The Australasian College of Phlebology

13th Annual Scientific Meeting & Workshops

THE AUSTRALASIAN COLLEGE OF PHLEBOLOGY

06-11 February 2010 | The Langham Auckland | New Zealand | www.phlebology.com.au

Conference Proceedings





06-11 February 2010 | The Langham Auckland | New Zealand | www.phlebology.com.au

VENUE AND CONTACTS

Venue
The Langham Auckland
83 Symonds Street, Auckland 1140
New Zealand
Tel: (64)(9)379 5132
Fax: (64)(9)377 9367
www.langhamhotels.co.nz

The Langham Auckland is a 30 minute drive from Auckland International Airport. The average taxi fare from airport to hotel is NZ$75.00 depending on traffic. For those wishing to travel in style one of The Langham's limousines can be booked to meet you at the airport.

Contacts
General College Information

Requests for information about the ACP and its mission may be directed to:
Zivka Curkoski
College Administrator
Australasian College of Phlebology Inc.
P.O. Box 549
Bondi Junction NSW 1355 Australia
Suite 1602, 520 Oxford St
Bondi Junction NSW 2022
Phone: +61 2 9386 1811
Fax: +61 2 9386 1822
Email: info@phlebology.com.au
Web: www.phlebology.com.au

ACP 2010 Conference Organisers
Conference Matters, the official 2010 Meeting Organiser, will process registrations and abstracts. Information about the commercial exhibition as well as the organization and sponsorship of special events may also be obtained from the Organizing Secretariat.

For further information contact:
ACP 2010 Meeting Organiser
Conference Matters
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Whangarei 0140
New Zealand
Phone: +64 21 164 3815
Fax: +64 9 437 4089
Email: info@conferencematters.co.nz
Website: www.conferencematters.co.nz/index_acp.php

Registration and Hotel Accommodation
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Exhibition and Sponsorship
Requests about sales opportunities or questions by industry partners should be directed to:

Leon Olsen
Conference Matters
Phone: +64 21 164 3815
Fax: +64 9 437 4089
Email: leon@conferencematters.co.nz

TABLE OF CONTENTS

WELCOME FROM THE COLLEGE PRESIDENT

Kia ora Dear Colleagues and Friends,

On behalf of the Organising Committee, it is my great privilege and pleasure to welcome you to the 'City of Sails' (Auckland, New Zealand), hosting the 13th Annual Scientific Meeting (ASM) and Workshops of the Australasian College of Phlebology. This conference celebrates the 10th anniversary of the formation of the Australasian College of Phlebology.

We have put together a stimulating scientific program that will highlight the latest scientific advances in our field along with high quality keynote and symposium lectures. The invited international keynote speakers include

- Prof. Imre Bihari, Phlebologist, Vascular Surgeon, Hungary
- Dr Attilio Cavezzi, Phlebologist, Vascular Surgeon, Italy
- Prof. Philip Coleridge-Smith, Phlebologist, Vascular Surgeon,UK
- Prof. JJ Guex, UIP Treasurer, Phlebologist, Vascular Physician, France
- Dr Ted King, Phlebologist, USA
- Dr Nick Morrison, President American College of Phlebology, Vascular Surgeon, USA
- Assoc. Prof. Toshio Nakayama Prof of Biomedical Engineering and Fluid Mechanics, Japan
- Assoc. Prof. Makoto Ohta, Prof of Biomedical Engineering and Fluid Mechanics, Japan
- Dr Michel Schadeck, Phlebologist, Vascular Physician, France
- Dr Marc Vuylsteke, Vascular Surgeon, Belgium

The 3 day ASM includes keynote lectures, original papers, panel discussions, and the popular 'Controversies in Phlebology' key-pad interactive debates. As usual, the Program's emphasis is on good science and evidence based medicine.

Pre-conference courses include a 2-day Basic Phlebology Course covering all aspects of sclerotherapy, and a concurrent 2-day Advanced Phlebology Course covering interventional techniques, coagulation, dermatology and rheology workshops. The format of these courses emphasise a tutorial type sessions providing interaction with the participants.

The popular one-day Diagnostic Imaging Ultrasound Workshop will run on the last day of the meeting for ultrasound enthusiasts.

The Scanmedics Conference Welcome Party, The 'Last Drink', on Waiheke Island will be unforgettable…ensure you have your tickets!

The Conferring Ceremony and the Conference Dinner will be again a highlight of this year's meeting. The gothic Auckland Town Hall will host our Conferring Ceremony promising entertainment and glamour enjoyed by the delegates in our previous events.

I look forward to seeing you during the meeting!

Ka kite ano,

Kurosh Parsi

Kurosh Parsi
President, Australasian College of Phlebology

KEYNOTE & INVITED INTERNATIONAL SPEAKERS

2010 KEN MYERS ORATOR

Professor Earl Owen

Professor Earl Owen, known as the Father of Microsurgery designed micro instruments, microscopes and new operations to save congenitally abnormal babies from dying at birth in the 1960s. He was the co-leader of that team and the same group that also performed the world's first double hand transplantation.

Professor Masud Behnia

Masud Behnia has worked in experimental and numerical fluid mechanics and heat transfer for over 25 years. He has, in particular, extensively studied two-phase flow systems using experiments and CFD simulations. He has substantial experience in validating numerical results by comparison with experimental data. Results of his research have been widely published in journals and conferences and his career total publications include more than 350 refereed papers.

Professor Imre Bihari

Imre Bihari studied at the Medical Faculty of Semmelweis University in Budapest. He spent 29 years working for the National Medical Center, Medical University, and became University Associate Professor, Department of Cardiac and Vascular Surgery.

Supported by:

Dr Atillio Cavezzi

Dr Atillio Cavezzi is a vascular surgeon from S. Benedetto del Tronto, Italy. Atillio has undoubtebly been instrumental in promotion of foam, ultrasound guided sclerotherapy as a legitimate alteranative to surgery in many countries and in particular in Australia and New Zealand. Atillio is an international teacher of phlebology and lymphology, has hundreds of publications and is the author or co-author of a number of books in Phlebology and lymphology.

Supported by: *Wagner Medical*

Professor Philip Coleridge Smith

Professor Coleridge Smith is a Reader in Surgery at UCL Medical School, London UK. He pioneered the introduction of duplex ultrasonography in the clinical investigation of venous disease in the UK. Professor Coleridge Smith has pioneered the introduction of ultrasound guided foam sclerotherapy for the treatment of varicose veins into the UK and keeps series of over one thousand patients under review.

Supported by:

Dr Jean Jerome Guex

Jean Jerome Guex, MD, FACPh is coauthor of the definitive book on sclerotherapy, Treatment of Varicose and Telangiectatic Leg Veins, 4th Edition. He is Past President of la Societe Francaise de Phlebologie and Treasurer of the Union Internationale de Phlebologie. He is a Member of the American Venous Forum and is a Fellow and Honorary Member of the American College of Phlebology. Emeritus Fellow of the Australasian College of Phlebology and Member of the Board of Directors of the American College of Phlebology.

Supported by:

Dr Ted King

Dr. King is a clinical assistant professor at the Medical School of the University of Illinois in Chicago. Dr. King has expertise in ultrasound venous mapping, endovenous thermal and chemical ablation, ultrasound-guided foam sclerotherapy, and visually guided liquid and foam sclerotherapy. His research interests include all endovenous treatment modalities. Clinically, Dr. King's clinical interests include the non-surgical treatment of symptomatic vulvar and labial varices, Klippel-Trenaunay Syndrome, Restless Legs Syndrome secondary to varicose vein disease, recurrent varicose veins after previous treatment, venous stasis ulcers, and the cosmetic treatment of hand and facial veins.

Dr Nick Morrison

Nick Morrison, MD, FACS, FACPh is a world-renowned leader in the field of phlebology who has dedicated his medical practice to veins. He is a fellow with the American College of Surgeons and American College of Phlebology and President-elect of the American College of Phlebology. He established the Morrison Vein Institute in Scottsdale, AZ and is a partner in the Morrison Training Institute for physicians, nurses, and ultrasound technologists.

Professor Ken Myers

Prof Ken Myers has had a major interest in venous disease for more than 25 years. Professor Myers is the Chancellor of the Australasian College of Phlebology and has participated in or organised many international phlebology meetings. He has been at the forefront of developing new techniques such as echosclerotherapy and endovenous laser therapy.

Associate Professor Makoto Ohta

Makoto Ohta is Associate Professor, Institute of Fluid Science, Tohoku University, Sendai, Japan. Assoc. Prof Ohta's has a particular interest in fluid mechanics, blood flow, biomaterials and the role of engineering in the medical field. He holds an heuristic perspective on health treatment, with a belief that not only doctors and pharmacologists hold the key for future treatments, but that engineers will also help to create new procedures.

Professor Neil Piller

Professor Neil Piller is the Director of the Lymphoedema Assessment Clinic, Department of Centre. He is Australasian Editor of Lymphatic Research and Biology and on the Editorial Board of US and Chinese Journals of Lymphology. Neil has released a DVD on "The Vital Essence - Understanding the lymphatic system in Health and Disease" and is the main Author of "The Lymphoedema Handbook" published in 2006. He was the Chair of the 2009 International Society of Lymphology meeting in Australia.

Dr Michel Schadeck

Dr Michel Schadeck is a phlebologist and angiologist and a Past President of French Society of Phlebology practicing in Paris. He has been credited with the development of ultrasound guided sclerotherapy in 1985 and has been instrumental in the globalisation of this treatment modality. Dr Shadeck was the co-founder of the European School of Phlebology (1989) and a founding member of the European Venous Forum (1999). He has published two books and more than 45 scientific papers in the fields of sclerotherapy, ultrasound guided sclerotherapy, superficial venous investigations, varicose disease and treatment in childhood, mercury bath-pressotherapy, lymphology and epidemiology.

Supported by: kreussler smith&nephew

Professor André van Rij

André M van Rij is Professor of Surgery at the Dunedin School of Medicine University of Otago where he directs the Vascular Research Unit. His research has focused on venous disease and the biology of varicose vein recurrence and venous thrombosis. His translational research bridges new basic research into the venous clinic. Professor van Rij is a vascular surgeon and President of the NZ Association of General Surgeons. Professor van Rij is the Deputy Chancellor of the Australasian College of Phlebology.

Dr Marc Vuylsteke

Dr Marc Vuylsteke is a vascular surgeon at St-Andries Hospital, Tielt, Belgium. Marc has published many articles on endovenous laser treatment. He is a member of the Benelux Society of Phlebology and is on the organising committee for the 11th meeting of the European Venous Forum in Antwerp, June 2010.

Supported by: DEVICE CONSULTING

ABOUT THE ACP

The Australasian College of Phlebology (ACP) is a multi-specialty organization dedicated to promotion of phlebology research, teaching and training in Australasia.

Our membership includes medical practitioners and other health professionals such as scientists and sonographers dedicated to education and research in the field of phlebology. Our members have a shared interest in phlebology, but represent a variety of medical specialties, including vascular surgery and medicine, dermatology, haematology, interventional radiology, general surgery, and family medicine.

Since its inception in 1993, the ACP has been active in promoting education and research in phlebology and serves the general public as a resource regarding vein disorders. Public educational initiatives such as patient education seminars, GP education workshops and media interviews are undertaken by College Fellows on a regular basis. Our mission is to improve the standards of practice and patient care as it relates to venous disorders.

The ACP is a member of the Union International Phlebologie (UIP), a multi-national organization that has member phlebology organizations from 35 countries from Europe, North America, Latin America, and Asia.

Annual Scientific Meetings and Workshops of ACP were initiated in 1994. These meetings have been instrumental in disseminating knowledge and experience among specialists from many medical disciplines

City view | Mt Eden | Auckland

THE AUSTRALASIAN
COLLEGE OF
PHLEBOLOGY

Academic Board

Chancellor	Prof. Kenneth A. Myers
Dep. Chancellor	Prof. Andre van Rij

Executive Board

President	Dr Kurosh Parsi
Vice President	Dr David Jenkins
Honorary Secretary	Dr Louis Loizou
Honorary Treasurer	Dr Paul Thibault
Committee Members	Dr Ivor Berman
	Prof Lourens Bester
	Dr Jacqui Chirgwin
	Dr Paul Dinnen
	Dr Gabrielle McMullin

Regional Faculties

State	Chairman
NSW	Dr David Jenkins
QLD	Dr Paul Dinnen
VIC	Dr Stefania Roberts

Committees & Divisions

Committee	Chairman
AMC Accreditation Taskforce	Dr Kurosh Parsi
Board of Censors	Dr Kurosh Parsi
Conferring Ceremony	Dr Louis Loizou
Continuing Professional Development	Dr Mark Elvy
Finance and Fundraising	Dr Louis Loizou
Information Technology	Dr Kurosh Parsi
Diagnostic Imaging Taskforce	Dr Gary Frydman
Ethics and Professional Standards	Dr Louis Loizou
Research and Scientific Committee	Prof Ken Myers
Scientific Meetings	Dr Kurosh Parsi
Standards Committee	Dr John Barrett
Training	Dr David Jenkins
Newsletter Editor	Dr Jacqui Chirgwin
Preceptorships	Dr Louis Loizou
Public Education	Dr Gabrielle McMullin
Workshops	Dr Louis Loizou

Interest Groups

Interest Group	Chairman
Ambulatory Phlebectomy	Dr Mark Elvy
Interventional Phlebology	Prof Lourens Bester
Lymphology	Prof. Neil Piller
Thrombosis and Haemostasis	Dr Kurosh Parsi
Ulcer Management	Dr Mark Elvy
Ultrasound in Phlebology	Ms. Darryl Queenin
Vascular Malformations	Dr Kurosh Parsi

Administration

College Administrator	Zivka Curkoski
Education Officer	Shoshana Dannon
Accounts	Match Wu

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ORGANISING COMMITTEE

THE AUSTRALASIAN
COLLEGE OF
PHLEBOLOGY

Program Chair:
Dr Kurosh Parsi

Basic Phlebology Course Coordinator:
Dr Louis Loizou

Advanced Phlebology Course Coordinator:
Dr Kurosh Parsi

Conference Organising Committee:
Dr Kurosh Parsi, Dr David Jenkins, Dr Louis Loizou, Dr Paul Thibault

Conferring Ceremony Organising Committee:
Dr Louis Loizou, Dr Kurosh Parsi, Ms. Annie Silkman

Conference Welcome Party Oraganising Committee:
Dr Louis Loizou, Dr Paul Dinnen, Dr Stefania Roberts, Ms. Annie Silkman, Ms Yana Parsi

Diagnostic Imaging Workshops Coordinator:
Ms Annie Morgan

Diagnostic Imaging Workshops Organising Committee:
Ms. Bronwen Allen, Dr Oswaldo Cooley Andrade, Ms Yana Parsi, Ms. Daryl Queenin

Auckland Local Support Committee:
Dr John Barrett, Ms. Bronwen Allen, Ms. Darryl Queenin

ACP 2010 Speakers

KEN MYERS ORATION

Prof. Earl Owen, Pioneer of Microsurgery, University of Sydney

INVITED INTERNATIONAL SPEAKERS

1. Dr Attilio Cavezzi, Phlebologist, Vascular Surgeon, Italy
2. Prof. Philip Coleridge Smith, Phlebologist, Vascular Surgeon, UK
3. Prof. Jean Jerome Guex, Phlebologist, Vascular Physician, France
4. Dr Ted King, Phlebologist, USA
5. Dr Michel Schadeck, Phlebologist, Vascular Physician, France
6. Dr Nick Morrison, Phlebologist, Vascular Surgeon, USA
7. Assoc. Prof. Toshio Nakayam, Professor of Biomedical Engineering and Fluid Mechanics, Japan
8. Assoc. Prof. Makoto Ohta, Professor of Biomedical Engineering and Fluid Mechanics, Japan
9. Dr Marc Vuylsteke, Phlebologist, Vascular Surgeon, Belgium

KEYNOTE LECTURES

1. Prof. Imre Bihari, Phlebologist, Vascular Surgeon, Hungary
2. Prof. Philip Coleridge Smith, Phlebologist, Vascular Surgeon, UK
3. Dr Nick Morrison, Phlebologist, Vascular Surgeon, USA
4. Prof. Ken Myers, Phlebologist, Vascular Surgeon, Melbourne
5. Prof. Andre van Rij, Phlebologist, Vascular Surgeon, Dunedin

GUEST LECTURES

1. Prof. Masud Behnia, Mechanical Engineering and Fluid Dynamics, Sydney University
2. Ms Katja Beitat, Healthcare Complaints Commission, NSW
3. Dr Attilio Cavezzi, Phlebologist, Vascular Surgeon, Italy
4. Prof. Philip Coleridge Smith, Phlebologist, Vascular Surgeon, UK
5. Dr. Sanjeev Chunilal, Haematologist, Auckland
6. Prof. Jean Jerome Guex, Phlebologist, Vascular Physician, France
7. Prof. Karkenahalli Srinivas (NSW) School of Aerospace, Mechanical and Mechatronic Engineering, University of Sydney
8. Dr Nick Morrison, Phlebologist, Vascular Surgeon, USA
9. Assoc. Prof. Makoto Ohta, Professor of Biomedical Engineering and Fluid Mechanics, Japan
10. Dr Abdullah Omari, Phlebologist, Vascular Physician, Sydney
11. Prof. Neil Piller, Lymphologist, Adelaide
12. Dr Michel Schadeck, Phlebologist, Vascular Physician, France

LOCAL SCIENTIFIC FACULTY

- Dr John Barrett, Phlebologist, Auckland
- Prof. Masud Behnia, Professor of Mechanical Engineering and Fluid Dynamics, University of Sydney
- Dr Ivor Berman, Phlebologist, Interventional Radiologist, Melbourne
- Prof. Lourens Bester, Vascular Anomalies Specialist, Interventional Radiologist, Sydney
- Dr Peter Chapman-Smith, Phlebologist, Whangarei
- Dr Jacqui Chirgwin, Phlebologist, Newcastle
- Dr Sanjeev Chunilal, Haematologist, Auckland
- Dr Paul Dinnen, Phlebologist, Vascular Surgeon, Gold Coast
- Dr Mark Elvy, Phlebologist, Sydney
- Dr Gary Frydman, Phlebologist, Vascular Surgeon, Melbourne
- Dr David Jenkins, Phlebologist, Sydney
- Dr Chris Lekich, Barrister, Phlebology Registrar, Gold Coast
- Dr Louis Loizou, Phlebologist, Melbourne
- Dr Sanjay Nadkarni, Phlebologist, Interventional Radiologist, Perth
- Prof. Ken Myers, Phlebologist, Vascular Surgeon, Melbourne
- Dr Abdullah Omari, Vascular Physician, Sydney
- Dr Kurosh Parsi, Phlebologist, Dermatologist, Sydney
- Dr John Pereira, Vascular Anomalies Specialist, Interventional Radiologist, Sydney
- Prof. Neil Piller, Lymphologist, Adelaide
- Dr Stefania Roberts, Phlebologist, Melbourne
- Dr George Somjen, Phlebologist, Vascular Surgeon, Melbourne
- Dr Paul Thibault, Phlebologist, Newcastle
- Prof. Andre van Rij, Phlebologist, Vascular Surgeon, Dunedin

DIAGNOSTIC IMAGING WORKSHOPS

Tutors

- Ms. Bronwen Allen, Vascular Sonographer, Auckland
- Dr Oswaldo Cooley Andrade, Vascular Sonographer, Sydney
- Ms Daryl Queenin, Vascular Sonographer, Auckland
- Ms Annie Morgan, Senior Vascular Sonographer, Sydney
- Ms Yana Parsi, Vascular Sonographer, Sydney

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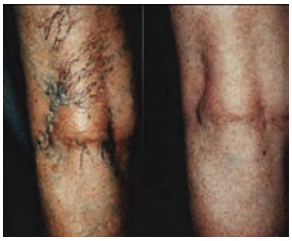

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PROGRAM AT A GLANCE

The academic program will cover many aspects of phlebology. Who should attend: vascular surgeons and physicians, dermatologists, coagulation haematologists, interventional radiologists, sclerotherapists, general practitioners, sonographers, vascular biology and coagulation scientists, residents, fellows in training, medical students, nursing staff.

Program Overview

	Saturday 06 Feb	Sunday 07 Feb	Monday 08 Feb	Tuesday 09 Feb	Wednesday 10 Feb	Thursday 11 Feb
	Registration Desk Open daily from 7:30-5:30pm					
07.00		Combined Session Emergencies in Phlebology - Part 2	Breakfast with the Stars	The Paperless Office Breakfast	Medicolegal Breakfast	
07.30	Combined Session Emergencies in Phlebology - Part 1					
08.00		Basic Phlebology Course / Advanced Phlebology Course				
08.30				Controversies in Phlebology 1	Controversies in Phlebology 2	
09.00			Endovenous Laser Symposium 1			
09.30				Small Vein Symposium	Segmental Incompetence	
10.00						
10.30						
11.00				Basic Science Research / Ultrasound Interest Group	Scientific Methods & Phelebology / Free Papers	
11.30			Sclerotherapy Symposium 1			
12.00		Combined Sessions				
12.30						
13.00	Basic Phlebology Course / Advanced Phlebology Course					Diagnostic Imaging Sonography Workshops
13.30						
14.00						
14.30				Venous Disease Update	Sclerotherapy Symposium 2	
15.00		Afternoon Free	Afternoon Free			
15.30						
16.00						
16.30						
17.00					Endovenous Laser Symposium 2	
17.30			Pre-Ceremony Drinks	Venous Thromboembolism		
18.00		Scanmedics Welcome Cocktail Party	Conferring Ceremony			
18.30						
19.00	Conference Welcome Cocktails	'The Last Drink' Wine Tasting Challenge & Yes Minister				
19.30						
20.00						
20.30		Cable Bay Vineyard, Waiheke Island				
21.00						
21.30			Gala Dinner Auckland Town Hall			
22.00						
22.30						
23.00						

CONFERENCE & EXHIBITION LAYOUT

The Langham Auckland – Plenary Room (Room and Exhibition Area)

Exhibitors: Booth Reference

Booth	Organisation
1	Wagner Medical
3-4	Smith & Nephew
5	The Celon Method - MD Solutions
7	Sydmed
8-9	Total Library Solutions
11	InSight Oceania
12	OBEX
13-14	Covidien
15	Scanmedics
17	SonoSite
19	Medical Specialties Australia
20	NZMS / AMS / Sole Healthcare
21	GE Healthcare
22	Toshiba
23-24	Regional Health
25-18	Device Consulting

Exhibitors Listing

Covidien 13-14
Mr Travis Stephenson

Device Consulting.....18 & 25
Mr Milivoj Boltuzic
Mr Gavin Dimitri
Ms Magalie Terry

GE Healthcare 21
Christine Rieger

InSight Oceania 11
Mr Greg Clark

Medical Specialties Australia . 19
Jacqui Mitchell
Stephanie Sherlock
Paul Turner

NZMS/AMS/Sole Healthcare . 20
Mr Bill Woodward

OBEX 12
Mr Jack Johnston
Mrs Jane Young

Regional Health .....23 & 24
Alisa Gray
Amanda Punch

Scanmedics 16
Mr Shaun Connolly
Mr John Hunter

Smith & Nephew.....3 & 4
Mr David Blair
Ms Ann Gentry

SonoSite 17
Mr Richard Scott

Sydmed 7
Lucy Watson

The Celon Method 5
Mr Damien Rayner

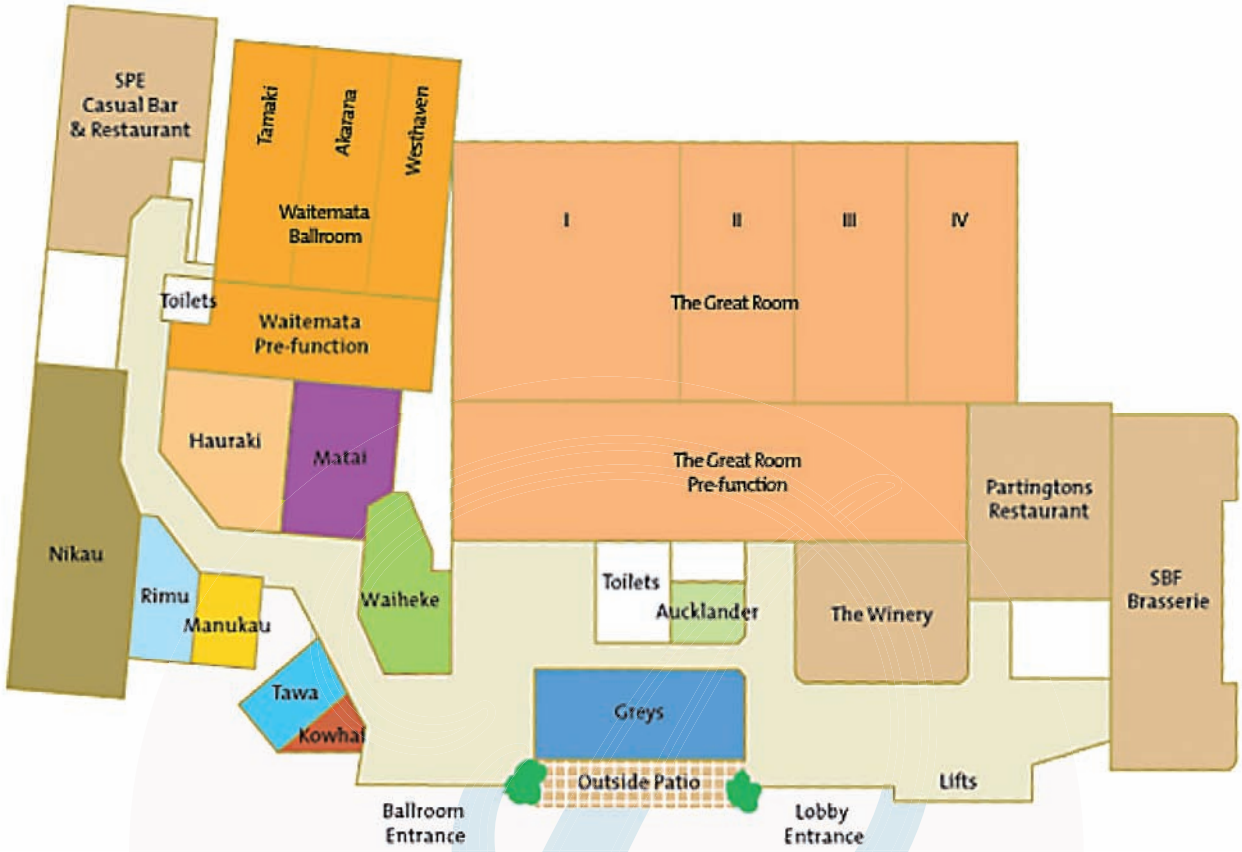
Toshiba 22
Grant Campbell
Sarah Colley
Beth Knight
John Riley

Total Library Solutions.....8 & 9
Mr Colin Greenwood

Wagner Medical..... 1
Mr Sam Wagner

HOTEL LAYOUT

The Langham Auckland Conference Rooms



Room Locations

Basic Phlebology 2 day Course
Saturday 06 February ..... Westhaven
Sunday 07 February ..... Westhaven

Advanced Phlebology 2 day Course
Saturday 06 February ..... Tamaki
Sunday 07 February ..... Tamaki

Basic and Advanced Phlebology Combined Sessions
Saturday 06 February ..... Westhaven
Sunday 07 February ..... Westhaven

Welcome Cocktail Function
Saturday 06 February ..... Greys

Scanmedics Welcome Cocktail Party
Sunday 07 February ..... Cable Bay Vineyard

Exhibition and Main Conference
Monday 08 February..... The Great Room
Tuesday 09 February ..... The Great Room
Wednesday 10 February.... The Great Room

Speaker Setup Room
Sat 06 – Wed 10 February ..... Aucklander

Breakfast Sessions
Greys
Monday 08 February..... Breakfast in Italy
Tuesday 09 February .... The Paperless Office
Wed 10 February ..... Medicolegal Breakfast

Diagnostic Imaging Workshops
Thurs 11 February ..... Westhaven

General Information

Parking and Shuttle

The Langham Hotel
83 Symonds Street, Auckland
P (09) 379 5132

The Langham, Auckland offers Valet Parking at $30.00 per car. Self-parking in a public car park adjacent to the hotel is available.
All parking is subject to availability.

The Langham, Auckland provides a complimentary 24 seater Shuttle Bus from the Hotel to Downtown Auckland from 7:00am to 9:30pm each day and return

Health Club
The use of the Health Clud and heated pool facilities on the 2nd floor is complimentary.

Telephone Directory

Emergency services 111
(fire/police/ambulance)

Registration desk..... 09 300 2913

Accommodation
Langham Hotel..... 09 379 5132

Accident & medical clinic
Quay Med 68 Beach Rd..... 09 919 2555
Monday – Friday 8.00am – 7.00pm
Saturday 10.00am – 2.00pm

After hours pharmacy..... 09 520 6634

Auckland visitors centre 09 366 6888

Taxi services
Corporate Cabs..... 09 377 0773
Co-op Taxis..... 09 300 3000
Super Shuttle 09 522 5100

Airlines Reservations Arrival/Departure Information

Air New Zealand..... 09 357 3000
09 306 5560

Qantas..... 09 357 8900
09 306 5564

Saturday 06 February
Basic and Advanced Phlebology Course

	Basic Phlebology Course	Advanced Phlebology Course
0700 - 1730	**Registration**	**Registration**
	Combined Sessions - Basic Phlebology Course & Advanced Phlebology Course **Westhaven Room** CHAIR: Dr Louis Loizou	
0700 - 0845	**Emergencies in Phlebology - Part 1** Advanced Cardiac Life Support for Phlebologists Dr John Vassiliadis (NSW) Emergency Physician	
0900 - 1030	**STREAM A** **Basic Phlebology Course** **(Phlebology Part I)** **Westhaven Room** Registration Required CHAIR: Dr Stefania Roberts MODERATOR: Dr Louis Loizou	**STREAM B** **Advanced Phlebology Course** **(Phlebology Part II)** **Tamaki Room** Registration Required CHAIR: Prof Andre van Rij MODERATOR: Dr Paul Thibault
0900 - 0945	**Introduction to Sclerotherapy** Dr Stefania Roberts (VIC) Phlebologist	0900 - 1000 **Physiology** Basic Concepts & Functional Measures Prof Andre van Rij (NZ) Phlebologist, Vascular Surgeon
0945 - 1030	**Patient Assessment and CEAP Classification** Dr Louis Loizou (VIC) Phlebologist	1000 - 1030 **Physiology** **Laser Doppler in Phlebology** Prof. Imre Bihari (Hungary)
1030 - 1100	**Morning Tea**	
	Basic Phlebology Course **Westhaven Room** CHAIR: Dr Stefania Roberts MODERATOR: Dr Louis Loizou	**Advanced Phlebology Course** **Tamaki Room** CHAIR: Dr Attilio Cavezzi MODERATOR: Dr Mark Elvy
1100 - 1145	**How to Set up a Sclerotherapy Practice** Dr Louis Loizou (VIC) Phlebologist	1100 - 1230 **Lymphology Workshop** Diagnosis & Classification How to Investigate Lymphodema Prof. Neil Piller (SA)
1145 - 1230	**Informed Consent and Medicolegal Issues** Dr Chris Lekich (QLD) Barrister	
1230 - 1330	**Lunch**	
	Basic Phlebology Course **Westhaven Room** CHAIR: Dr Stefania Roberts MODERATOR: Dr Louis Loizou	**Advanced Phlebology Course** **Tamaki Room** CHAIR: Dr Ivor Berman MODERATOR: Dr Kurosh Parsi
1330 - 1500	**Sclerotherapy Contraindications and Complications** Dr Paul Thibault (NSW) Phlebologist	1330 - 1500 **Vascular Anomalies** Dr Kurosh Parsi (NSW) Phlebologist
1500 - 1530	**Afternoon Tea**	
1530 - 1800	**CW-Doppler and PPG Hands-on Workshop** Dr Louis Loizou (VIC) Phlebologist Dr David Jenkins (NSW) Phlebologist	1530 - 1630 **Catheters, Wires, Embolic Agents and Devices** Prof. Lourens Bester (NSW) Interventional Radiologist 1630 - 1700 **How I Treat AVMs** Dr Sanjay Nadkarni (WA) Interventional Radiologist 1700 - 1730 **How I Treat AVMs** Prof. Lourens Bester (NSW) Interventional Radiologist 1730 - 1800 **Panel Discussion**
1900 - 2100	**CONFERENCE WELCOME COCKTAILS** Live music, refreshments and cocktails while catching up with colleagues	

	Basic Phlebology Course	Advanced Phlebology Course
0700 - 1730	**Registration**	**Registration**
	Combined Sessions - Basic Phlebology Course & Advanced Phlebology Course **Westhaven Room** CHAIR: Dr Louis Loizou	
0700 - 0745	**Emergencies in Phlebology - Part 2** Anaphylaxis in Phlebology Dr John Vassiliadis (NSW) Emergency Physician	
0800 - 0930	**STREAM A** **Basic Phlebology Course** **(Phlebology Part I)** **Westhaven Room** Registration Required CHAIR: Dr Louis Loizou MODERATOR: Dr Stefania Roberts	**STREAM B** **Advanced Phlebology Course** **(Phlebology Part II)** **Tamaki Room** Registration Required CHAIR: Dr Mark Elvy MODERATOR: Dr Andrew Stirling
0800 - 0825	**Sclerotherapy of Reticular and Telangiectic Veins: How I Do It** Prof Imre Bihari (Hungary) Phlebologist, Vascular Surgeon	0800 - 1000 **Phlebectomy Workshop** Dr Attilio Cavezzi (Italy) Phlebologist, Vascular Surgeon
0825 - 0850	**Sclerotherapy of Reticular and Telangiectic Veins: How I Do It** Prof. Philip Coleridge Smith (UK) Phlebologist, Vascular Surgeon	
0850 - 0915	**Sclerotherapy of Reticular and Telangiectic Veins: How I Do It** Dr JJ Guex (France) Phlebologist, Angiologist	
0915 - 0940	**Sclerotherapy of Reticular and Telangiectic Veins: How I Do It** Dr Michel Schadeck (France) Phlebologist, Angiologist	
0940 - 1000	**Panel Discussion**	
1000 - 1030	**Morning Tea**	
	Combined Sessions - Basic Phlebology Course & Advanced Phlebology Course **Westhaven Room** CHAIR: Dr Michel Schadeck	
1030 - 1145	**Sclerosants and the Coagulation** Dr Kurosh Parsi (NSW) Phlebologist, Dermatologist	
1145 - 1200	**Short Break**	
	Combined Session - Basic Phlebology Course & Advanced Phlebology Course **Westhaven Room** CHAIR: Prof Andre van Rij MODERATOR: Prof Ken Myers	
1200 - 1330	**Rheology - Fluid Dynamics of Blood Flow - Modelling and Simulation** Basic Concepts, Movement of Liquids in Liquids & Movement of Foams in Liquids Prof. Masud Behnia (NSW) - Prof of Mechanical Engineering, University of Sydney Prof. Srinivas Karkenahalli (NSW) - Deputy Head, School of Aerospace, Mechanical and Mechatronic Engineering Assoc. Prof. Makoto Ohta (Japan) - Prof of Biomedical Engineering and Fluid Mechanics, Tohoku University Assoc. Prof. Toshio Nakayama (Japan) - Prof of Biomedical Engineering and Fluid Mechanics, Tohoku University	
1330 - 1430	**Lunch**	
	Afternoon Free	
1800 - 2200	SCANMEDICS PRODUCTS YOU TRUST FROM PEOPLE YOU KNOW  **Conference Welcome Party** 'The Last Drink' Waiheike Island, Cable Bay Vineyard Maori Welcome - Live Music - Cocktails and Canapes **Yes Minister** Sir Humphrey addresses the EVLT item number **Wine Tasting Challenge** Grand Judge: Dr Louis Loizou **Wineroos vs All Noirs vs Team World**  NZD$65.00 pp	

SCANMEDICS
PRODUCTS YOU TRUST FROM PEOPLE YOU KNOW.

Conference Welcome Party

Wine Tasting Competition & Yes Minister Cable Bay Vineyard

GRAND JUDGE: Dr Lou Loizou

Wineroos		All Noirs		Team World
Representing Australia:	VS	**Representing NZ:**	VS	**Representing The World:**
Prof. Masud Behnia (NSW - Mudgee Enthusiast)		Dr Peter Chapman Smith (Pinot for breakfast)		Prof. Philip Coleridge Smith (UK)
Dr Gurjit Dhillon (VIC)		Dr Kamal Karl (Pinot for lunch)		Dr JJ Guex (France)
Dr Stefania Roberts (VIC)		Dr John Barrett (Pinot for breakfast & lunch)		Dr Nick Morrison (USA)
Dr Paul Thibault (NSW - Hunter Valley Resident)		Mystery Guest		Dr Michel Schadeck (France)

Prepare early, YOUR COUNTRY NEEDS YOU!

Features: Maori Welcome • Yes Minister • Wine Tasting Challenge • Limbo Challenge & More... Includes ferry transfer from hotel

NZD$65.00 per person

Time: 6PM , Sunday 7th February, Cable Bay Vineyard, Waiheke Is.
Dress Code: Island Style

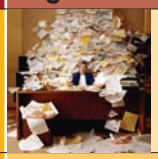


Scientific Program

0700 - 1730	**Registration**	
0700 - 0815	 **What's New in Phlebology in Italy and Around the World?** **Breakfast with the Stars** **Greys Room** Dr Attilio Cavezzi Phlebologist, Vascular Surgeon, Italy CHAIR: Dr Louis Loizou NZD$65.00 per person 	
0825 - 0830	**CONFERENCE WELCOME:** Dr Kurosh Parsi - ACP President	
	ENDOVENOUS SYMPOSIUM 1 - The Great Room CHAIR: Prof Ken Myers MODERATOR: Dr John Barrett	
0830 - 0900	**KEYNOTE LECTURE:** EVLA - Does the Wavelength Matter?	Prof. Ken Myers (VIC)
0900 - 0930	**GUEST LECTURE:** The Complementary Roles of Surgery, Endovenouse Laser Ablation, and Foam Sclerotherapy in the Treatment of Venous Insufficiency - the U.S. Perspective	Dr Nick Morrison (USA)
0930 - 0945	Endovenous Laser Treatment: 1500 nm vs. 980 nm - a Comparative Trial	Dr Mark Vuylsteke (BEL)
0945 - 1000	The proximal great saphenous vein: Recanalisation, reflux & recurrence after endovenous laser treatment	Dr George Somjen (VIC)
1000 - 1015	High Energy Endovenous Laser Ablation and Saw-Knife Phlebectomy	Prof. Imre Bihari (HUN)
1015 - 1030	Panel Discussion	
1030 - 1100	**Exhibition & Morning Tea**	
	SCLEROTHERAPY SYMPOSIUM 1 - The Great Room CHAIR Dr Paul Thibault MODERATOR: Dr Mark Malouf	
1100 - 1130	**KEYNOTE LECTURE:** Foam Sclerotherapy - The State of the Art	Prof P. Coleridge-Smith (UK)
1130 - 1145	Liquid or Foam - Which is Better?	Dr Michel Schadeck (FRA)
1145 - 1200	Catheter Directed Sclerotherapy and Phlebectomy	Dr Attilio Cavezzi (ITA)
1200 - 1215	Ultrasound Guided Sclerotherapy - what do we know for sure?	Prof. Ken Myers (VIC)
1215 - 1230	Froth Treatment	Prof. Imre Bihari (HUN)
1230 - 1245	Experience with concomitant ultrasound-guided foam sclerotherapy and endovenous laser treatment in chronic venous disorder and its influence on Health Related Quality of Life (HRQL): interim analysis of more than 1000 consecutive procedures.	Dr Ted King (USA)
1245 - 1300	Panel Discussion	
1300 - 1400	**Exhibition & Lunch**	
	Afternoon Free	

	Location: Auckland Town Hall (Transport from Hotel Organised)
1730 - 1830	**Pre-Ceremony Drinks**
1830 - 1930	**Conferring Ceremony and Launch of the New Zealand Faculty** Australasian College of Phlebology Ken Myers Oration: Professor Earl Owen, University of Sydney 
1930 - 2300	**Gala Dinner**

Scientific Program

0700 - 1730	**Registration**
0700 - 0745	 Complimentary Breakfast Session - Greys Room Secrets of the Paperless Office Do you find yourself working in IT rather than medicine at times? Mr Rafic Habib - Managing Director - ISN Solutions
	CONTROVERSIES IN PHLEBOLOGY 1 - Small Veins Symposium - The Great Room CHAIR: Dr Kurosh Parsi MODERATOR: Dr Stefania Roberts
0800 - 0830	**KEYNOTE LECTURE -** Curing the Incurable — Prof P. Coleridge Smith (UK)
	Keypad Interactive Session - How would you treat (Sclerosant/concentration/technique) ... ? (1 minute per question) 1. Sporadic telangiectasias of ant. thigh (more reticular veins than telangiectasias) 2. Widespread spontaneous matting of both legs with no previous treatment 3. Gets matting every time you treat her 4. Very fine spider veins which are barely visible 5. Gets severe pigmentation 6. Extensive small vein disease with no varicose veins
0830 - 0900	Audience Survey — Dr Kurosh Parsi (NSW)
0900 - 1000	Expert Panel Opinion - Panel members have 6 minutes each to answer the above questions Prof. Imre Bihari (Hungary) Dr Attilio Cavezzi (Italy) Prof. Philip Coleridge Smith (UK) Dr JJ Guex (France) Dr David Jenkins (NSW) Dr Michel Schadeck (France) Dr Paul Thibault (NSW)
1000 - 1030	Panel Discussion
1030 - 1100	**Exhibition & Morning Tea**

	STREAM A **Basic Science Research** The Great Room CHAIR: Prof. Andre van Rij MODERATOR: Dr Michel Schadeck		**STREAM B** **Ultrasound Interest Group** Greys Room CHAIR: Ms Annie Morgan MODERATOR: Ms Daryl Queenin
1100 - 1115	**Variables in Foam Sclerotherapy with Tessari Method: Experimental Data** Dr Attilio Cavezzi (Italy)	1100 - 1115	**Pelvic Congestion Syndrome** Martin Necas (NZ)
1115 - 1130	**Interaction of Detergent Sclerosants with Fibrinolytic Mechanisms** Dr Kurosh Parsi (NSW)	1115 - 1130	**Emergencies in the Phlebology Laboratory - a Sonographers Role** Annie Morgan (NSW)
1130 - 1145	**Detergent Sclerosants Interfere with Platelet Activation and Aggregation** Dr Anne Pilotelle (NSW)	1130 - 1145	**Outside the Box- if not venous what else to look for in the Lower limb vein assessment** Scott Allen (NZ)
1145 - 1200	**Overall Thrombotic Activity of Detergent Sclerosants: Thromboelastographic Data** David Du (NSW)	1145 - 1200	**The changing role of the Venous Duplex Scan in the era of endovenous thermal ablation** Mr Gary Frydman (VIC)
1200 - 1215	**Fibrinolytic and Thrombolytic Activity of Detergent Sclerosants** Dr Kurosh Parsi (NSW)	1200 - 1215	**Reporting Vein Maps Effectively for the Phlebologist** Martin Necas (NZ)
1215 - 1230	**Questions**	1215 - 1230	**Questions**
1230 - 1330	**Exhibition &Lunch**		

Scientific Program - Continued

	VENOUS DISEASE UPDATE - The Great Room CHAIR: Dr Paul Dinnen MODERATOR: Dr David Jenkins	
1330 - 1400	**KEYNOTE LECTURE -** Venoactive Drugs - Gimmick or Medicine?	Prof P. Coleridge Smith (UK)
1400 - 1415	Multiple Sclerosis and Cerebral Venous Insufficiency	Dr Paul Thibault (NSW)
1415 - 1430	Prevalence of Reflux in the Great Saphenous Vein as a Function of Diameter	Dr Nick Morrison (USA)
1430 - 1445	Venous Perforators in Normal Lower Limbs Ultrasound Characterisation and Comparison with Resin Caste Anatomy	Prof. Andre van Rij (NZ)
1445 - 1500	Venous Incompetence in Children	Dr Michel Schadeck (FRA)
1500 - 1515	Relationship Between Number of Pregnancies and Great Saphenous Vein Diameter	Dr Nick Morrison (USA)
1515 - 1530	Progression and recurrence of vein disease in patients treated with endovenous laser ablation: Two-four year experience. Is there a place for the phrase recurrent varices after laser or reval?	Dr Ted King (USA)
1530 - 1545	Questions	
1545 - 1615	**Exhibition & Afternoon Tea**	
	VENOUS THROMBOEMBOLISM - The Great Room CHAIR: Prof. Andre van Rij MODERATOR: Dr Sanjeev Chunilal	
1615 - 1645	**GUEST LECTURE -** The Future of New Antithrombotics	Dr Sanjeev Chunilal (NZ)
1645 - 1715	**GUEST LECTURE -** Venous Thromboembolism: An Update of What's New	Dr Abdullah Omari (NSW)
1715 - 1730	The Time Sequence of the Development of Axial Deep Reflux Following Lower Limb DVT A Prospective Study over 5 Years	Prof. Andre van Rij (NZ)
1730 - 1745	Challenging Cases In VTE	Dr Abdullah Omari (NSW)
1745 - 1800	Simple Interventions Improve Adherence to Thromboprophylaxis Guidelines	Dr Deborah Wright (NZ)
1800 - 1815	Questions	

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Scientific Program

0700 - 1730	**Registration**
0700 - 0800	**MEDICOLEGAL BREAKFAST - Greys Room** PRESENTERS: Dr Chris Lekich, Barrister in Law Ms Katja Beitat, HCCC, NSW NZD$65.00 per person 
0700 - 0705	Introduction - Dr Chris Lekich
0705 - 0725	Who is getting sued for treating veins - Dr Chris Lekich
0725 - 0745	Why Patients Complain and What Happens After? - Ms Katja Beitat
0745 - 0800	Panel Discussion
	CONTROVERSIES IN PHLEBOLOGY 2 - Segmental Venous Incompetence Symposium - The Great Room CHAIR: Dr Paul Dinnen MODERATOR: Dr Paul Tibault
0800 - 0830	**KEYNOTE LECTURE -** Preserving The Great Saphenous Vein - A Lost Cause? — Prof Imre Bihari (HUN)
	Keypad Interactive Session What would your treat strategy be if .... ? (1 minute per question) 1. Prox GSV competent, distal incompetent 2. Prox GSV incompetent but distal competent 3. AAGSV or PAGSV incompetent but GSV competent 4. GSV and intersaphenous veins incompetent and the mid-third of SSV incompetent 5. SSV incompetent, inter-saphenous veins incompetent, PAV incompetent, but GSV competent 6. Mid-third of GSV incompetent
0830 - 0900	Audience Survey — Dr Kurosh Parsi (NSW)
0900 - 1000	Expert Panel Opinion - Panel members have 6 minutes each to answer the above questions Prof. Imre Bihari (Hungary) Dr Attilio Cavezzi (Italy) Prof. Philip Coleridge Smith (UK) Dr JJ Guex (France) Dr Nick Morrison (USA) Prof. Ken Myers (VIC) Dr Michel Schadeck (France)
1000 - 1030	Panel Discussion
1030 - 1100	**Exhibition & Morning Tea**

	STREAM A **Free Papers** The Great Room CHAIR: Dr Mark Elvy MODERATOR: Mr Gary Frydman		**STREAM B** **Scientific Methods and Phlebology** Greys Room CHAIR: Prof. Philip Coleridge Smith MODERATOR: Prof. Andre van Rij
1100 - 1115	**Popliteal vein compression, DVT and the efficacy of calf compressors** Dr David Huber (NSW)	1100 - 1120	**Guest Lecture** **How Not to Get Rejected!** Prof. Philip Coleridge Smith, Editor, European Journal of Vascular Endovascular Surgery
1115 - 1130	**Minimally invasive surgey for Varicose veins. Its role in 2010** Mr Gary Frydman (VIC)	1120 - 1140	**Guest Lecture** **Something Wrong With Those Numbers!** Prof. Ken Myers (VIC)
1130 - 1145	**Computational Blood Flow Analysis to Assess Effect of Stenosis Symmetry** Afiqah Hamzah (NSW)	1140 - 1200	**Guest Lecture** **Patient Reported Outcomes** Dr JJ Guex (France)
1145 - 1200	**Acute Hepatitis following Methoxyfluorane Analgesia during Sclerotherapy** Dr Stuart McMaster (QLD)	1200 - 1220	**Guest Lecture** **Blood Flow Fluid Mechanics: How and What We Measure** Prof. Masud Behnia (NSW)
1200 - 1215	**When Will the Bubbles Burst? Foam Stability: Air vs. CO_2** Dr Chris Lekich (QLD)	1220 - 1230	**Questions**
1215 - 1230	**Questions**		
1230 - 1330	**Exhibition & Lunch**		

Scientific Program

	SCLEROTHERAPY SYMPOSIUM 2 - The Great Room CHAIR: Dr Louis Loizou MODERATOR: Dr David Jenkins	
1330 - 1400	**KEYNOTE LECTURE -** Bubbles in the Brain - What do we know?	Dr Nick Morrison (USA)
1400 - 1415	The French Polidoconal Registry - a Survey Covering 3357 Patient Years	Dr JJ Guex (FRA)
1415 - 1430	Complications of Duplex Guided Sclerotherapy of the Small Saphenous Vein Study of a Population of 4984 Patients	Dr Michel Schadeck (FRA)
1430 - 1445	EVLA vs. Foam UGS for Saphenous Trunks - 5 Year Prospective Outcome Data	Dr Peter Chapman Smith (NZ)
1445 - 1500	Safety of Large Volume Foam UGS Combined with ELVA	Dr Peter Chapman Smith (NZ)
1500 - 1515	Topical Nitrates in the Treatment of Sclerotherapy Induced Skin Necrosis: Case Presentation	Dr David Jenkins (NSW)
1515 - 1530	Panel Discussion and Questions	
1530 - 1600	**Exhibition & Afternoon Tea**	
	ENDOVENOUS SYMPOSIUM 2 - The Great Room CHAIR: Prof Ken Myers MODERATOR: Dr John Barrett	
1600 - 1615	Endovenous Laser Ablation: Intraluminal Centralisation of Fibre-Tip can Perfectionate the Technique A Histological Study	Dr Marc Vuylsteke (BEL)
1615 - 1630	How safe and effective is high energy endovenous laser ablation?	Dr Ted King (USA)
1630 - 1645	Timing of Foam Sclerotherapy with EVLA - Stat or Delayed	Dr Peter Chapman Smith (NZ)
1645 - 1700	The distal great saphenous vein: Recanalisation, reflux, incompetent perforating veins after endovenous laser treatment	Dr George Somjen (VIC)
1700 - 1715	Endovenous Coil Ablation for Varicose Veins – A Safety and Efficacy Trial	Mr Gary Frydman (VIC)
1715 - 1730	Thinking outside the box in treating an incompetent GSV: coils, onyx and other methods	Dr Sanjay Nadkarni (WA)
1730 - 1745	Can saphenous and sural nerve paresthesia be prevented during ELT?	Dr Ted King (USA)
1745 - 1800	Panel Discussion	
1800 - 1805	Closing Remarks	

Auckland | City of Sails

Special Event:

Breakfast with the Stars
Greys Room

Guest Speaker: Dr Attilio Cavezzi, Phlebologist, Vascular Surgeon, Italy

What's New in Phlebology?
The Local Scene in Italy and Around the Globe

Monday 08 February, Greys Room, Langham Hotel, Auckland from 7:00am - 8:15am

Menu: Typical Italian Breakfast

FEE NZD$65 per person

Special Event:

MEDICOLEGAL BREAKFAST

Greys Room

Why Patients Complain and What Happens After?
Healthcare Complaints Commission, NSW
Who is Getting Sued for Treating Veins?

PRESENTERS: Dr Chris Lekich, Barrister in Law - Ms Katja Beitat, HCCC, NSW

Wednesday 10 February, Greys Room, Langham Hotel, Auckland from 7:00am - 8:00am

FEE NZD$65.00 per person

	Diagnostic Imaging Sonography Workshops	
0700 - 1730	**Registration**	
	Diagnostic Imaging Ultrasound Hands-on Workshops Westhaven Room Registration Required	
0800 - 0805	**Introduction**	Annie Morgan
0805 - 0900	**Knobology** - Insight - Sonosite - Toshiba	 Wendy Miller John Grimshaw Sarah Colley
0900 -1030	Lower Limb Venous Anatomy and Nomenclature	Dr Atillio Cavezzi
1030 - 1100	**Morning Tea**	
1100- 1115	Pelvic Vein Assessment	Martin Necas
1115-1215	**Workshop** **Pelvic Vein Scanning** Westhaven Room Martin Necas	
1215- 1230	Arterial Assessment for the Phlebology Laboratory	Annie Morgan
1115-1215	**Workshop** **Arterial Duplex and ABI** Westhaven Room AnnieMorgan	
1300-1400	**Lunch**	
1400-1415	Lower Limb Venous Mapping	Bronwen Allen/Darryl Queenin
1415-1530	**Workshop** **Lower Limb Vein Mapping** Westhaven Room Martin Necas Annie Morgan Bronwen Allen Darryl Queenin	
1530-1600	**Afternoon Tea**	
1600-1615	Upper Limb Venous Duplex Examination	Martin Necas
1615-1630	Lower Limb DVT scans	Osvaldo Cooley Andrade
1630-1800	**Workshop 1** **Upper Limb Venous Scan** Westhaven Room Martin Necas Annie Morgan **Workshop 2** **Lower Limb DVT scan** Westhaven Room Osvaldo Cooley Andrade Bronwen Allen Daryl Queenin	
1800	Wrap-up	

Workshops proudly supported by:

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TRANSPORTATION

Langham Hotel Limousine Service

Guests can be picked up from the airport by a chauffeur who will have an accommodation registration card for the guest in the Limousine - you can complete the card during the journey - the chauffeur will take a swipe of your credit card for guarantee and will also have the keys for your room(s) so you can go straight to your designated room upon arrival at the hotel.

The cost is: $90.00 including GST from Airport to the hotel and $75.00 including GST from Hotel to the airport. Indicate on the conference registration form if you would like to book a Limousine transfer.

Taxis and shuttles

Auckland Airport licenses specific taxi and shuttle companies to ensure airport visitors and travellers receive a high standard of service. All taxi and shuttle companies are able to drop you off at the airport, however only licensed companies are able to pick you up from the designated taxi ranks at the terminal buildings.

Taxi and shuttle ranks are located outside the arrivals area (door 8) at the international terminal. You can pre-book with one of the companies listed below or just turn up at the terminal ranks – taxis and shuttles are always available.Indicative fares from the airport into the city is between NZ$60 – NZ$80 one-way for a taxi. For specific fare pricing, contact the taxi and shuttle companies directly.

Auckland Combined Citicabs Taxis
Phone: +64 9 300 1111 Website: www.citicabs.co.nz
Auckland Co-op Taxis
Phone: +64 9 300 3000 Website: www.cooptaxi.co.nz
Corporate Cabs
Phone: +64 9 377 0773 Website: www.corporatecabs.co.nz

VISA

Before you travel to New Zealand, please check that your passport is ready for the trip. Your passport must be:

- Valid for at least 3 months beyond your intended departure date.
- Not damaged, defaced or excessively worn.
- Showing a visa or permit, if you require one.

Do you need a New Zealand visa or permit?

You do not need a visa or permit to visit New Zealand if you are:

- A New Zealand citizen or Resident Permit holder
- An Australian citizen travelling on an Australian passport
- An Australian resident with a current Australian resident return visa
- A British citizen and or British passport holder who can produce evidence of the right to reside permanently in the UK (you can stay up to six months)
- A citizen of a country which has a visa waiver agreement with New Zealand

For more detailed information check out the Visa free countries section of the Immigration New Zealand website:
http://glossary.immigration.govt.nz/VisaFreeCountries.htm

TRAVEL INSURANCE

The conference organisers recommend that delegates purchase travel insurance including cover for non-refundable meeting registration fees.

ELECTRICITY

240/250 volts AC 50HZ. Universal outlets for 110 volts (shavers only) are standard in hotels, apartments and motels

PAYMENT

All prices are in New Zealand dollars including GST. All online registration must be paid by credit card via the website. Please note that debits to your credit card will appear as Conference Matters on your statement. If you complete a registration form manually and pay via cheque, please note cheques or drafts must be in New Zealand currency, drawn on an New Zealand bank and free of all charges.

FOOD & BEVERAGE

Specify dietary requirements on the registration form.

Coffee Breaks

Coffee breaks are included in the registration fee and will be served in several locations, including the Exhibition Area, to delegates from Saturday, 06 February, 2010 to Wednesday, 10 February 2010 during the session breaks.

Lunch

Lunch breaks are included in the registration fee and will be served in several locations, including the Exhibition Area, to delegates from Saturday, 06 February, 2010 to Wednesday, 10 February 2010 during the session breaks.

LANGUAGE

English is the official Congress language and no translation services are offered.

REGISTRATION & BADGES

Please go to the Congress website at www.phlebology.com.au for online registration. The other option is to use the registration form at the back of this announcement or to print the PDF file of the registration form off the website, and send the completed form to the Conference Secretariat either by fox or by mail. All participants, including speakers and chairmen, must submit a completed registration form.

Name Badges

Name badges must be visible and used at all times, anywhere at the Langham Hotel for access to the meeting and official social functions.

RULES

Smoking Policy

The ACP 2010 Meeting is a non-smoking event. Participants are kindly requested to refrain from smoking in the meeting venue, including the Exhibition Area.

Mobile Phones

Delegates are kindly requested to keep their mobile phones silenced in the rooms where scientific and educational sessions are being held, as well as during poster sessions.

SPEAKER'S SETUP ROOM

Speakers are asked to bring their formatted PowerPoint presentations to the Speaker's Preview Room the day before or at least one session before their scheduled presentation. Files from keydrives or CD-ROMs can be transferred to the Congress servers at that time. All conference rooms contain state-of-the-art technical equipment.

The Speakers' Setup Room will be open as follows:

Saturday February 06, 2010	7:30 AM - 7:00 PM
Sunday February 07, 2010	7:30 AM - 5:00 PM
Monday February 08, 2010	7:30 AM - 7:00 PM
Tuesday February 09, 2010	7:30 AM - 7:00 PM
Wednesday February 10, 2010	7:30 AM - 7:00 PM

INTERNET CONNECTIONS

The Langham Hotel has a business room available with internet access. Internet also available in rooms.

The Langham Hotel | Auckland

83 Symonds Street, Auckland 1140, New Zealand

The Langham Hotel Auckland exudes a timeless elegance that celebrates the past, yet embraces the future. As a luxury Auckland hotel, you will be enchanted with the tradition of graceful living.

The Langham is particularly recognised for:

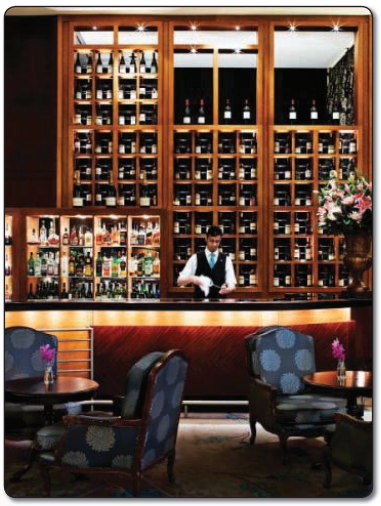
- Outstanding 5 star luxury hotel accommodation (comprising 410 rooms, including 70 The Langham Club rooms and 12 suites)
- Exceptional restaurants, lounges and bars
- Rejuvenating Chuan Spa, unique to this luxury Auckland hotel
- Excellent leisure facilities, including a well-equipped fitness studio,heated swimming pool, sauna and jacuzzi
- 24-hour room service

The Langham Hotel Auckland is among the 'Leading Hotels of the World'.

Location

The Langham Hotel Auckland is conveniently located:

- Close to key motorway access points
- Within walking distance of the waterfront and downtown business and shopping areas
- Near the beautiful Auckland Domain and the Auckland War Memorial Museum
- With complimentary daily shuttle service to the city centre



The Winery| The Langham | Auckland

Accommodation Options:

Classic Room:

Located on levels 1 to 4, these rooms are stylishly opulent and decorated in tones that complement the pleasingly light-hued furniture

Executive Room:

Located on levels 5 and 6, these rooms are richly decorated in sumptuous silks and velvets. These rooms include complimentary internet access is available in the mini business centre on floors 5 and 6.

Club Room:

Tastefully appointed in the most luxurious upholstery fabrics, these rooms also offer all the extra luxury and privileges of The Langham Club including access to the exclusive Club lounge and complimentary use of the business centre. The Langham Club Room and Suite guests will enjoy butler service and complimentary hot and cold breakfast items, two hours of evening cocktails and canapés in the hotel club lounge.

Bed and Full Buffet Breakfast rate – please add $30incGST to the room rate, per person.

Accommodation Rates:

All rates shown in NZ Dollars

Room	1-2 people
Classic Room	$210
Executive Room	$255
Club Room	$335

Accommodation Confirmation:

Conference Matters has negotiated a reduced rate for conference delegates during the conference. All accommodation booking must be made through Conference Matters. Accommodation will not be processed unless accompanied by full payment.

Change of booking:

All changes to reservations must be made in writing to Conference Matters, not the Hotel.

Refund:

A refund will only be made if notification of cancellation is received in writing 30 days prior to your reservation date.

Check-in and check-out:

Standard check-in time at hotel is 3.00 pm onwards. If a room is required prior to this time Conference Matters should be advised as hotel may otherwise charge an additional fee. Delegates arriving after 6.00 pm should indicate the estimated time of arrival, as the hotel, if not notified of a late arrival, may release the room to other guests. Check-out time is 11.00am. Any departure after 11.00 am is subject to a charge.

Club Room| The Langham | Auckland

INDEX OF SPEAKERS & ABSTRACTS

CN=Course Notes Book

INDEX OF SPEAKERS & ABSTRACTS Continued

CN=Course Notes Book

0830 - 0900 Mon 08 February

KEYNOTE LECTURE
EVLA - does the Wavelength Matter?

Ken Myers
Victoria Vein Clinic, Melbourne, Australia

Several commercial systems are now available for endovascular laser ablation (EVLA). Wavelengths range from 809 to 1500nm with more to come. Each manufacturer recommends settings for power and pullback speed but without evidence to show that these provide the best outcome. The energy supplied per unit length varies between different manufacturers. The effect of laser energy is dependent on wavelength, power, probe withdrawal rate and whether energy is continuous or pulsed. Planck's formula indicates that energy is proportional to frequency so that higher wavelengths require more exposure time.

The aim is to obtain a balance between applying sufficient energy to ensure adequate damage to the vein for long-term success but with the least energy required to minimise early patient discomfort. This is likely to vary according to the vein diameter and other factors. Animal and clinical histological studies appear to show more even vein destruction and lower frequency of vein perforation with longer wavelengths and these studies need to be expanded.

There is a need for clinical studies with long-term survival analysis to determine the best protocol for each frequency and then to compare the different frequencies for long-term outcome. These studies need to be performed independent of manufacturer support.

Room: The Great Room

Notes

0900 - 0930 Mon 08 February

GUEST LECTURE
The Complementary Roles of Surgery, Endovenouse Laser Ablation, and Foam Sclerotherapy in the Treatment of Venous Insufficiency - the U.S. Perspective

Nick Morrison [1,2]
[1]**Morrison Vein Institute, Arizona, USA**
[2]**Morrison Training Institute, Arizona, USA**

Traditional surgical treatment is waning in the U.S. with endovenous ablation techniques playing an increasingly important role. In the U.S. three methods are used to achieve venous ablation of diseased veins: endovenous thermal ablation using radiofrequency (RF) or laser energy, and foamed detergent agents. Following these techniques, additional treatment is required for any remaining portion of the great and/or small saphenous vein, persistently incompetent perforator veins, and varicose tributaries additionally, typically with either injection sclerotherapy and/or microphlebectomy. Early reports demonstrate over 85% successful ablation for thermal ablation and over 70% for foam sclerotherapy. Complications are reported infrequently and are generally short-lived. Adequate follow up is important to assure successful treatment and to direct retreatment when necessary. Retreatment of chemical or thermal ablation with ultrasound guided foam sclerotherapy is very effective and much easier than surgical retreatment.

Conclusions
Modern surgical techniques, and radiofrequency, laser, and chemical endovenous ablation are generally safe and play complementary roles in the treatment of chronic venous insufficiency. Ultrasound guided foam sclerotherapy has enjoyed considerable acceptance in Europe, Australasia, and South America. At this time, this technique remains an investigational, if not intriguing method in the U.S. Further long-term efficacy data is needed.

Absent careful follow up and adjunctive treatment, the practitioner and patient will be left with unsatisfactory results.

Room: The Great Room

Notes

0930 - 0945 Mon 08 February

Endovenous Laser Treatment: 1500 nm vs. 980 nm - a Comparative Trial

Marc Vuylsteke
Sint-Andries Hospital, Tielt, Belgium

Aims
The destruction induced during endovenous laser treatment (ELT) of the saphenous vein and the perivenous tissue in an animal model (goats) was analysed. Differences in vein wall destruction produced by two laser types, the 980 and 1500 nm diode lasers, were evaluated histologically.

Methods
In 14 goats, 28 lateral saphenous veins were treated with ELT. In 14 veins we used the 980 nm diode laser and in the remnant a 1500 nm laser. Postoperatively the veins were removed at different stages and sent for histological examination.

Results
Immediately removed veins after ELT show an uneven destruction of the vein wall. Veins harvested one week postoperatively show inflammatory tissue at their periphery. Two and three weeks postoperatively, organization is very extensive. In some cases, recanalization begins in a semi-lunar manner at the contralateral side of the laser hit. Veins treated with a 980 nm laser show deeper ulceration with more perivenous tissue destruction compared with veins treated with a 1500 nm diode laser.

Conclusions
The ELTof veins produces an unevenly distributed damage. The cell necrosis is far more extensive than expected. Using a 1500 nm laser correlates with less penetrating ulcerations and more circumferential damage.

Room: The Great Room

Notes

0945 - 1000 Mon 08 February

The proximal great saphenous vein: Recanalisation, reflux and recurrence after endovenous laser treatment

George Somjen [1,2]
[1]Frankston Hospital, Peninsula Health, Melbourne, Australia
[2]Monash University, Melbourne, Australia

Aims
The objective of the study was to examine long term changes in the proximal great saphenous vein (GSV) after endovenous laser treatment (ELT).

Methods
115 legs of 88 consecutive patients were included in the study. All patients were treated with the Biolitec (980 nm) diode laser system from knee to groin. The extent of vein obliteration, recanalisation and the presence of reflux in the proximal GSV were investigated with the ultrasound during the two year follow-up.

Results
The GSV was successfully obliterated in all patients (115 legs). Early thrombus extension up to the saphenofemoral junction (SFJ) occurred only in 6 legs (5%). The SFJ later reopened in all of those cases.
In the long term the SFJ and the very proximal segment of the GSV remained free of reflux in 84% of cases. Late thrombus retraction leading to incompetence in the proximal GSV occurred in 8 instances (7%), often associated with anterior accessory saphenous vein reflux (AASV). More extensive late recanalisation of the GSV was found in 10 legs (9%).

Conclusion
Following ELT the proximal segment of the GSV remained patent and competent in the majority of cases. Subsequent treatment of recurrent GSV/AASV reflux may be indicated to avoid clinical recurrence.

Room: The Great Room

Notes

1000 - 1015 Mon 08 February

High Energy Endovenous Laser Ablation and Saw-Knife Phlebectomy

Imre Bihari
National Health Service Center, Cardiovascular Surgical Department, Budapest, Hungary

Aims
In our first 30 cases there were 4 recanalisations and our aim was to decrease the number of this type of complication. According to the experience of T. Proebstle and others, the delivered laser energy was raised to improve results.

Methods
In 2.5 years 230 lower limbs were operated on. After the first 30 cases laser energy was increased from 30 to 100 Joule/cm. Cooled tumescent local anaesthetic is employed (3⁰C). For phlebectomy usually we use a saw-knife. Compression bandages, later stockings have to be worn for 3-4 weeks.

Results
Every treated vein was occluded (100 %).There was no full recanalisation during the observation period, 1-32 (mean 11) months; however, segmental recanalisation occurred in 2 cases (closed, without any reflux). The one serious complication was a pulmonary embolism, without detectable deep venous thrombosis. In addition there were sometimes temporary suffusions, pigmentation, ankle swelling, hyperesthesia and numbness.

Conclusion
We have good experience with the combination of high energy laser, cooled tumescent local anaesthetic and the use of saw-knife for phlebectomy. These are early results which have to be followed up over several years.

Room: The Great Room

Notes

1100 - 1130 Mon 08 February

KEYNOTE LECTURE
Foam Sclerotherapy - The State of the Art

Philip Coleridge Smith [1,2]
[1]The London Vein Institute, London, UK
[2]Department of Surgery, UCL Medical School, The Middlesex Hospital, London, UK

Aims
To review published evidence concerning treatment of varicose veins using ultrasound guided foam sclerotherapy (UGFS) to assess the safety and efficacy of this treatment.

Methods
Medical literature databases including Medline, Embase, were searched for recent literature concerning UGFS. Papers describing the early results and later outcome have been assessed and their main findings included in this summary.

Results
Few randomised studies have been published in this field and much of the available data comes from clinical series reported by individual clinicians.

It is clear that foam sclerotherapy is far more effective than liquid sclerotherapy and that ultrasound imaging allows the treatment to be delivered accurately to affected veins. There is evidence that 3% polidocanol foam is no more effective than 1% polidocanol foam. The optimum ratio of gas to liquid is 4:1, although a range of ratios is reported in published work. There is a wide variation in the volume used as well as the method by which it is injected. The use of carbon dioxide foam reduces the systemic complications, particularly visual disturbance, as compared to air foams. Very few serious adverse events have been reported in the literature despite the widespread use of this method. Rates of recanalisation of saphenous trunks following UGFS are similar to those observed after endovenous laser and endovenous RF ablation of veins, as well as the residual incompetence after surgical treatment.

Conclusions
UGFS is a safe and effective method of treating varicose veins. The relative advantages or disadvantages of this treatment in the longer term have yet to be published.

Room: The Great Room

Notes

1130 - 1145 Mon 08 February

Liquid or Foam - Which is Better?

Michel Schadeck
Paris, France

Aims
The reappearance of the foam as a sclerosant agent has modified the therapeutic approach of the varicose disease.
The objective is to summarise advantages and disadvantages of the foam compared to the liquid one.

Methods
A randomized study comparing foam to liquid using duplex guided sclerotherapy of the great saphenous veins with Lauromacrogol 400 3% is performed. Just after the injection of liquid form, an alternative compression with the probe induces the occurrence of a spasm.

Results
The population studied is of 100 patients in two groups, one treated with foam and the other one with the liquid form. After one session, we observe a disappearance of the reflux in 82% of the cases with foam versus 51% with the liquid form.
Compared to the study already published, our work shows the interest of the alternative compression in the occurrence of the spasm.
The possibility to induce a spasm of the vein with the liquid form induces different therapeutic attitude depending on different criteria.

Conclusion
Today, the different properties of these two forms of sclerosing agents, enable, to drive almost all the problems that the varicose disease induces.

Room: The Great Room

Notes

1145 - 1200 Mon 08 February

Catheter Directed Sclerotherapy and Phlebectomy

Attilio Cavezzi
S.Benedetto del Tronto , Italy

Design
Prospective clinical series

Aims
To assess the short-mid term efficacy and safety of the association phlebectomy (PHL) of the varices + concomitant trans-catheter foam sclerotherapy (TCFS) of the saphenous veins.

Patients and Methods
Since November 2006 nearly 160 patients underwent PHL+ TCFS in local anaesthesia; 58 patients (42 F, 16 M) (63 limbs), were randomly reviewed at 6-30 (mean 17, SD ± 6.6) months; mean age and BMI were 51 y. and 27.9; most patients were C2 (CEAP) and had GSV incompetence; mean saphenous calibre 7.4 mm (SD ± 3.2). Clinical and colour-duplex investigation (CDI), together with visual analogue scale (VAS) for main symptoms, were performed. 5.1 mls (SD ± 1.7) of 3% STS/POL sclerosant foam (Tessari method and CO2/O2) were injected through an intrasaphenous 4-F long catheter.

Results
VAS improvement was reported in all cases. The CDI-based outcomes were: a) mean saphenous diameter 1.8 mm (SD:+/- 1.4), b) 64% vein occlusion rate, c) antegrade flow in 11%, d) reflux< 1 sec. in 13% and reflux> 1 sec. in 12% of the limbs. No varicose veins in 94% of the limbs. Complications: one gastrocnemius vein thrombosis, two superficial thrombophlebites. Additional tumescence infiltration of the saphenous compartment improved the results.

Conclusions
The combination of PHL and TCFS is a cheap, effective and safe procedure

Room: The Great Room

Notes

1200 - 1215 Mon 08 February

Foam sclerotherapy: What do we know conclusively?

Ken Myers and Stefania Roberts
Victoria Vein Clinic, Melbourne, Australia

Foam sclerotherapy by the Tessari method is widely used. Liquid or foam is selected for small veins but it is not known which gives best results. Ultrasound-guided sclerotherapy (UGS) is preferred for larger in selected patients with a clear advantage for foam. Sclerosants interfere with clotting showing anticoagulant activity in high concentrations but procoagulant activity with low concentrations. Cell lysis is attenuated by plasma proteins .

Histology demonstrates intimal destruction within two minutes and intimal separation by 15-30 minutes but there are no late studies. Many factors affect results including foam preparation, selecting suitable veins and patients and injection techniques, but the optimal technique is unknown. Tessari and Cavessi studied 4:1 gas/fluid ratio foam but there is little information about alternative preparations, comparative effects of the sclerosants used or sclerosant concentrations. Nor is it known how UGS compares to other treatments.

Anaphylaxis or thromboembolic complications are rare and there is a low incidence of minor systemic events. Foam escapes to the right heart and Transcranial Doppler shows frequent middle cerebral artery signals but MRI does not show that these cause brain damage No manouvre appears to effectively reduce escape of foam. Foam sclerotherapy is a fertile field for further research.

Room: The Great Room

Notes

1215 - 1230 Mon 08 February

Froth Treatment

Imre Bihari
National Health Service Center, Cardiovascular Surgical Department, Budapest, Hungary

Aims
To improve the results of liquid sclerotherapy in middle range varicose vein cases.

Methods
By tapping the syringe containing liquid and air some foam develops on the surface of the sclerosing agent. Different concentrations of polidocanol were used to judge the efficacy of this material.

Results
It seems that froth increases the efficacy of the sclerosing agent by 2-3 times. If a more diluted solution is used, more material is necessary to achieve a good result. It was observed that the response of the vein can be judged after some minutes because the vein hardens within this time.

Conclusion
Making froth is faster and easier than making foam, which means middle range varicose veins are suitable for this treatment. Compared to foam treatment, further assistance and accessories are not necessary. Final efficacy can be judged during the treatment. Froth is more effective than the liquid sclerosing agent. This can be used in everyday practice: if the liquid sclerosing agent is not effective, then merely tapping the syringe a few times will increase the effectiveness of the medicine.

Room: The Great Room

Notes

1230 - 1245 Mon 08 February

Experience with concomitant ultrasound-guided foam sclerotherapy and endovenous laser treatment in chronic venous disorder and its influence on Health Related Quality of Life (HRQL): interim analysis of more than 1000 consecutive procedures.

Ted King[1], Glen Coulomb[2], Raj Guptan[3]
[1]Vein Clinics of America, Oak Brook, IL, USA
[2]Vein Clinics of America, Naperville, IL, USA
[3]Venous Research Foundation, Downers Grove, IL, USA

Aims
To evaluate the efficacy of combined Endovenous Laser Treatment (ELT) and Ultrasound-guided foam sclerotherapy (USGFS) on chronic venous disorder and to assess its effect on patients' Health Related Quality of Life (HRQL).

Methods
A prospective series of 1304 varicose veins in 1007 consecutive subjects treated with ELT on refluxing saphenous truncal, non-saphenous, and incompetent perforating veins. USGFS was utilized to treat refluxing, symptomatic varicose tributaries that were not amenable to ELT alone. The Venous Dysfunction Score (VDS) and HRQL were assessed. All of the patients had Duplex ultrasound scanning at 24-72 hours, at 1 week, and 1, 3, 6, 12, and 24 months.

Results
At 1 month, there was continued reflux (> 0.5 seconds) in 26 SFJs (3.0%, n=824) and 4 SPJ s (2.6%, n=155). At a mean of 12 ±10 months of follow-up, 4 SFJs (1.6%, n=245) and 1 SPJ (1.6%, n=62) had reflux. Overall, there was elimination of reflux in 98% of junctions. The anterior and posterior accessory saphenous veins (n=195), cranial extensions of the small saphenous vein (n=39), and non-saphenous veins and incompetent perforators (n=40) all had sustained response at 12 months ($p<0.001$). Sequentially assessed VDS showed significant improvement ($p<0.001$) as did the patients' Aberdeen Varicose Vein Questionnaire (AVVQ) scores at 1-2 years ($p<0.001$). Thirty-two patients (2.9%) had some medial calf numbness at one month that completely resolved in six (18.8%) by 6 months. There were two cases of superficial phlebitis. There was one asymptomatic popliteal DVT and one uncomplicated superficial skin burn that resolved with no treatment beyond observation. No PE, thrombophlebitis, or visual disturbance occurred.

Conclusions
Concomitant ultrasound-guided foam sclerotherapy with ELT is safe and highly efficacious in the management of saphenous truncal, tributary and non-saphenous vein reflux. CVD patients treated with this combination therapy demonstrated significant improvement in their HRQL.

Room: The Great Room

Notes

0800 - 0830 Tues 09 February

KEYNOTE LECTURE
Curing the Incurable

Philip Coleridge Smith [1,2]
[1]**The London Vein Institute, London, UK**
[2]**Department of Surgery, UCL Medical School, The Middlesex Hospital, London, UK**

Aims
To review one phlebologist's experience of managing telangiectases of the lower limb which have failed treatment in the hands of other sclerotherapists and surgeons.

Methods
Review of clinical records of patients attending a private clinic for management of venous disease of the lower limb.

Results
Patients reaching the clinic came from a number of sources and had previously undergone a range of treatments. Previous treatments included laser and IPL sessions, sclerotherapy, surgery including saphenous stripping and phlebectomies, endovenous laser and RF ablation of veins.

The main clinical problem which resulted from these treatments was an unsatisfactory cosmetic response with persistence of telangiectases, combined in some cases with persistent saphenous varices.

Treatments for persistent telangiectases after laser, IPL and sclerotherapy included foam sclerotherapy for incompetent saphenous trunks and varices, conventional sclerotherapy including treatment of associated reticular varices and ultrasound guided sclerotherapy of feeding veins.

In patients who had previously been treated surgically, almost all problems arose in those who had undergone surgical treatment for recurrent varicose veins. Ultrasound imaging showed that surgery had failed to eliminate saphenous trunks and tributaries especially where recurrence was due to neovascularisation. Recurrent varices were managed by foam sclerotherapy followed by conventional sclerotherapy for reticular varices and telangiectases.

Conclusion
Most 'incurable' cosmetic vein problems can be addressed by systematic identification and elimination of all classes of vein giving rise to the problem.

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1100 - 1115 Tues 09 February

Variables in Foam Sclerotherapy with Tessari Method: Experimental Data

Attilio Cavezzi[1], L.Tessari[2], M. Rosso[3], A. Cabrera Garrido[4]
[1]S.Benedetto del Tronto (AP), Italy
[2]Peschiera del Garda (VR), Italy
[3]Padova, Italy
[4]Granada, Spain

Aims
To assess main variables in foam sclerotherapy based on Tessari method.

Methods
An experimental study was performed to assess Tessari sclerosant foam (SF) features, also testing different types of syringes, gases, catheters, needles, and assessing SF variations with sodium tetradecylsulfate(STS) or polidocanol (POL).

Results
Density of SF was 0,16-0,20(STS) and 0,18-0,24(POL) g/l. Half life was 150"-180" for STS SF and 180"-240" for POL SF. SF formed with air at 60" had mean bubble radius of 33μ and 38μ for STS and POL respectively and halved figures at 10"-30"; CO2-based SF had the smallest bubble radius; CO2+O2 based SF was more durable than CO2 based SF. The reproducibility test (20 subjects) showed no statistically significant difference as to SF density, half-life and bubble size. SF passage through 27-30G needles resulted in larger bubbles and lower SF duration; 30-50% reduction of the three-way valve hole produced a slightly denser SF. A few low-silicone syringe brands produced much more durable and denser SF. Half-life and bubble size slightly changed according to catheter brand.

Conclusions
Tessari method has a good reproducibility; bubble size and SF duration may depend upon the type of drug, gas, syringes and needles which are used.

Room: The Great Room

Notes

1115 - 1130 Tues 09 February

Interaction of Detergent Sclerosants with Fibrinolytic Mechanisms

Kurosh Parsi[1,2], Thomas Exner[3], David Dang Fung Ma[1,2], Joanne Emily Joseph[1,2]
[1]Haemotology Research Laboratory, St Vincents Hospital, Sydney, Australia
[2]The University of New South Wales, Sydney, Australia
[3]Haematex Research Laboratory, Sydney, Australia

Aims
To investigate the effects of Sodium Tetradecyl Sulphate (STS) and Polidocanol (POL) on fibrinolytic mechanisms.

Methods
Measurements were done with serial dilutions of sclerosants in whole blood (WB), platelet rich (PRP) and platelet poor plasma (PPP). Control experiments were done in 5% bovine serum (BSA) spiked with the enzyme/inhibitor. Plasminogen was measured with a chromogenic assay. Alpha-2-antiplasmin (AP) activity, plasmin-alpha-2-antiplasmin (PAP) complexes, plasminogen activator inhibitor-1 (PAI-1) activity, tissue plasminogen activator (t-PA) total antigen, t-PA activity and t-PA/PAI-1 complexes were measured by ELISA. Thrombin activatable fibrinolysis inhibitor (TAFI) antigen and activated TAFI antigen were measured by ELSA and Western blotting.

Results
At high concentration (>0.3%), STS destroyed plasminogen, PAI-1, t-PA/PAI-1 complexes and total t-PA antigen but increased t-PA activity. At low concentrations (<0.6%), both agents reduced PAP complexes and increased AP activity, an effect which increased with increasing concentrations. STS increased PAI-1 activity, t-PA/PAI-1 complexes and TAFI levels. POL increased TAFI and the total t-PA antigen.

Conclusion
STS demonstrated a non-prothrombotic (destruction of PAI-1, t-PA/PAI-1 complexes), anti-fibrinolytic (destruction of plasminogen, increase in AP) effect at high concentrations. At low concentrations, both agents demonstrated a pro-thrombotic, anti-fibrinolytic (increase in PAI-1, total t-PA antigen, AP and TAFI) activity.

Room: The Great Room

Notes

1130 - 1145 Tues 09 February

Detergent Sclerosants Interfere with Platelet Activation and Aggregation

Anne Pilotelle[1], David Du[1], Kurosh Parsi[1,2,3]
[1]Haemotology Research Laboratory, St Vincents Hospital, Sydney, Australia
[2]The University of New South Wales, Sydney, Australia
[3]Haematex Research Laboratory, Sydney, Australia

Aims
To investigate the effects of Sodium Tetradecyl Sulphate (STS) and Polidocanol (POL) on platelet function.

Methods
Platelet and platelet microparticles (PMP) counts were done by flow cytometry using CD41a and Annexin V antibodies. Overall platelet function was measured by Platelet Function Assay 100 (PFA-100). Platelet activation was measured by ELISA for soluble P-selectin and CD40L. von Willibrand factor (vWF) was measured by ELISA and Collagen Binding Assay (CBA). Platelet aggregation was measured by impedance aggregometry (Multiplate Analyser).

Results
Platelets were destroyed by both sclerosants at concentration above 0.3%. PMPs were released in concentrations up to 0.6% STS and 0.3% POL but were then destroyed. Both agents at low concentrations (<0.3%) activated platelets, shortened the PFA closure time and increased P-selectin but at higher concentrations prolonged the closure time. Low concentration STS increased vWF and CD40L but destroyed these antigens at higher concentrations. Platelet aggregation was suppressed by low concentration sclerosants in a concentration dependant manner.

Conclusion
Low concentration sclerosants activated platelets and released PMPs. Platelet aggregation was suppressed by increasing concentrations of both agents. Platelets and PMP were destroyed by high concentration sclerosants.

Room: The Great Room

Notes

Overall Thrombotic Activity of Detergent Sclerosants: Thromboelastographic Data

David Du[1], Anne Pilotelle[1] , Kurosh Parsi[1,2]

[1]Phlebology Research Laboratory, Sydney, Australia
[2]Haematology Research Laboratory, St Vincent's Hospital, Sydney, Australia
[3]The University of New South Wales, Sydney, Australia

Aims
To determine the overall thrombotic activity of Sodium Tetradecyl Sulphate (STS) and Polidocanol (POL) in vitro.

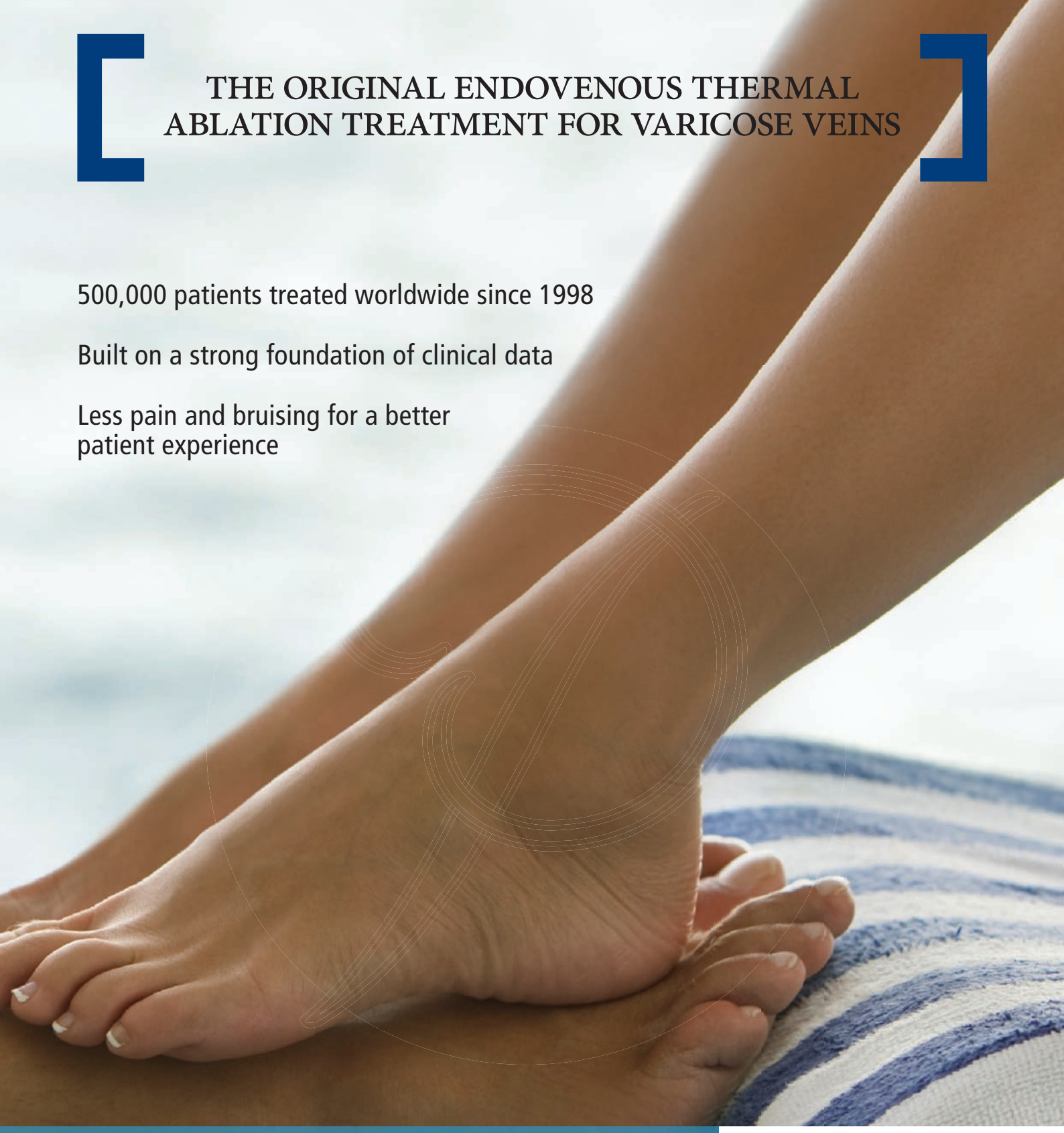
Methods
Various dilutions of sclerosants in whole blood were tested using an impedence based rotational thromboelstography method (ROTEM® delta, Pentapharm GmbH). 4 reagents (in-TEM®, ex-TEM®, fib-TEM® and ap-TEM®) were utilized according to the standard protocols. Analysis of ROTEM® results were done by comparing clot parameters.

Results
Increasing concentrations of both sclerosants lead to an increase in the clotting time (CT) while clot formation rate (CFR) and maximum clot firmness (MCF) decreased. Weak clots with reduced firmness were formed by low concentration sclerosants. Increasing concentrations of sclerosants lead to a reduction in the firmness of the formed clot. Clot formation was completely inhibited by 0.6% STS and 1.2% POL.

Conclusion
Sclerosants are capable of forming clots at low concentrations. With increasing concentrations, the clots formed become weaker and it takes longer to form a clot.

Room: The Great Room

Notes



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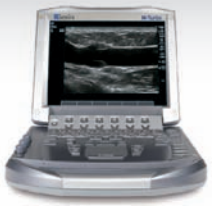

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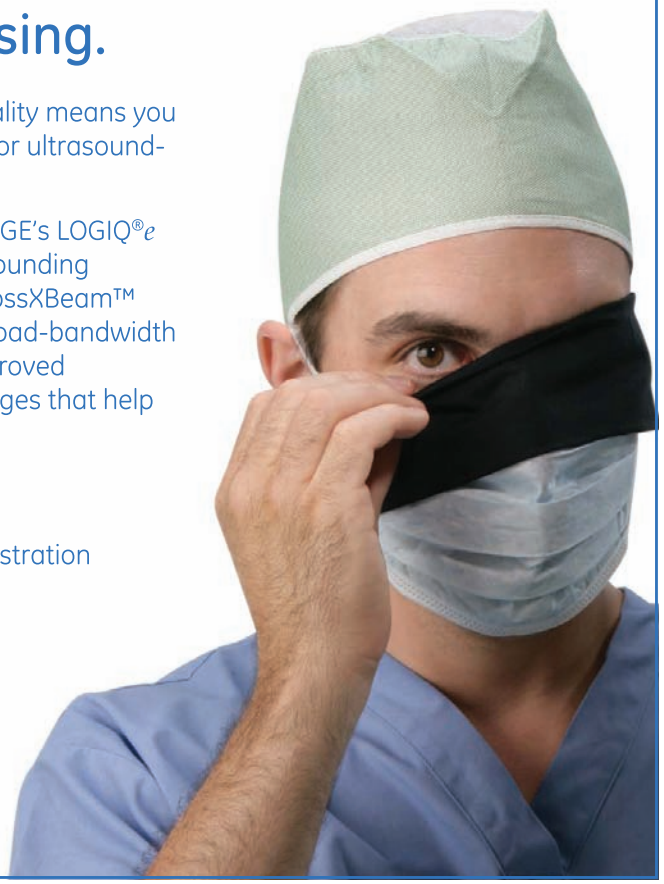

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1200 - 1215 Tues 09 February

Fibrinolytic and Thrombolytic Activity of Detergent Sclerosants

Kurosh Parsi [1,2], Thomas Exner [3], Joyce Low [4], David Dang Fung Ma [1,2], Joanne Emily Joseph [1,2]

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[4]Haemostasis Laboratory, Sydpath, St Vincent's Hospital, Sydney, Australia

Aims
To investigate the fibrinolytic and thrombolytic activity of Sodium Tetradecyl Sulphate (STS) and Polidocanol (POL) in vitro.

Methods
Fibrinogen was measured using the von Clauss method. Fibrinolysis was studied by turbidity measurements in cross-linked and non-cross-linked fibrin agarose gel and cross-linked fibrin powder. Effect on factor XIII (FXIII) was studied by ELISA. Clot lysis was studied by turbidity measurements in microtitre wells. D-dimer was measured by VIDAS, STA Liatest and AxSym assays.

Results
STS (but not POL) at 0.6% and higher destroyed fibrinogen and non-cross-linked fibrin. STS had a similar fibrinolytic profile to t-PA but was 100,000 times weaker. STS at 0.15% and higher completely destroyed FXIII. Neither sclerosant had a significant effect on cross-linked fibrin. STS artefactually elevated D-dimer in VIDAS ELISA assay but not in other assays tested.

Conclusion
STS prevented the formation of a stable fibrin clot by destruction of fibrinogen, non-cross-linked fibrin and FXIII.

Room: The Great Room

Notes

1100 - 1115 Tues 09 February

Pelvic Congestion Syndrome

Martin Necas[1,2]
[1]Waikato Hospital Vascular Lab, Hamilton, New Zealand
[2]Tristram Vascular Ultrasound, Hamilton, New Zealand

Waikato Hospital Vascular Lab, Tristram Vascular Ultrasound

Incompetence of the ovarian veins has been implicated in a wide range of clinical problems including pelvic venous congestion and lower extremity varices. It is therefore worthwhile to investigate the ovarian veins and pelvic veins in select patients presenting to the phlebologist with atypical varicose veins. Sonographers and sonologists should also extend their venous examination into the abdomen and pelvis when lower extremity varicose veins are being supplied by a pelvic source.

Ovarian vein reflux is relatively uncommon in nulliparous women but is remarkably common the multiparous. The vast majority of these women are asymptomatic, but a small proportion will present with a variety of clinical features of pelvic congestion or pelvic contribution to lower extremity varices.

Sonography of the ovarian and pelvic veins is not difficult and is technically achievable in the vast majority of patients. Transabdominal approach is suitable for the assessment of reflux in pelvic vein. In a woman with lower extremity varices of pelvic origin, this is the preferred examination. When a woman presents with clinical complaints suggesting pelvic venous congestion, gynaecologic opinion and transvaginal pelvic ultrasound should also be sought to exclude other coexisting pathologies.

Room: Greys

Notes

1115 - 1130 Tues 09 February

Emergencies in the Phlebology Laboratory - a Sonographers Role

Annie Morgan
Sydney Skin and Vein Clinic, Sydney, Australia

The objective of this presentation is to highlight the potential hazards in the day to day practice of interventional Phlebology and how to be prepared to manage them effectively.

From the moment a patient walks through the door of our phlebology laboratory there is a duty of care to keep them safe with no injury incurred during any of the steps to assess their veins and to treat them. However, no matter how careful one is, there will be incidents beyond one's control that, if managed appropriately, need not be catastrophic or lethal.

As a Sonographer in this environment, it serves well to be **aware** of potential emergencies or hazards and more importantly how to **safely** prepare for such occasions and manage them to minimise the morbidity.

The emergencies that will be reviewed include vasovagal episodes, needle stick injuries, inadvertent intra-arterial injection, endovenous laser ablation related incidents, drug administration incidents, thrombosis and embolus. Potentially lethal emergencies for example cardio respiratory arrest and anaphylaxis will be addressed also.

The key message is to be aware, be prepared and expect the unexpected.

Room: Greys

Notes

1130 - 1145 Tues 09 February

Ultrasound of Lower Limb - Overview of Common MSK Pathlogies

Scott Allen[1,2], Andrew Graham[2]
[1]Sound Experience Ltd, Auckland, New Zealand
[2]Ultrasound Projects Limited, Auckland, New Zealand

Present examples of non-vascular lower limb abnormalities seen with diagnostic ultrasound.

Methods
Powerpoint presentation of cases of the hip, thigh, knee and calf. These will show examples of common joint, ligament, tendon, and muscle pathologies.

Conclusion
A brief overview of lower limb musculoskeletal pathology seen with diagnostic ultrasound

Room: Greys

Notes

1145 - 1200 Tues 09 February

The changing role of the Venous Duplex Scan in the era of endovenous thermal ablation

Gary Frydman[1,2]
[1]Medical Director Western Vascular Centre, Melbourne, Australia
[2]Visiting Vascular Surgeon, Western Health , Melbourne, Australia

With the advent of endovenous thermal ablation as a important method for the treatment of varicose veins, more information is required to be delivered to the referring doctor than previously has been the case. I will aim to identify the areas where more reporting requirements are needed for the treating doctor.

Room: Greys

Notes

1200 - 1215 Tues 09 February

Interaction of Detergent Sclerosants with Fibrinolytic Mechanisms

Martin Necas[1,2]
[1]Waikato Hospital Vascular Lab, Hamilton, New Zealand
[2]Tristram Vascular Ultrasound, Hamilton, New Zealand

Vascular ultrasound examinations of the lower extremity veins are some of the most technically challenging tests done under ultrasound visualization. This complex diagnostic work needs to be accurately reflected in a clear, concise, high quality vascular worksheet or report.

Most plebologists are interested in a graphical report, rather than wordy non-descript text. Despite huge leaps in computer information technology in recent years, the remarkable fact is that most vascular worksheets today are still drawn by the sonographer by hand as they were 30 years ago. While some sonographers draw beautiful works of art which are a pleasure to review, others produce less desirable reports which are difficult to interpret. Worse yet, if an investigation is done in one centre but treatment in another centre, failure to clearly report the findings may necessitate an investigation being repeated.

This presentation will showcase a range of simple but effective reporting strategies which the audience can easily adapt in their clinical practice.

Room: Greys

Notes

1330 - 1400 Tues 09 February

KEYNOTE LECTURE
Venoactive Drugs - Gimmick or Medicine?

Philip Coleridge Smith[1,2]
[1]The London Vein Institute, London, UK
[2]Department of Surgery, UCL Medical School, The Middlesex Hospital, London, UK

Aims
To review medical literature concerning the use of phlebotonic drugs.

Results
Logical use of drugs in the management of venous disease.

Varicose veins and oedema
In temperate climates the use of compression stockings is generally considered to be the most appropriate conservative measure. However, in hot climates the wearing of stockings is less acceptable for patients who may find that they cause intolerable discomfort. There may be some rationale in prescribing phlebotonics in these circumstances.

Diosmine and hesperidine may be useful in trophic disorders as well as cramps and swelling. Rutosides may benefit oedema.

Level of recommendation: 2b

Venous ulcers
Compression treatment and surgery to treat incompetent superficial varices and perforating veins are the main lines of management in patients with venous leg ulcers. Only two drugs have been shown to have any influence on venous ulcer healing in a meta-analysis, pentoxifylline and micronised purified flavonoid fraction (MPFF). Both should be used in combination with compression and standard wound management. Efficacy is probably most apparent in large (5 – 10 cm) long standing ulcers (more than 6 months). These drugs have few side effects and could be considered when compression alone has proved to be ineffective in countries where these compounds have been licensed.

Level of recommendation: 1b.

A PGE-1 analogue has also been shown to have efficacy in promoting venous ulcer healing, but this is confined to one randomised controlled trial. In addition, this drug must be given by intravenous infusion and has some significant side effects. More detailed work is required before a recommendation can be made for use in venous disease.

Room: The Great Room

Notes

1400 - 1415 Tues 09 February

Multiple Sclerosis and Cerebral Venous Insufficiency

Paul Thibault
Central Vein & Cosmetic Medical Centre, Newcastle, Australia

The hypothesis that multiple sclerosis is related to chronic cerebral venous insufficiency (CCSVI) was initially proposed by Professor Paolo Zamboni, University of Ferra, Italy. The concept of CCSVI is described as a pathophysiologic state where blood from the brain and spine is impeded by stenoses in the veins that drain the spine and brain. Blood refluxes back into the brain and spine to cause oedema and leakage of red blood cells and fluids into the cerebral and spinal tissue. The resultant slowed perfusion causes hypoxia in the brain. Plasma and iron from blood deposited in the brain tissue also has damaging effects.

So far, every MS patient tested for CCSVI has it according to Dr. Paolo Zamboni. Around 600 patients have been tested to date. In addition 1700 patients and controls are being tested for it by Jacobs Neurological Institute at SUNY Buffalo. No controls or patients with other neurological diseases tested so far by Prof Zamboni have CCSVI.

The presentation will detail the evidence of MS being caused by CCSVI and the patterns of obstruction or stenoses found by Prof Zamboni. Early results of endovascular treatment will be presented.

Room: The Great Room

Notes

1415 - 1430 Tues 09 February

Prevalence of Reflux in the Great Saphenous Vein as a Function of Diameter

Nick Morrison[1,2]
[1]Morrison Vein Institute, Arizona, USA
[2]Morrison Training Institute, Arizona, USA

To determine if diameter measurement is a useful secondary variable in the evaluation of valvular insufficiency of the great saphenous vein (GSV) in the thighs of a series of Ecuadorian patients.

Methods

Evaluation for chronic valvular insufficiency of the GSV was performed in the standing position in 356 limbs. The duplex equipment used was a laptop-based machine. The relationship between mid-thigh GSV diameter measurements and reflux longer than 1 second is reported herein.

Results

Prevalence of reflux is demonstrated in the table below.

PREVALENCE OF REFLUX

GSV Mid-Thigh Diameter	Women	Men
≥6mm	38/38 (100%)	8/8 (100%)
5mm	20/22 (91%)	7/9 (78%)
4mm	19/46 (41%)	4/8 (50%)
3mm	25/133 (19%)	1/16 (6%)
2mm	5/62 (8%)	0/5 (0%)
1mm	No reflux detected	No reflux detected

Conclusions

In a group of Ecuadorian patients, diameter measurement in the mid thigh can be an effective secondary measurement to establish valvular insufficiency of the GSV, particularly if a contradiction exists without reflux being detected in GSV larger than 5 mm in diameter. Presence of reflux still needs to be evaluated even in veins as small as 2 mm in diameter.

Room: The Great Room

Notes

1430 - 1445 Tues 09 February

Venous Perforators in Normal Lower Limbs - Ultrasound Characterisation and Comparison with Resin Caste Anatomy

Andre van Rij
Professor of Surgery & Head of Section, Surgery, Dunedin School of Medicine, Dunedin, New Zealand

Not available at time of print

Room: The Great Room

Notes

1445 - 1500 Tues 09 February

Venous Incompetence in Children

Michel Schadeck
Paris, France

Aims
Chronic venous insufficiency (CVI) is common in children and adolescents, often beginning very early. This work proposes an investigation and management plan using the reflux witch is a major item in the initial assessment and follow-up.

Methods
Duplex scanning, although unable to truly quantify reflux, has since helped to classify it by type, height, outcome topography, and the relationship between subject age and topography. These parameters are combined with clinical examination to score the severity at presentation and monitor the disease course.

Results
Results show that the frequency of CVI in the young depends on the study population and ranges from 3% to 10%, depending on age. They confirm its progression with age, which has been confirmed using the Clinical-Etiology-Anatomy-Pathophysiology (CEAP) classification. Continuous-wave Doppler ultrasound has been used in a small number of epidemiological studies to determine the prevalence of great saphenous vein reflux in childhood

Conclusion
Reflux generally begins around the knee and progresses proximally with age. It may appear before or after puberty. Despite the substantial advance in characterization of CVI and reflux in the young, a consensus has yet to be reached as to treatment indications and modalities.

Room: The Great Room

Notes

1500 - 1515 Tues 09 February

Relationship Between Number of Pregnancies and Great Saphenous Vein Diameter

Nick Morrison[1,2]
[1]Morrison Vein Institute, Arizona, USA
[2]Morrison Training Institute, Arizona, USA

Aims
Number of pregnancies has been mentioned as a risk factor for chronic venous insufficiency. This analysis investigated if number of pregnancies correlated with GSV diameter.

Methods
One hundred seventy-eight Ecuadorian women who perceived they had leg venous problems were evaluated by duplex ultrasonography using a laptop-based machine. Median number of pregnancies of 178 women, 51±3 years of age, was 4 (range 0-15). GSV diameter in mm was measured at mid thigh with the patient standing. Statistical analysis included calculation of correlation coefficients and t-tests.

Results
Correlation coefficient between number of pregnancies and left GSV diameter calculated for the entire data set was low: 0.06. The correlation coefficient calculated for the average GSV diameter of each subgroup increased to 0.48. GSV diameter was smallest for women without pregnancies, 2.6±0.5 mm (P<.001). GSV diameter of women having one pregnancy, 2.8±1.6 mm, was not significantly different than subgroups with less (P=.30) or more pregnancies (P=.17). Largest GSV diameters were: 4.2±3.4 mm (N=9 pregnancies), 4.1±2.5 mm (N>10), 4.1±2.8 mm (N=2) and 4.0±2.8 mm (N=5). The average GSV diameters for >9 or 1-8 pregnancies were not significantly different (P=.50).

Conclusions
GSV diameter increased with one pregnancy. Otherwise, the number of pregnancies was not related to GSV diameter.

Room: The Great Room

Notes

1515 - 1530 Tues 09 February

Progression and recurrence of vein disease in patients treated with endovenous laser ablation: Two-four year experience. Is there a place for the phrase recurrent varices after laser or reval?

Ted King
Vein Clinics of America, Oak Brook, IL, USA

Aims
The incidence of recurrence of reflux at the SFJ and SPJ after endovenous laser treatment (ELT) has been well studied. However, tracts of recurrent flow also occur in the GSV and SSV away from the junctions after laser ablation. This study looks at how often new vein disease develops after ELT, as well as where, when, and why.

Methods
A retrospective analysis of 50 cases (66 veins) treated with 980 and 1320 nm ELT. Thorough Duplex ultrasound scanning was performed at 24-45 months follow-up, average: 28.8 months. All segments of vein with any reflux (>0.5 sec.) were noted and recorded as progression (new vein disease) or recurrence (recurrent or continued flow through previously-lased vein segments).

Results
Recurrent SFJ reflux: 3/50 (6.0%); SPJ: 0/9. Recurrent truncal reflux without junctional involvement: proximal GSV, 5/50 (10%); 8/50 (16%); SSV, 1/9 (11.1). New reflux in non-saphenous vein segments (progression): 34/50 (68%) with 6/34 (17/6%) arising from saphenous trunks and 28/34 (82.4%) arising from incompetent perforators. IPs above knee: 23 in 11/34 (32.4%) causing 15.6% of new vein disease. IPs below knee: 42 in 25/34 (73.5%) causing 28.6% of new vein disease. Total IPs: 73 in 31/36 (86.1%). No vein disease found: 14/50 (28%).

Conclusions
Unlike ultrasound findings at one year follow-up, two-four year ultrasound follow-up after ELT shows new vein disease to be seven times more common than recurrent disease in previously treated veins. Disease progression in non-saphenous veins is 5.5 times more common than saphenous truncal progression. New incompetent perforators accounted for virtually all non-saphenous vein progression. New IPs in the calf were 3 times more common than those in the thigh. At 28.8 months of follow-up, 72% of patients had ultrasonographic and/or visible progressive and/or recurrent vein disease. Regarding the long term success of ELT, coining the term REVAL might be appropriate.

Room: The Great Room

Notes

1615 - 1645 Tues 09 February

GUEST LECTURE
The Future of New Antithrombotics

Sanjeev Chunilal
North Shore Hospital, Auckland, New Zealand

Heparin and low molecular weight heparin (LMWH) therapy for 5-7 days followed by oral vitamin K antagonists (OVKA) therapy, till recently has been the standard of care for the acute treatment for venous thromboembolism (VTE). Recent randomised trials have shown that the new oral anticoagulants such as the direct acting thrombin inhibitors (DTI) and the direct acting factor Xa inhibitors (DXI) have shown superiority or similar efficacy in the prevention of VTE in orthopaedic patients. For acute treatment of acute VTE, the DTI's have shown similar efficacy to OVKA for long term prevention of VTE after initial treatment with heparin therapy.

Studies testing the efficacy of acute DXI therapy for treatment of VTE are currently ongoing but have not shown any safety concerns to date. Whilst these phase 3 studies are exciting and suggest suitable alternatives to OVKA are now available, longer term data (phase 4) are required before younger patients who require lifelong therapy should be offered longer term therapy with these drugs.

Unlike oral Vitamin K antagonists and heparins, these new agents do not have simple readily available or cheap antidotes to reverse bleeding if required. This remains a major limitation of these agents.

Room: The Great Room

Notes

1645 - 1715 Tues 09 February

GUEST LECTURE
ACCP 2008 Guidelines: What's New

Abdullah Omari
Head of Vascular Medicine and Staff Specialist, St. Vincent's General Hospital, Sydney Australia

Not available at time of print

Room: The Great Room

1715 - 1730 Tues 09 February

The Time Sequence of the Development of Axial Deep Reflux Following Lower Limb DVT - a Prospective Study over 5 Years

Andre van Rij
Professor of Surgery & Head of Section, Surgery, Dunedin School of Medicine, Dunedin, New Zealand

Not available at time of print

Room: The Great Room

Notes

1730 - 1745 Tues 09 February

Challenging Cases In VTE

Abdullah Omari
Head of Vascular Medicine and Staff Specialist, St. Vincent's General Hospital, Sydney Australia

Not available at time of print

Room: The Great Room

Notes

1745 - 1800 Tues 09 February

Simple Interventions Improve Adherence to Thromboprophylaxis Guidelines

Deborah Wright, M Fancourt, W Gilkison, F El-Haddawi, S Kyle, D Mosquera
Department of Surgery, Taranaki Base Hospital, New Plymouth, New Zealand

Aims
Thromboprophylaxis is the responsibility of every surgeon. The aims of this study were
1. To compare performance with Australasian Guidelines on Venous Thromboprophylaxis and
2. To determine whether simple interventions changed performance.

Methods
This was a 12 month prospective study on a general surgical ward in a provincial New Zealand Hospital. A snapshot assessment of thromboprophylaxis was performed on all ward patients on 22 occasions using a structured survey instrument (13 pre-intervention and 9 post intervention).

Intervention consisted of education of staff, drug chart modifications and placement of alert stickers.

Results
A total of 174 patients were assessed, 100 pre-intervention and 74 post intervention.

Anti-embolism stockings were appropriate in 50% of pre intervention ward patients (50 of 50) and 85% (63 of 74) post intervention ($p<0.0001$, 2). Enoxaparin was appropriate in 46% (46 of 100) and 69% (51 of 74) of pre and post intervention patients respectively ($p= 0.004$).

Exact adherence to post operative guidelines occurred in 25% (25 of 100) patients pre-intervention and in 62% (46 of 74) post intervention ($p<0.0001$), although most patients (85%) received some form of prophylaxis.

Conclusions
Adherence to thromboprophylaxis guidelines can be improved by simple, cheap, transferrable interventions.

Room: The Great Room

Notes

0800 - 0830 Wed 10 February

Preserving Great Saphenous Vein - A Lost Cause?

Imre Bihari
National Health Service Center, Cardiovascular Surgical Department, Budapest, Hungary

Aims
What is the aim of great saphenous vein preservation? Was it successful in the last 30 years?

Methods
Sapheno-femoral junction ligature, plasty, wrapping, distant sclerotherapy.

Results
Wrapping and distant sclerotherapy gave good results only for two years, ligature and plasty were efficient for 5 years.

Conclusion
The main aim of great saphenous vein preservation is its usage as a bypass material. Treatment of the great saphenous vein is recommended only if it is varicose, the normal vein must be saved. After a temporary enthusiasm fewer and fewer colleagues deal with saving varicose veins. It seems that the time span, about 20 years between varicose vein and bypass surgery, is too long to save a non-healthy vein in a patient who is prone to varicose vein disease. It seems the subject of debate is the femoral part of the great saphenous vein, because the crural part in most cases is healthy. Femoral part preservation is recommended if the patients atherosclerosis is known at the time of varicose vein surgery. A question for the future is whether new methods such as different medicines and angioplasty or stent implantation will be used instead of bypass surgery?

Room: The Great Room

Notes

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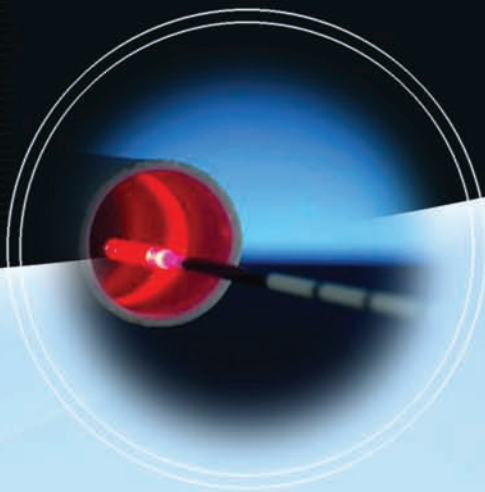

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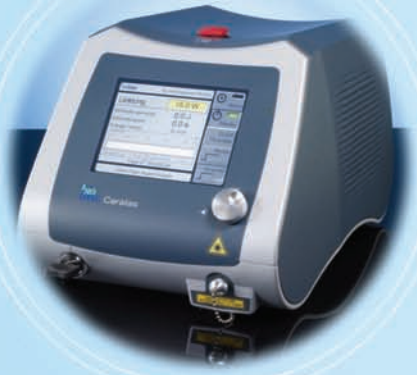
  With this new technology, extra-long catheters and guide wires are a thing of the past.
- The Procedure can be performed with less tumescence providing substantial time savings.



Technical Specifications:	Details of Kit:
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2.5 m fiber length	6 French sheath / dilator 11/23 cm length
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1100 - 1115 Wed 10 February

Popliteal vein compression, DVT and the efficacy of calf compressors

David Huber[1] Anthony Levine[2], Jacqueline Huber[2]
[1]Wollongong Hospital, Wollongong, Australia
[2]St Vincent's Hospital Sydney, Sydney, Australia

Aims
To investigate the relationship between popliteal vein compression and DVT, specifically looking at the efficacy of calf compressors.

Methods
16 subjects (32 popliteal veins) had standard calf compressors fitted. The flow velocity in the popliteal veins was measured using duplex ultrasound. Subjects were placed in the same position as supine and immobile patients undergoing surgery (with the heel offloaded). Peak flow was measured during calf compressor inflation and an average of 3 measurements was used for analysis. Two knee positions were analysed:

1. knee unsupported with the heel elevated (hyperextended)
2. knee flexed 5°-10°

Results
There is a highly significant ($p<0.0007$) difference in the flow velocities, with a rise in the peak flow velocity when the knee is unsupported. Pearson correlation -0.49 ($P<0.005$)

Conclusion
Current heel PU prevention protocols require the heel to be offloaded. This is inadvertently causing popliteal vein compression. This in turn leads to poor venous outflow and this study shows that the function of calf compressors is compromised. The effectiveness of calf compressors is enhanced if the knee is flexed 5°-10°.

A review of recent literature looking at the association between popliteal vein compression and DVT will also be presented.

Room: The Great Room

Notes

1115 - 1130 Wed 10 February

Minimally invasive surgery for Varicose veins. Its role in 2010

Gary Frydman[1,2]
[1]Medical Director Western Vascular Centre, Melbourne, Australia
[2]Visiting Vascular Surgeon, Western Health , Melbourne, Australia

Aims
To review the role & results for minimally invasive varicose veins surgery from the literature and present early results from my personal series.

Methods
The technique involves multiple avulsions of the varicose veins with salvage of the axial saphenous vein in patients where the axial saphenous vein has been shown to be refluxing. A review of the literature has been undertaken and will be presented. In my own series patient selection will be explained with follow up results of up to four months.

Results
This technique allows early return to normal activities. Results from published series show good long term success rates similar to standard surgical repair. Removal of the varicose reservoir will reverse the reflux in the saphenous vein in most cases.

Conclusion
It appears that minimally invasive varicose veins surgery with removal of the varicose reservoir with preservation of the refluxing saphenous vein may play a role in the management of varicose veins in 2010.

Room: The Great Room

Notes

1130 - 1145 Wed 10 February

Computational Blood Flow Analysis to Assess Effect of Stenosis Symmetry

Afiqah Hamzah[1,2], Andy Yong[2], Masud Behnia[1],Leonard Kritharides[2]
[1]Department of Mechanical Engineering, University Of Sydney, Sydney, Australia
[2]Cardiology Department, Concord Hospital, Sydney, Australia

Aims
To determine the difference in blood flow characteristics between a symmetric and asymmetric stenosis within a blood vessel.

Methods
1. Using SolidWorks software (DS SolidWorks Corp., Concord, USA)\, two simple models of a blood vessel was created, each representing symmetric and asymmetric stenosis respectively. All models have the same area percentage reduction.
2. Computational fluid dynamic (CFD) simulation analysis was performed on the models, using ANSYS CFX (ANSYS Inc, Canonsburg, USA). Constant laminar flow at 0.9g/s and Newtonian fluid properties were assumed.
3. Pressure gradient, maximum wall shear stress (WSS) and average WSS were compared for the two models.

Results
1. Both models have similar average wall shear stress (asymmetric: 58 Pa, symmetric: 60 Pa)
2. The asymmetric model had higher maximum wall shear stress (207 Pa vs. 167 Pa)
3. The asymmetric model had larger pressure gradient (31.3 Pa vs. 26.9 Pa)

Conclusion
It is important to ensure accurate representation of blood vessel geometry in estimating blood flow characteristics.

Room: The Great Room

Notes

1145 - 1200 Wed 10 February

Acute Hepatitis following Methoxyfluorane Analgesia during Sclerotherapy

Stuart McMaster
The Grange Vein Clinic, Grange, Queensland, Australia

Aims
A case presentation describing a 33 yr old patient who developed acute hepatitis following the use of methoxyfluorane analgesia on three occasions for analgesia during ultrasound guided sclerotherapy treatment.

Methods
The case is described followed by a brief review of the literature regarding the history and safety profile of methoxyfluorane.

Results
Whilst there have been previous descriptions of hepatotoxicity related to larger dosages and or recreational abuse of methoxyfluorane, there are no reports worldwide of acute hepatitis following repeated treatments at currently recommended dosage. Methoxyfluorane (marketed as penthrane) is only available in Australia and New Zealand and is widely used for outpatient analgesia. This is an important potentially fatal adverse effect that practitioners should be aware of.

Conclusion
Methoxyfluorane, whilst generally well tolerated, has the potential for severe adverse liver toxicity even at therapeutic doses, in otherwise well patients. Practitioners must be aware of this potential when prescribing this medication.

Room: The Great Room

Notes

1200 - 1215 Wed 10 February

When Will the Bubble Burst? - Foam Stability: Air vs. CO2

Christopher Lekich[1], David Du[2], Kurosh Parsi[1,2]
[1]Sydney Skin and Vein Clinic, Sydney, Australia
[2]Phlebology Research Laboratory, Sydney, Australia

Aims
To compare the stability of detergent sclerosant foams using air or CO2 as the foaming gas.

Materials and Methods
1.5% STS foam was prepared using a modified Tessari method. 0.6 ml of 1.5% STS solution was mixed with 2.4 ml air or CO2 using 1 and 3ml syringes (Luer-Lok™, Terumo®) connected via a three way stopcock (BD Connecta™) and 5 micron filter hubs (FH-5000, Braun Medical Inc). Room air was collected at 22ºC. CO2 was sourced from CO2MMANDER™ delivery system (Portable Medical Devices, FL, USA) using a Silver Bullet™ CO2 cartridge. Air vs. CO2 foam degradation was observed macroscopically and microscopically.

Results

	Test	STS Air Foam	STS CO2 Foam
Foam Longevity	Macroscopic bubble degradation by 50% of 3ml of foam in a syringe	3 minutes	50 seconds
	Microscopic Bubble Degradation	3 minutes	6 minutes
Bubble Size	Microscopically at one minute foam bubble size averaged	107.9 um diameter	75.2 um diameter
	Microscopically at three minutes foam bubble size averaged	116.5 um diameter	57.2 um diameter

Conclusion
Macroscopically, foam prepared with air appears more stable. Microscopically, CO2 prepared foam has a smaller average bubble size over a greater length of time compared to foam prepared with air.
The addition of CO2 for foam preparation appeared to improve microscopic bubble stability.

Room: The Great Room

Notes

1100 – 1120 Wed 10 February

GUEST LECTURE
How Not to Get Rejected!

Philip Coleridge Smith[1,2]
[1]The London Vein Institute, London, UK
[2]Department of Surgery, UCL Medical School, The Middlesex Hospital, London, UK

Aims
To review an editor's experience of phlebological papers submitted to scientific journals.

Results
The crimes committed by hopeful authors of scientific articles range from those deserving capital punishment to incompetent use of the apostrophe.

The most major problems relate to the writing and content of papers. Many authors will not have English as their native language which I am happy to accept. However, submitting a paper written with poor English grammar will mean that the editor is left with a lot of work to do. This is possibly acceptable for an important paper but if the editor and reviewers can't understand the meaning of the work rejection is inevitable. Some authors forget to write down what they have done in the way of experimental work, methods of measurement or even results. A long discussion justifies the reason for the paper. To be published, a paper must be comprehensible and repeatable by other investigators, so all the information on experimental methods, analysis and conclusions must be there.

The abstract is the first item I read, but sometimes this contains little of the methods or results of the work. Since this is all that anyone looking at MedLine or PubMed will see, time taken in crafting an abstract will pay dividends.

Some authors are more devious and results appear to have been created by dubious science or have even been invented! I once looked at a graph submitted by an author which represented a clinical measurement and found that it fitted a mono-exponential regression line to an accuracy of better than 1%. Other scientific work covering hundreds of thousands of measurements made in thousands of patients over 10 years was summarised in a single paper with 4 graphs. Less severe crimes include optimistic or over enthusiastic use of statistical analysis. The God, SPSS has to be worshipped so data are often quoted to several places of decimals and sometimes the phrase 'p=0.000' appears in the text. This has no meaning since we can never be that certain about anything! Please read the documentation on this program before using the output from it to enrage the editor!

Conclusions
Whilst there are many ways to upset the editor, diligent preparation of a manuscript will give you the best chance of publication.

Room: Greys

Notes

1120 - 1140 Wed 10 February

GUEST LECTURE
Something Wrong With Those Numbers!

Ken Myers
Victoria Vein Clinic, Melbourne, Australia

Phlebology seems to be almost the last discipline to require appropriate statistical techniques to show long-term outcome after treatment. Most articles present results with interval success rates; for example, a study starts with say 1000 patients and by five years 100 are still under observation of which 90 are still successful so that the outcome is reported as having 90% success at five years. This conveniently ignores the many failures in the other 900 patients who no longer elect to attend.

The appropriate reporting technique is termed survival analysis and this has been widely used for some 50 years. It requires clear definition of entry and end points and of success and failure. Follow-up is at the last date that the patient is seen, either currently under review or lost to follow-up, or the date if the patient dies. The simplest reporting technique is actuarial life table analysis in which each interval success rate is multiplied by the previous interval success rate to calculate a cumulative success rate.

A more widely used though more complicated technique is the product-limit method of Kaplan and Meier. Long-term outcome must be reported by either technique and assistance from a statistician is strongly recommended.

Room: Greys

Notes

1140 – 1200 Wed 10 February

GUEST LECTURE
Patient Reported Outcomes (PRO) and Chronic Venous Disorders (CVD)

Jean-Jerome Guex
Nice, France

Demonstrating the efficacy of any treatment requires appropriate outcomes for judgment and an appropriate and sound association of these.

A treatment must be based on a logical pathophysiological hypothesis, but we know that there is no complete correlation between pathophysiological findings and clinical features.
Physician reported outcomes such as VCSS are convenient, easily evaluated and relevant. However, they remain biased and don't provide with sufficient level of evidence, especially in non double blind RCTs.
Patient reported outcomes are the ultimate referee and QoL or PRO cannot be overlooked. They increase the power of the studies and give the patient the central role they should never have lost.

PROs are the ultimate outcome for health care interventions.
PROs increase the level of evidence of clinical trials
PROs are here to stay.

Multiple outcome measures are necessary to address the multiple aspects of the disease.
Physician reported outcomes are swift to acquire but biased by the observer-expectancy effect.

Whether we like it or not, the reign of the almighty doctor is over, patients decide if they are happy with the outcomes or not.

Room: Greys

Notes

1200 – 1220 Wed 10 February

GUEST LECTURE
Blood Flow Fluid Mechanics: How and What We Measure

Masud Behnia
Office of Dean of Graduate Studies, The University of Sydney, Sydney, Australia

Unlike water, blood flow is non-Newtonian in nature. In addition the flow is pulsating and three dimensional. One should also consider the fact that the blood vessel is not of any regular shape which varies as the blood flow takes place through it. Due to these and other reasons in-situ measurements in blood are very difficult and cannot be easily carried out. Therefore, in most cases for an understanding of the flow behaviour in blood either experimental or numerical modelling is performed.

Room: Greys

Notes

1330 - 1400 Wed 10 February

KEYNOTE LECTURE
Bubbles in the Brain - What do we know?

Nick Morrison[1,2]
[1]Morrison Vein Institute, Arizona, USA
[2]Morrison Training Institute, Arizona, USA

Introduction
Systemic and specific central nervous system (CNS) symptoms have been described after foam sclerotherapy of lower extremity veins.

Methods
We have investigated foam migration after injection of leg veins, and have studied a variety of maneuvers intended to limit central migration. Further, we have compared symptoms following foam injection using various gases for foam production, and attempted to correlate cerebral emboli with symptoms.

Results
We now know that foam injected into superificial leg veins will result in demonstrable intra-cardiac echogenic signals in all patients, and in the presence of a right-to-left shunt, cerebral emboli can be detected. Maneuvers such as leg raising, limitations on injectate volume, or maintaining patient immobility all fail to prevent such emboli. Systemic and CNS symptoms are generally less frequently seen using a more biocompatible gas than air, such as a carbon dioxide/oxygen mixture, to produce foam from a liquid detergent sclerosant. Correlation of symptoms with cerebral emboli is not clear, and it has been suggested that vasoactive substances related to endothelial destruction with foam sclerotherapy may play a role in patient's symptoms.

Conclusions
More investigation is required to determine the cause(s) of systemic and CNS symptoms infrequently seen following foam sclerotherapy.

Room: The Great Room

Notes

1400 - 1415 Wed 10 February

The French Polidoconal Registry - a Survey Covering 3357 Patient Years

Jean-Jerome Guex
Nice, France

Aims
Short and mid-term side effects of sclerotherapy, in particular with Polidocanol (Lauromacrogol 400) have been previously described in our registry of 12,173 sessions. The objective of this follow-up registry was to evaluate the long term incidence of adverse events with Polidocanol.

Methods
The Physicians involved in the initial French Registry were contacted and asked to partake in the follow-up survey. Initially included patients were controlled at the latest possible date in order to determine if a complication had occurred after the end of the initial survey.

Results
Data on 1,605 patients included during the French Registry were reviewed with a maximum follow up of 60 months covering 3,357 patient years. A total of 5 (0.39 %) adverse events were observed in patients treated with liquid Polidocanol and 46 (1.14%) in patients treated with Polidocanol foam. Most frequent side effects were visual disturbances with a total number of 14 and most severe were 8 muscular vein thrombosis. The onset of side effects was mostly observed directly after sclerotherapy or in the first 6 months afterwards (84% in the first year). One DVT recurrence occurred in a patient with heterozygote Factor V Leiden after stopping anticoagulant treatment (foam sclerotherapy).

Conclusions
Foam sclerotherapy is a recognized reference method in the treatment of varicose veins of all types. Polidocanol demonstrates in this study that it is a safe sclerosing agent at short and long term.

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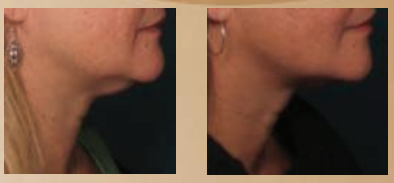

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1415 - 1430 Wed 10 February

Complications of Duplex Guided Sclerotherapy of the Small Saphenous Vein Study of a Population of 4984 Patients

Michel Schadeck
Paris, France

Aims
To establish in a population of 4984 patients the complications following the Duplex guided sclerotherapy (DGS) of the small saphenous veins (SSV).

Methods
An open prospective study is performed on patients having varicose disease. The different sclerosing agents were (Tétradécyl sodium sulfate [TDS] 3% and Polidocanol (Pol) 3%), with the liquid or foam form.

Results
The number of saphenous veins treated is of 4974 with 891 SSV.
The follow-up is of 59 months. The foam 3% was used in 57, 57% of the cases versus 39, 8% for the liquid.

The mean of volume was of 1,9cc and the concentration of 2, 9%. The main observed complications in this population of 891 SSV were:
- DVT 14
- SVT 3
- Necrosis 1

The DVT occurred in 0, 56% of the cases using the liquid form and 2, 25% with the foam.
Foam 3% induces four times more DVT than liquid 3%.

Conclusion
The SSV was first considered as a dangerous axis to be treated. Today, also the DGS has become easier, it has to be performed very carefully. In order to avoid a DVT, we have to avoid foam on patients with vascular risk.

Room: The Great Room

Notes

1430 - 1445 Wed 10 February

EVLA vs. Foam UGS for Saphenous Trunks - 5 Year Prospective Outcome Data

Peter Chapman-Smith
Skin and Vein Clinic, Whangarei, New Zealand

UGFS and EVLA combined with UGFS distally and for tributaries are methods to treat varicose veins. The efficacy , closure rates and retreatment rates over 5 year follow up are presented, with a summary of adverse outcomes which were non serious.

UGFS is cheaper, with lower primary success, but is readily repeatable and has high patient acceptance. Clinical recurrence at 5 years was 4%.

1320nm EVLA under tumescent anaesthesia alone , combined with concomitant UGFS of all sources of reflux is demonstrated to be preferable, with lower recurrence rates , high safety and no serious adverse outcomes. Vein access is by Seldinger technique, and veins as small as 2mm can be accessed. Extrafascial veins can be treated with careful tumescence.

Both methods are popular with patients, with immediate ambulation and return to activity. The thrombophilic risk is very low. Comorbidities rarely are a contraindication.

Saphenous trunks can be effectively closed by either technique, the medium term results more impressive for EVLA.

Room: The Great Room

Notes

1445 - 1500 Wed 10 February

Safety of Large Volume Foam UGS Combined with ELVA

Peter Chapman-Smith
Skin and Vein Clinic, Whangarei, New Zealand

Ultrasound guided foam sclerotherapy (UGSF) is used to treat varicose veins, combined with endovenous laser ablation (EVLA) to occlude distal trunks and tributaries.

Maximum recommended guidelines of 10mls foam/day for safe UGSF treatment (European Consensus group, and the ACP) may not apply to UGSF during EVLA. Using larger than recommended volumes , a 5 year prospective study is reported using STS foam volumes of up to 30mls per leg. Treatment was efficacious , with no severe neurologic adverse outcomes observed.

High intensity signals (HITS) on transcranial doppler monitoring (TCD) of the middle cerebral artery (MCA) often detect gas emboli, even with small foam volumes, and do not correlate with adverse clinical outcomes. Decompression illness and cerebral gas embolism (CAGE) in divers cause neuronal functional deterioration related to the endothelial effects of small air bubbles rapidly transiting the cerebral circulation, rather than physical bubble effects. Symptoms as headache, dizziness, light headedness, migraine, and scotomata are reported with UGSF. The release of vasoactive substances from bubble passage may cause these transient CNS symptoms.

Gas emboli occurring during UGSF have doubtful clinical significance. New guidelines for EVLA are required.

Room: The Great Room

Notes

1500 - 1515 Wed 10 February

The Use of Trinitroglycerine Patches for the Treatment of Dermal Necrosis following Sclerotherapy

David Jenkins
Burwood, New South Wales, Australia

Aims
To demonstrate that trinitroglycerine (TNG) patches may enable a scar free resolution of dermal necrosis following superficial sclerotherapy.

Methods
Transdermal TNG patches were used as an occlusive dressing (12 hours per day) for two months following inadvertent intra-arteriolar injection during superficial sclerotherapy.

Results
The ulcerated skin healed rapidly and without evidence of scarring resulting in an excellent long term cosmetic result.

Conclusion
TNG patches may provide a useful adjunct to the management of dermal necrosis following superficial sclerotherapy.

Room: The Great Room

Notes

1600 - 1615 Wed 10 February

Endovenous Laser Ablation: Intraluminal Centralisation of Fibre-Tip can Perfectionate the Technique - a Histological Study

Marc Vuylsteke
Sint-Andries Hospital, Tielt, Belgium

Aims
In this histological study, the lateral saphenous vein of the goat was
treated using a tulip laser fibre. This study aims to establish whether prevention of direct contact between the fibre tip and the vein wall prevents ulceration and perforation of the vein wall and perivenous tissue destruction.

Materials and Methods
Ten lateral saphenous veins were treated, using the tulip catheter, in
goats under general anaesthesia. Ten more veins were treated with a normal bare fibre.
Postoperatively the veins were removed immediately, at 10 days and after 3 weeks for histological examination. Destruction of the vessel wall was measured and perivenous tissue destruction was quantified using a graded scale.

Results
Ulceration and perforation were prevented when using the tulip catheter. Tulip-catheter-treated veins show a transmural vein wall necrosis in, on average, 80% of the total circumference compared to 64% in bare-fibre treated veins. Less perivenous tissue destruction was seen with the new catheter. Three weeks after treatment,we found regression of the perivenous tissue destruction.

Conclusions
EVLA using the tulip catheter avoids ulceration and perforation of the vein associated with treatment using a bare fibre. It also results in more even circumferential vein wall necrosis and less perivenous tissue destruction.

Room: The Great Room

Notes

1615 - 1630 Wed 10 February

How safe and effective is high energy endovenous laser ablation?

Ted King
Vein Clinics of America, Oak Brook, IL, USA

Aims
Many currently recommend delivery of higher energy levels during ELT. Typically, a linear endovenous energy density (LEED) of 70-80 J/cm is used; even higher for larger veins. When endovenous fluence equivalents (EFE), measured in J/cm2, is used to estimate energy requirements for ELT, large veins often necessitate the use of 100 J/cm or more. This study looks at the safety and efficacy of using more than 100 J/cm during ELT.

Methods
A prospective study of consecutive ELT cases requiring an LEED of more than 100 J/cm, as estimated by calculating EFE needed, based on vein size and laser wavelength. This was compared with a sex and age matched cohort who were treated with less than 100J/cm due to their smaller vein size.

Results
To date, 171 successive cases (195 veins) using more than 100 J/cm have been performed. The range of LEED was 100.0-337.9 J/cm with an average of 132.1±36.3. All had mild post-procedure discomfort and bruising requiring NSAID usage and GCS and other complications were mild and essentially equivalent in the higher and lower energy groups. The incidence of continued reflux through the SFJ and SPJ were 2.0 and 5.0% at 6 months follow-up in the higher energy group and 5.0 and 9.4% in the lower energy group.

Conclusions
It would appear that the use of LEEDs higher than 100J/cm when performing ELT is as safe and more effective than using LEEDs lower than 100J/cm, especially when treating larger veins. There appears to be no apparent difference with the type of laser used (980 nm and 1320 nm). It would also appear that these results provide further confirmation that EFE is a useful tool in determining energy delivery requirements for vein treatment, even when those energy levels are higher than typically used. Further study is ongoing.

Room: The Great Room

Notes

1630 - 1645 Wed 10 February

Timing of Foam Sclerotherapy with EVLA - Stat or Delayed

Peter Chapman-Smith
Skin and Vein Clinic, Whangarei, New Zealand

2 groups of patients were treated with 1320nm EVLA combined with foam UGS on the day and at different timing of the next UGS treatment. All patients were treated by the same personnel , with identical techniques and equipment . 3:1 air/3% STS foam mixture was used.

The first group had a second UGS treatment the following day to suit travel arrangements. The second group had treatment delayed an average of 5 days later(range 2-92 days). Serial US follow up at 4-6 weeks, 6 mths and 12 mths post EVLA determined efficacy and safety.

Closure of trunkal vessels (distal to the EVLA segment) and junctions were similar in both groups. Adverse outcomes for both groups were matched, not serious, with no DVTs or PEs. Average foam volumes were higher in the first group, which required a lesser numbers of UGS treatments. Matting, staining and scotomata were more frequent in this group however, with more leg persistent swelling in group 2.

UGS treatment appears to be safe and effective if repeated within 24 hours of EVLA with 1320nm.

Room: The Great Room

Notes

1645 - 1700 Wed 10 February

The distal great saphenous vein: Recanalisation, reflux, incompetent perforating veins after endovenous laser treatment

George Somjen[1,2]
[1]Frankston Hospital, Peninsula Health, Melbourne, Australia
[2]Monash University, Melbourne, Australia

Aims
The objective of the study was to examine long term changes in the distal great saphenous vein (GSV) after endovenous laser treatment (ELT).

Methods
115 legs of 88 consecutive patients were included in the study. Two years follow-up data were analyzed. GSV obliteration, recanalisation and perforating vein incompetence were investigated with the duplex ultrasound. Reflux in the distal GSV was reviewed.

Results
In 55% of legs GSV incompetence extended below the knee before ELT. At the end of the follow-up distal GSV reflux was present in 65% of legs û 10% increase.
Immediately after the procedure, in 19 legs (17%), heat related thrombus progressed into the distal GSV beyond the treated segment. Subsequently the thrombus recanalised and the distal GSV became incompetent. Late reopening of the distal segment of the treated GSV was seen in and additional 4 patients (3.5%). Extensive delayed recanalisation was found in 10 legs (9%). The number of incompetent perforating veins did not change significantly. The development of new incompetent thigh perforating veins appeared to be associated with GSV recanalisation and reflux.

Conclusion
Following endovenous laser obliteration distal GSV reflux was frequent. ELT from the calf to the groin may be indicated to avoid clinical recurrence.

Room: The Great Room

Notes

1700 - 1715 Wed 10 February

Endovenous Coil Ablation for Varicose Veins – A Safety and Efficacy Trial

Gary Frydman[1,2]
[1]Medical Director Western Vascular Centre, Melbourne, Australia
[2]Visiting Vascular Surgeon, Western Health , Melbourne, Australia

Aims
Ultrasound guided sclerotherapy has become a proven treatment in the management of varicose veins. This technique appears less effective as the axial vein becomes larger than 8mm in diameter. This study is aimed to assess the safety and efficacy of placement of endovenous coils into the refluxing axial vein to prevent reflux and improve the results of standard ultrasound guided sclerotherapy in patients with refluxing veins with diameter of greater than 8mm.

Methods
48 patients were recruited following approval of the study by the ethics committee. 3 patients had both legs treated on different dates so 51 limbs were studied. The procedure involved percutaneous access of the refluxing axial saphenous vein under local anaesthetic. A 5 fr sheath was then inserted into the vein and a catheter placed about 2-4 cm below the junction with the deep vein. Two endovenous coils were then inserted into the saphenous vein under ultrasound control. Foamed 3% aethoxysclerol was then inserted into the saphenous vein via the catheter. Ambulatory phlebectomies were then performed under tumescent anaesthetic. All procedures were performed at the Williamstown Hospital as a day case under local anaesthetic and sedation. Patients were reviewed at 1 week, 6 weeks and 6 months following the treatment.

Results
The procedure was successfully performed in all patients although in 2 patients the second coil was not deployed correctly. All patients were discharged on the same day. Complications included 1 case of a popliteal DVT following great saphenous vein treatment and another patient had a puncture site infection treated with oral antibiotics.
Three Patients were lost to follow up at 6 months. The saphenous vein was occluded as planned in all patients at 1 week and 6 weeks. At 6 months, 6/48 limbs had reopened and were patent. Reflux was demonstrated in 4 limbs although in 2 cases no reflux was demonstrated.

Conclusion
Endovenous coil ablation is a safe and efficacious procedure for the treatment of varicose veins associated with a refluxing axial saphenous vein with a diameter of greater than 8mm. Modification of the coils however may improve the results. Follow up studies are planned following modification of the coils.

Room: The Great Room

Notes

1715 - 1730 Wed 10 February

Thinking outside the box in treating an incompetent GSV: coils, onyx and other methods

Sanjay Nadkarni
Vascular Interventional Radiology Clinic, Perth, Western Australia

Aims
Achieve safe and successful closure of incopetent GSV

Methods
Ultrasound guided access into incompetent GSV. Using fluoroscopy/DSA a 4f C2 catheter and angled glide wire is used to selectively cannulate branch/branches just distal to SFJ. If GSV cannot be accessed under ultrasound an up and over technique using fluoroscopy/DSA can be used to antegradely access the GSV. Once catheter position secured delivery of coils(various types including detachable)in proximal GSV.

Then choice of using various agents including onyx (ethylene vinyl alcohol co polymer or traditional agents such as foam to treat the incompetent GSV.Some authors also report the use of alcohol to treat GSV. All my cases had concurrent ONYX or foam or subsequent EVLT.

Results
All cases performed(5) demonstrated complete oclusion of incompetent SFJ on 6 month survellance duplex.

All cases had concurrent or subsequent treatment with EVLT(980nm) or foam (1.5% sts) or onyx(1 case)

Conclusion
Use of coils combined with traditional foam or newer embolic agents such as ONYX offers an alternative to treatment of an incompetent GSV.

Room: The Great Room

Notes

1730 - 1745 Wed 10 February

Can saphenous and sural nerve paresthesia be prevented during ELT?

Ted King
Vein Clinics of America, Oak Brook, IL, USA

Aims
To determine if it is possible to minimize the risk of thermal injury to the saphenous and/or sural nerves during the performance of ELT.

Methods
Using a Siemens Accuson X300 ultrasound machine with a 5-13MHz transducer the zone of contact (ZOC) between the distal GSV and the saphenous nerve and the SSV and the sural nerve were seen. The ZOCs were determined by observing the upper and lower points of contact (POCs) between the great and small saphenous veins and the corresponding nerves. The saphenous nerve POCs were measured from the central prominence of the medial malleolus. The sural nerve POCs were measured from the floor.

Results
The saphenous ZOC was measured in 248 consecutive legs undergoing ELT of the GSV. The sural ZOC was measured in 73 consecutive legs undergoing ELT of the SSV. The range of the saphenous upper POC was 7.0-29.0cm above the medial malleolus (Average: 17.6cm, Median: 17.5cm, S.D.: 4.4cm). The ZOC range was 2.0-21.0cm below the upper POC (Average: 9.9cm, Median: 9.5cm, S.D.: 3.9cm). The range of the sural upper POC was 28.5-34.0cm (Average: 25.9 cm, Median: 26.0cm, S.D.: 3.5cm). The ZOC range was 4.0-10.5cm below the upper POC (Average: 6.3cm, Median: 6.0cm, S.D.: 2.0cm). There were no complaints of parasthesias after any of these procedures.

Conclusions
Identification of the saphenous and sural nerve ZOCs with the GSV and SSV is easily accomplished with only minor practice. If the desired result is to lase as much of the GSV or SSV as possible, the safest approach would be to introduce the fiber at a location determined by ultrasound visualization of the pertinent nerve. Without ultrasound nerve identification, insertion of the fiber should be 18cm (2 S.D. = 26cm) above the medial malleolus for the GSV and 26cm (2 S.D. = 33cm.) above the floor for the SSV.

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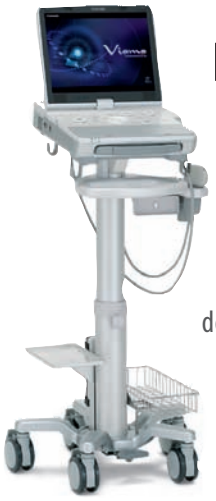

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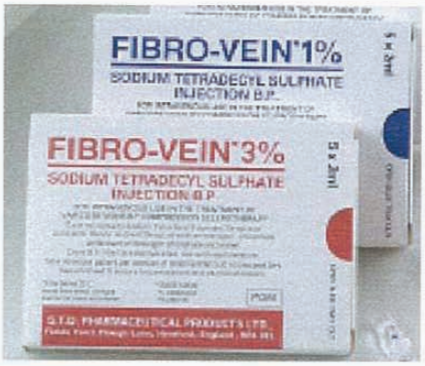

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