The state of endovenous ablation therapy in Turkey: Is it always really indicated?

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Abstract

An explosion in the treatment options of superficial truncal venous insufficiency has occurred all over the world as well as in Turkey. Public health service and limited funds restrict physicians in decision making between criteria based on clinical severity and payment criteria of public health insurance. This dilemma seems to go on. Reasons for this dilemma are discussed in this review.

Introduction

In western populations the incidence of venous insufficiency varies from 7% up to 55%. In the VEYT-I study similar results were obtained in western Turkey and near 20% of Turkish people have different types of varicosities (1,2). But unfortunately, the importance of venous insufficiency and related syndromes like varicosity or thromboembolism and related complications was underestimated.

During the past decade, an explosion in the treatment options has occurred all over the world. Endovenous ablation therapy has nearly replaced the conventional surgical treatments for patients with superficial venous insufficiency (3-5). This was also the case in Turkey.

Short History

Puglisi et al. (6) introduced laser treatment of the insufficient great saphenous vein in 1989. In 1996 first publications were made and in 2001 FDA approved laser treatment of great saphenous vein.

In Turkey, Sargül A. was the first who used endovenous laser for the treatment of insufficient great saphenous vein and varicosities. But to my knowledge he didn’t publish his experience. In recent years Bozkurt AK. (Istanbul) and Demirkılıç U. (Ankara) spent great effort to get these new techniques more common (6).

Endovenous procedures were not paid by the health insurance in Turkey, first. But with great effort of vascular surgeons endovenous laser treatment became a treatment modality in Turkey which was covered by the health insurance, but not other endovenous procedures, like endovenous radiofrequency. Discussions about right indications and criteria for endovenous therapies took place between health insurance and delegates of vascular surgery. In the beginning of 2013 an agreement was reached and the criteria for endovenous laser and radiofrequency ablation was published by the national health insurance in cooperation with the ministry of health.

Recent Techniques for Endovenous Ablation

Nowadays endovenous techniques have been developed to treat superficial truncal venous insufficiency. One of the oldest technique is foam sclerotherapy or ultrasound guided foam sclerotherapy. Other well known procedures are endovenous laser with different wave length and endovenous radiofrequency. There are different laser brands on the market all with different features of laser device and laser fiber. Options for radiofrequency is still quite small.
In last years some other techniques have been introduced. The first is endovenous steam ablation, but the effectiveness is still discussed in literature (7). Other new techniques are mechanochemical endovenous ablation (ClariveinTM) and endovenous cyanoacrylate (VenaSealTM) (8). In spite of advantages like not to require tumescnet anaesthesia these last two techniques have not been proven yet.

Indications for Endovenous Ablation

Symptomatic patients who have varicose veins, edema, skin changes, or ulceration (CEAP 2-6) with axial reflux in one or more superficial truncal veins are considered candidates for therapy. Initially, a patient should be treated conservatively, and intervention can be considered when there are persistent symptoms or signs of progressive chronic venous disease (9,10).

Discussions on Indications for Endovenous Ablation

There is no doubt about indications for endovenous ablation of superficial truncal venous insufficiency. But in countries with public health services and limited funds discussions about indications were of great importance (11,12). In Turkey, some criteria like vein diameter, the presence of insufficiency and a scoring parameter were defined as essential and these criteria had to be approved by two cardiovascular surgeons and one radiologist or two radiologists and one cardiovascular surgeon.

If criteria are based on clinical severity, patients with uncomplicated varicose veins (C2,3) are denied treatment even if they have a standing occupation that requires them to sit down to alleviate severe discomfort. Conversely, patients with extensive lipodermatosclerosis often fulfill the severity criteria but may decline intervention for personal reasons, even if they are told that this is a precursor for ulceration (11).

Another influencing factor may be decision making are hospital stay costs and early recovery to work. In most countries with limited funds early recovery to work is not as important as in industrialized countries. Therefore minimal invasive techniques are not attributed necessary and treatment comfort for both the physician and the patient could be ignored.

Physicians in Turkey performing endovenous treatments are mostly cardiovascular surgeons. Many of them are working in hospitals where only vascular surgery is performed and the infrastructure is inadequate for cardiac surgery. So, in practice, although they are cardiovascular surgeons they work as vascular surgeons.

Conclusion

Present conditions of health care make it very difficult for performance dependent working physicians to achieve the right balance between indication, clinical severity and indication criteria.

However, in daily practice, there are some problems to be solved. First, the diagnosis of venous insufficiency has to be precise (13). Vascular surgeons mostly do not have enough experience in vascular duplex. Additionally, the cooperation between radiologist and vascular surgeon is mostly poor. The second subject is the lack of excellent skills for endovenous procedures and complementary techniques (9-14). Another subject is the use of products with inadequate quality standards sometimes causing unusual complications (15). The last subject, the vascular surgeon should have the possibility to use more than one technique.

Diagnosis related health financing and limited funds limit hospital management and vascular surgeons. This might cause inadequate conditions. Nevertheless, diagnosis of superficial truncal venous insufficiency has to be precise and diagnostic criteria has to meet health insurance criteria.

Some vascular surgeons prefer selecting patients only with active working life for endovenous therapy, others disagree with this opinion. I think, this controversy will go on.

Although authors from all over the world suggest endovenous ablation for the treatment of superficial truncal venous insufficiency limited health funds should be spent carefully, but on the other hand insured people have the right to get the best available diagnosis and treatment options. To avoid misuse of endovenous treatment appropriate criteria of public health service have to be met. Criteria of Turkish public health service cover patients from C2 to C6. But these conditions should not be abused. It should be noted that the saphenous vein is a graft for more serious conditions, therefore it should be preserved for probable bypass operations if possible. On the other hand, public health service has always the authority to restrict medical procedures, even if necessary.

To achieve highest quality intensive hand-on duplex and endovenous courses have to be performed more often. Cooperation of radiologists and vascular surgeons have to be optimised. Patient have to be informed about right diagnosis and different treatment options. And perhaps, vascular surgery should be separated from cardiovascular surgery to get special training on vascular conditions only.

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Conflicts of Interest

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