Sclerotherapy Techniques

Sclerotherapy developed in the mid 1800s following the invention of the syringe in 1851. By the end of the 19th century it was considered a dangerous procedure and not to be recommended. This was mainly due to the hazardous solutions being used. Following World War 1 safer solutions were used and a renaissance of 'the injection technique' during the 1920s saw the popularity of sclerotherapy dramatically increase. With the development of antibiotics and safer anaesthetics, surgical management flourished from the 1930s until recent years.

Superficial sclerotherapy – has been used for the treatment of varicose veins that didn't look bad enough to the treating doctor to justify surgery, to tidy up persistent varicose veins that remained after surgery, or if the patient didn't want surgery in the first place. The hit-and-miss nature of the procedure guaranteed variable and poor results. It was recognised from the 1920s that a good cosmetic result could be achieved, however, social attitudes towards seeking cosmetic improvement, frequent complications from injecting and the absence of ultrasound assessment precluded the refinement of sclerotherapy techniques until the 1990s!

The three major techniques of the 20th century (Tournay, Sigg and Fegan) will be presented, as well as that of Hobbs and the 'combined technique' which involves injecting from superficial to deep, proximal to distal and largest to smallest. The advantages and disadvantages of various techniques described in sclerotherapy texts will be discussed.

David Jenkins
MB BS FACP
Phlebologist
Burwood NSW