Update on Management and Treatment of Venous Insufficiency in the Outpatient Setting

Identification, Work-up, and Treatment

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OPENING Late Spring 2020
Vein Nevada History and Provider Team

- Founded in 2016
- Provider Team includes:
  - Dr. Stefan Franciosa
  - Alicia Garaventa, APRN, RNFA
  - Nancy Inman, PA-C
- Offices in Reno & Carson City
- New Office to open late spring 2020 in Las Vegas
Why Treat Chronic Venous Insufficiency?

- More than cosmetic
- Ulcers x 10 yrs.
- Wound care 3 times a week for years
- Severe Pain
- Great saphenous vein ablation 2 yrs. Ago - No improvement

Comprehensive Vein Treatment will fix this
How Common is Venous Disease?

Venous disease is 2x more common than coronary heart disease (CHD) and 5x more common than peripheral arterial disease (PAD).

How Many Are Affected by Vein Disease

- Superficial venous reflux is **progressive** and if left untreated will worsen over time.
- An estimated 25 million people in the United States of America have venous insufficiency
  - Only a mere 1.7 million seek treatment annually
  - Over 23 million Americans go untreated

Insurance Coverage

• Medical vein disease is covered by commercial insurance carriers and Medicare
• HUGE misconception that vein disease is not covered
• Vein disease is a REAL medical condition and is treated as such by insurance companies

• When is Vein Disease covered?
  • Symptoms not controlled by medical grade compression stockings, exercise, OTC NSAIDS and elevation (conservative treatment)
  • Swelling of the lower extremity
  • Symptomatic bulging varicose veins
  • Skin changes from venous insufficiency
  • Ulcers, both healed and active
Epidemiology of Venous Disease

• Heredity
  • Autosomal dominant inheritance with variable penetrance

• Gender
  • Higher incidence amongst women than men with no clear age differences
  • Women
    • Obesity
    • Lower levels of physical activity
    • Higher systolic blood pressure
    • Older age at menopause
    • Eight or more hours in sedentary activities (sitting or standing)
  • Men
    • Lower levels of physical activity
    • Higher smoking rates

Venous Disease: Heredity

The risk of developing vein disease is:

• 90% if both parents had vein disease
• 62% for females if one parent had vein disease
• 25% for males if one parent had vein disease
• 20% if neither parent had vein disease

Venous Anatomy

- Three vein systems:
  - Deep Veins
  - Superficial Veins
  - Perforator Veins
Venous Anatomy

Deep Venous Anatomy

- Deep veins are usually NOT the source of skin changes, pain, and recurrent ulcerations*
- Deep vein reflux usually disappears after superficial and perforating vein reflux is treated**

Superficial Venous Anatomy

- Superficial vein reflux
  - Saphenous vein reflux causes the medical symptoms/problems associated with vein disease
    - Skin changes
    - Ulcerations
    - Edema
    - Pain
    - Cramping
    - Itching
    - Heaviness
    - Achiness

Venous Anatomy

PERFORATOR VEINS

- Accessory saphenous vein
- Saphenous vein
- Muscle
- Perforator vein
- Femoral vein
- Femoral artery

- Superficial compartment
- Saphenous space
- Deep compartment

- Valve
- Failed valve
- Deep vein
- Superficial vein
- Perforator vein
Perforating Veins

- Competent perforating veins carry blood from the superficial to deep venous system.
- Incompetent perforating veins cause blood to flow from the deep to superficial venous system, creating localized venous hypertension.

Localized venous hypertension leads to localized skin changes, pain, edema, and recurrent ulcerations.

Whiddon LL, MD. The treatment of venous ulcers of the lower extremities. Proc. 2007:October;20(4);363-366
Pathophysiology

Valvular dysfunction
Venous hypertension
Protein and RBC extravasation
Chronic inflammatory state
Dermal fibrosis
Matrix fibers rupture
Venous ulcer
CEAP Classification for Venous Insufficiency

**Clinical***
- C₀: No clinical signs
- C₁: Small varicose veins
- C₂: Large varicose veins
- C₃: Edema
- C₄: Skin changes without ulceration
- C₅: Skin changes with healed ulceration
- C₆: Skin changes with active ulceration

**Etiology***
- Eₑ: Congenital
- Eₚ: Primary
- Eₛ: Secondary
  - (usually due to prior DVT)

**Anatomy***
- Aₛ: Superficial veins
- Aₐ: Deep veins
- Aₚ: Perforating veins

**Pathophysiology***
- Pₑ: Reflux
- Pₙ: Obstruction

"Early application of compression should be performed to correct swelling and progressive scarring and to initiate the healing process by improving the venous microcirculation."

Koehler R. Specific Steps to Effective Management of Venous Ulceration. Supplement to Wounds June 2010.

Symptoms of Chronic Venous Disease

- Aching
- Fatigue, heaviness in legs
- Pain: throbbing, burning, stabbing
- **Cramping**
- Swelling (peripheral edema)
- Itching
- **Restless legs**
- Numbness
Restless Leg Syndrome

- **98%** of the patients who were RLS positive were found to have concurrent chronic venous disease (CVD)
  - The presence of cramps was significantly higher in RLS positive subjects
- Treating the vein disease often alleviates RLS symptoms
- **89%** of RLS patients clinically improve after vein ablation

Leg Cramps at Night

- Leg cramps at night are commonly associated with vein disease
- May happen several times a night
- Very disruptive to sleep
- Patients have usually tried many different remedies without success
- About 90% of the time the cramps improve after vein treatment
Venous Neuropathy

• Chronic venous insufficiency is associated with peripheral neuropathy (perineural inflammation)

• Burning, tingling and numbness are common in vein disease

• If other causes are excluded approximately 60-70% of patients improve after treating the vein disease
Venous Disease: Physical Exam

- Telangiectasias
- Reticular veins
- Varicose veins
- Lower leg dermatitis
- Recurrent cellulitis
- Hyperpigmentation
- Edema
- Healed or active ulcerations
Visible Signs of Vein Disease

**Telangiectasias**
- Also known as “spider veins”
- Increase in frequency with age
- 53% of patients complain of pain and discomfort
- 85% of patients experience relief of symptoms after sclerotherapy treatment*
- Often indicates more extensive venous disease

**Reticular Veins**
- Enlarged, greenish-blue appearing veins
- Frequently associated with clusters of telangiectasias
- May be symptomatic, especially in dependent areas of leg

*Note: Sclerotherapy is a nonsurgical procedure used to treat varicose and spider veins.
Varicose Veins

- Commonly located along the medial thigh and calf
- At least 20% of patients with varicosities are at risk of ulceration
- Only visibly present in about half of vein disease patients
Other Half of Vein Disease

Skin Changes

• Often on medial aspect of lower leg and ankle
• Recurrent cellulitis or chronic eczematous skin changes
• Predictor of future ulceration

Progression of Vein Disease

Corona phlebectatica → Hyperpigmentation → Erythema, venous eczema → Lipodermatosclerosis, fibrosis → Atrophie Blanche → Ulceration
Corona Phlebectatica

- Early sign of saphenous insufficiency
- Resistant to sclerotherapy
Edema

• Venous insufficiency is a common cause of leg swelling
Hyperpigmentation

- Hemosiderin staining of skin
- Result of increased venous pressure
Atrophie Blanche

- Pre-ulcerative skin changes
Lipodermatosclerosis

- Hard skin, constricted lower leg
Venous Ulcers

- Most advanced vein disease
When to Consider Treatment for Vein Disease

- Symptoms (aching, pain, swelling, etc.) unresponsive to conservative measures
- Restless Legs
- Unable to tolerate compression
- Skin changes suggestive of chronic venous insufficiency
- Impending or active ulceration
- Hemorrhage (Spontaneous Bleeding)
- PHLEBOLYMPHEDEMA/LYMPHEDEMA
Suspected Vein Disease: Work-Up

- **Detailed Ultrasound**
- Conservative Therapy
- Procedures
  - Endovenous ablation
  - VenaSeal Closure
  - Ambulatory Phlebectomy
  - Ultrasound-Guided Sclerotherapy
Identified Pathology  | Standard venous ultrasound | Detailed venous ultrasound
---|---|---
Deep vein reflux, DVT | X | X
Saphenous vein reflux |  | X
Perforating vein reflux |  | X

Not all ultrasounds are the same!

94% of vein disease is **missed** by standard “Rule Out DVT” ultrasounds

Only 6% of limbs with venous ulceration have *isolated* deep vein reflux

Do NOT accept a “negative” ultrasound with any legs like these:
Suspected Vein Disease: Treatment Options

- Detailed Ultrasound
- **Conservative Therapy**
- Procedures
  - Endovenous ablation
  - Ambulatory Phlebectomy
  - Ultrasound-Guided Sclerotherapy
Conservative Therapy

- Exercise
  - At least 30 minutes daily
- Leg elevation
- Pain medication
  - OTC NSAIDs
- Warm compresses
- Cool soaks
- Compression stockings
Conservative Therapy: Compression Stockings

- Improves venous outflow, increases velocity of blood flow
- Reduces the risk of thrombosis
- Reduces symptoms of aching, fatigue, pain, and swelling
- Important for the treatment of venous ulcers

Photo courtesy of Juzo
Compression stockings: Disadvantages

- Often poorly tolerated by patients
- Difficult to put on and take off
  - Especially in elderly, patients with arthritis, etc.
- Symptom relief is usually limited and temporary
Suspected Vein Disease: Treatment Options

- Detailed Ultrasound
- Conservative Therapy
- Procedures
  - Endovenous ablation
  - VenaSeal Closure
  - Ambulatory Phlebectomy
  - Ultrasound-Guided Sclerotherapy
MEDTRONIC ENDOVENOUS TREATMENT PORTFOLIO
LEADING WITH UNRIVALLED TECHNOLOGY

**ClosureFast™ System**
- Tumescent and/or general anesthesia used
- Small puncture site
- Up to 2 weeks of post procedure limitations
- Use of compression stockings post procedure

**ClosureFast™ RFS Stylet**
- The only endovenous radiofrequency ablation device indicated for the treatment of incompetent perforator veins
- Used with the ClosureFast™ system

**VenaSeal™ Closure System**
- Uses an advanced medical adhesive to safely and effectively close the diseased vein segment
- No anesthesia
- No risk of thermal injury
- Rapid return to normal activities
- No compression stocking*

*Note: VenaSeal™ Closure System may not be used in all patients. Please consult a qualified healthcare professional for more information.
Endovenous Thermal Ablation

- Used to treat saphenous and perforating veins
- Office-based procedure
- Takes approximately 30 minutes
- Local anesthesia
- 95% closure at 1 year.
- Can be done using radiofrequency or laser
**CLOSUREFAST™ VS. OTHER TREATMENT MODALITIES**  
**CLINICALLY PROVEN STANDARD OF CARE**

500 patients (580 limbs) with GSV reflux were randomized to receive one of the following:

- RF Ablation (n=125)
- Endovenous Laser Ablation (n=125)
- Vein Stripping (n=125)
- Ultrasound-Guided Foam Sclerotherapy (n=125)

**Duplex ultrasound imaging was done before and after the procedure (3 days, 1 month, and 1 year)**

<table>
<thead>
<tr>
<th>Primary Endpoints</th>
<th>RF Ablation (n=125)</th>
<th>Endovenous Laser Ablation (n=125)</th>
<th>Vein Stripping (n=125)</th>
<th>Ultrasound-Guided Foam Sclerotherapy (n=125)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy at 1 year (reflux-free rate)</td>
<td>95.2%</td>
<td>94.2%</td>
<td>95.2%</td>
<td>83.7%*</td>
</tr>
<tr>
<td>Post Intervention Pain Scores* (1-10)</td>
<td>1.21**</td>
<td>2.58</td>
<td>2.25</td>
<td>1.60**</td>
</tr>
<tr>
<td>Time to return to normal activities (days)</td>
<td>1**</td>
<td>2</td>
<td>4</td>
<td>1**</td>
</tr>
<tr>
<td>Time to resume work (days)</td>
<td>2.9**</td>
<td>3.6</td>
<td>4.3</td>
<td>2.9**</td>
</tr>
<tr>
<td>Indirect cost (£) Lost work</td>
<td>560</td>
<td>840</td>
<td>1120</td>
<td>560</td>
</tr>
<tr>
<td>Total costs (£)</td>
<td>1996</td>
<td>2200</td>
<td>2199</td>
<td>1559</td>
</tr>
</tbody>
</table>

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**Primary Endpoints**
- GSV closure expressed in vessel patency (treatment failure) one year post procedure.

**Secondary Endpoints**
- Pain, absence from work and normal activity
- Scores of SF-36TM*
- Aberdeen Varicose Vein Symptom Severity Score (AVVSS)
- Venous Clinical Severity Score (VCSS)

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* p < 0.001 UFGS compared to other groups  
** p < 0.001 compared to EVLA and stripping  
***In the 10-day period post-procedure.  
Rasmussen et al. Randomized clinical trial comparing endovenous laser ablation, radiofrequency ablation, foam sclerotherapy and surgical stripping for great saphenous varicose veins. BJS 2011;98:1079-1087
Endovenous Ablation

Disposable catheter inserted into vein

Vein heats and collapses

Catheter withdrawn, closing vein
Venefit Procedure Video
Post-Procedure Care

- Walking is encouraged; a minimum of 30 mins. daily
- Return to normal activities immediately
- Wear compression stockings for 1 week
- Follow-up ultrasound done between 2 and 7 days post procedure

*Individual results may vary
VenaSeal Closure System

- Proprietary cyanoacrylate-based adhesive
- VenaSeal™ adhesive is delivered in 0.10 cc allotments along the length of the targeted vein segment.
- Non-tumescent, non-thermal technique
- Covered by Medicare Starting 01/01/2018!
# VenaSeal Closure System

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Feasibility Study(^5)</th>
<th>eSCOPE Trial(^6)</th>
<th>VeClose Study(^7) (U.S. Pivotal Trial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective, single-center study</td>
<td>Prospective, multi-center, post-market study</td>
<td>Prospective, multi-center, randomized controlled trial</td>
<td></td>
</tr>
<tr>
<td>Patients Enrolled (n)</td>
<td>38</td>
<td>70</td>
<td>242*</td>
</tr>
<tr>
<td>Closure Rate</td>
<td>3-year: 94.7%</td>
<td>3-year: 88.5%</td>
<td>VenaSeal™ 2-year: 95.3%</td>
</tr>
<tr>
<td>Definition of Closure</td>
<td>No discrete segment of patency &gt;5 cm in the treated vein segment</td>
<td>No discrete segment of patency &gt;10 cm in the treated vein segment</td>
<td>No discrete segment of patency &gt;5 cm in the treated vein segment</td>
</tr>
<tr>
<td>Serious Adverse Events Related to Study Device or Procedure</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
VenaSeal Procedure Animation
Treatment of Bulging Varicose Veins: Phlebectomy

- Removal of bulging varicose veins through a 0.5 – 1.0 cm incision
- Requires only local anesthetic
- Performed in the office
Phlebectomy Results
Phlebectomy Results
Cosmetic Treatment of Telangiectasias

- Sclerotherapy treatment is the most effective
- Laser may be helpful
- Multiple treatments usually required
- Reduces symptoms in 85% of patients

- Injection sclerotherapy of asymptomatic smaller varicose veins, reticular veins and telangiectasias is considered cosmetic
  - Often performed using ultrasound guidance for tributaries that are poorly visualized on the surface

WHY SHOULD WE CARE ABOUT VENOUS LEG ULCER PATIENTS

1 million people in the U.S. are affected by venous leg ulcers

21% of all wounds seen in wound care clinics are characterized as venous ulcers

70%-90% of lower extremity ulcers are venous

$14.9 billion is spent annually to treat venous ulcers

Due to pain, mobility limitations and other consequences, venous leg ulcers have been associated with increased rates of depression and substantial decreases in patient quality of life.

1 Internal Data, Dymedex Study
2 The Outpatient Wound Clinic Market 2013 Report and Analytics, Not Health Analytics (2010-2012 claims data)
7 Green J, Jester R. Health-related quality of life and chronic venous leg ulceration: part 1. Wound Care 2009;December:S12-S17
EVIDENCE BASED TREATMENT ALGORITHM

An Evidence Based Algorithm for Treating Venous Leg Ulcers Utilizing the Cochrane Database of Systematic Reviews

**Ulcer Treatment**
1. Debridement of ulcer
2. Exudate management and moisture balance
3. Infection control
4. Address and systemic condition

**Compression (Gold Standard)**
- Multi-layer elastic compression dressing should always be used unless there is a concurrent arterial disease
- Use intermittent compression pumps for patients that cannot use multi-layer compression

**Assess for negative baseline factors**
1. Ulcer >10cm²
2. Duration X>12
3. PAD
4. X>50% fibrous tissue

**Consider systemic agents**

**Dressing of choice**
- No evidence to show any dressing is more effective
  - Possible use of Cadexomer Iodine

**Failure to get closure of x>40% in 4 weeks**

**Continue Compression Wound Management**

**Bi-layered living skin equivalent**
(up to 5 applications as required)

- Healed ulcers should be maintained with compressive stockings and appropriate skin care.
- Possible surgical intervention to prevent recurrence.

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1. Howard M. Kimme et al. An Evidence-Based Algorithm for Treating Venous Leg Ulcers Utilizing the Cochrane Database of Systematic Reviews. WOUNDS 2013;25(9):242-250
Evidence Based Treatment for VLUs

- Venous leg ulcer outcomes are optimized when patients receive multidisciplinary care and evidence-based wound management. Dermatology, geriatrics, podiatry, and surgery are just a few specialties that may be utilized to improve outcomes.¹
- Significant decreases in healing time and costs are associated with guideline adherence. Among veterans with VLUs, those who receive guideline-concordant wound care are 2.5 times more likely to achieve wound healing than are those who receive non-concordant care.¹

¹ Howard M. Kimmel et al. An Evidence-Based Algorithm for Treating Venous Leg Ulcers Utilizing the Cochrane Database of Systematic Reviews. WOUNDS 2013;25(9):242-250
# AVF/SVS 2014 Guidelines for Venous Ulcers

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Venous Duplex Ultrasound</strong></td>
<td>1B</td>
</tr>
<tr>
<td>Guideline 3.9: We recommend comprehensive venous duplex ultrasound examination of the lower extremity in all patients with suspected venous leg ulcer.</td>
<td></td>
</tr>
<tr>
<td><strong>Ablation-Prevent Recurrence</strong></td>
<td>1B</td>
</tr>
<tr>
<td>Guideline 6.2: In a patient with a venous leg ulcer (C6) and incompetent superficial veins that have axial reflux directed to the bed of the ulcer, we recommend ablation* of the incompetent veins in addition to standard compressive therapy to prevent recurrence.</td>
<td></td>
</tr>
<tr>
<td><strong>Ablation-Ulcer Healing</strong></td>
<td>2C</td>
</tr>
<tr>
<td>Guideline 6.1: In a patient with a venous leg ulcer (C6) and incompetent superficial veins that have axial reflux directed to the bed of the ulcer, we suggest ablation* of the incompetent veins in addition to standard compressive therapy to improve ulcer healing.</td>
<td></td>
</tr>
<tr>
<td><strong>Ablation-Prevent Ulceration</strong></td>
<td>2C</td>
</tr>
<tr>
<td>Guideline 6.4: In a patient with skin changes at risk for venous leg ulcer (C4b) and incompetent superficial veins that have axial reflux directed to the bed of the affected skin, we suggest ablation* of the incompetent superficial veins in addition to standard compressive therapy to prevent ulceration.</td>
<td></td>
</tr>
<tr>
<td><strong>Venous angioplasty &amp; Stent recanalization-Prevent Recurrence &amp; Ulcer Healing</strong></td>
<td>1C</td>
</tr>
<tr>
<td>Guideline 6.14: In a patient with inferior vena cava or iliac vein chronic total occlusion or severe stenosis, with or without lower extremity deep venous reflux disease, that is associated with skin changes at risk for venous leg ulcer (C4b), healed venous leg ulcer (C5), or active venous leg ulcer (C6), we recommend venous angioplasty and stent recanalization in addition to standard compression therapy to aid in venous ulcer healing and to prevent recurrence.</td>
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</tr>
</tbody>
</table>

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*Multiple RCTs show strong and consistent evidence that modern open surgery, radiofrequency, and laser ablation are equivalent in effect and safety

ABLATION: A PROVEN SOLUTION FOR PATIENTS WITH LOWER EXTREMITY ULCERS

Six-month patient follow-up demonstrates a significant change in ulcer size and healing rate from pre-to post-ablation. Early intervention and treatment with compression and ablation can significantly improve quality of life for patients with this condition.

Ablation method used was radiofrequency ablation (Medtronic ClosureFast™ procedure).

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1 Howard M. Kimmel et al. An Evidence-Based Algorithm for Treating Venous Leg Ulcers Utilizing the Cochrane Database of Systematic Reviews. WOUNDS 2013;25(9):242-250
Ulcer Recurrence at 1 year


Venous Leg Ulcers and Incompetent Perforator Veins

- 80% of Venous Ulcers are Associated with Incompetent Perforator Veins (IPVs)
- CEAP Classification and IPVs
  - Those with C4 disease were found to have IPVs 84% of the time.
  - Those with C5 or C6 disease were found to have IPVs 90% of the time
- Most IPVs are associated with incompetent superficial veins.

Case study: Venous Ulceration

- 52 year old female patient with history of non-healing wounds despite 2 years of wound care and consistent use of medical grade compression
- No significant PMHx
- Positive FamHx for venous disease in her mother and grandmother
- Previous bilateral GSV vein stripping in 2016
Case study: Venous Ulceration
Case study: Venous Ulceration

- Detailed venous ultrasound findings:
  - Stripped Proximal Bilateral Great Saphenous Veins
  - Incompetent Right Anterior Accessory Great Saphenous Vein
  - Incompetent Bilateral Small Saphenous Veins
  - Multiple Bilateral Incompetent Perforator Veins
Case study: Venous Ulceration

- 68 y/o female
- LLE ulcer had been present for 1 year despite multiple episodes of antibiotics, regular wound care, compression stocking use and multiple skin biopsies
Case study: Venous Ulceration

- Detailed venous ultrasound findings:
  - Incompetent Bilateral Great Saphenous Veins
  - Incompetent Left Anterior Accessory Great Saphenous Vein
  - Incompetent Bilateral Small Saphenous Veins
  - Incompetent perforating vein directly subjacent to the ulceration
Case study: Venous Ulceration

• The patient immediately noted improvement in leg pain, redness and swelling after closure of the saphenous and perforating veins

• At the three month follow-up, ulcer had decreased in size with near complete closure
Case study: Venous Ulceration

- 87 y/o female
- LLE ulcer and non-healing wounds had been present and recurrent for the last 3 years despite regular wound care.
Case study: Venous Ulceration

- Detailed venous ultrasound findings:
  - Incompetent Left Great Saphenous Vein
  - Incompetent Left Small Saphenous Vein
  - Multiple incompetent perforating veins directly subjacent to the ulcerations
Case study: Venous Ulceration

- Results after 4 weeks!!
Case study: Venous Ulceration

- 75 y/o male
- Recurrent cellulitis with MRSA requiring multiple episodes of IV antibiotic
- Severe stasis dermatitis/ulcerations
- RFA B/L GSVs in 2013
Case study: Venous Ulceration

- Detailed Venous Ultrasound Findings:
  - Previous RFA with closure of the proximal GSVs only
  - Incompetent Distal Bilateral Great Saphenous Veins and Right Anterior Accessory Great Saphenous Vein
  - Incompetent Bilateral Small Saphenous Vein
  - Multiple incompetent perforating veins in the calves
Case study: Venous Ulceration

6 week follow-up
Case study: Venous Ulceration

- 49 y/o male
- First leg ulcer in 2012 which took approximately 12 months to heal with formal wound care
- Ulcers recurred in February 2016
- Right GSV stripped in 2006
- Multiple failed skin grafts
- Ulcer enlargement despite state of the art wound care
- Severe stasis dermatitis/lipodermatosclerosis and ulcerations
Case study: Venous Ulceration

- Detailed Venous Ultrasound Findings:
  - Previous Vein Stripping of the Right GSV only
  - Incompetent Left GSV
  - Incompetent Bilateral Distal Great Saphenous Veins
  - Incompetent Bilateral Small Saphenous Vein
  - Multiple incompetent perforating veins in the calves subjacent and surrounding the ulcerations
  - Very Dilated Varicose Veins
Case study: Venous Ulceration

6 week follow-up
Thank You!

Questions?

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