

Litigation Claims in Vascular Surgery in the United Kingdom's NHS
Markides G.A., Subar D., Al-Khaffaf H. *Eur J Vasc Endovasc Surg* 2008; 36:452-7.

Objectives: To establish the incidence, costs and causes of medical negligence claims in relation to vascular surgery in the UK's NHS.

Methods: All claims related to vascular surgery reported to the NHS Litigation Authority from April 1995 to April 2007 were included in the study. Data was subsequently reviewed, coded and analysed.

Results: 395 claims were identified (mean: 49/year over last 5 years) of which 303 had been settled. Damage compensation was given in 160 cases, with overall litigation costs of approximately 17 million pounds (£21 million). The main complaint reasons in successful claims were intra-operative problems (50%), failure/delay of treatment (14%) and failure/delay of diagnosis (11%). Varicose vein (VV) surgery was involved in 48% of successful claims, with intra-operative nerve and vessel damage being the major causes. Peripheral vascular disease (PVD) and abdominal aortic aneurysm (AAA) disease were the next two types of disease/procedures involved in successful claims with 21% and 6% respectively.

Conclusions: The number of claims related to vascular surgery has remained stable over the past 5 years. Improved consenting and higher surgical skill levels especially in relation to VV surgery and increased diagnostic vigilance in PVD, AAA disease and infections are potential areas for future improvement.

The Role of Superficial Venous Surgery in the Management of Venous Ulcers: A Systematic Review

Howard D.P.J., Howard A., Kothari A., Wales L., Guest M., Davies A.H. *Eur J Vasc Endovasc Surg* 2008;36:458-65.

Background: The complicated natural history of venous ulcers requires the continued development and improvement of treatments to ensure the most effective management. Compression therapy or surgical correction of superficial venous incompetence (SVI) are currently the main methods employed for the treatment for venous ulceration (VU). This review compares and summarises the healing and recurrence rates for each treatment modality used over the last thirty years.

Methods: Sixty-one articles investigating compression and superficial venous surgical treatments were obtained from a systematic search of electronic databases (Medline, Embase, The Cochrane Library, and Google Scholar) and then an expanded reference list review. Patient demographics, CEAP classification, patterns of venous insufficiency, type of intervention, length of follow up, healing and recurrence rates for venous ulceration was assessed. Inadequate data in seven reports led to their exclusion. Recent randomised controlled trials (RCTs) specifically comparing superficial surgery to compression therapy were reviewed and data from non-randomised and/or 'small' clinical studies prior to 2000 underwent summation analysis.

Results: Five RCTs since 2000 demonstrate a similar healing rate of VU with surgery and conservative compression treatments, but a reduction

in ulcer recurrence rate with surgery. The effect of deep venous incompetence (DVI) on the ulcer healing is unclear, but sub-group analysis of long-term data from the ESCHAR trial suggests that although surgery results in a less impressive reduction in ulcer recurrence in patients with DVI, these patients appear to still benefit from surgery due to the haemodynamic and clinical benefits that result. The RCTs also highlight that a significant proportion of VU patients are unsuitable for surgical treatment.

Summation of data from earlier studies (before 2000), included twenty-one studies employing conservative compression alone resulted in an overall healing rate of 65% (range 34-95%) and ulcer recurrence of 33% (range 0-100%). In thirty-one studies investigating superficial venous surgery, the overall rate of ulcer healing was 81% (range 40-100%) with a post-operative recurrence rate of 15% (range 0-55%). The duration of follow up care in the surgical studies was approximately twice as long as in the conservative studies, which would lend to more reliable recurrence data.

Conclusions: Evidence from the current literature, would suggest that superficial venous surgery is associated with similar rates of ulcer healing to compression alone, but with less recurrence. The effects of post-operative compression and DVI on the efficacy of surgery are still unclear.

Randomised Trial of Flush Saphenofemoral Ligation for Primary Great Saphenous Vein Varicose Veins

Winterborn R.J., Foy C., Heather B.P., Earnshaw J.J. *Eur J Vasc Endovasc Surg* 2008;36:477-84.

Objectives: The aim of this study was to assess different techniques of saphenofemoral ligation in the treatment of primary varicose veins.

Methods: One hundred and eighty-two patients (210 legs) with primary saphenofemoral junction incompetence were randomised to standard saphenofemoral ligation (transfixion with an absorbable suture) (SSL) or flush saphenofemoral ligation (oversewing with 4/0 polypropylene) (FSL). All legs underwent additional great saphenous vein stripping and multiple phlebectomies. Patients underwent assessment preoperatively, and at 6 weeks, 1 year and 2 years postoperatively with clinical examination, duplex imaging and completion of the Aberdeen Varicose Vein Symptom Severity Score (AVVSSS).

Results: A total of 148 patients (172 legs) attended follow-up at 2 years postoperatively. Recurrent varicose veins were visible in 30 legs (33 per cent) in the SSL group and 26 legs (32 per cent) in the FSL group ($P = 0.90$). Neovascularisation was present in 20 groins (22 per cent) in the SSL group and 15 groins (19 per cent) in the FSL group ($P = 0.57$). Nine cases of neovascularisation in the SSL group and five in the FSL group directly resulted in clinical recurrence ($P = 0.37$).

Conclusions: Flush ligation of the saphenofemoral junction confers no advantage over standard ligation with respect to clinical recurrence and neovascularisation.

Registration number: ISRCTN20235689 (<http://www.controlled-trials.com>).