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RESEARCH ARTICLE

VARICOSE VEINS AN UNCOMMON PRESENTATION.

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Abstract

Variation in superficial venous system anatomy is well known, but varicose vein in that is less commonly reported. Our patient had Posterior Accessory Saphenous Vein varicosity with complete aplasia of Great Saphenous Vein, We have done Radiofrequency ablation of the posterior accessory Saphenous vein which is not reported in literature so far.

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Introduction:-

Superficial venous system of lower limb has variable anatomy, Great Saphenous Vein may be duplicated in leg and thigh or there may be segmental hypoplasia. Complete aplasia of Great Saphenous Vein is very rare. In our case the Great Saphenous Vein was absent for whole length on one limb and segmentally in other limb. Superficial venous drainage of limb was through an alternate course and there was varicosity in those veins. This is a very rare presentation and rarely reported in literature.

Case summary:-

43 years old female, with no other comorbid diseases had dilated tortuous veins in both lower limbs for the past 20 years, and it was asymptomatic initially but for the past 2 years the right side became symptomatic. She had dull aching pain on prolonged standing. There was no history of Deep Vein Thrombosis or lower limb trauma or surgery (except Lap. Cholecystectomy 7 yrs ago). She is married, having two children and no other family member affected with similar illness.

On examination patient had varicose veins on both lower limbs. On right side, varicosities were present on the posterolateral aspect of leg and posteromedial aspect of thigh.

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There was no hyperpigmentation/edema or ulcer on ankle, and there was no thrill or bruit over the dilated vein

Doppler examination:-

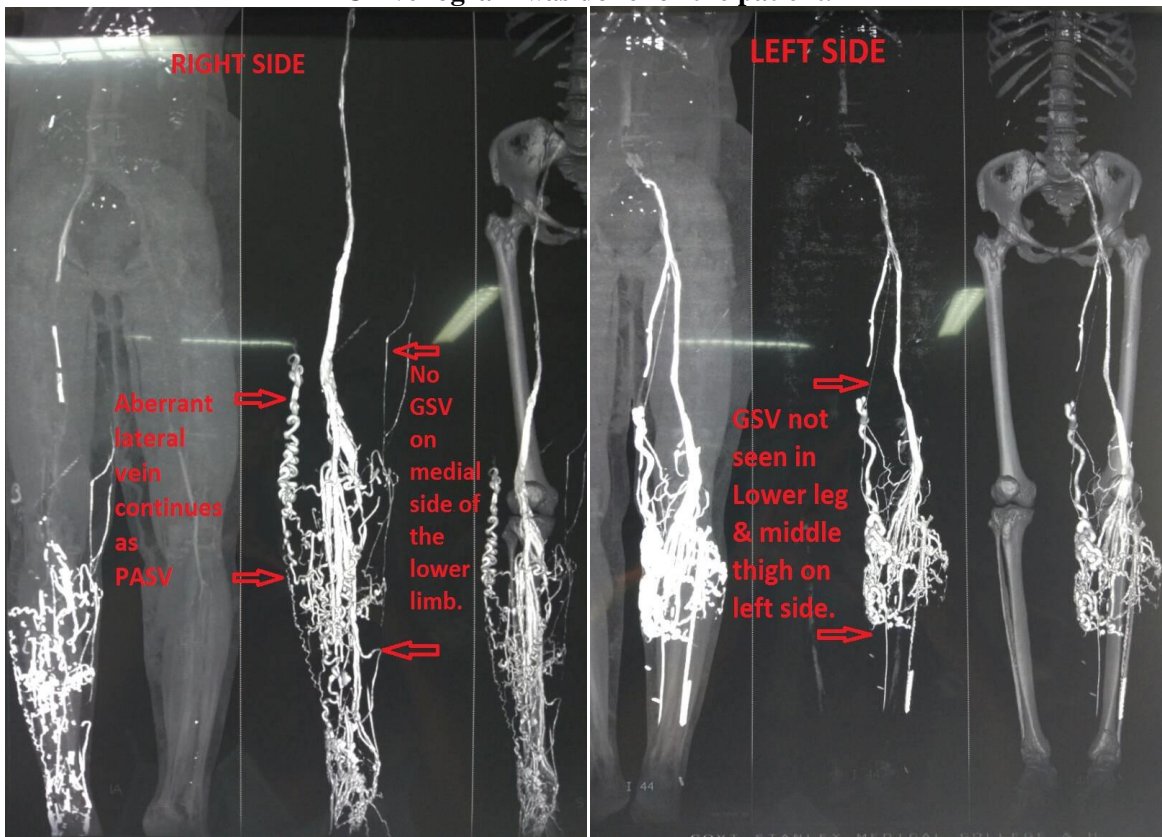
On the Right side- Sapheno Femoral Junction was incompetent with reflux of 1750 milliseconds, Sapheno Popliteal junction, was high ending. Great Saphenous Vein at leg & lower thigh was not visualised on right side. (Complete aplasia)

On the left side Sapheno Femoral Junction was incompetent with reflux of 1800 milliseconds. Sapheno Popliteal junction was normal. On left side Great Saphenous Vein was not visualised in lower leg, visualised in upper leg knee and lower thigh, again not visualized in middle thigh and seen in upper thigh. (Segmental hypoplasia).

On the right side dilated veins were present in the posterolateral aspect of leg which passes lateral to medial behind the knee and continues as Posterior Accessory vein in mid thigh which then forms confluence with Anterior Accessory Saphenous Vein and joins Superficial femoral vein to form Common Femoral Vein.

Deep veins well developed with no obstructive or reflux signs. Gonadal and Pelvic veins were normal.

CT venogram was done for the patient.



Doppler findings were confirmed and IVC was found to be normal.

There was no evidence of any micro arteriovenous communications.

Patient was symptomatic on right side and was advised class II compression stockings initially. Since symptoms were not resolved, Radio Frequency Ablation of Posterior Accessory Saphenous Vein (thigh segment) with Multiple Stab Avulsion of below knee segment veins was done. Compression dressing applied Post Operative period was uneventful and patient was discharged on 2nd post operative day.

Discussion:-

Alternative superficial-to-deep drainage systems exist and are occasionally important in the pathophysiology of chronic venous disease. Lateral superficial veins are remnants of the embryonic vena marginalis lateralis. Other pathways include the sciatic drainage system from the posterior thigh to the internal iliac system, the lateral subdermic system draining toward the deep femoral and inferior gluteal veins, drainage through the obturator veins, and alternative venous pathways along the round ligament.

In this case, popliteal, and femoral veins were well developed, so the possibility of Klippel-Trenaunay syndrome or persistent sciatic vein was excluded.

Aplasia is defined as a complete absence of a vein from its normal anatomic location. The most likely cause of aplasia is the result of segmental failure of a critical anastomosis¹. Hypoplasia and aplasia represent a significant risk factor for the development of reflux and varicosities

The incidence of aplasia of Great Saphenous Vein and Sapheno Femoral Junction 0.3%².

In literature there is only one report of aplasia of GSV and Anterior Accessory Saphenous vein varicosity and laser ablation of that AASV by N.Labropoulos³.

Clinical relevants	N.Labropoulos-case	Our case
Age	60 yrs/female	43 yrs/female
Side	Left	Right
Pathology	AASV/Complete aplasia of GSV/Hypoplasia of GSV on other side	PASV/Complete aplasia of GSV/Hypoplasia of GSV on other side
Family history	Positive	Negative
Perforators	Competent	Competent
Intervention	EVLA/MSA	RFA/MSA

In this case it was a Posterior Accessory Saphenous Vein , with entire GeratSaphenous Vein Aplasia and we have done RadioFrequencyAblation with Multiple Stab Avulsion.

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