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Cause-related strategy for superficial and saphenous phlebitis with one year follow-up.

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Background: Superficial or saphenous phlebitis is usually treated by use of compression stockings and anticoagulants. However, most of these cases seem to occur due to underlying venous insufficiency. This study examines a novel strategy including immediate exclusion of the source of reflux.

Patients and methods: 43 patients with saphenous (n = 28) or tributary phlebitis (n = 15) were included in this prospective study. Inclusion criteria: Obstructive phlebitis with relevant clinical symptoms (pain limiting daily activities), ultrasound proof of active or masked reflux. Exclusion criteria: Previous vein treatment < 3 months, DVT. Steps: 1) removal of thrombus by manual catheter aspiration and/or thrombus expression, 2) termination of reflux beginning at the origin (GSV, AA, SSV, perforator vein) by laser occlusion (810 - 1470 nm, 50 - 200 J/cm) and sclerofoam injection (Aethoxysklerol 1-2%), 3) local or systemic analgetics and anti-inflammatory drugs (Ibuprofene p.o., Diclofenac ointment).

Results: Relief of local pain, cessation of oral analgetics and of anticoagulants was obtained within 0 – 5 days (mean: 2.8 d). Initial and permanent occlusion of the reflux source (laser treated) was obtained in all cases (43/43). Within 6 months of FU, 41/43 cases (95.3%) required additional sclerofoam injections (2 – 6 ml). Between month 6 and 12 further sclerofoam (2 – 4 ml) was required in 12/43 cases (27.9%). There was no complication, in particular no case of DVT during FU.

Conclusions: The reported method with the advantages of fast clinical improvement and shorter anticoagulation period may become an alternative to traditional strategies. A randomized controlled study comparing traditional and novel strategies was denied by our clinic´s ethics committee but may be feasible and interesting for other investigators.

Note: Please mention target vein diameters pre- after treatment and during follow-up!