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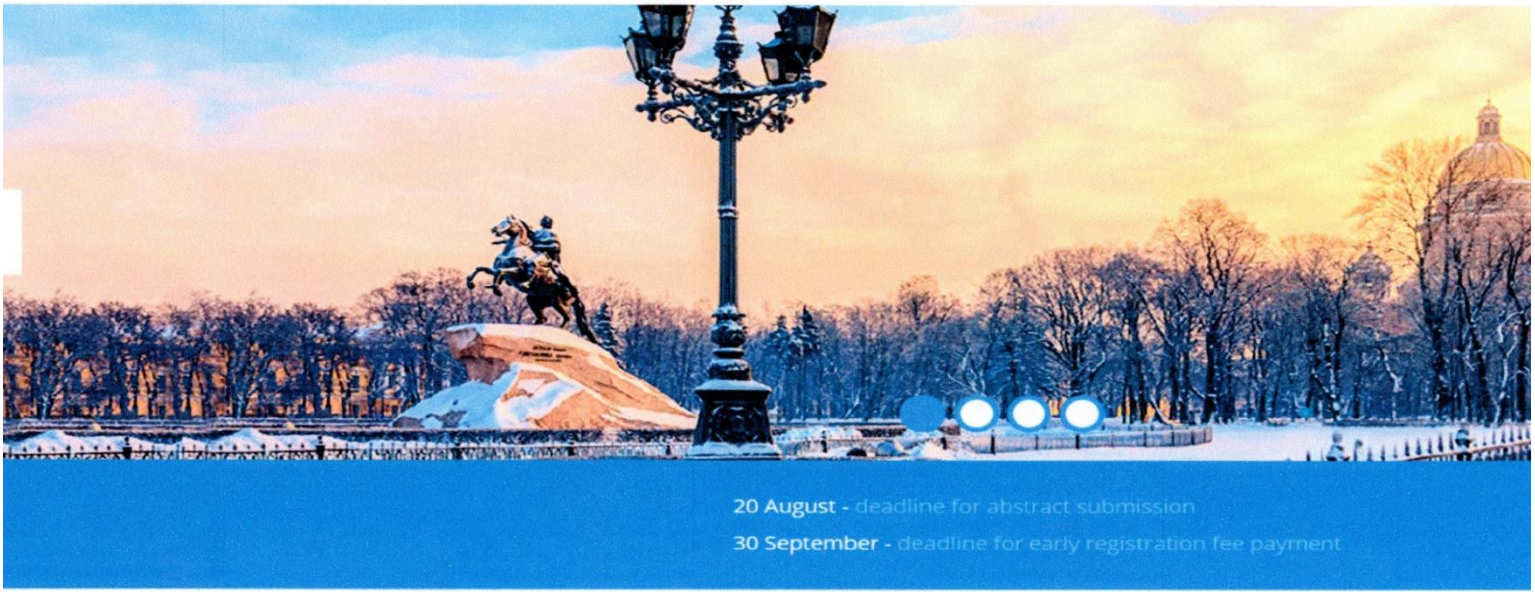

How will recurrence occur after endovenous ablation ?

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Introduction

Although endovenous ablation for varicose veins achieves favorable outcomes. But there are also reports of recurrence.

Aims

We investigated the relevant factors and evaluation of pattern of recurrence after endovenous ablation.

Methods

We studied 2760 patients who underwent endovenous ablation between January 2013 and December 2017 (966 men/1794 women; age, 65.8 ± 13.9 years; classification, C1: 25/C2: 2108/C3: 44/C4a: 432/C4b: 83/C5: 38/C6: 30). GSV was treated in 2208 patients, and SSV in 552. The devices used were Laser 980 in 480 patients, Laser 1470 in 1257, and ClosureFast in 1023. Based on the standard procedure, ablation was applied at 10 mm peripherally from the junction for both GSV and SSV and at 20 mm from the proximal end of the popliteal crease for high-bifurcation-type SSV (Fig.1). The patients were followed up via ultrasonography for 6-12 months after surgery. The endpoints were the distance (mm) from SFJ / SPJ to the occluded stump, the ablated vein reduction rate (postoperative diameter/preoperative diameter x 100) (%), and the number of branches draining to the SFJ. Pathological conditions of recurrence concern were defined as inadequate ablation in the early postoperative period, distance to the occluded stump >50 mm, an elevated reduction rate, and recanalization of branches around the SFJ in the intermediate postoperative period[3].

Results

Twenty-one patients were finally included (5 men/16 women; age, 65.8 ± 10.1 years; classification, C2: 12/C4a: 5/C4b: 1/C6: 9). GSV was treated in 14 patients, and SSV in 7. Laser 1470 was used in 8 patients, and ClosureFast in 13 (Fig.2). In the early postoperative period, the vein was patent in 1 patient, and the distance to the occluded stump was > 50 mm in 6. In the intermediate postoperative period, the distance was > 50 mm in 7 patients (mean period: 91.5 days) (Fig.3). One patient developed a varicose vein in a neovessel at the occluded stump. The postoperative ablated vein reduction rates and number of branches were 33.4% and 14.6% and 0.42 and 1.14 in the early and intermediate postoperative periods, respectively.

Conclusion

This study comparing cases with and without recurrence concerns demonstrated that recurrence is not causally related with occlusion proximal to the junction between a branch to be blocked and a deep vein or a favorable rate of reduction in the preoperative vein diameter. Factors for recurrence after endovenous ablation were investigated.