Management of varicose veins of lower limb

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The term varicose veins includes the dilatedvenules. dilated superficial veins. -dil~ted and tourtuousaaphenouaveins and the dilated superficialveins of the post phlebitic syndrome.The veins draining the lower limb are the superficial• deep and communicatingveins which connectthe superficial to the deep veins. The superficial veinsare the long and short saphenous veins and their tributaries.The deep veins are the planter digital veins.anterior and posterior tibial veins. popliteal vein andfemoral vein. The comnnmicatingveins are the ends of-long and short saphenous veins. mid thigh perforatingveins and the internal and external ankle perforatingveins.Venousreturn from the legs depends on the visatergofrom the feart. the thoracic and abdominal pressureduring respu-atiori and the skeletal muscle pumpinthe calf during walking.Normally. there is markeddecrease in the saphenousvein pressure with exercise after which there isgradual return of venous pressure to n01’lllallevels. Invaricose veins there are lesser decreases in venouspressure with exercise and more rapid return to nO.t’ll1allevels whenwalking ceases.Fifteen to twenty per cent of the adult populationhave varicose veins. Afamilial history has beennoted in fifteen per cent of the patients. The femaleto male ratio is five to one.Although a familial predisposition is probably themost .1Jnportantcause of primary varicose veins , suchfactors as prolonged periods of standing, obesity andpregnancy are aggravating factors.The seco~dary varicose veins usually follow an ,attack of deep’ vein thrombosis (and the resulting mani- .~ ,,festations are called post-phlebitic syndrome) but theyare also present in arteriovenous fistula and klippel-Trenaunay syndrome.Somepatients complain only of the cosmotic appearanceof their leg. Others will complain of a tirdnessin the leg, a heaviness of the leg, or a dull or throbbingpain in the leg. The pain or discomfort in characteristicallyrelieved by elevation of the leg. Itching, dermatitis,night cramps, and eventually ulceration maybedescribed by the patient.Cl.inical evaluation, .includ.ing the Trend;I.enbergor Perhes test and the presence of stasis dematitisor ulceration, is helpful but .inconsistent guide tothe status of the deep end perforat.ing ve.ins. Likewise,venography, plays a role .in the def.ini tion ofthe al tered hemodynamics.in the calf IllU.sclo-venouspump.Measurementof ambulatory venous pressure hasbeen the diagnostic standard for evaluation of thesuperficial venous hypertension that characterizes,end is responsible for, the cutaneous pathology .inchronic venous .insufficiency.Doppler ultrasonography.is as non .invasive diagnosticmethod.which is useful for evaluation of patientswith chronic venous .insufficiency.The complications of varicose ve.ins .include superficialthrombophlebitis, haemorrhage which maybe fataland skin and

subcutaneous complications which .includeecchymosis, p~~entat.ion, oedema, induration, de.rmatitis,ulceration and subcutaneous calc:.11losis.The treatment of choic~ for most varicose veinswithout complications is conservative managementconsist.ing of exercise, elevation, and fitted elastic stock-.ing.Injection compression sclerotherapy aims at .obliteratingsuperficial varices by injection of sclerosant,followed by compression, which is maintained until thevaricose segment is converted into a fibrous cord. ~hesuccess rates vary from 21%to 99%.Surgical treatment is based on tying the long andshort saphenous veins in the groin and popliteal fossaend stripping the superficial vessels , together withtying incompetent perforating vessels. The success ratesvary from 40%to 98.6 %.