

2. High ligation and stripping of the incompetent greater saphenous vein, high ligation, and stripping of the lesser saphenous vein, and SEPS were performed in most patients. This cohort represents a mixed material including elimination of reflux in the greater and lesser saphenous veins and interruption of the calf perforators. It is a scientific misinterpretation to describe the obtained results as a consequence of the subfascial endoscopic perforator ligation only. Unfortunately, many other authors make the same mistake.
3. The authors have classified the VRTs as “uninterpretable,” if the calf could not empty below the baseline at the end of each tiptoe maneuver. In reality, such findings represent a severe venous disturbance. When the results given in Table I are evaluated from this point of view, then postoperatively six patients showed an amelioration, 11 patients a deterioration, and 13 patients remained unchanged when compared with the preoperative values. Therefore, a conclusion can be drawn that this treatment deteriorated the venous hemodynamics in 36% of cases, and an amelioration was achieved in only 20% of cases. This is certainly no positive result. The authors conclude, on the contrary, that the clinical results are satisfactory and that the plethysmography is a poor test for the assessment of reflux.
4. In the discussion from the auditorium, an important question was discussed, namely, whether the SEPS procedure is reimbursed and is billed as a perforator ligation. The most important question, however, was not asked: namely, whether the incompetent calf-perforating veins really play a role in the pathogenesis of the chronic venous insufficiency. The answer is NO! It is a proved fact (a) that the insufficient calf-perforating veins are not the cause of the chronic venous insufficiency,¹ (b) that the selective ligation of them does not improve the venous hemodynamics,²⁻⁴ and (c) that the selective elimination of the saphenous reflux in patients with primary varicose veins and insufficient calf perforators repairs the venous disturbance and restores normal hemodynamic conditions in spite of the persistence of insufficient calf perforators.¹ In my paper published in 1996 I showed that in most patients with primary varicose veins and chronic venous insufficiency, the preoperative plethysmographic parameters (refill time t-90 and t-50 as well as refill volume, obtained with strain gauge plethysmography) were equal to zero (ie, severe venous disturbance, but according to the criterion of Illig and co “uninterpretable”). After selective elimination of the saphenous reflux (high ligation, no stripping, no ligation of the perforating veins), the parameters in nearly all patients returned to normal val-

ues. This is the proof that saphenous reflux and not insufficient calf perforators are responsible for the venous disturbance in primary varicose veins.

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Reply

Dr Recek's letter addresses two general issues: methodology of testing and underlying philosophy of pathogenesis and treatment.

We believe that the presence or absence of reflux can be reproducibly documented with the patient in 10 degrees of Trendelenburg. We are, however, in agreement that the upright position is the most physiologically sound, especially for the quantification of reflux (valve closure time). The “severe venous disturbance” he describes is, we believe, an artifact of a poor test and not indicative of any “real” hemodynamic change.

Dr Recek does not believe that the perforating veins play a role in the pathogenesis of chronic venous disease. We obviously disagree, and recognize that persuasive evidence can be cited on both sides of the argument. Whether or not ablation of incompetent perforators offers benefit over superficial ablation alone (or, indeed, nonoperative care) will only be answered by well-organized prospective randomized trials.

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