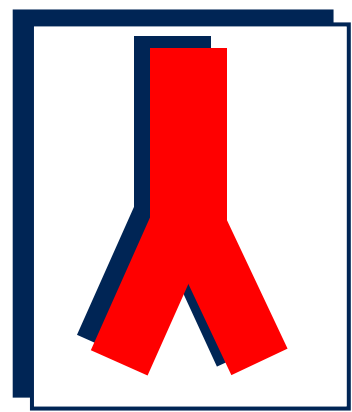


Will Butcher – Vascular Surgery

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General Practitioner Information:

SUPERFICIAL THROMBOPHLEBITIS

This is a relatively common complication of varicose veins. Typically, a patient with a history of varicose veins complains that the veins or some of the veins have become tender and hard. At times the pain is quite severe and can be quite disconcerting. This is especially true if it occurs during pregnancy. Mostly, however, with time the patient will recover completely. There are several things that can be done to help.

Stockings: good quality compression stocking will help to prevent extension of the thrombus and also provide a significant analgesic function. If the Thrombophlebitis is in the thigh, thigh length stockings will be needed, but if localised to the calf knee high is all that is required.

Anti-coagulants: Anticoagulation for a brief period (6 weeks) has been shown to be beneficial, and in this day and age where oral agents are easily available this seems reasonable. I tend not to provide anticoagulants for mild attacks but certainly an attack that extends to the sapheno-femoral junction should be considered for anticoagulation.

Anti-inflammatories: These are the mainstay of analgesia for this condition and may be very helpful. Local anti-inflammatory gel application is also helpful although possibly the massage is as important as the medication.

Antibiotics: This is a common thing, many patients with thrombophlebitis have a very red patch and the possibility of infection is difficult to rule out. In truth it is not an infective condition and antibiotics are not usually part of the treatment.

Rest and elevation: Elevation while resting is probably helpful to reduce the pain, however, ambulation is likely to help prevent extension of the attack so encourage walking rather than resting up too much.

Stronger pain killers: Some patients struggle to sleep at first and may need something tougher at first. I am usually quite reluctant, but concede that where the pain is in the inner thigh in a habitual side sleeper this may be tricky. A soft pillow wedges between their knees may help with this. The stocking (even in bed at night) will also help with this.

Ultrasound:

A duplex ultrasound will be diagnostic and is probably important to exclude extension to the Sapheno femoral junction or beyond. It is also important to be sure that there is no DVT. If the SFJ is involved or there is a tongue of thrombus in the Common femoral vein the patient should be anticoagulated. The practice of ligating the SFJ in these cases is out of date given the easy availability of anticoagulation. Follow up Ultrasound to “see how it is going” is not required. For the most part symptomatic resolution is all we are looking for to ensure recovery.

Surgery:

As indicated above the practice of ligating the SFJ to prevent extension is probably out of date. Surgery to the varicose veins during an attack is also a bad idea, although it will to some extent short circuit the attack, the surgery is usually so much trickier and much less likely to be complete that I tend to wait until the attack has completely

Appointments:

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This practice prefers to receive referrals through Medical Objects (4187883F: John Flynn and 4187888K for Gold Coast Private hospital)

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settled down (6 months). In a significant number of cases after a good quality attack of superficial thrombophlebitis the varicose veins are a lot better and some patients may choose to wait for intervention. This is reasonable, however, nearly all patients will suffer repeat episodes in time.

What to expect:

In general, this is a self-limiting condition. Most patients will begin to feel that things are improving within a week or so. The leg may remain lumpy and tender for up to 10 weeks though, the lumpiness may take even longer to go if the veins were large. Wearing a stocking is by a long way the most effective analgesic. Because the body is designed to remove clots from vessels the vein will almost always recanalize over time. For the most part the veins will come to look just as bad as they did previously. My feeling is that once you have had one attack you have marked yourself as someone who will have further attacks.

Flying:

Although there is no specific guidance, I feel flying is probably safe, the patients should be taking an anticoagulant (Aspirin is NOT sufficient). I tend to feel a DOAC or Clexane are best, Warfarin is a bit heavy handed unless the patient has an allergy to heparins. They should also definitely wear a stocking.