>
<td>Dr Paul Thibault (NSW)</td>
</tr>
<tr>
<td>1415</td>
<td>Prevalence of Reflux in the Great Saphenous Vein as a Function of Diameter</td>
<td>Dr Nick Morrison (USA)</td>
</tr>
</tbody>
</table>
| 1430 | Venous Perforators in Normal Lower Limbs  
Ultrasound Characterisation and Comparison with Resin Caste Anatomy | Prof. Andre van Rij (NZ) |
| 1445 | Venous Incompetence in Children | Dr Michel Schadeck (FRA) |
| 1500 | Relationship Between Number of Pregnancies and Great Saphenous Vein Diameter | Dr Nick Morrison (USA) |
| 1515 | Progression and recurrence of vein disease in patients treated with endovenous laser ablation: Two-four year experience. Is there a place for the phrase recurrent varices after laser or reval? | Dr Ted King (USA) |

#### Questions

#### Exhibition & Afternoon Tea

**VENOUS THROMBOEMBOLISM - The Great Room**  
**CHAIR:** Prof. Andre van Rij  
**MODERATOR:** Dr Sanjeev Chunilal

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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>1615</td>
<td>GUEST LECTURE - The Future of New Antithrombotics</td>
<td>Dr Sanjeev Chunilal (NZ)</td>
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<tr>
<td>1645</td>
<td>GUEST LECTURE - Venous Thromboembolism: An Update of What’s New</td>
<td>Dr Abdullah Omari (NSW)</td>
</tr>
</tbody>
</table>
| 1715 | The Time Sequence of the Development of Axial Deep Reflux Following Lower Limb DVT  
A Prospective Study over 5 Years | Prof. Andre van Rij (NZ) |
| 1730 | Challenging Cases In VTE | Dr Abdullah Omari (NSW) |
| 1745 | Simple Interventions Improve Adherence to Thromboprophylaxis Guidelines | Dr Deborah Wright (NZ) |
| 1800 | Questions | |
## Scientific Program

### MEDICOLEGAL BREAKFAST - Greys Room

**PRESENTERS:** Dr Chris Lekich, Barrister in Law  
Ms Katja Beitat, HCCC, NSW

NZD$65.00 per person

**0700 - 0705**  
Introduction - Dr Chris Lekich

**0705 - 0725**  
Who is getting sued for treating veins - Dr Chris Lekich

**0725 - 0745**  
Why Patients Complain and What Happens After? - Ms Katja Beitat

Panel Discussion

### CONTROVERSIES IN PHLEBOLOGY 2 - Segmental Venous Incompetence Symposium - The Great Room

**CHAIR:** Dr Paul Dinnen  
**MODERATOR:** Dr Paul Tibault

**0800 - 0830**  
**KEYNOTE LECTURE -** Preserving The Great Saphenous Vein - A Lost Cause?  
Prof Imre Bihari (HUN)

Keypad Interactive Session  
What would your treat strategy be if .... ? (1 minute per question)
1. Prox GSV competent, distal incompetent
2. Prox GSV incompetent but distal competent
3. AAGSV or PAGSV incompetent but GSV competent
4. GSV and intersaphenous veins incompetent and the mid-third of SSV incompetent
5. SSV incompetent, inter-saphenous veins incompetent, PAV incompetent, but GSV competent
6. Mid-third of GSV incompetent

**0830 - 0900**  
Audience Survey  
Dr Kurosh Parsi (NSW)

**0900 - 1000**  
Expert Panel Opinion - Panel members have 6 minutes each to answer the above questions  
Prof. Imre Bihari (Hungary)  
Dr Attilio Cavezzi (Italy)  
Prof. Philip Coleridge Smith (UK)  
Dr JJ Guex (France)  
Dr Nick Morrison (USA)  
Prof. Ken Myers (VIC)  
Dr Michel Schadeck (France)

### STREAM A - Free Papers  
**The Great Room**  
**CHAIR:** Dr Mark Elvy  
**MODERATOR:** Mr Gary Frydman

**1100 - 1115**  
Popliteal vein compression, DVT and the efficacy of calf compressors  
Dr David Huber (NSW)

**1115 - 1130**  
Minimally invasive surgery for Varicose veins. Its role in 2010  
Mr Gary Frydman (VIC)

**1130 - 1145**  
Computational Blood Flow Analysis to Assess Effect of Stenosis Symmetry  
Aliqah Hamzah (NSW)

**1145 - 1200**  
Acute Hepatitis following Methoxyflurane Analgesia during Sclerotherapy  
Dr Stuart McMaster (QLD)

**1200 - 1215**  
When Will the Bubbles Burst? Foam Stability: Air vs. CO2  
Dr Chris Lekich (QLD)

### STREAM B - Scientific Methods and Phlebology  
**Greys Room**  
**CHAIR:** Prof. Philip Coleridge Smith  
**MODERATOR:** Prof. Andre van Rij

**1100 - 1120**  
Guest Lecture  
How Not to Get Rejected!  
Prof. Philip Coleridge Smith, Editor, European Journal of Vascular Endovascular Surgery

**1120 - 1140**  
Guest Lecture  
Something Wrong With Those Numbers!  
Prof. Ken Myers (VIC)

**1140 - 1200**  
Guest Lecture  
Patient Reported Outcomes  
Dr JJ Guex (France)

**1200 - 1220**  
Guest Lecture  
Blood Flow Fluid Mechanics: How and What We Measure  
Prof. Masud Behnia (NSW)

### Questions

**1220 - 1230**  
Questions

**1230 - 1330**  
Exhibition & Lunch

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**Wednesday 10 February**  
**Scientific Program**

**06-11 February 2010 | The Langham Auckland | New Zealand**
### Scientific Program

#### SCLEROTHERAPY SYMPOSIUM 2 - The Great Room

**CHAIR:** Dr Louis Loizou  
**MODERATOR:** Dr David Jenkins

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1330 - 1400</td>
<td><strong>KEYNOTE LECTURE</strong> - Bubbles in the Brain - What do we know?</td>
<td>Dr Nick Morrison (USA)</td>
</tr>
<tr>
<td>1400 - 1415</td>
<td>The French Polidocanal Registry - a Survey Covering 3357 Patient Years</td>
<td>Dr JJ Guex (FRA)</td>
</tr>
<tr>
<td>1415 - 1430</td>
<td>Complications of Duplex Guided Sclerotherapy of the Small Saphenous Vein Study of a Population of 4984 Patients</td>
<td>Dr Michel Schadeck (FRA)</td>
</tr>
<tr>
<td>1430 - 1445</td>
<td>EVLA vs. Foam UGS for Saphenous Trunks - 5 Year Prospective Outcome Data</td>
<td>Dr Peter Chapman Smith (NZ)</td>
</tr>
<tr>
<td>1445 - 1500</td>
<td>Safety of Large Volume Foam UGS Combined with ELVA</td>
<td>Dr Peter Chapman Smith (NZ)</td>
</tr>
<tr>
<td>1500 - 1515</td>
<td>Topical Nitrates in the Treatment of Sclerotherapy Induced Skin Necrosis: Case Presentation</td>
<td>Dr David Jenkins (NSW)</td>
</tr>
<tr>
<td>1515 - 1530</td>
<td>Panel Discussion and Questions</td>
<td></td>
</tr>
<tr>
<td>1530 - 1600</td>
<td><strong>Exhibition &amp; Afternoon Tea</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### ENDOVENOUS SYMPOSIUM 2 - The Great Room

**CHAIR:** Prof Ken Myers  
**MODERATOR:** Dr John Barrett

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1600 - 1615</td>
<td>Endovenous Laser Ablation: Intraluminal Centralisation of Fibre-Tip can Perfectionate the Technique A Histological Study</td>
<td>Dr Marc Vuylsteke (BEL)</td>
</tr>
<tr>
<td>1615 - 1630</td>
<td>How safe and effective is high energy endovenous laser ablation?</td>
<td>Dr Ted King (USA)</td>
</tr>
<tr>
<td>1630 - 1645</td>
<td>Timing of Foam Sclerotherapy with EVLA - Stat or Delayed</td>
<td>Dr Peter Chapman Smith (NZ)</td>
</tr>
<tr>
<td>1645 - 1700</td>
<td>The distal great saphenous vein: Recanalisation, reflex, incompetent perforating veins after endovenous laser treatment</td>
<td>Dr George Somjen (VIC)</td>
</tr>
<tr>
<td>1700 - 1715</td>
<td>Endovenous Coil Ablation for Varicose Veins – A Safety and Efficacy Trial</td>
<td>Mr Gary Frydman (VIC)</td>
</tr>
<tr>
<td>1715 - 1745</td>
<td>Thinking outside the box in treating an incompetent GSV. coils, onyx and other methods</td>
<td>Dr Sanjay Nadkarni (WA)</td>
</tr>
<tr>
<td>1745 - 1800</td>
<td>Can saphenous and sural nerve paresthesia be prevented during ELT?</td>
<td>Dr Ted King (USA)</td>
</tr>
<tr>
<td>1800 - 1805</td>
<td>Panel Discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Closing Remarks</strong></td>
<td></td>
</tr>
</tbody>
</table>

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*Auckland | City of Sails*
Special Event:

Breakfast with the Stars
Greys Room

Guest Speaker: Dr Attilio Cavezzi, Phlebologist, Vascular Surgeon, Italy

What’s New in Phlebology?
The Local Scene in Italy and Around the Globe

Monday 08 February, Greys Room, Langham Hotel, Auckland from 7:00am - 8:15am
Menu: Typical Italian Breakfast

FEE NZD$65 per person

Special Event:

MEDICOLEGAL BREAKFAST
Greys Room

Why Patients Complain and What Happens After?
Healthcare Complaints Commission, NSW
Who is Getting Sued for Treating Veins?

PRESENTERS: Dr Chris Lekich, Barrister in Law - Ms Katja Beitat, HCCC, NSW

Wednesday 10 February, Greys Room, Langham Hotel, Auckland from 7:00am - 8:00am

FEE NZD$65.00 per person
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0700 - 1730</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>0800 - 0805</td>
<td>Introduction</td>
<td>Annie Morgan</td>
</tr>
<tr>
<td>0805 - 0900</td>
<td>Knobology</td>
<td>Wendy Miller, John Grimshaw, Sarah Colley</td>
</tr>
<tr>
<td>0900 - 1030</td>
<td>Lower Limb Venous Anatomy and Nomenclature</td>
<td>Dr Attilio Cavezzi</td>
</tr>
<tr>
<td>1030 - 1100</td>
<td>Morning Tea</td>
<td></td>
</tr>
<tr>
<td>1100 - 1115</td>
<td>Pelvic Vein Assessment</td>
<td>Martin Necas</td>
</tr>
<tr>
<td>1115 - 1215</td>
<td>Workshop Pelvic Vein Scanning</td>
<td>Martin Necas</td>
</tr>
<tr>
<td>1215 - 1230</td>
<td>Arterial Assessment for the Phlebology Laboratory</td>
<td>Annie Morgan</td>
</tr>
<tr>
<td>1300 - 1400</td>
<td>Lunch</td>
<td>Bronwen Allen/Darryl Queenin</td>
</tr>
<tr>
<td>1400 - 1415</td>
<td>Lower Limb Venous Mapping</td>
<td>Bronwen Allen/Darryl Queenin</td>
</tr>
<tr>
<td>1415 - 1530</td>
<td>Workshop Lower Limb Vein Mapping</td>
<td>Martin Necas, Annie Morgan, Bronwen Allen, Darryl Queenin</td>
</tr>
<tr>
<td>1530 - 1600</td>
<td>Afternoon Tea</td>
<td>Martin Necas</td>
</tr>
<tr>
<td>1600 - 1615</td>
<td>Upper Limb Venous Duplex Examination</td>
<td>Martin Necas</td>
</tr>
<tr>
<td>1615 - 1630</td>
<td>Lower Limb DVT scans</td>
<td>Osvaldo Cooley Andrade</td>
</tr>
<tr>
<td>1630 - 1800</td>
<td>Workshop 1 Upper Limb Venous Scan</td>
<td>Martin Necas, Annie Morgan</td>
</tr>
<tr>
<td></td>
<td>Workshop 2 Lower Limb DVT scan</td>
<td>Osvaldo Cooley Andrade</td>
</tr>
<tr>
<td>1800</td>
<td>Wrap-up</td>
<td></td>
</tr>
</tbody>
</table>

Workshops proudly supported by:
ACP 2010: General Information

TRANSPORTATION
Langham Hotel Limousine Service
Guests can be picked up from the airport by a chauffeur who will have an accommodation registration card for the guest in the limousine - you can complete the card during the journey - the chauffeur will take a swipe of your credit card for guarantee and will also have the keys for your room(s) so you can go straight to your designated room upon arrival at the hotel.

The cost is: $90.00 including GST from Airport to the hotel and $75.00 including GST from Hotel to the airport. Indicate on the conference registration form if you would like to book a limousine transfer.

Taxis and shuttles
Auckland Airport licenses specific taxi and shuttle companies to ensure airport visitors and travellers receive a high standard of service. All taxi and shuttle companies are able to drop you off at the airport, however only licensed companies are able to pick you up from the designated taxi ranks at the terminal buildings.

Taxi and shuttle ranks are located outside the arrivals area (door 8) at the international terminal. You can pre-book with one of the companies listed below or just turn up at the terminal ranks - taxis and shuttles are always available. Indicative fares from the airport into the city is between NZ$60 – NZ$80 one-way for a taxi. For specific fare pricing, contact the taxi and shuttle companies directly.

Auckland Combined Citicabs Taxis
Phone: +64 9 300 1111 Website: www.citicabs.co.nz

Auckland Co-op Taxis
Phone: +64 9 300 3000 Website: www.cooptaxi.co.nz

Corporate Cabs
Phone: +64 9 377 0773 Website: www.corporatecabs.co.nz

VISA
Before you travel to New Zealand, please check that your passport is ready for the trip. Your passport must be:
• Valid for at least 3 months beyond your intended departure date.
• Not damaged, defaced or excessively worn.
• Showing a visa or permit, if you require one.

Do you need a New Zealand visa or permit?
You do not need a visa or permit to visit New Zealand if you are:
• A New Zealand citizen or Resident Permit holder
• An Australian citizen travelling on an Australian passport
• An Australian resident with a current Australian resident return visa
• A British citizen and or British passport holder who can produce evidence of the right to reside permanently in the UK (you can stay up to six months)
• A citizen of a country which has a visa waiver agreement with New Zealand

For more detailed information check out the Visa free countries section of the Immigration New Zealand website: http://glossary.immigration.govt.nz/VisaFreeCountries.htm

TRAVEL INSURANCE
The conference organisers recommend that delegates purchase travel insurance including cover for non-refundable meeting registration fees.

ELECTRICITY
240/250 volts AC 50HZ. Universal outlets for 110 volts (shavers only) are standard in hotels, apartments and motels.

PAYMENT
All prices are in New Zealand dollars including GST. All online registration must be paid by credit card via the website. Please note that debits to your credit card will appear as Conference Matters on your statement. If you complete a registration form manually and pay via cheque, please note cheques or drafts must be in New Zealand currency, drawn on an NZ bank and free of all charges.

FOOD & BEVERAGE
Specify dietary requirements on the registration form.

Coffee Breaks
Coffee breaks are included in the registration fee and will be served in several locations, including the Exhibition Area, to delegates from Saturday, 06 February, 2010 to Wednesday, 10 February 2010 during the session breaks.

Lunch
Lunch breaks are included in the registration fee and will be served in several locations, including the Exhibition Area, to delegates from Saturday, 06 February, 2010 to Wednesday, 10 February 2010 during the session breaks.

LANGUAGE
English is the official Congress language and no translation services are offered.

REGISTRATION & BADGES
Please go to the Congress website at www.phlebology.com.au for online registration. The other option is to use the registration form at the back of this announcement or to print the PDF file of the registration form off the website, and send the completed form to the Conference Secretariat either by fax or by mail. All participants, including speakers and chairmen, must submit a completed registration form.

Name Badges
Name badges must be visible and used at all times, anywhere at the Langham Hotel for access to the meeting and official social functions.

RULES
Smoking Policy
The ACP 2010 Meeting is a non-smoking event. Participants are kindly requested to refrain from smoking in the meeting venue, including the Exhibition Area.

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

SPEAKER’S SETUP ROOM
Speakers are asked to bring their formatted PowerPoint presentations to the Speaker’s Preview Room the day before or at least one session before their scheduled presentation. Files from keydrives or CD-ROMs can be transferred to the Congress servers at that time. All conference rooms contain state-of-the-art technical equipment.

The Speakers’ Setup Room will be open as follows:
Saturday February 06, 2010 7:30 AM - 7:00 PM
Sunday February 07, 2010 7:30 AM - 5:00 PM
Monday February 08, 2010 7:30 AM - 7:00 PM
Tuesday February 09, 2010 7:30 AM - 7:00 PM
Wednesday February 10, 2010 7:30 AM - 7:00 PM

INTERNET CONNECTIONS
The Langham Hotel has a business room available with internet access. Internet also available in rooms.
The Langham Hotel Auckland 83 Symonds Street, Auckland 1140, New Zealand

The Langham Hotel Auckland exudes a timeless elegance that celebrates the past, yet embraces the future. As a luxury Auckland hotel, you will be enchanted with the tradition of graceful living.

The Langham is particularly recognised for:

- Outstanding 5 star luxury hotel accommodation (comprising 410 rooms, including 70 Langham Club rooms and 12 suites)
- Exceptional restaurants, lounges and bars
- Rejuvenating Chuan Spa, unique to this luxury Auckland hotel
- Excellent leisure facilities, including a well-equipped fitness studio, heated swimming pool, sauna and jacuzzi
- 24-hour room service

The Langham Hotel Auckland is among the ‘Leading Hotels of the World’.

Location

The Langham Hotel Auckland is conveniently located:

- Close to key motorway access points
- Within walking distance of the waterfront and downtown business and shopping areas
- Near the beautiful Auckland Domain and the Auckland War Memorial Museum
- With complimentary daily shuttle service to the city centre

Accommodation Options:

**Classic Room:**
Located on levels 1 to 4, these rooms are stylishly opulent and decorated in tones that complement the pleasingly light-hued furniture

**Executive Room:**
Located on levels 5 and 6, these rooms are richly decorated in sumptuous silks and velvets. These rooms include complimentary internet access is available in the mini business centre on floors 5 and 6.

**Club Room:**
Tastefully appointed in the most luxurious upholstery fabrics, these rooms also offer all the extra luxury and privileges of The Langham Club including access to the exclusive Club lounge and complimentary use of the business centre. The Langham Club Room and Suite guests will enjoy butler service and complimentary hot and cold breakfast items, two hours of evening cocktails and canapés in the hotel club lounge.

Bed and Full Buffet Breakfast rate – please add $30 inc GST to the room rate, per person.

Accommodation Confirmation:

Conference Matters has negotiated a reduced rate for conference delegates during the conference. All accommodation booking must be made through Conference Matters. Accommodation will not be processed unless accompanied by full payment.

Change of booking:

All changes to reservations must be made in writing to Conference Matters, not the Hotel.

Refund:

A refund will only be made if notification of cancellation is received in writing 30 days prior to your reservation date.

Check-in and check-out:

Standard check-in time at hotel is 3.00 pm onwards. If a room is required prior to this time Conference Matters should be advised as hotel may otherwise charge an additional fee. Delegates arriving after 6.00 pm should indicate the estimated time of arrival, as the hotel, if not notified of a late arrival, may release the room to other guests. Check-out time is 11.00 am. Any departure after 11.00 am is subject to a charge.
# INDEX OF SPEAKERS & ABSTRACTS

<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>DATE</th>
<th>TIME</th>
<th>TOPIC</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S. Allen (NZ)</td>
<td>Tues 09 Feb</td>
<td>11:30 - 11:45</td>
<td>Outside the Box: if not venous what else to look for in the lower limb vein assessment</td>
<td>50</td>
</tr>
<tr>
<td>M. Behnia (NSW)</td>
<td>Sun 07 Feb</td>
<td>12:00 - 13:30</td>
<td>Fluid Dynamics of Blood Flow - Modelling and Simulation</td>
<td>CN203</td>
</tr>
<tr>
<td>K. Baitat (NSW)</td>
<td>Wed 10 Feb</td>
<td>12:00 - 12:20</td>
<td>Guest Lecture: Blood Flow Fluid Mechanics. How and What We Measure</td>
<td>N/A</td>
</tr>
<tr>
<td>T. King (USA)</td>
<td>Wed 10 Feb</td>
<td>07:00 - 08:00</td>
<td>MEDICOLEGAL BREAKFAST</td>
<td>N/A</td>
</tr>
<tr>
<td>I. Bihari (HUN)</td>
<td>Sat 06 Feb</td>
<td>15:30 - 16:30</td>
<td>Catheters, Wires, Embolic Agents and Devices</td>
<td>N/A</td>
</tr>
<tr>
<td>C. Lekich (QLD)</td>
<td>Wed 10 Feb</td>
<td>12:00 - 12:15</td>
<td>When Will the Bubbles Burst? Foam Stability: Air vs. CO2</td>
<td>N/A</td>
</tr>
<tr>
<td>G. Frydman (VIC)</td>
<td>Mon 08 Feb</td>
<td>10:00 - 10:30</td>
<td>Physiology Laser Doppler in Phlebology</td>
<td>CN123</td>
</tr>
<tr>
<td>D. Huber (NSW)</td>
<td>Sat 06 Feb</td>
<td>10:00 - 10:30</td>
<td>Physiology Laser Doppler in Phlebology</td>
<td>N/A</td>
</tr>
<tr>
<td>L. Bester (NSW)</td>
<td>Sat 06 Feb</td>
<td>07:00 - 08:25</td>
<td>Sclerotherapy of Reticular and Telangiectic Veins: How I Do It</td>
<td>N/A</td>
</tr>
<tr>
<td>D. Jenkins (NSW)</td>
<td>Sun 07 Feb</td>
<td>08:00 - 09:30</td>
<td>Phlebectomy Workshop</td>
<td>N/A</td>
</tr>
<tr>
<td>P. Coleridge Smith (UK)</td>
<td>Mon 08 Feb</td>
<td>11:00 - 11:30</td>
<td>KEYNOTE LECTURE - Foam Sclerotherapy: The State of the Art</td>
<td>64</td>
</tr>
<tr>
<td>P. Chapman-Smith (NZ)</td>
<td>Wed 10 Feb</td>
<td>09:00 - 09:06</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 1 - Small Veins Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td>S. Chunilal (NZ)</td>
<td>Wed 10 Feb</td>
<td>14:30 - 14:45</td>
<td>EVLA vs. Foam UGS for Saphenous Trunks - 5 Year Prospective Outcome Data</td>
<td>79</td>
</tr>
<tr>
<td>I. Cavezzi (ITA)</td>
<td>Sun 07 Feb</td>
<td>08:00 - 09:30</td>
<td>Phlebectomy Workshop</td>
<td>N/A</td>
</tr>
<tr>
<td>J. Guex (FRA)</td>
<td>Mon 08 Feb</td>
<td>10:00 - 10:15</td>
<td>High Energy Endovenous Laser Ablation and Saw-Knife Phlebectomy</td>
<td>32</td>
</tr>
<tr>
<td>P. Chapman-Smith (NZ)</td>
<td>Wed 10 Feb</td>
<td>10:00 - 10:30</td>
<td>Physiology Laser Doppler in Phlebology</td>
<td>37</td>
</tr>
<tr>
<td>S. Karkenahalli (NSW)</td>
<td>Mon 08 Feb</td>
<td>11:00 - 11:30</td>
<td>KEYNOTE LECTURE - Foam Sclerotherapy: The State of the Art</td>
<td>33</td>
</tr>
<tr>
<td>P. Coleridge Smith (UK)</td>
<td>Mon 08 Feb</td>
<td>07:00 - 08:15</td>
<td>What’s New in Phlebology in Italy and Around the World?</td>
<td>35</td>
</tr>
<tr>
<td>D. Du (NSW)</td>
<td>Tues 09 Feb</td>
<td>11:15 - 12:00</td>
<td>Catheter Directed Sclerotherapy and Phlebectomy</td>
<td>51</td>
</tr>
<tr>
<td>G. Frydman (VIC)</td>
<td>Wed 10 Feb</td>
<td>09:00 - 09:06</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 2 - Segmental Venous Incompetence Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td>T. King (USA)</td>
<td>Wed 10 Feb</td>
<td>08:00 - 08:30</td>
<td>KEYNOTE LECTURE - Preserving The Great Saphenous Vein - A Lost Cause?</td>
<td>60</td>
</tr>
<tr>
<td>D. Jenkins (NSW)</td>
<td>Wed 10 Feb</td>
<td>09:00 - 09:06</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 2 - Segmental Venous Incompetence Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td>P. Chapman-Smith (NZ)</td>
<td>Wed 10 Feb</td>
<td>11:15 - 12:00</td>
<td>Overall Thrombotic Activity of Detergent Sclerosants: Thromboelastographic Data</td>
<td>55</td>
</tr>
<tr>
<td>J. Guex (FRA)</td>
<td>Mon 08 Feb</td>
<td>10:00 - 10:15</td>
<td>High Energy Endovenous Laser Ablation and Saw-Knife Phlebectomy</td>
<td>60</td>
</tr>
<tr>
<td>H. Wang (USA)</td>
<td>Wed 10 Feb</td>
<td>09:00 - 09:06</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 2 - Segmental Venous Incompetence Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td>I. Cavezzi (ITA)</td>
<td>Sun 07 Feb</td>
<td>07:00 - 08:25</td>
<td>Sclerotherapy of Reticular and Telangiectic Veins: How I Do It</td>
<td>64</td>
</tr>
<tr>
<td>P. Chapman-Smith (NZ)</td>
<td>Wed 10 Feb</td>
<td>09:14 - 09:20</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 1 - Small Veins Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td>S. Chunilal (NZ)</td>
<td>Sun 07 Feb</td>
<td>10:00 - 10:30</td>
<td>Physiology Laser Doppler in Phlebology</td>
<td>65</td>
</tr>
<tr>
<td>P. Coleridge Smith (UK)</td>
<td>Mon 08 Feb</td>
<td>11:00 - 11:30</td>
<td>KEYNOTE LECTURE - Foam Sclerotherapy: The State of the Art</td>
<td>33</td>
</tr>
<tr>
<td>S. Karkenahalli (NSW)</td>
<td>Mon 08 Feb</td>
<td>11:00 - 11:20</td>
<td>Guest Lecture - How Not to Get Rejected</td>
<td>71</td>
</tr>
<tr>
<td>D. Du (NSW)</td>
<td>Tues 09 Feb</td>
<td>11:15 - 12:00</td>
<td>Minimally invasive surgery for Varicose Veins. its role in 2010</td>
<td>N/A</td>
</tr>
<tr>
<td>G. Frydman (VIC)</td>
<td>Wed 10 Feb</td>
<td>10:00 - 10:15</td>
<td>High Energy Endovenous Laser Ablation and Saw-Knife Phlebectomy</td>
<td>60</td>
</tr>
<tr>
<td>J. Guex (FRA)</td>
<td>Sun 07 Feb</td>
<td>08:25 - 08:50</td>
<td>Sclerotherapy of Reticular and Telangiectic Veins: How I Do It</td>
<td>91</td>
</tr>
<tr>
<td>P. Coleridge Smith (UK)</td>
<td>Mon 08 Feb</td>
<td>11:00 - 11:30</td>
<td>KEYNOTE LECTURE - Foam Sclerotherapy: The State of the Art</td>
<td>33</td>
</tr>
<tr>
<td>D. Du (NSW)</td>
<td>Tues 09 Feb</td>
<td>11:45 - 12:00</td>
<td>Overall Thrombotic Activity of Detergent Sclerosants: Thromboelastographic Data</td>
<td>59</td>
</tr>
<tr>
<td>G. Frydman (VIC)</td>
<td>Wed 10 Feb</td>
<td>10:00 - 10:15</td>
<td>High Energy Endovenous Laser Ablation and Saw-Knife Phlebectomy</td>
<td>37</td>
</tr>
<tr>
<td>D. Du (NSW)</td>
<td>Tues 09 Feb</td>
<td>11:15 - 11:30</td>
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<td>67</td>
</tr>
<tr>
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<td>Wed 10 Feb</td>
<td>10:00 - 10:15</td>
<td>High Energy Endovenous Laser Ablation and Saw-Knife Phlebectomy</td>
<td>67</td>
</tr>
<tr>
<td>D. Du (NSW)</td>
<td>Tues 09 Feb</td>
<td>11:45 - 12:00</td>
<td>Overall Thrombotic Activity of Detergent Sclerosants: Thromboelastographic Data</td>
<td>68</td>
</tr>
<tr>
<td>D. Jenkins (NSW)</td>
<td>Sat 06 Feb</td>
<td>15:30 - 16:00</td>
<td>CVW-Doppler and PPG Workshop</td>
<td>N/A</td>
</tr>
<tr>
<td>J. Guex (FRA)</td>
<td>Sun 07 Feb</td>
<td>08:50 - 09:15</td>
<td>Sclerotherapy of Reticular and Telangiectic Veins: How I Do It</td>
<td>CN97</td>
</tr>
<tr>
<td>T. King (USA)</td>
<td>Wed 10 Feb</td>
<td>12:00 - 13:30</td>
<td>Fluid Dynamics of Blood Flow - Modelling and Simulation</td>
<td>59</td>
</tr>
<tr>
<td>A. Hamzah (NSW)</td>
<td>Wed 10 Feb</td>
<td>14:00 - 14:15</td>
<td>The French Polidocanol Registry - A Survey Covering 3357 Patient Years</td>
<td>73</td>
</tr>
<tr>
<td>D. Huber (NSW)</td>
<td>Wed 10 Feb</td>
<td>11:10 - 11:15</td>
<td>Politeal vein compression, DVT and the efficacy of calf compressors</td>
<td>76</td>
</tr>
<tr>
<td>D. Jenkins (NSW)</td>
<td>Sat 06 Feb</td>
<td>15:30 - 16:00</td>
<td>CVW-Doppler and PPG Workshop</td>
<td>N/A</td>
</tr>
<tr>
<td>S. Karkenahalli (NSW)</td>
<td>Sun 07 Feb</td>
<td>12:00 - 12:30</td>
<td>Experience with concomitant ultrasound-guided foam sclerotherapy and endovenous laser treatment in chronic venous disorder and its influence on Health Related Quality of Life (HRQL): interim analysis of more than 1000 consecutive procedures.</td>
<td>58</td>
</tr>
<tr>
<td>T. King (USA)</td>
<td>Mon 08 Feb</td>
<td>12:30 - 12:45</td>
<td>Experience with concomitant ultrasound-guided foam sclerotherapy and endovenous laser treatment in chronic venous disorder and its influence on Health Related Quality of Life (HRQL): interim analysis of more than 1000 consecutive procedures.</td>
<td>38</td>
</tr>
<tr>
<td>C. Lekich (QLD)</td>
<td>Wed 10 Feb</td>
<td>16:15 - 16:30</td>
<td>How safe and effective is high energy endovenous laser ablation?</td>
<td>83</td>
</tr>
<tr>
<td>A. Hamzah (NSW)</td>
<td>Wed 10 Feb</td>
<td>17:30 - 17:45</td>
<td>Can saphenous and saphenous nerve parasthesia be prevented during ELT?</td>
<td>88</td>
</tr>
<tr>
<td>D. Jenkins (NSW)</td>
<td>Sat 06 Feb</td>
<td>11:45 - 12:30</td>
<td>Informed Consent and Medicolegal Issues</td>
<td>N/A</td>
</tr>
<tr>
<td>C. Lekich (QLD)</td>
<td>Wed 10 Feb</td>
<td>07:00 - 08:00</td>
<td>MEDICOLEGAL BREAKFAST</td>
<td>N/A</td>
</tr>
<tr>
<td>T. King (USA)</td>
<td>Wed 10 Feb</td>
<td>12:00 - 12:15</td>
<td>When Will the Bubbles Burst? Foam Stability: Air vs. CO2</td>
<td>70</td>
</tr>
</tbody>
</table>
INDEX OF SPEAKERS & ABSTRACTS Continued

<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>DATE</th>
<th>TIME</th>
<th>TOPIC</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>L. Loizou (VIC)</td>
<td>Sat 06 Feb</td>
<td>0945 - 1030</td>
<td>Patient Assessment and CEP Classification</td>
<td>CN33</td>
</tr>
<tr>
<td></td>
<td>Sat 06 Feb</td>
<td>1100 - 1145</td>
<td>How to Set up a Sclerotherapy Practice</td>
<td>CN45</td>
</tr>
<tr>
<td></td>
<td>Sat 06 Feb</td>
<td>1530 - 1800</td>
<td>CVV-Doppler and PPG Workshop</td>
<td>CN79</td>
</tr>
<tr>
<td>S. McMaster (QLD)</td>
<td>Wed 10 Feb</td>
<td>1145 - 1200</td>
<td>Acute Hepatitis following Methoxysiloxane Analgesia during Sclerotherapy</td>
<td>69</td>
</tr>
<tr>
<td>A. Morgan (NSW)</td>
<td>Tues 09 Feb</td>
<td>1115 - 1130</td>
<td>Emergencies in the Phlebology Laboratory - a Sonographers Role</td>
<td>29</td>
</tr>
<tr>
<td>N. Morrison (USA)</td>
<td>Mon 08 Feb</td>
<td>0900 - 0930</td>
<td>GUEST LECTURE: The Complementary Roles of Surgery, Endovenous Laser Ablation, and Foam Sclerotherapy in the Treatment of Venous Insufficiency - the U.S. Perspective</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>1415 - 1430</td>
<td>Prevalence of Reflux in the Great Saphenous Vein as a Function of Diameter</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>1500 - 1515</td>
<td>Relationship Between Number of Pregnancies and Great Saphenous Vein Diameter</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>0927 - 0933</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 2 - Segmental Venous Incompetence Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>1330 - 1400</td>
<td>KEYNOTE LECTURE - Bubbles in the Brain - What do we know?</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Mon 08 Feb</td>
<td>0830 - 0900</td>
<td>KEYNOTE LECTURE - EVLA - Does the Wavelength Matter?</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Mon 08 Feb</td>
<td>1200 - 1215</td>
<td>Ultrasound Guided Sclerotherapy - what do we know for sure?</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>0934 - 0940</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 2 - Segmental Venous Incompetence Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>1120 - 1140</td>
<td>Guest Lecture: Something Wrong With Those Numbers!</td>
<td>72</td>
</tr>
<tr>
<td>K. Myers (VIC)</td>
<td>Sat 06 Feb</td>
<td>1530 - 1700</td>
<td>How I Treat AVFs</td>
<td>CN166</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>1715 - 1730</td>
<td>Thinking outside the box in treating an incompetent GSV: coils, onyx and other methods</td>
<td>87</td>
</tr>
<tr>
<td>T. Nakayama (JAP)</td>
<td>Sun 07 Feb</td>
<td>1200 - 1330</td>
<td>Fluid Dynamics of Blood Flow - Modelling and Simulation</td>
<td>CN203</td>
</tr>
<tr>
<td>M. Necas (NZ)</td>
<td>Tues 09 Feb</td>
<td>1100 - 1115</td>
<td>Pelvic Congestion Syndrome</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>1200 - 1215</td>
<td>Reporting Vein Maps Effectively for the Phlebologist</td>
<td>52</td>
</tr>
<tr>
<td>M. Ohta (JAP)</td>
<td>Sun 07 Feb</td>
<td>1200 - 1330</td>
<td>Fluid Dynamics of Blood Flow - Modelling and Simulation</td>
<td>CN203</td>
</tr>
<tr>
<td>A. Omari (NSW)</td>
<td>Tues 09 Feb</td>
<td>1645 - 1715</td>
<td>GUEST LECTURE - Venous Thromboembolism: An Update of What's New</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>1730 - 1745</td>
<td>Challenging Cases In VTE</td>
<td>62</td>
</tr>
<tr>
<td>K. Parsi (NSW)</td>
<td>Sat 06 Feb</td>
<td>1330 - 1500</td>
<td>Vascular Anomalies</td>
<td>CN153</td>
</tr>
<tr>
<td></td>
<td>Sun 07 Feb</td>
<td>1030 - 1145</td>
<td>Sclerotherapeutics Coagulation</td>
<td>CN187</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>0830 - 0900</td>
<td>Audience Survey - CONTROVERSIES IN PHLEBOLOGY 1 - Small Veins Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>1115 - 1130</td>
<td>Interaction of Detergent Sclerosants with Fibrinolytic Mechnisms</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>1200 - 1215</td>
<td>Fibrinolytic and Thrombolytic Activity of Detergent Sclerosants</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>0830 - 0900</td>
<td>Audience Survey - CONTROVERSIES IN PHLEBOLOGY 2 - Segmental Venous Incompetence Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td>N. Piller (SA)</td>
<td>Sat 06 Feb</td>
<td>1100 - 1230</td>
<td>Lymphology Workshop Diagnosis &amp; Classification: How to Investigate lymphoedema</td>
<td>CN139</td>
</tr>
<tr>
<td>A. Pilotelle (NSW)</td>
<td>Tues 09 Feb</td>
<td>1130 - 1145</td>
<td>Detergent Sclerosants Interfere with Platelet Activation and Aggregation</td>
<td>43</td>
</tr>
<tr>
<td>S. Roberts (VIC)</td>
<td>Sat 06 Feb</td>
<td>0900 - 0945</td>
<td>Introduction to Sclerotherapy</td>
<td>CN25</td>
</tr>
<tr>
<td>M. Schadeck (FRA)</td>
<td>Sun 07 Feb</td>
<td>0915 - 0940</td>
<td>Sclerotherapy of Reticular and Telangiectic Veins: How I Do It</td>
<td>CN109</td>
</tr>
<tr>
<td></td>
<td>Mon 08 Feb</td>
<td>1130 - 1145</td>
<td>Liquid or Foam - Which is Better?</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>0935 - 0941</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 1 - Small Veins Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>1445 - 1500</td>
<td>Venous Incompetence in Children</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>0941 - 0946</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 2 - Segmental Venous Incompetence Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>1415 - 1430</td>
<td>Complications of Duplex Guided Sclerotherapy of the Small Saphenous Vein Study of a Population of 4984 Patients</td>
<td>78</td>
</tr>
<tr>
<td>G. Somjen (VIC)</td>
<td>Mon 08 Feb</td>
<td>0945 - 1000</td>
<td>The proximal great saphenous vein: Reocnisation, reflux &amp; recurrence after endovenous laser treatment</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>1645 - 1700</td>
<td>The distal great saphenous vein: Reocnisation, reflux &amp; recurrence after endovenous laser treatment</td>
<td>85</td>
</tr>
<tr>
<td>P. Thibault (NSW)</td>
<td>Sat 06 Feb</td>
<td>1330 - 1500</td>
<td>Sclerotherapy Contraindications and Complications</td>
<td>CN55</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>0935 - 0941</td>
<td>Expert Panel - CONTROVERSIES IN PHLEBOLOGY 1 - Small Veins Symposium</td>
<td>N/A</td>
</tr>
<tr>
<td>A. van Rij (NZ)</td>
<td>Sat 06 Feb</td>
<td>1400 - 1415</td>
<td>Multiple Sclerosis and Cerebral Venous Insufficiency</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Sat 06 Feb</td>
<td>0900 - 1000</td>
<td>Physiology: Basic Concepts &amp; Functional Measures</td>
<td>CN117</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>1430 - 1445</td>
<td>Venous Perforators in Normal Lower Limbs: Ultrasound Characterisation and Comparison with Resin Caste Anatomy</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Tues 09 Feb</td>
<td>1715 - 1730</td>
<td>The Time Sequence of the Development of Axial Deep Reflux Following Lower Limb DVT: A Prospective Study over 5 Years</td>
<td>61</td>
</tr>
<tr>
<td>J. Vassiliadis (NSW)</td>
<td>Sat 06 Feb</td>
<td>0700 - 0845</td>
<td>Advanced Cardiac Life Support for Phlebologists</td>
<td>CN7</td>
</tr>
<tr>
<td></td>
<td>Sun 07 Feb</td>
<td>0700 - 0745</td>
<td>Anaphylaxis in Phlebology</td>
<td>CN15</td>
</tr>
<tr>
<td>M. Vuylsteke (BEL)</td>
<td>Mon 08 Feb</td>
<td>0930 - 0945</td>
<td>Endovenous Laser Treatment: 1500 nm vs. 980 nm - a Comparative Trial</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Wed 10 Feb</td>
<td>1600 - 1615</td>
<td>Endovenous Laser Ablation: Intraluminal Centralisation of Fibre-Tip can Perfectionate the Technique: A Histological Study</td>
<td>82</td>
</tr>
<tr>
<td>D. Wright (NZ)</td>
<td>Tues 09 Feb</td>
<td>1745 - 1800</td>
<td>Simple Interventions Improve Adherence to Thromboprophylaxis Guidelines</td>
<td>63</td>
</tr>
</tbody>
</table>
KEYNOTE LECTURE
EVLA - does the Wavelength Matter?

Ken Myers
Victoria Vein Clinic, Melbourne, Australia

Several commercial systems are now available for endovascular laser ablation (EVLA). Wavelengths range from 809 to 1,500 nm with more to come. Each manufacturer recommends settings for power and pullback speed but without evidence to show that these provide the best outcome. The energy supplied per unit length varies between different manufacturers. The effect of laser energy is dependent on wavelength, power, probe withdrawal rate and whether energy is continuous or pulsed. Planck’s formula indicates that energy is proportional to frequency so that higher wavelengths require more exposure time.

The aim is to obtain a balance between applying sufficient energy to ensure adequate damage to the vein for long-term success but with the least energy required to minimise early patient discomfort. This is likely to vary according to the vein diameter and other factors. Animal and clinical histological studies appear to show more even vein destruction and lower frequency of vein perforation with longer wavelengths and these studies need to be expanded.

There is a need for clinical studies with long-term survival analysis to determine the best protocol for each frequency and then to compare the different frequencies for long-term outcome. These studies need to be performed independent of manufacturer support.

Room: The Great Room

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GUEST LECTURE

The Complementary Roles of Surgery, Endovenous Laser Ablation, and Foam Sclerotherapy in the Treatment of Venous Insufficiency - the U.S. Perspective

Nick Morrison 1,2
1Morrison Vein Institute, Arizona, USA
2Morrison Training Institute, Arizona, USA

Traditional surgical treatment is waning in the U.S. with endovenous ablation techniques playing an increasingly important role. In the U.S. three methods are used to achieve venous ablation of diseased veins: endovenous thermal ablation using radiofrequency (RF) or laser energy, and foamed detergent agents. Following these techniques, additional treatment is required for any remaining portion of the great and/or small saphenous vein, persistently incompetent perforator veins, and varicose tributaries additionally, typically with either injection sclerotherapy and/or microphlebectomy. Early reports demonstrate over 85% successful ablation for thermal ablation and over 70% for foam sclerotherapy. Complications are reported infrequently and are generally short-lived. Adequate follow up is important to assure successful treatment and to direct retreatment when necessary. Retreatment of chemical or thermal ablation with ultrasound guided foam sclerotherapy is very effective and much easier than surgical retreatment.

Conclusions

Modern surgical techniques, and radiofrequency, laser, and chemical endovenous ablation are generally safe and play complementary roles in the treatment of chronic venous insufficiency. Ultrasound guided foam sclerotherapy has enjoyed considerable acceptance in Europe, Australasia, and South America. At this time, this technique remains an investigational, if not intriguing method in the U.S. Further long-term efficacy data is needed.

Absent careful follow up and adjunctive treatment, the practitioner and patient will be left with unsatisfactory results.

Room: The Great Room

Notes
Endovenous Laser Treatment: 1500 nm vs. 980 nm - a Comparative Trial

Marc Vuylsteke
Sint-Andries Hospital, Tielt, Belgium

Aims
The destruction induced during endovenous laser treatment (ELT) of the saphenous vein and the perivenous tissue in an animal model (goats) was analysed. Differences in vein wall destruction produced by two laser types, the 980 and 1500 nm diode lasers, were evaluated histologically.

Methods
In 14 goats, 28 lateral saphenous veins were treated with ELT. In 14 veins we used the 980 nm diode laser and in the remnant a 1500 nm laser. Postoperatively the veins were removed at different stages and sent for histological examination.

Results
Immediately removed veins after ELT show an uneven destruction of the vein wall. Veins harvested one week postoperatively show inflammatory tissue at their periphery. Two and three weeks postoperatively, organization is very extensive. In some cases, recanalization begins in a semi-lunar manner at the contralateral side of the laser hit. Veins treated with a 980 nm laser show deeper ulceration with more perivenous tissue destruction compared with veins treated with a 1500 nm diode laser.

Conclusions
The ELT of veins produces an unevenly distributed damage. The cell necrosis is far more extensive than expected. Using a 1500 nm laser correlates with less penetrating ulcerations and more circumferential damage.

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The proximal great saphenous vein: Recanalisation, reflux and recurrence after endovenous laser treatment

George Somjen 1,2
1 Frankston Hospital, Peninsula Health, Melbourne, Australia
2 Monash University, Melbourne, Australia

Aims
The objective of the study was to examine long term changes in the proximal great saphenous vein (GSV) after endovenous laser treatment (ELT).

Methods
115 legs of 88 consecutive patients were included in the study. All patients were treated with the Biolitec (980 nm) diode laser system from knee to groin. The extent of vein obliteration, recanalisation and the presence of reflux in the proximal GSV were investigated with the ultrasound during the two year follow-up.

Results
The GSV was successfully obliterated in all patients (115 legs). Early thrombus extension up to the saphenofemoral junction (SFJ) occurred only in 6 legs (5%). The SFJ later reopened in all of those cases. In the long term the SFJ and the very proximal segment of the GSV remained free of reflux in 84% of cases. Late thrombus retraction leading to incompetence in the proximal GSV occurred in 8 instances (7%), often associated with anterior accessory saphenous vein reflux (AASV). More extensive late recanalisation of the GSV was found in 10 legs (9%).

Conclusion
Following ELT the proximal segment of the GSV remained patent and competent in the majority of cases. Subsequent treatment of recurrent GSV/AASV reflux may be indicated to avoid clinical recurrence.

Room: The Great Room

Notes
High Energy Endovenous Laser Ablation and Saw-Knife Phlebectomy

Imre Bihari
National Health Service Center, Cardiovascular Surgical Department, Budapest, Hungary

Aims
In our first 30 cases there were 4 recanalisations and our aim was to decrease the number of this type of complication. According to the experience of T. Proebstle and others, the delivered laser energy was raised to improve results.

Methods
In 2.5 years 230 lower limbs were operated on. After the first 30 cases laser energy was increased from 30 to 100 Joule/cm. Cooled tumescent local anaesthetic is employed (3⁰C). For phlebectomy usually we use a saw-knife. Compression bandages, later stockings have to be worn for 3-4 weeks.

Results
Every treated vein was occluded (100%). There was no full recanalisation during the observation period, 1-32 (mean 11) months; however, segmental recanalisation occurred in 2 cases (closed, without any reflux). The one serious complication was a pulmonary embolism, without detectable deep venous thrombosis. In addition there were sometimes temporary suffusions, pigmentation, ankle swelling, hyperesthesia and numbness.

Conclusion
We have good experience with the combination of high energy laser, cooled tumescent local anaesthetic and the use of saw-knife for phlebectomy. These are early results which have to be followed up over several years.

Room: The Great Room

Notes
KEYNOTE LECTURE
Foam Sclerotherapy - The State of the Art

Philip Coleridge Smith 1,2
1 The London Vein Institute, London, UK
2 Department of Surgery, UCL Medical School, The Middlesex Hospital, London, UK

Aims
To review published evidence concerning treatment of varicose veins using ultrasound guided foam sclerotherapy (UGFS) to assess the safety and efficacy of this treatment.

Methods
Medical literature databases including Medline, Embase, were searched for recent literature concerning UGFS. Papers describing the early results and later outcome have been assessed and their main findings included in this summary.

Results
Few randomised studies have been published in this field and much of the available data comes from clinical series reported by individual clinicians.

It is clear that foam sclerotherapy is far more effective than liquid sclerotherapy and that ultrasound imaging allows the treatment to be delivered accurately to affected veins. There is evidence that 3% polidocanol foam is no more effective than 1% polidocanol foam. The optimum ratio of gas to liquid is 4:1, although a range of ratios is reported in published work. There is a wide variation in the volume used as well as the method by which it is injected. The use of carbon dioxide foam reduces the systemic complications, particularly visual disturbance, as compared to air foams. Very few serious adverse events have been reported in the literature despite the widespread use of this method. Rates of recanalisation of saphenous trunks following UGFS are similar to those observed after endovenous laser and endovenous RF ablation of veins, as well as the residual incompetence after surgical treatment.

Conclusions
UGFS is a safe and effective method of treating varicose veins. The relative advantages or disadvantages of this treatment in the longer term have yet to be published.

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Notes
**Liquid or Foam - Which is Better?**

**Michel Schadeck**  
Paris, France

**Aims**  
The reappearance of the foam as a sclerosant agent has modified the therapeutic approach of the varicose disease. The objective is to summarise advantages and disadvantages of the foam compared to the liquid one.

**Methods**  
A randomized study comparing foam to liquid using duplex guided sclerotherapy of the great saphenous veins with Lauromacrogol 400 3% is performed. Just after the injection of liquid form, an alternative compression with the probe induces the occurrence of a spasm.

**Results**  
The population studied is of 100 patients in two groups, one treated with foam and the other one with the liquid form. After one session, we observe a disappearance of the reflux in 82% of the cases with foam versus 51% with the liquid form.

Compared to the study already published, our work shows the interest of the alternative compression in the occurrence of the spasm.

The possibility to induce a spasm of the vein with the liquid form induces different therapeutic attitude depending on different criteria.

**Conclusion**  
Today, the different properties of these two forms of sclerosing agents, enable, to drive almost all the problems that the varicose disease induces.

**Room: The Great Room**
Catheter Directed Sclerotherapy and Phlebectomy

Attilio Cavezzi
S. Benedetto del Tronto, Italy

Design
Prospective clinical series

Aims
To assess the short-mid term efficacy and safety of the association phlebectomy (PHL) of the varices + concomitant trans-catheter foam sclerotherapy (TCFS) of the saphenous veins.

Patients and Methods
Since November 2006 nearly 160 patients underwent PHL+ TCFS in local anaesthesia; 58 patients (42 F, 16 M) (63 limbs), were randomly reviewed at 6-30 (mean 17, SD ± 6.6) months; mean age and BMI were 51 y and 27.9; most patients were C2 (CEAP) and had GSV incompetence; mean saphenous calibre 7.4 mm (SD ± 3.2). Clinical and colour-duplex investigation (CDI), together with visual analogue scale (VAS) for main symptoms, were performed. 5.1 mls (SD ± 1.7) of 3% STS/POL sclerosant foam (Tessari method and CO2/O2) were injected through an intrasaphenous 4-F long catheter.

Results
VAS improvement was reported in all cases. The CDI-based outcomes were: a) mean saphenous diameter 1.8 mm (SD:±1.4); b) 64% vein occlusion rate, c) antegrade flow in 11%, d) reflux< 1 sec. in 13% and reflux> 1 sec. in 12% of the limbs. No varicose veins in 94% of the limbs. Complications: one gastrocnemius vein thrombosis, two superficial thrombophlebites. Additional tumescence infiltration of the saphenous compartment improved the results.

Conclusions
The combination of PHL and TCFS is a cheap, effective and safe procedure.

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Notes
Foam sclerotherapy: What do we know conclusively?

Ken Myers and Stefania Roberts
Victoria Vein Clinic, Melbourne, Australia

Foam sclerotherapy by the Tessari method is widely used. Liquid or foam is selected for small veins but it is not known which gives best results. Ultrasound-guided sclerotherapy (UGS) is preferred for larger in selected patients with a clear advantage for foam. Sclerosants interfere with clotting showing anticoagulant activity in high concentrations but procoagulant activity with low concentrations. Cell lysis is attenuated by plasma proteins.

Histology demonstrates intimal destruction within two minutes and intimal separation by 15-30 minutes but there are no late studies. Many factors affect results including foam preparation, selecting suitable veins and patients and injection techniques, but the optimal technique is unknown. Tessari and Cavessi studied 4:1 gas/liquid ratio foam but there is little information about alternative preparations, comparative effects of the sclerosants used or sclerosant concentrations. Nor is it known how UGS compares to other treatments.

Anaphylaxis or thromboembolic complications are rare and there is a low incidence of minor systemic events. Foam escapes to the right heart and Transcranial Doppler shows frequent middle cerebral artery signals but MRI does not show that these cause brain damage. No manoeuvre appears to effectively reduce escape of foam. Foam sclerotherapy is a fertile field for further research.

Room: The Great Room

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Froth Treatment

Imre Bihari
National Health Service Center, Cardiovascular Surgical Department, Budapest, Hungary

Aims
To improve the results of liquid sclerotherapy in middle range varicose vein cases.

Methods
By tapping the syringe containing liquid and air some foam develops on the surface of the sclerosing agent. Different concentrations of polidocanol were used to judge the efficacy of this material.

Results
It seems that froth increases the efficacy of the sclerosing agent by 2-3 times. If a more diluted solution is used, more material is necessary to achieve a good result. It was observed that the response of the vein can be judged after some minutes because the vein hardens within this time.

Conclusion
Making froth is faster and easier than making foam, which means middle range varicose veins are suitable for this treatment. Compared to foam treatment, further assistance and accessories are not necessary. Final efficacy can be judged during the treatment. Froth is more effective than the liquid sclerosing agent. This can be used in everyday practice: if the liquid sclerosing agent is not effective, then merely tapping the syringe a few times will increase the effectiveness of the medicine.

Room: The Great Room

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Experience with concomitant ultrasound-guided foam sclerotherapy and endovenous laser treatment in chronic venous disorder and its influence on Health Related Quality of Life (HRQL): interim analysis of more than 1000 consecutive procedures.

Ted King¹, Glen Coulomb², Raj Guptan³
¹Vein Clinics of America, Oak Brook, IL, USA
²Vein Clinics of America, Naperville, IL, USA
³Venous Research Foundation, Downers Grove, IL, USA

Aims
To evaluate the efficacy of combined Endovenous Laser Treatment (ELT) and Ultrasound-guided foam sclerotherapy (USGFS) on chronic venous disorder and to assess its effect on patients’ Health Related Quality of Life (HRQL).

Methods
A prospective series of 1304 varicose veins in 1007 consecutive subjects treated with ELT on refluxing saphenous truncal, non-saphenous, and incompetent perforating veins. USGFS was utilized to treat refluxing, symptomatic varicose tributaries that were not amenable to ELT alone. The Venous Dysfunction Score (VDS) and HRQL were assessed. All of the patients had Duplex ultrasound scanning at 24-72 hours, at 1 week, and 1, 3, 6, 12, and 24 months.

Results
At 1 month, there was continued reflux (> 0.5 seconds) in 26 SFJs (3.0%, n=824) and 4 SPJs (2.6%, n=155). At a mean of 12 ±10 months of follow-up, 4 SFJs (1.6%, n=245) and 1 SPJ (1.6%, n=62) had reflux. Overall, there was elimination of reflux in 98% of junctions. The anterior and posterior accessory saphenous veins (n=195), cranial extensions of the small saphenous vein (n=39), and non-saphenous veins and incompetent perforators (n=40) all had sustained response at 12 months (p<0.001). Sequentially assessed VDS showed significant improvement (p<0.001) as did the patients’ Aberdeen Varicose Vein Questionnaire (AVVQ) scores at 1-2 years (p<0.001). Thirty-two patients (2.9%) had some medial calf numbness at one month that completely resolved in six (18.8%) by 6 months. There were two cases of superficial phlebitis. There was one asymptomatic popliteal DVT and one uncomplicated superficial skin burn that resolved with no treatment beyond observation. No PE, thrombophlebitis, or visual disturbance occurred.

Conclusions
Concomitant ultrasound-guided foam sclerotherapy with ELT is safe and highly efficacious in the management of saphenous truncal, tributary and non-saphenous vein reflux. CVD patients treated with this combination therapy demonstrated significant improvement in their HRQL.

Room: The Great Room

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**KEYNOTE LECTURE**  
Curing the Incurable

**Philip Coleridge Smith** \(^1,2\)  
\(^1\)The London Vein Institute, London, UK  
\(^2\)Department of Surgery, UCL Medical School, The Middlesex Hospital, London, UK

**Aims**  
To review one phlebologist’s experience of managing telangiectases of the lower limb which have failed treatment in the hands of other sclerotherapists and surgeons.

**Methods**  
Review of clinical records of patients attending a private clinic for management of venous disease of the lower limb.

**Results**  
Patients reaching the clinic came from a number of sources and had previously undergone a range of treatments. Previous treatments included laser and IPL sessions, sclerotherapy, surgery including saphenous stripping and phlebectomies, endovenous laser and RF ablation of veins.

The main clinical problem which resulted from these treatments was an unsatisfactory cosmetic response with persistence of telangiectases, combined in some cases with persistent saphenous varices.

Treatments for persistent telangiectases after laser, IPL and sclerotherapy included foam sclerotherapy for incompetent saphenous trunks and varices, conventional sclerotherapy including treatment of associated reticular varices and ultrasound guided sclerotherapy of feeding veins.

In patients who had previously been treated surgically, almost all problems arose in those who had undergone surgical treatment for recurrent varicose veins. Ultrasound imaging showed that surgery had failed to eliminate saphenous trunks and tributaries especially where recurrence was due to neovascularisation. Recurrent varices were managed by foam sclerotherapy followed by conventional sclerotherapy for reticular varices and telangiectases.

**Conclusion**  
Most ‘incurable’ cosmetic vein problems can be addressed by systematic identification and elimination of all classes of vein giving rise to the problem.

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Variables in Foam Sclerotherapy with Tessari Method: Experimental Data

Attilio Cavezzi¹, L. Tessari², M. Rosso³, A. Cabrera Garrido⁴  
¹S. Benedetto del Tronto (AP), Italy  
²Peschiera del Garda (VR), Italy  
³Padova, Italy  
⁴Granada, Spain

Aims  
To assess main variables in foam sclerotherapy based on Tessari method.

Methods  
An experimental study was performed to assess Tessari sclerosant foam (SF) features, also testing different types of syringes, gases, catheters, needles, and assessing SF variations with sodium tetradecylsulfate (STS) or polidocanol (POL).

Results  
Density of SF was 0.16-0.20 (STS) and 0.18-0.24 (POL) g/l. Half-life was 150"-180" for STS SF and 180"-240" for POL SF. SF formed with air at 60° had mean bubble radius of 33µ and 38µ for STS and POL respectively and halved figures at 10°-30°; CO₂-based SF had the smallest bubble radius; CO₂+O₂ based SF was more durable than CO₂ based SF. The reproducibility test (20 subjects) showed no statistically significant difference as to SF density, half-life and bubble size. SF passage through 27-30G needles resulted in larger bubbles and lower SF duration; 30-50% reduction of the three-way valve hole produced a slightly denser SF. A few low-silicone syringe brands produced much more durable and denser SF. Half-life and bubble size slightly changed according to catheter brand.

Conclusions  
Tessari method has a good reproducibility; bubble size and SF duration may depend upon the type of drug, gas, syringes and needles which are used.

Room: The Great Room

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Interaction of Detergent Sclerosants with Fibrinolytic Mechanisms

Kurosh Parsi¹,², Thomas Exner³, David Dang Fung Ma¹,², Joanne Emily Joseph¹,²
¹Haematology Research Laboratory, St Vincents Hospital, Sydney, Australia
²The University of New South Wales, Sydney, Australia
³Haematex Research Laboratory, Sydney, Australia

Aims
To investigate the effects of Sodium Tetradecyl Sulphate (STS) and Polidocanol (POL) on fibrinolytic mechanisms.

Methods
Measurements were done with serial dilutions of sclerosants in whole blood (WB), platelet rich (PRP) and platelet poor plasma (PPP). Control experiments were done in 5% bovine serum (BSA) spiked with the enzyme/inhibitor. Plasminogen was measured with a chromogenic assay. Alpha-2-antiplasmin (AP) activity, plasmin-alpha-2-antiplasmin (PAP) complexes, plasminogen activator inhibitor-1 (PAI-1) activity, tissue plasminogen activator (t-PA) total antigen, t-PA activity and t-PA/PAI-1 complexes were measured by ELISA. Thrombin activatable fibrinolysis inhibitor (TAFI) antigen and activated TAFI antigen were measured by ELISA and Western blotting.

Results
At high concentration (>0.3%), STS destroyed plasminogen, PAI-1, t-PA/PAI-1 complexes and total t-PA antigen but increased t-PA activity. At low concentrations (<0.6%), both agents reduced PAP complexes and increased AP activity, an effect which increased with increasing concentrations. STS increased PAI-1 activity, t-PA/PAI-1 complexes and TAFI levels. POL increased TAFI and the total t-PA antigen.

Conclusion
STS demonstrated a non-prothrombotic (destruction of PAI-1, t-PA/PAI-1 complexes), anti-fibrinolytic (destruction of plasminogen, increase in AP) effect at high concentrations. At low concentrations, both agents demonstrated a pro-thrombotic, anti-fibrinolytic (increase in PAI-1, total t-PA antigen, AP and TAFI) activity.

Room: The Great Room

Notes
Detergent Sclerosants Interfere with Platelet Activation and Aggregation

Anne Pilotelle¹, David Du¹, Kurosh Parsi¹,²,³
¹Haemotology Research Laboratory, St Vincents Hospital, Sydney, Australia
²The University of New South Wales, Sydney, Australia
³Haematex Research Laboratory, Sydney, Australia

Aims
To investigate the effects of Sodium Tetradecyl Sulphate (STS) and Polidocanol (POL) on platelet function.

Methods
Platelet and platelet microparticles (PMP) counts were done by flow cytometry using CD41a and Annexin V antibodies. Overall platelet function was measured by Platelet Function Assay 100 (PFA-100). Platelet activation was measured by ELISA for soluble P-selectin and CD40L. von Willibrand factor (vWF) was measured by ELISA and Collagen Binding Assay (CBA). Platelet aggregation was measured by impedance aggregometry (Multiplate Analyser).

Results
Platelets were destroyed by both sclerosants at concentration above 0.3%. PMPs were released in concentrations up to 0.6% STS and 0.3% POL but were then destroyed. Both agents at low concentrations (<0.3%) activated platelets, shortened the PFA closure time and increased P-selectin but at higher concentrations prolonged the closure time. Low concentration STS increased vWF and CD40L but destroyed these antigens at higher concentrations. Platelet aggregation was suppressed by low concentration sclerosants in a concentration dependant manner.

Conclusion
Low concentration sclerosants activated platelets and released PMPs. Platelet aggregation was suppressed by increasing concentrations of both agents. Platelets and PMP were destroyed by high concentration sclerosants.

Room: The Great Room

Notes
Overall Thrombotic Activity of Detergent Sclerosants: Thromboelastographic Data

David Du¹, Anne Pilotelle¹, Kurosh Parsi¹,²

¹Phlebology Research Laboratory, Sydney, Australia
²Haematology Research Laboratory, St Vincent’s Hospital, Sydney, Australia
³The University of New South Wales, Sydney, Australia

Aims
To determine the overall thrombotic activity of Sodium Tetradecyl Sulphate (STS) and Polidocanol (POL) in vitro.

Methods
Various dilutions of sclerosants in whole blood were tested using an impedance based rotational thromboelastography method (ROTEM® delta, Pentapharm GmbH). 4 reagents (in-TEM®, ex-TEM®, fib-TEM® and ap-TEM®) were utilized according to the standard protocols. Analysis of ROTEM® results were done by comparing clot parameters.

Results
Increasing concentrations of both sclerosants lead to an increase in the clotting time (CT) while clot formation rate (CFR) and maximum clot firmness (MCF) decreased. Weak clots with reduced firmness were formed by low concentration sclerosants. Increasing concentrations of sclerosants lead to a reduction in the firmness of the formed clot. Clot formation was completely inhibited by 0.6% STS and 1.2% POL.

Conclusion
Sclerosants are capable of forming clots at low concentrations. With increasing concentrations, the clots formed become weaker and it takes longer to form a clot.

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Fibrinolytic and Thrombolytic Activity of Detergent Sclerosants

Kurosh Parsi.1,2, Thomas Exner.3, Joyce Low.4, David Dang Fung Ma.1,2, Joanne Emily Joseph.1,2

1Haematology Research Laboratory, St Vincent’s Hospital, Sydney, Australia
2The University of New South Wales, Sydney, Australia
3Haematex Research Laboratory, Sydney, Australia
4Haemostasis Laboratory, Sydpath, St Vincent’s Hospital, Sydney, Australia

Aims
To investigate the fibrinolytic and thrombolytic activity of Sodium Tetradecyl Sulphate (STS) and Polidocanol (POL) in vitro.

Methods
Fibrinogen was measured using the von Clauss method. Fibrinolysis was studied by turbidity measurements in cross-linked and non-cross-linked fibrin agarose gel and cross-linked fibrin powder. Effect on factor XIII (FXIII) was studied by ELISA. Clot lysis was studied by turbidity measurements in microtitre wells. D-dimer was measured by VIDAS®61650; STA Liatest and AxSym assays.

Results
STS (but not POL) at 0.6% and higher destroyed fibrinogen and non-cross-linked fibrin. STS had a similar fibrinolytic profile to t-PA but was 100,000 times weaker. STS at 0.15% and higher completely destroyed FXIII. Neither sclerosant had a significant effect on cross-linked fibrin. STS artefactually elevated D-dimer in VIDAS ELISA assay but not in other assays tested.

Conclusion
STS prevented the formation of a stable fibrin clot by destruction of fibrinogen, non-cross-linked fibrin and FXIII.

Room: The Great Room

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Pelvic Congestion Syndrome

Martin Necas¹,²
¹Waikato Hospital Vascular Lab, Hamilton, New Zealand
²Tristram Vascular Ultrasound, Hamilton, New Zealand

Waikato Hospital Vascular Lab, Tristram Vascular Ultrasound

Incompetence of the ovarian veins has been implicated in a wide range of clinical problems including pelvic venous congestion and lower extremity varices. It is therefore worthwhile to investigate the ovarian veins and pelvic veins in select patients presenting to the phlebologist with atypical varicose veins. Sonographers and sonologists should also extend their venous examination into the abdomen and pelvis when lower extremity varicose veins are being supplied by a pelvic source.

Ovarian vein reflux is relatively uncommon in nulliparous women but is remarkably common in multiparous. The vast majority of these women are asymptomatic, but a small proportion will present with a variety of clinical features of pelvic congestion or pelvic contribution to lower extremity varices.

Sonography of the ovarian and pelvic veins is not difficult and is technically achievable in the vast majority of patients. Transabdominal approach is suitable for the assessment of reflux in pelvic vein. In a woman with lower extremity varices of pelvic origin, this is the preferred examination. When a woman presents with clinical complaints suggesting pelvic venous congestion, gynaecologic opinion and transvaginal pelvic ultrasound should also be sought to exclude other coexisting pathologies.

Room: Greys

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Emergencies in the Phlebology Laboratory - a Sonographers Role

Annie Morgan
Sydney Skin and Vein Clinic, Sydney, Australia

The objective of this presentation is to highlight the potential hazards in the day to day practice of interventional Phlebology and how to be prepared to manage them effectively.

From the moment a patient walks through the door of our phlebology laboratory there is a duty of care to keep them safe with no injury incurred during any of the steps to assess their veins and to treat them. However, no matter how careful one is, there will be incidents beyond one’s control that, if managed appropriately, need not be catastrophic or lethal.

As a Sonographer in this environment, it serves well to be aware of potential emergencies or hazards and more importantly how to safely prepare for such occasions and manage them to minimise the morbidity.

The emergencies that will be reviewed include vasovagal episodes, needle stick injuries, inadvertent intraarterial injection, endovenous laser ablation related incidents, drug administration incidents, thrombosis and embolus. Potentially lethal emergencies for example cardio respiratory arrest and anaphylaxis will be addressed also.

The key message is to be aware, be prepared and expect the unexpected.

Room: Greys
Ultrasound of Lower Limb - Overview of Common MSK Pathologies

Scott Allen¹ ², Andrew Graham²
¹Sound Experience Ltd, Auckland, New Zealand
²Ultrasound Projects Limited, Auckland, New Zealand

Present examples of non-vascular lower limb abnormalities seen with diagnostic ultrasound.

Methods
Powerpoint presentation of cases of the hip, thigh, knee and calf. These will show examples of common joint, ligament, tendon, and muscle pathologies.

Conclusion
A brief overview of lower limb musculoskeletal pathology seen with diagnostic ultrasound

Room: Greys

Notes
The changing role of the Venous Duplex Scan in the era of endovenous thermal ablation

Gary Frydman¹,²
¹Medical Director Western Vascular Centre, Melbourne, Australia
²Visiting Vascular Surgeon, Western Health, Melbourne, Australia

With the advent of endovenous thermal ablation as an important method for the treatment of varicose veins, more information is required to be delivered to the referring doctor than previously has been the case. I will aim to identify the areas where more reporting requirements are needed for the treating doctor.

Room: Greys

Notes
Interaction of Detergent Sclerosants with Fibrinolytic Mechanisms

Martin Necas¹,²
¹Waikato Hospital Vascular Lab, Hamilton, New Zealand
²Tristram Vascular Ultrasound, Hamilton, New Zealand

Vascular ultrasound examinations of the lower extremity veins are some of the most technically challenging tests done under ultrasound visualization. This complex diagnostic work needs to be accurately reflected in a clear, concise, high quality vascular worksheet or report.

Most plebologists are interested in a graphical report, rather than wordy non-descriptive text. Despite huge leaps in computer information technology in recent years, the remarkable fact is that most vascular worksheets today are still drawn by the sonographer by hand as they were 30 years ago. While some sonographers draw beautiful works of art which are a pleasure to review, others produce less desirable reports which are difficult to interpret. Worse yet, if an investigation is done in one centre but treatment in another centre, failure to clearly report the findings may necessitate an investigation being repeated.

This presentation will showcase a range of simple but effective reporting strategies which the audience can easily adapt in their clinical practice.

Room: Greys

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**KEYNOTE LECTURE**

**Venoactive Drugs - Gimmick or Medicine?**

**Philip Coleridge Smith**

1. The London Vein Institute, London, UK
2. Department of Surgery, UCL Medical School, The Middlesex Hospital, London, UK

**Aims**

To review medical literature concerning the use of phlebotonic drugs.

**Results**

Logical use of drugs in the management of venous disease.

**Varicose veins and oedema**

In temperate climates the use of compression stockings is generally considered to be the most appropriate conservative measure. However, in hot climates the wearing of stockings is less acceptable for patients who may find that they cause intolerable discomfort. There may be some rationale in prescribing phlebotonics in these circumstances.

Diosmine and hesperidine may be useful in trophic disorders as well as cramps and swelling. Rutosides may benefit oedema.

**Level of recommendation: 2b**

**Venous ulcers**

Compression treatment and surgery to treat incompetent superficial varices and perforating veins are the main lines of management in patients with venous leg ulcers. Only two drugs have been shown to have any influence on venous ulcer healing in a meta-analysis, pentoxifylline and micronised purified flavonoid fraction (MPFF). Both should be used in combination with compression and standard wound management. Efficacy is probably most apparent in large (5 – 10 cm) long standing ulcers (more than 6 months). These drugs have few side effects and could be considered when compression alone has proved to be ineffective in countries where these compounds have been licensed.

**Level of recommendation: 1b.**

A PGE-1 analogue has also been shown to have efficacy in promoting venous ulcer healing, but this is confined to one randomised controlled trial. In addition, this drug must be given by intravenous infusion and has some significant side effects. More detailed work is required before a recommendation can be made for use in venous disease.

**Room: The Great Room**

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Multiple Sclerosis and Cerebral Venous Insufficiency

Paul Thibault
Central Vein & Cosmetic Medical Centre, Newcastle, Australia

The hypothesis that multiple sclerosis is related to chronic cerebral venous insufficiency (CCSVI) was initially proposed by Professor Paolo Zamboni, University of Ferrara, Italy. The concept of CCSVI is described as a pathophysiologic state where blood from the brain and spine is impeded by stenoses in the veins that drain the spine and brain. Blood refluxes back into the brain and spine to cause oedema and leakage of red blood cells and fluids into the cerebral and spinal tissue. The resultant slowed perfusion causes hypoxia in the brain. Plasma and iron from blood deposited in the brain tissue also has damaging effects.

So far, every MS patient tested for CCSVI has it according to Dr. Paolo Zamboni. Around 600 patients have been tested to date. In addition 1700 patients and controls are being tested for it by Jacobs Neurological Institute at SUNY Buffalo. No controls or patients with other neurological diseases tested so far by Prof Zamboni have CCSVI.

The presentation will detail the evidence of MS being caused by CCSVI and the patterns of obstruction or stenoses found by Prof Zamboni. Early results of endovascular treatment will be presented.

Room: The Great Room

Notes
Prevalence of Reflux in the Great Saphenous Vein as a Function of Diameter

Nick Morrison¹,²
¹Morrison Vein Institute, Arizona, USA
²Morrison Training Institute, Arizona, USA

To determine if diameter measurement is a useful secondary variable in the evaluation of valvular insufficiency of the great saphenous vein (GSV) in the thighs of a series of Ecuadorian patients.

Methods
Evaluation for chronic valvular insufficiency of the GSV was performed in the standing position in 356 limbs. The duplex equipment used was a laptop-based machine. The relationship between mid-thigh GSV diameter measurements and reflux longer than 1 second is reported herein.

Results
Prevalence of reflux is demonstrated in the table below.

<table>
<thead>
<tr>
<th>GSV Mid-Thigh Diameter</th>
<th>Women</th>
<th>Men</th>
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<tbody>
<tr>
<td>≥6mm</td>
<td>38/38 (100%)</td>
<td>8/8 (100%)</td>
</tr>
<tr>
<td>5mm</td>
<td>20/22 (91%)</td>
<td>7/9 (78%)</td>
</tr>
<tr>
<td>4mm</td>
<td>19/46 (41%)</td>
<td>4/8 (50%)</td>
</tr>
<tr>
<td>3mm</td>
<td>25/133 (19%)</td>
<td>1/16 (6%)</td>
</tr>
<tr>
<td>2mm</td>
<td>5/62 (8%)</td>
<td>0/5 (0%)</td>
</tr>
<tr>
<td>1mm</td>
<td>No reflux detected</td>
<td>No reflux detected</td>
</tr>
</tbody>
</table>

Conclusions
In a group of Ecuadorian patients, diameter measurement in the mid thigh can be an effective secondary measurement to establish valvular insufficiency of the GSV, particularly if a contradiction exists without reflux being detected in GSV larger than 5 mm in diameter. Presence of reflux still needs to be evaluated even in veins as small as 2 mm in diameter.

Room: The Great Room

Notes
Venous Perforators in Normal Lower Limbs - Ultrasound Characterisation and Comparison with Resin Caste Anatomy

Andre van Rij
Professor of Surgery & Head of Section, Surgery, Dunedin School of Medicine, Dunedin, New Zealand

Not available at time of print

Room: The Great Room

Notes
Venous Incompetence in Children

Michel Schadeck
Paris, France

Aims
Chronic venous insufficiency (CVI) is common in children and adolescents, often beginning very early. This work proposes an investigation and management plan using the reflux which is a major item in the initial assessment and follow-up.

Methods
Duplex scanning, although unable to truly quantify reflux, has since helped to classify it by type, height, outcome topography, and the relationship between subject age and topography. These parameters are combined with clinical examination to score the severity at presentation and monitor the disease course.

Results
Results show that the frequency of CVI in the young depends on the study population and ranges from 3% to 10%, depending on age. They confirm its progression with age, which has been confirmed using the Clinical-Etiology-Anatomy-Pathophysiology (CEAP) classification. Continuous-wave Doppler ultrasound has been used in a small number of epidemiological studies to determine the prevalence of great saphenous vein reflux in childhood.

Conclusion
Reflux generally begins around the knee and progresses proximally with age. It may appear before or after puberty. Despite the substantial advance in characterization of CVI and reflux in the young, a consensus has yet to be reached as to treatment indications and modalities.

Room: The Great Room

Notes
Relationship Between Number of Pregnancies and Great Saphenous Vein Diameter

Nick Morrison

Morrison Vein Institute, Arizona, USA
Morrison Training Institute, Arizona, USA

Aims
Number of pregnancies has been mentioned as a risk factor for chronic venous insufficiency. This analysis investigated if number of pregnancies correlated with GSV diameter.

Methods
One hundred seventy-eight Ecuadorian women who perceived they had leg venous problems were evaluated by duplex ultrasonography using a laptop-based machine. Median number of pregnancies of 178 women, 51±3 years of age, was 4 (range 0-15). GSV diameter in mm was measured at mid thigh with the patient standing. Statistical analysis included calculation of correlation coefficients and t-tests.

Results
Correlation coefficient between number of pregnancies and left GSV diameter calculated for the entire data set was low: 0.06. The correlation coefficient calculated for the average GSV diameter of each subgroup increased to 0.48. GSV diameter was smallest for women without pregnancies, 2.6±0.5 mm (P<.001). GSV diameter of women having one pregnancy, 2.8±1.6 mm, was not significantly different than subgroups with less (P=.30) or more pregnancies (P=.17). Largest GSV diameters were: 4.2±3.4 mm (N=9 pregnancies), 4.1±2.5 mm (N>10), 4.1±2.8 mm (N=2) and 4.0±2.8 mm (N=5). The average GSV diameters for >9 or 1-8 pregnancies were not significantly different (P=.50).

Conclusions
GSV diameter increased with one pregnancy. Otherwise, the number of pregnancies was not related to GSV diameter.

Room: The Great Room

Notes
Progression and recurrence of vein disease in patients treated with endovenous laser ablation: Two-four year experience. Is there a place for the phrase recurrent varices after laser or reval?

Ted King  
Vein Clinics of America, Oak Brook, IL, USA

Aims
The incidence of recurrence of reflux at the SFJ and SPJ after endovenous laser treatment (ELT) has been well studied. However, tracts of recurrent flow also occur in the GSV and SSV away from the junctions after laser ablation. This study looks at how often new vein disease develops after ELT, as well as where, when, and why.

Methods
A retrospective analysis of 50 cases (66 veins) treated with 980 and 1320 nm ELT. Thorough Duplex ultrasound scanning was performed at 24-45 months follow-up, average: 28.8 months. All segments of vein with any reflux (>0.5 sec.) were noted and recorded as progression (new vein disease) or recurrence (recurrent or continued flow through previously-lased vein segments).

Results
Recurrent SFJ reflux: 3/50 (6.0%); SPJ: 0/9. Recurrent truncal reflux without junctional involvement: proximal GSV, 5/50 (10%); 8/50 (16%); SSV, 1/9 (11.1). New reflux in non-saphenous vein segments (progression): 34/50 (68%) with 6/34 (17/6%) arising from saphenous trunks and 28/34 (82.4%) arising from incompetent perforators. IPs above knee: 23 in 11/34 (32.4%) causing 15.6% of new vein disease. IPs below knee: 42 in 25/34 (73.5%) causing 28.6% of new vein disease. Total IPs: 73 in 31/36 (86.1%). No vein disease found: 14/50 (28%).

Conclusions
Unlike ultrasound findings at one year follow-up, two-four year ultrasound follow-up after ELT shows new vein disease to be seven times more common than recurrent disease in previously treated veins. Disease progression in non-saphenous veins is 5.5 times more common than saphenous truncal progression. New incompetent perforators accounted for virtually all non-saphenous vein progression. New IPs in the calf were 3 times more common than those in the thigh. At 28.8 months of follow-up, 72% of patients had ultrasonographic and/or visible progressive and/or recurrent vein disease. Regarding the long term success of ELT, coining the term REVAL might be appropriate.

Room: The Great Room

Notes
GUEST LECTURE
The Future of New Antithrombotics

Sanjeev Chunilal
North Shore Hospital, Auckland, New Zealand

Heparin and low molecular weight heparin (LMWH) therapy for 5-7 days followed by oral vitamin K antagonists (OVKA) therapy, till recently has been the standard of care for the acute treatment for venous thromboembolism (VTE). Recent randomised trials have shown that the new oral anticoagulants such as the direct acting thrombin inhibitors (DTI) and the direct acting factor Xa inhibitors (DXI) have shown superiority or similar efficacy in the prevention of VTE in orthopaedic patients. For acute treatment of acute VTE, the DTI’s have shown similar efficacy to OVKA for long term prevention of VTE after initial treatment with heparin therapy.

Studies testing the efficacy of acute DXI therapy for treatment of VTE are currently ongoing but have not shown any safety concerns to date. Whilst these phase 3 studies are exciting and suggest suitable alternatives to OVKA are now available, longer term data (phase 4) are required before younger patients who require lifelong therapy should be offered longer term therapy with these drugs.

Unlike oral Vitamin K antagonists and heparins, these new agents do not have simple readily available or cheap antidotes to reverse bleeding if required. This remains a major limitation of these agents.

Room: The Great Room

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1645 - 1715  Tues 09 February

GUEST LECTURE
ACCP 2008 Guidelines: What’s New

Abdullah Omari
Head of Vascular Medicine and Staff Specialist, St. Vincent’s General Hospital, Sydney Australia

Not available at time of print

Room: The Great Room

1715 - 1730  Tues 09 February

The Time Sequence of the Development of Axial Deep Reflux Following Lower Limb DVT - a Prospective Study over 5 Years

Andre van Rij
Professor of Surgery & Head of Section, Surgery, Dunedin School of Medicine, Dunedin, New Zealand

Not available at time of print

Room: The Great Room

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Challenging Cases In VTE

Abdullah Omari
Head of Vascular Medicine and Staff Specialist, St. Vincent’s General Hospital, Sydney Australia

Not available at time of print

Room: The Great Room
Simple Interventions Improve Adherence to Thromboprophylaxis Guidelines

Deborah Wright, M Fancourt, W Gilkison, F El-Haddawi, S Kyle, D Mosquera
Department of Surgery, Taranaki Base Hospital, New Plymouth, New Zealand

Aims
Thromboprophylaxis is the responsibility of every surgeon. The aims of this study were
1. To compare performance with Australasian Guidelines on Venous Thromboprophylaxis and
2. To determine whether simple interventions changed performance.

Methods
This was a 12 month prospective study on a general surgical ward in a provincial New Zealand Hospital. A snapshot assessment of thromboprophylaxis was performed on all ward patients on 22 occasions using a structured survey instrument (13 pre-intervention and 9 post intervention).

Intervention consisted of education of staff, drug chart modifications and placement of alert stickers.

Results
A total of 174 patients were assessed, 100 pre-intervention and 74 post intervention.

Anti-embolism stockings were appropriate in 50% of pre-intervention ward patients (50 of 100) and 85% (63 of 74) post intervention (p<0.0001). Enoxaparin was appropriate in 46% (46 of 100) and 69% (51 of 74) of pre and post intervention patients respectively (p= 0.004).

Exact adherence to post operative guidelines occurred in 25% (25 of 100) patients pre-intervention and in 62% (46 of 74) post intervention (p<0.0001), although most patients (85%) received some form of prophylaxis.

Conclusions
Adherence to thromboprophylaxis guidelines can be improved by simple, cheap, transferrable interventions.

Room: The Great Room
Preserving Great Saphenous Vein - A Lost Cause?

Imre Bihari  
National Health Service Center, Cardiovascular Surgical Department, Budapest, Hungary

Aims  
What is the aim of great saphenous vein preservation? Was it successful in the last 30 years?

Methods  
Sapheno-femoral junction ligature, plasty, wrapping, distant sclerotherapy.

Results  
Wrapping and distant sclerotherapy gave good results only for two years, ligature and plasty were efficient for 5 years.

Conclusion  
The main aim of great saphenous vein preservation is its usage as a bypass material. Treatment of the great saphenous vein is recommended only if it is varicose, the normal vein must be saved. After a temporary enthusiasm fewer and fewer colleagues deal with saving varicose veins. It seems that the time span, about 20 years between varicose vein and bypass surgery, is too long to save a non-healthy vein in a patient who is prone to varicose vein disease. It seems the subject of debate is the femoral part of the great saphenous vein, because the crural part in most cases is healthy. Femoral part preservation is recommended if the patients atherosclerosis is known at the time of varicose vein surgery. A question for the future is whether new methods such as different medicines and angioplasty or stent implantation will be used instead of bypass surgery?

Room: The Great Room
ELVeS® RADIAL – The all-round solution with a built-in safety concept

The new ELVeS® RADIAL Fiber will change the future of endovenous laser treatment radically. In combination with the ELVeS® PainLess Laser System, this unique fiber system changes vein treatment technology.

The patented ELVeS® RADIAL Fiber is the first radial emitting laser fiber worldwide used for endovenous laser treatments of the Greater Saphenous Vein / Smaller Saphenous Vein in Patients with Superficial Vein Reflux.

Key benefits of ELVeS® RADIAL

- The ELVeS® RADIAL Fiber applies energy faster and more accurately than any other fiber available in the endovenous market.
- The radial (360°) energy emission ensures homogenous photothermal destruction of the vein wall, allowing safe closure of the vein.
- The efficient radiation concept of ELVeS® RADIAL makes optimal use of the laser energy applied.
- By avoiding perforation of the vein wall and associated thermal irritation of the surrounding tissue, intra- and post-operative pain is minimized, as are ecchymosis and other side-effects.
- A micropuncture kit is used to insert the ELVeS® RADIAL Fiber directly into the vein in a fast and safe one-step procedure. Optimal monitoring of the fiber tip is possible thanks to its excellent ultrasound visibility.

With this new technology, extra-long catheters and guide wires are a thing of the past.
- The Procedure can be performed with less tumescence providing substantial time savings.

Technical Specifications:

<table>
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<th>Description</th>
<th>Details</th>
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<tr>
<td>Radial light emission</td>
<td></td>
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<tr>
<td>2.5 m fiber length</td>
<td></td>
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<tr>
<td>Diameter of the ELVeS® RADIAL Fiber:</td>
<td>1.3mm +/- 0.05mm</td>
</tr>
<tr>
<td>Diameter of the ELVeS® RADIAL Fiber tip:</td>
<td>1.85mm +/- 0.05mm</td>
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</table>

Details of Kit:

- Use in combination with a 1470nm ELVeS® PainLess Laser (Ceralas E)
- 6 French sheath / dilator 11/23 cm length
- 0.035” x 45 cm guide wire
- 19G x 7cm access needle
- Art. Nr. 501 100 110 ELVeS® RADIAL-Kit

For more information or a demonstration please contact:

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Popliteal vein compression, DVT and the efficacy of calf compressors

David Huber¹ Anthony Levine², Jacqueline Huber²
¹Wollongong Hospital, Wollongong, Australia
²St Vincent’s Hospital Sydney, Sydney, Australia

Aims
To investigate the relationship between popliteal vein compression and DVT, specifically looking at the efficacy of calf compressors.

Methods
16 subjects (32 popliteal veins) had standard calf compressors fitted. The flow velocity in the popliteal veins was measured using duplex ultrasound. Subjects were placed in the same position as supine and immobile patients undergoing surgery (with the heel offloaded). Peak flow was measured during calf compressor inflation and an average of 3 measurements was used for analysis. Two knee positions were analysed:

1. knee unsupported with the heel elevated (hyperextended)
2. knee flexed 5°-10°

Results
There is a highly significant (p<0.0007) difference in the flow velocities, with a rise in the peak flow velocity when the knee is unsupported. Pearson correlation -0.49 (P<0.005)

Conclusion
Current heel PU prevention protocols require the heel to be offloaded. This is inadvertently causing popliteal vein compression. This in turn leads to poor venous outflow and this study shows that the function of calf compressors is compromised. The effectiveness of calf compressors is enhanced if the knee is flexed 5°-10°.

A review of recent literature looking at the association between popliteal vein compression and DVT will also be presented.

Room: The Great Room
Minimally invasive surgery for Varicose veins. Its role in 2010

Gary Frydman1,2
1Medical Director Western Vascular Centre, Melbourne, Australia
2Visiting Vascular Surgeon, Western Health, Melbourne, Australia

Aims
To review the role & results for minimally invasive varicose veins surgery from the literature and present early results from my personal series.

Methods
The technique involves multiple avulsions of the varicose veins with salvage of the axial saphenous vein in patients where the axial saphenous vein has been shown to be refluxing. A review of the literature has been undertaken and will be presented. In my own series patient selection will be explained with follow up results of up to four months.

Results
This technique allows early return to normal activities. Results from published series show good long term success rates similar to standard surgical repair. Removal of the varicose reservoir will reverse the reflux in the saphenous vein in most cases.

Conclusion
It appears that minimally invasive varicose veins surgery with removal of the varicose reservoir with preservation of the refluxing saphenous vein may play a role in the management of varicose veins in 2010.

Room: The Great Room

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Computational Blood Flow Analysis to Assess Effect of Stenosis Symmetry

Afiqah Hamzah1,2, Andy Yong2, Masud Behnia1, Leonard Kritharides2
1Department of Mechanical Engineering, University Of Sydney, Sydney, Australia
2Cardiology Department, Concord Hospital, Sydney, Australia

Aims
To determine the difference in blood flow characteristics between a symmetric and asymmetric stenosis within a blood vessel.

Methods
1. Using SolidWorks software (DS SolidWorks Corp., Concord, USA), two simple models of a blood vessel were created, each representing symmetric and asymmetric stenosis respectively. All models have the same area percentage reduction.
2. Computational fluid dynamic (CFD) simulation analysis was performed on the models, using ANSYS CFX (ANSYS Inc, Canonsburg, USA). Constant laminar flow at 0.9g/s and Newtonian fluid properties were assumed.
3. Pressure gradient, maximum wall shear stress (WSS) and average WSS were compared for the two models.

Results
1. Both models have similar average wall shear stress (asymmetric: 58 Pa, symmetric: 60 Pa)
2. The asymmetric model had higher maximum wall shear stress (207 Pa vs. 167 Pa)
3. The asymmetric model had larger pressure gradient (31.3 Pa vs. 26.9 Pa)

Conclusion
It is important to ensure accurate representation of blood vessel geometry in estimating blood flow characteristics.

Room: The Great Room
Acute Hepatitis following Methoxyfluorane Analgesia during Sclerotherapy

Stuart McMaster
The Grange Vein Clinic, Grange, Queensland, Australia

Aims
A case presentation describing a 33 yr old patient who developed acute hepatitis following the use of methoxyfluorane analgesia on three occasions for analgesia during ultrasound guided sclerotherapy treatment.

Methods
The case is described followed by a brief review of the literature regarding the history and safety profile of methoxyfluorane.

Results
Whilst there have been previous descriptions of hepatotoxicity related to larger dosages and or recreational abuse of methoxyfluorane, there are no reports worldwide of acute hepatitis following repeated treatments at currently recommended dosage. Methoxyfluorane (marketed as penthrane) is only available in Australia and New Zealand and is widely used for outpatient analgesia. This is an important potentially fatal adverse effect that practitioners should be aware of.

Conclusion
Methoxyfluorane, whilst generally well tolerated, has the potential for severe adverse liver toxicity even at therapeutic doses, in otherwise well patients. Practitioners must be aware of this potential when prescribing this medication.

Room: The Great Room
When Will the Bubble Burst? - Foam Stability: Air vs. CO2

Christopher Lekich¹, David Du², Kurosh Parsi¹,²
¹Sydney Skin and Vein Clinic, Sydney, Australia
²Phlebology Research Laboratory, Sydney, Australia

Aims
To compare the stability of detergent sclerosant foams using air or CO2 as the foaming gas.

Materials and Methods
1.5% STS foam was prepared using a modified Tessari method. 0.6 ml of 1.5% STS solution was mixed with 2.4 ml air or CO2 using 1 and 3ml syringes (Luer-Lok™, Terumo®) connected via a three way stopcock (BD Connecta™) and 5 micron filter hubs (FH-5000, Braun Medical Inc). Room air was collected at 22°C. CO2 was sourced from CO2MMANDER™ delivery system (Portable Medical Devices, FL, USA) using a Silver Bullet™ CO2 cartridge. Air vs. CO2 foam degradation was observed macroscopically and microscopically.

Results

<table>
<thead>
<tr>
<th></th>
<th>Test</th>
<th>STS Air Foam</th>
<th>STS CO2 Foam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foam Longevity</td>
<td>Macroscopic bubble degradation by 50% of 3ml of foam in a syringe</td>
<td>3 minutes</td>
<td>50 seconds</td>
</tr>
<tr>
<td></td>
<td>Microscopic Bubble Degradation</td>
<td>3 minutes</td>
<td>6 minutes</td>
</tr>
<tr>
<td>Bubble Size</td>
<td>Microscopically at one minute foam bubble size averaged</td>
<td>107.9 um diameter</td>
<td>75.2 um diameter</td>
</tr>
<tr>
<td></td>
<td>Microscopically at three minutes foam bubble size averaged</td>
<td>116.5 um diameter</td>
<td>57.2 um diameter</td>
</tr>
</tbody>
</table>

Conclusion
Macroscopically, foam prepared with air appears more stable. Microscopically, CO2 prepared foam has a smaller average bubble size over a greater length of time compared to foam prepared with air. The addition of CO2 for foam preparation appeared to improve microscopic bubble stability.

Room: The Great Room

Notes

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GUEST LECTURE
How Not to Get Rejected!

Philip Coleridge Smith¹,²
¹The London Vein Institute, London, UK
²Department of Surgery, UCL Medical School, The Middlesex Hospital, London, UK

Aims
To review an editor’s experience of phlebological papers submitted to scientific journals.

Results
The crimes committed by hopeful authors of scientific articles range from those deserving capital punishment to incompetent use of the apostrophe.

The most major problems relate to the writing and content of papers. Many authors will not have English as their native language which I am happy to accept. However, submitting a paper written with poor English grammar will mean that the editor is left with a lot of work to do. This is possibly acceptable for an important paper but if the editor and reviewers can’t understand the meaning of the work rejection is inevitable. Some authors forget to write down what they have done in the way of experimental work, methods of measurement or even results. A long discussion justifies the reason for the paper. To be published, a paper must be comprehensible and repeatable by other investigators, so all the information on experimental methods, analysis and conclusions must be there.

The abstract is the first item I read, but sometimes this contains little of the methods or results of the work. Since this is all that anyone looking at Medline or PubMed will see, time taken in crafting an abstract will pay dividends.

Some authors are more devious and results appear to have been created by dubious science or have even been invented! I once looked at a graph submitted by an author which represented a clinical measurement and found that it fitted a mono-exponential regression line to an accuracy of better than 1%. Other scientific work covering hundreds of thousands of measurements made in thousands of patients over 10 years was summarised in a single paper with 4 graphs. Less severe crimes include optimistic or over enthusiastic use of statistical analysis. The God, SPSS has to be worshipped so data are often quoted to several places of decimals and sometimes the phrase ‘p=0.000’ appears in the text. This has no meaning since we can never be that certain about anything! Please read the documentation on this program before using the output from it to enrage the editor!

Conclusions
Whilst there are many ways to upset the editor, diligent preparation of a manuscript will give you the best chance of publication.

Room: Greys

Notes
Phlebology seems to be almost the last discipline to require appropriate statistical techniques to show long-term outcome after treatment. Most articles present results with interval success rates; for example, a study starts with say 1000 patients and by five years 100 are still under observation of which 90 are still successful so that the outcome is reported as having 90% success at five years. This conveniently ignores the many failures in the other 900 patients who no longer elect to attend.

The appropriate reporting technique is termed survival analysis and this has been widely used for some 50 years. It requires clear definition of entry and end points and of success and failure. Follow-up is at the last date that the patient is seen, either currently under review or lost to follow-up, or the date if the patient dies. The simplest reporting technique is actuarial life table analysis in which each interval success rate is multiplied by the previous interval success rate to calculate a cumulative success rate.

A more widely used though more complicated technique is the product-limit method of Kaplan and Meier. Long-term outcome must be reported by either technique and assistance from a statistician is strongly recommended.

Room: Greys
Demonstrating the efficacy of any treatment requires appropriate outcomes for judgment and an appropriate and sound association of these.

A treatment must be based on a logical pathophysiological hypothesis, but we know that there is no complete correlation between pathophysiological findings and clinical features. Physician reported outcomes such as VCSS are convenient, easily evaluated and relevant. However, they remain biased and don’t provide with sufficient level of evidence, especially in non double blind RCTs. Patient reported outcomes are the ultimate referee and QoL or PRO cannot be overlooked. They increase the power of the studies and give the patient the central role they should never have lost.

PROs are the ultimate outcome for health care interventions.
PROs increase the level of evidence of clinical trials
PROs are here to stay.

Multiple outcome measures are necessary to address the multiple aspects of the disease. Physician reported outcomes are swift to acquire but biased by the observer-expectancy effect.

Whether we like it or not, the reign of the almighty doctor is over, patients decide if they are happy with the outcomes or not.

Room: Greys

Notes
GUEST LECTURE
Blood Flow Fluid Mechanics: How and What We Measure

Masud Behnia
Office of Dean of Graduate Studies, The University of Sydney, Sydney, Australia

Unlike water, blood flow is non-Newtonian in nature. In addition the flow is pulsating and three dimensional. One should also consider the fact that the blood vessel is not of any regular shape which varies as the blood flow takes place through it. Due to these and other reasons in-situ measurements in blood are very difficult and cannot be easily carried out. Therefore, in most cases for an understanding of the flow behaviour in blood either experimental or numerical modelling is performed.

Room: Greys

Notes
KEYNOTE LECTURE
Bubbles in the Brain - What do we know?

Nick Morrison¹,²
¹Morrison Vein Institute, Arizona, USA
²Morrison Training Institute, Arizona, USA

Introduction
Systemic and specific central nervous system (CNS) symptoms have been described after foam sclerotherapy of lower extremity veins.

Methods
We have investigated foam migration after injection of leg veins, and have studied a variety of maneuvers intended to limit central migration. Further, we have compared symptoms following foam injection using various gases for foam production, and attempted to correlate cerebral emboli with symptoms.

Results
We now know that foam injected into superficial leg veins will result in demonstrable intra-cardiac echo-genic signals in all patients, and in the presence of a right-to-left shunt, cerebral emboli can be detected. Maneuvers such as leg raising, limitations on injectate volume, or maintaining patient immobility all fail to prevent such emboli. Systemic and CNS symptoms are generally less frequently seen using a more biocompatible gas than air, such as a carbon dioxide/oxygen mixture, to produce foam from a liquid detergent sclerosant. Correlation of symptoms with cerebral emboli is not clear, and it has been suggested that vasoactive substances related to endothelial destruction with foam sclerotherapy may play a role in patient’s symptoms.

Conclusions
More investigation is required to determine the cause(s) of systemic and CNS symptoms infrequently seen following foam sclerotherapy.

Room: The Great Room
The French Polidoconal Registry - a Survey Covering 3357 Patient Years

Jean-Jerome Guex
Nice, France

Aims
Short and mid-term side effects of sclerotherapy, in particular with Polidocanol (Lauromacrogol 400) have been previously described in our registry of 12,173 sessions. The objective of this follow-up registry was to evaluate the long term incidence of adverse events with Polidocanol.

Methods
The Physicians involved in the initial French Registry were contacted and asked to partake in the follow-up survey. Initially included patients were controlled at the latest possible date in order to determine if a complication had occurred after the end of the initial survey.

Results
Data on 1,605 patients included during the French Registry were reviewed with a maximum follow up of 60 months covering 3,357 patient years. A total of 5 (0.39 %) adverse events were observed in patients treated with liquid Polidocanol and 46 (1.14%) in patients treated with Polidocanol foam. Most frequent side effects were visual disturbances with a total number of 14 and most severe were 8 muscular vein thrombosis. The onset of side effects was mostly observed directly after sclerotherapy or in the first 6 months afterwards (84% in the first year). One DVT recurrence occurred in a patient with heterozygote Factor V Leiden after stopping anticoagulant treatment (foam sclerotherapy).

Conclusions
Foam sclerotherapy is a recognized reference method in the treatment of varicose veins of all types. Polidocanol demonstrates in this study that it is a safe sclerosing agent at short and long term.

Room: The Great Room

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Scanmedics, your leading supplier of cutting-edge, clinically proven aesthetic technology proudly introduces:

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Complications of Duplex Guided Sclerotherapy of the Small Saphenous Vein Study of a Population of 4984 Patients

Michel Schadeck  
Paris, France

Aims  
To establish in a population of 4984 patients the complications following the Duplex guided sclerotherapy (DGS) of the small saphenous veins (SSV).

Methods  
An open prospective study is performed on patients having varicose disease. The different sclerosing agents were (Tétradécyl sodium sulfate [TDS] 3% and Polidocanol [Pol] 3%), with the liquid or foam form.

Results  
The number of saphenous veins treated is of 4974 with 891 SSV.  
The follow-up is of 59 months. The foam 3% was used in 57, 57% of the cases versus 39, 8% for the liquid. 

The mean of volume was of 1,9cc and the concentration of 2, 9%. The main observed complications in this population of 891 SSV were:

- DVT 14
- SVT 3
- Necrosis 1

The DVT occurred in 0, 56% of the cases using the liquid form and 2, 25% with the foam. Foam 3% induces four times more DVT than liquid 3%.

Conclusion  
The SSV was first considered as a dangerous axis to be treated. Today, also the DGS has become easier, it has to be performed very carefully. In order to avoid a DVT, we have to avoid foam on patients with vascular risk.

Room: The Great Room

Notes
EVLA vs. Foam UGS for Saphenous Trunks - 5 Year Prospective Outcome Data

Peter Chapman-Smith
Skin and Vein Clinic, Whangarei, New Zealand

UGFS and EVLA combined with UGFS distally and for tributaries are methods to treat varicose veins. The efficacy, closure rates and retreatment rates over 5 year follow up are presented, with a summary of adverse outcomes which were non serious.

UGFS is cheaper, with lower primary success, but is readily repeatable and has high patient acceptance. Clinical recurrence at 5 years was 4%.

1320nm EVLA under tumescent anaesthesia alone, combined with concomitant UGFS of all sources of reflux is demonstrated to be preferable, with lower recurrence rates, high safety and no serious adverse outcomes. Vein access is by Seldinger technique, and veins as small as 2mm can be accessed. Extrafascial veins can be treated with careful tumescence.

Both methods are popular with patients, with immediate ambulation and return to activity. The thrombophilic risk is very low. Comorbidities rarely are a contraindication.

Saphenous trunks can be effectively closed by either technique, the medium term results more impressive for EVLA.

Room: The Great Room
Safety of Large Volume Foam UGS Combined with ELVA

Peter Chapman-Smith
Skin and Vein Clinic, Whangarei, New Zealand

Ultrasound guided foam sclerotherapy (UGSF) is used to treat varicose veins, combined with endovenous laser ablation (EVLA) to occlude distal trunks and tributaries.

Maximum recommended guidelines of 10mls foam/day for safe UGSF treatment (European Consensus group, and the ACP) may not apply to UGSF during EVLA. Using larger than recommended volumes, a 5 year prospective study is reported using STS foam volumes of up to 30mls per leg. Treatment was efficacious, with no severe neurologic adverse outcomes observed.

High intensity signals (HITS) on transcranial doppler monitoring (TCD) of the middle cerebral artery (MCA) often detect gas emboli, even with small foam volumes, and do not correlate with adverse clinical outcomes. Decompression illness and cerebral gas embolism (CAGE) in divers cause neuronal functional deterioration related to the endothelial effects of small air bubbles rapidly transiting the cerebral circulation, rather than physical bubble effects. Symptoms as headache, dizziness, light headedness, migraine, and scotomata are reported with UGSF. The release of vasoactive substances from bubble passage may cause these transient CNS symptoms.

Gas emboli occurring during UGSF have doubtful clinical significance. New guidelines for EVLA are required.

Room: The Great Room

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The Use of Trinitroglycerine Patches for the Treatment of Dermal Necrosis following Sclerotherapy

David Jenkins
Burwood, New South Wales, Australia

Aims
To demonstrate that trinitroglycerine (TNG) patches may enable a scar free resolution of dermal necrosis following superficial sclerotherapy.

Methods
Transdermal TNG patches were used as an occlusive dressing (12 hours per day) for two months following inadvertent intra-arteriolar injection during superficial sclerotherapy.

Results
The ulcerated skin healed rapidly and without evidence of scarring resulting in an excellent long term cosmetic result.

Conclusion
TNG patches may provide a useful adjunct to the management of dermal necrosis following superficial sclerotherapy.

Room: The Great Room

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Endovenous Laser Ablation: Intraluminal Centralisation of Fibre-Tip can Perfectionate the Technique - a Histological Study

Marc Vuylsteke
Sint-Andries Hospital, Tielt, Belgium

Aims
In this histological study, the lateral saphenous vein of the goat was treated using a tulip laser fibre. This study aims to establish whether prevention of direct contact between the fibre tip and the vein wall prevents ulceration and perforation of the vein wall and perivenous tissue destruction.

Materials and Methods
Ten lateral saphenous veins were treated, using the tulip catheter, in goats under general anaesthesia. Ten more veins were treated with a normal bare fibre. Postoperatively the veins were removed immediately, at 10 days and after 3 weeks for histological examination. Destruction of the vessel wall was measured and perivenous tissue destruction was quantified using a graded scale.

Results
Ulceration and perforation were prevented when using the tulip catheter. Tulip-catheter-treated veins show a transmural vein wall necrosis in, on average, 80% of the total circumference compared to 64% in bare-fibre treated veins. Less perivenous tissue destruction was seen with the new catheter. Three weeks after treatment, we found regression of the perivenous tissue destruction.

Conclusions
EVLA using the tulip catheter avoids ulceration and perforation of the vein associated with treatment using a bare fibre. It also results in more even circumferential vein wall necrosis and less perivenous tissue destruction.

Room: The Great Room

Notes
How safe and effective is high energy endovenous laser ablation?

Ted King
Vein Clinics of America, Oak Brook, IL, USA

Aims
Many currently recommend delivery of higher energy levels during ELT. Typically, a linear endovenous energy density (LEED) of 70-80 J/cm is used; even higher for larger veins. When endovenous fluence equivalents (EFE), measured in J/cm², is used to estimate energy requirements for ELT, large veins often necessitate the use of 100 J/cm or more. This study looks at the safety and efficacy of using more than 100 J/cm during ELT.

Methods
A prospective study of consecutive ELT cases requiring an LEED of more than 100 J/cm, as estimated by calculating EFE needed, based on vein size and laser wavelength. This was compared with a sex and age matched cohort who were treated with less than 100J/cm due to their smaller vein size.

Results
To date, 171 successive cases (195 veins) using more than 100 J/cm have been performed. The range of LEED was 100.0-337.9 J/cm with an average of 132.1±36.3. All had mild post-procedure discomfort and bruising requiring NSAID usage and GCS and other complications were mild and essentially equivalent in the higher and lower energy groups. The incidence of continued reflux through the SFJ and SPJ were 2.0 and 5.0% at 6 months follow-up in the higher energy group and 5.0 and 9.4% in the lower energy group.

Conclusions
It would appear that the use of LEEDs higher than 100J/cm when performing ELT is as safe and more effective than using LEEDs lower than 100J/cm, especially when treating larger veins. There appears to be no apparent difference with the type of laser used (980 nm and 1320 nm). It would also appear that these results provide further confirmation that EFE is a useful tool in determining energy delivery requirements for vein treatment, even when those energy levels are higher than typically used. Further study is ongoing.

Room: The Great Room
Timing of Foam Sclerotherapy with EVLA - Stat or Delayed

Peter Chapman-Smith
Skin and Vein Clinic, Whangarei, New Zealand

2 groups of patients were treated with 1320nm EVLA combined with foam UGS on the day and at different timing of the next UGS treatment. All patients were treated by the same personnel, with identical techniques and equipment. 3:1 air/3% STS foam mixture was used.

The first group had a second UGS treatment the following day to suit travel arrangements. The second group had treatment delayed an average of 5 days later (range 2-92 days). Serial US follow up at 4-6 weeks, 6 mths and 12 mths post EVLA determined efficacy and safety.

Closure of trunkal vessels (distal to the EVLA segment) and junctions were similar in both groups. Adverse outcomes for both groups were matched, not serious, with no DVTs or PEs. Average foam volumes were higher in the first group, which required a lesser numbers of UGS treatments. Matting, staining and scotomata were more frequent in this group however, with more leg persistent swelling in group 2.

UGS treatment appears to be safe and effective if repeated within 24 hours of EVLA with 1320nm.

Room: The Great Room
The distal great saphenous vein: Recanalisation, reflux, incompetent perforating veins after endovenous laser treatment

George Somjen¹,²
¹Frankston Hospital, Peninsula Health, Melbourne, Australia
²Monash University, Melbourne, Australia

Aims
The objective of the study was to examine long term changes in the distal great saphenous vein (GSV) after endovenous laser treatment (ELT).

Methods
115 legs of 88 consecutive patients were included in the study. Two years follow-up data were analyzed. GSV obliteration, recanalisation and perforating vein incompetence were investigated with the duplex ultrasound. Reflux in the distal GSV was reviewed.

Results
In 55% of legs GSV incompetence extended below the knee before ELT. At the end of the follow-up distal GSV reflux was present in 65% of legs ¿ 10% increase. Immediately after the procedure, in 19 legs (17%), heat related thrombus progressed into the distal GSV beyond the treated segment. Subsequently the thrombus recanalised and the distal GSV became incompetent. Late reopening of the distal segment of the treated GSV was seen in and additional 4 patients (3.5%). Extensive delayed recanalisation was found in 10 legs (9%). The number of incompetent perforating veins did not change significantly. The development of new incompetent thigh perforating veins appeared to be associated with GSV recanalisation and reflux.

Conclusion
Following endovenous laser obliteration distal GSV reflux was frequent. ELT from the calf to the groin may be indicated to avoid clinical recurrence.
Endovenous Coil Ablation for Varicose Veins – A Safety and Efficacy Trial

Gary Frydman 1,2
1Medical Director Western Vascular Centre, Melbourne, Australia
2Visiting Vascular Surgeon, Western Health, Melbourne, Australia

Aims
Ultrasound guided sclerotherapy has become a proven treatment in the management of varicose veins. This technique appears less effective as the axial vein becomes larger than 8mm in diameter. This study is aimed to assess the safety and efficacy of placement of endovenous coils into the refluxing axial vein to prevent reflux and improve the results of standard ultrasound guided sclerotherapy in patients with refluxing veins with diameter of greater than 8mm.

Methods
48 patients were recruited following approval of the study by the ethics committee. 3 patients had both legs treated on different dates so 51 limbs were studied. The procedure involved percutaneous access of the refluxing axial saphenous vein under local anaesthetic. A 5 fr sheath was then inserted into the vein and a catheter placed about 2-4 cm below the junction with the deep vein. Two endovenous coils were then inserted into the saphenous vein under ultrasound control. Foamed 3% aethoxysclerol was then inserted into the saphenous vein via the catheter. Ambulatory phlebectomies were then performed under tumescent anaesthetic. All procedures were performed at the Williamstown Hospital as a day case under local anaesthetic and sedation. Patients were reviewed at 1 week, 6 weeks and 6 months following the treatment.

Results
The procedure was successfully performed in all patients although in 2 patients the second coil was not deployed correctly. All patients were discharged on the same day. Complications included 1 case of a popliteal DVT following great saphenous vein treatment and another patient had a puncture site infection treated with oral antibiotics. Three Patients were lost to follow up at 6 months. The saphenous vein was occluded as planned in all patients at 1 week and 6 weeks. At 6 months, 6/48 limbs had reopened and were patent. Reflux was demonstrated in 4 limbs although in 2 cases no reflux was demonstrated.

Conclusion
Endovenous coil ablation is a safe and efficacious procedure for the treatment of varicose veins associated with a refluxing axial saphenous vein with a diameter of greater than 8mm. Modification of the coils however may improve the results. Follow up studies are planned following modification of the coils.

Room: The Great Room

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Thinking outside the box in treating an incompetent GSV: coils, onyx and other methods

Sanjay Nadkarni
Vascular Interventional Radiology Clinic, Perth, Western Australia

Aims
Achieve safe and successful closure of incopetent GSV

Methods
Ultrasound guided access into incompetent GSV. Using fluoroscopy/DSA a 4f C2 catheter and angled glide wire is used to selectively cannulate branch/branches just distal to SFJ. If GSV cannot be accessed under ultrasound an up and over technique using fluoroscopy/DSA can be used to antegradely access the GSV. Once catheter position secured delivery of coils (various types including detachable) in proximal GSV. Then choice of using various agents including onyx (ethylene vinyl alcohol co polymer or traditional agents such as foam to treat the incompetent GSV. Some authors also report the use of alcohol to treat GSV. All my cases had concurrent ONYX or foam or subsequent EVLT.

Results
All cases performed (5) demonstrated complete oclusion of incompetent SFJ on 6 month surveillance duplex. All cases had concurrent or subsequent treatment with EVLT (980nm) or foam (1.5% sts) or onyx (1 case)

Conclusion
Use of coils combined with traditional foam or newer embolic agents such as ONYX offers an alternative to treatment of an incompetent GSV.

Room: The Great Room
**Can saphenous and sural nerve paresthesia be prevented during ELT?**

**Ted King**
Vein Clinics of America, Oak Brook, IL, USA

**Aims**
To determine if it is possible to minimize the risk of thermal injury to the saphenous and/or sural nerves during the performance of ELT.

**Methods**
Using a Siemens Accuson X300 ultrasound machine with a 5-13MHz transducer the zone of contact (ZOC) between the distal GSV and the saphenous nerve and the SSV and the sural nerve were seen. The ZOCs were determined by observing the upper and lower points of contact (POCs) between the great and small saphenous veins and the corresponding nerves. The saphenous nerve POCs were measured from the central prominence of the medial malleolus. The sural nerve POCs were measured from the floor.

**Results**
The saphenous ZOC was measured in 248 consecutive legs undergoing ELT of the GSV. The sural ZOC was measured in 73 consecutive legs undergoing ELT of the SSV. The range of the saphenous upper POC was 7.0-29.0cm above the medial malleolus (Average: 17.6cm, Median: 17.5cm, S.D.: 4.4cm). The ZOC range was 2.0-21.0cm below the upper POC (Average: 9.9cm, Median: 9.5cm, S.D.: 3.9cm). The range of the sural upper POC was 28.5-34.0cm (Average: 25.9 cm, Median: 26.0cm, S.D.: 3.5cm). The ZOC range was 4.0-10.5cm below the upper POC (Average: 6.3cm, Median: 6.0cm, S.D.: 2.0cm). There were no complaints of parasthesias after any of these procedures.

**Conclusions**
Identification of the saphenous and sural nerve ZOCs with the GSV and SSV is easily accomplished with only minor practice. If the desired result is to lase as much of the GSV or SSV as possible, the safest approach would be to introduce the fiber at a location determined by ultrasound visualization of the pertinent nerve. Without ultrasound nerve identification, insertion of the fiber should be 18cm (2 S.D. = 26cm) above the medial malleolus for the GSV and 26cm (2 S.D. = 33cm.) above the floor for the SSV.

**Room: The Great Room**

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**Notes**

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