

# Morrison Vein Institute

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## **Myth: Wait until after your last pregnancy before correcting those veins....**

This may have been good **advice when stripping was the only definitive treatment**. Stripping is traumatic to tissue and disrupts connecting veins, leaving them to cause problems in the future. Stripping is associated with a significant inflammatory response resulting in neo-vascularization (New veins that the patient doesn't understand) and angiogenesis, the result of which is recurrent varicose veins. Stripping is also painful post-op and makes one's return to busy lives and duties difficult. Stripping also invariably leaves scars.

Now the **definitive treatment for varicose veins is Endovenous Radiofrequency Ablation (VNUS Closure) or Endovenous Laser Ablation of the refluxing Great Saphenous Vein and ultrasound guided injections of all refluxing perforators and tributaries**. With these minimally invasive procedures, the GSV is sealed with heat, becomes sclerotic and is subsequently reabsorbed. Usually, in a year, the GSV is absent by ultrasound. Venous flow is routed appropriately into the competent deep system reducing venous pressure in the leg. Ablation & Ultrasound guided injections are not traumatic to tissue, there is no significant neo-vascularization or angiogenesis, and thus the treated veins do not recur. Any discomfort post op is effectively treated with Tylenol or Ibuprofen. There is no downtime and the patient may return to work and family duties the same or following day. In some patients we also do ambulatory phlebectomy by which the bulging varicosities are removed through 1-2mm incisions, leaving minimal scarring.

For your patient with venous disease or troublesome veins, her **next pregnancy does not have to include the leg aching, fatigue, swelling and the pelvic or perineal pain** that is sometimes associated with pregnancy. Also your patient will not continue to damage her superficial venous system which pregnancy, in susceptible patients, always engenders. That damage may be related to the great increase in circulating blood volume during pregnancy or to the pressure of a large gravid uterus on lower extremity venous return. But the real culprit is thought to be Progesterone. There are progesterone receptors in the vein walls and they serve to dilate those walls. With progesterone levels increasing over the course of a pregnancy to almost double by delivery, venous valvular competence is overwhelmed. Often valves never return to full function. The deep venous system is well supported by muscle and therefore not as susceptible to the impact of progesterone.

**We would like to help your newly pregnant patients** who have venous insufficiency by measuring them for **graduated compression support hose** and advising them on methods to minimize the effect of the pregnancy on their veins. Elevation whenever sitting, walking at least 30 min. every day, and dorsiflexion exercises when unable to elevate legs are valuable in both normalizing venous pressure and increasing patient comfort. We would like to see your patient postpartum for vein treatment as soon as you feel that progesterone levels have normalized. We also can help with diagnosing and treating abnormal vaginal veins and pelvic veins. Please let us support your efforts in providing optimal women's health care.

Note: We are not contracted with insurance companies but Venous Insufficiency is not a cosmetic problem.

We are skilled at helping your patient recover her very appropriate, out of network medical benefits.

**MVI has three front office dedicated to scheduling and reimbursement.** We have been dedicated to comprehensive vein care for 10 years. Please review our video podcasts on current therapies on our website: [www.morrisonvein.com](http://www.morrisonvein.com) or email us at: [info@morrisonvein.com](mailto:info@morrisonvein.com) with any questions. Please feel free to contact us or give this site and email to your patients. Kathy Melfy RN, BSN