CHAPTER I

INTRODUCTION

I N T R O D U C T I O N

Varicose veins of the lower limbs and its complications are one of the most difficult problems in surgery.
Treatment is directed towards the varices and is not directed to the causative factors. Two main types of treatment are available; surgery and injection compression sclerotherapy, most of the surgical treatment based on the stripping of the superficial veins.

In the injection compression sclerotherapy the points of abnormal flow from the deep to the superficial veins are located, and the veins at these sites are then permanently obliterated by the injection of sclerosant drug, then application of continuous pressure. It is essentially based on the restoration of pumping capacity of the multiple pumps of the whole lower limbs rather than the eradication of the superficial varices or the opening-up of the proximal obstruction(Fegan 1963).

It should be appreciated that a considerable damage in the lower limb must have been inflicted before the signs and symptoms of varices are noticeable, however, it is unnecessary to restore the pumps completely to normal in order to relieve congestion and produce effective clinical cure.

In fact, if complete and perfect restoration of the pump were essential for successful treatment; then few patients would even be cured by any form of treatment (Fegan,1967).

History of the treatment of varicose veins by injection compression sclerotherapy.

The discovery of the hypodermic syringe by Francis Rynd (1851) and Pravage (1851) opened a new method in the treatment of varicose veins.

In 1850 , the treatment of varicose veins by injection began to attract the attension, Cassaiganc & Debout (1853) used the injection of iron perchloride and they reported some success, Muller in 1860 (Ochsner & Moharner ,1939) reported four cases successfully treated by injection of iron perchloride. Soule (1976) (Ochsner & Moharner,1939) noticed the development of inflammation and suppuration following iron perchloride injection and he adviced the use of compression to prevent dilatation of the veins after injection.
At the surgical congress of lyon in 1894 (Ochsner & Moharner 1939) the injection treatment of varicose veins was much discussed and was decided that this treatment should be abandoned.
In 1904, Tonel adviced injecting a varicose segment by 5% phenol solution.
Sicard (1911)noticed obliteration of veins following injection by Leuirgol solution, then he changed to injecting by

sodium salicylate in 20%, 30% & 40% solutions.

The injection compression sclerotherapy was discribed by Lincer (1916). In 1917 Kache introduced quinin and urethan. Sicord (1919) changed his technique by using sodium carbonate.

Sodium Morrhuate had became popular and its use was advocated by Rogers and Winchester ,1930 (Heineman,1967).

In the last 20 years,Fegan re-established the value of compression sclerotherapy as primary treatment of varicose veins using sodium tetradecyl sulphate.