

VENOUS Review

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inside this issue

<i>Understanding Vulvar Varicosities.....</i>	<i>Page 2</i>
<i>Free Screening Tuesdays: "Todos los Martes".....</i>	<i>Page 4</i>
<i>New Clinic: Catonsville, MD.....</i>	<i>Page 4</i>
<i>Meet our Newest Physicians.....</i>	<i>Page 4</i>
<i>Q&As.....</i>	<i>Page 5</i>
<i>Our Physicians & Locations.....</i>	<i>Page 7</i>



DVT Awareness Month: The Patient Perspective

By Robert C. Kiser, DO, MSPH

Essentialism: Tool and Stumbling Block

Often physicians fall into the trap of philosophical "Essentialism." We believe, as we were taught, that each disease entity is a specific thing, a rigid constellation of symptoms. We expect the anatomy of each patient to be that of our textbooks, and should it not, we consider it anomalous for diverging from the "essence" of "proper human anatomy." Such an erroneous view is a philosophical hold-over from Platonism and the notion of Platonic Ideals. In brief, Plato described mundane reality as a casting of shadows made by the true objects of reality, ideals, which are in essence perfect examples of their types. The concept of Platonic Ideals has permeated teaching in many ways, and certainly in medicine we are taught to expect that livers should look exactly as we are taught and that disease should present with rigid constellations of signs and symptoms. This is a pedagogical tool that helps us learn basic categories such as organs and disease by matching the object or entity presented to us with that list of descriptions which we know and which we may thereby apply a label. Taken to an extreme or misunderstood

as describing how reality is actually structured, however, essentialism blinds us to the numerous variations in how disease may present in an individual patient. In the words of Sir William Osler, "It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has," and "the good physician treats the disease; the great physician treats the patient who has the disease." The following is based on an interview with a real person whose life was changed by deep vein thrombosis (DVT) and the treatment thereof.

Meet Teri - DVT Survivor

Teri is a 36 year-old woman living in Chicago. In 2004, at the age of 27, she was flying home from a stay in Europe. The night before she had experienced vomiting and diarrhea. At the Amsterdam airport she stopped at the nurses' station and diagnosed with food poisoning. She was given an antidiarrheal, an antiemetic and "a sedative." She had a window seat in economy class, and slept most of 9 hour trip home. She recovered from her gastrointestinal distress, but in two days she began to notice a new symptom. "Two days after I landed in Chicago I had what



Continued on Page 3



Center for Vein
Restoration

VENOUS Review

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Understanding Vulvar Varicosities

By Theresa M. Soto, MD, FACOG, FACS

As patients and clinicians are becoming more familiar and comfortable with the examination, diagnosis and treatment of varicose veins of the lower extremities, vulvar varicosities remain an enigma. The more delicate nature of the issue, lack of understanding of the disease process, as well as the limited availability of diagnostic/treatment centers contributes to the lack of attention to this disorder.

Vulvar varicosities are dilated veins found in the labia majora and minora; more commonly in pregnant women as opposed to the non-pregnant population. While as many as one in ten pregnant women experience these troublesome veins and OB/GYN physicians easily diagnose this condition, there is little work-up or treatment of this condition once the pregnancy is completed.

Vulvar varicosities typically present in the second or third trimester of pregnancy and quite often they are asymptomatic, especially in a woman's first pregnancy. When symptomatic however, they may present with discomfort during walking, a sense of "swelling," "vulvar pressure," pruritis, pain, a palpable "lump" or dyspareunia. Excessive bleeding at the time of vaginal delivery in association with a perineal laceration, episiotomy or vaginal wall laceration may result in the formation of a pelvic sidewall or labial hematoma, but spontaneous bleeding from the varicosities is unusual. The presence of vulvar varicosities alone is not an indication for cesarean delivery. Thrombosis of one of these veins can occur, but this is a rare phenomenon as well.

The venous drainage of the vulva is via pudendal and perineal veins which then depend on competence of the ovarian, iliac and great saphenous veins. The majority of varicose veins of the vulva are caused by reflux in the pelvic veins; ovarian vein reflux¹, internal iliac vein reflux or a combination thereof. Incompetence of the great saphenous vein is often diagnosed in the setting of pelvic vein incompetence. Extension of varicosities into the medial thigh is a common finding in patients with varicosities of the vulva. During pregnancy, the rise in estrogen and progesterone production, in combination with the increasing physical load of pregnancy, contribute to venous insufficiency and symptomatic varicosities. With each subsequent pregnancy, symptoms typically present earlier in the course of gestation and are more significant.

Spontaneous improvement in the appearance of vulvar varicosities is typically seen within six to eight weeks post partum. While symptoms typically ease as well, there often remains a sense of "fullness," "swelling," and/or general "discomfort" beyond the post partum recovery period. Treatment during pregnancy is symptomatic with the use of compression garments, ice and topical anti-pruritics. As vulvar varicosities are rarely an isolated finding, a combined evaluation for venous insufficiency by Center for Vein Restoration

and Center for Vascular Medicine is indicated twelve weeks post delivery. Pelvic sonography and venography are the methods of choice for evaluation of the pelvic and vulvar venous systems while duplex ultrasound scanning of the lower extremities will provide information on the competence of the superficial system that includes the great saphenous veins.



With the diagnosis of ovarian vein reflux, a coil or chemical sclerosant can be placed into the ovarian vein resulting in closure of the vein with eradication of reflux in this vessel. Selective catheterization and foam sclerotherapy of the obturator vein and/or internal pudendal tributary veins may also be accomplished as indicated. Once the pelvic vein reflux has been treated, the patient returns for a follow-up scan at six weeks to evaluate her response to therapy. If the intervention has been successful; there is resolution of the pelvic vein reflux, the vulvar varicose veins may then be approached with foam sclerotherapy² injections. A period of observation (six to twelve months) is typically warranted prior to moving on to sclerotherapy as many vulvar varicosities will improve significantly after suppression of the pelvic vein reflux. When indicated, sclerotherapy may be injected either directly into the

vulvar varicose veins or under ultrasound guidance³, pending their visibility. It is just as important to manage the underlying venous incompetence prior to directly treating the visible varicosities as it is in treatment of venous insufficiency manifestations of the lower extremities.

Many women are hesitant to initiate a conversation on vulvar varicosities. This issue is often discovered in the course of discussing symptoms of pelvic pain, pelvic congestion syndrome or varicosities of the legs. Soliciting this information is vital in order to properly direct a woman's evaluation and treatment. As with venous insufficiency and varicosities of the

lower extremities, this is a medical problem, not simply a cosmetic concern. Presenting the condition in such a manner can reassure a patient that her issue is not simply an embarrassment, but a medical disorder that warrants attention. Due to the chronic nature of venous insufficiency, recurrence is possible and these patients should be followed at regular intervals to assess for return of symptoms or physical findings.

Footnote:

- 1 <http://www.collegeofphlebology.com/micro/conditions/ovarian-vein-reflux>
- 2 <http://www.collegeofphlebology.com/micro/treatments/ultrasound-guided-foam-sclerotherapy/>
- 3 <http://www.collegeofphlebology.com/micro/conditions/duplex-ultrasound/>

DVT Awareness Month: The Patient Perspective

Continued from Page 1

felt like a leg cramp in my left leg. I thought it was because I had done a lot of walking and touring in Europe, but it didn't get better," she said. "Three or four days later, I couldn't put any weight on it, it hurt just to get out of bed, it was very painful. I couldn't walk or drive." A friend drove her to a local hospital and there she was seen in the Emergency Department. She was informed that she had three deep vein thromboses in her left leg and that she would need to be admitted. She was admitted, started on a heparin drip, fitted with graduated compression stockings and put at complete bed rest. Teri says, "At that point I was pretty scared."

In many ways, other than her youth, Teri's profile shows several risk factors for DVT. She was a smoker, she was on birth control, and she had just experienced a long flight with immobility in a seated position. The hospital felt this was sufficient explanation for her DVTs, and did not run additional thrombophilia laboratories. She was in hospital for one week and discharged on warfarin with instructions to follow-up with a hematologist on staff who had briefly seen her in hospital (and may have had labs drawn). Unfortunately, the hematologist to whom she had been referred was out of network with her insurance, and so a different hematologist was sought. In the interim she had to see yet another hospital's anticoagulation clinic. She experienced side effects from the warfarin, including orthostatic hypotension, vertigo and a sort of motion sickness; "watching a train go by or copies coming out of the copy machine made me feel nauseated." She wanted to know how long she would be on anticoagulants, what the long-term effects would be and what her prognosis would be. When she finally met with the new hematologist and asked these questions she was told, "Well, with your genetic problem you will never be off of warfarin." This was the first she had been told that thrombophilia labs had been run and that she was found to have Factor V Leiden mutation. "I had never heard of it before then." It was a lot to take in, and there were implications for her future. She had just been told, at age 27, that she had a genetic ailment that predisposed her to getting blood clots and that she was facing a lifetime of taking medication. "Also I had just gotten married, and if we decided to have kids I would have to go off the coumadin and give myself daily heparin shots in the belly." She was given very little other information or genetic counseling, and so sought out information from the internet. She continued on warfarin and, because of difficulties stabilizing her INR, she had frequent lab draws.

Meet Teri: DVT Treatment Survivor

One year later, Teri attended a work Christmas party. She left the party about 11 p.m. On the train home she began to feel nauseated; "I didn't think I had

drunk that much, so I thought maybe I had gotten food poisoning again." By the time she reached her home, "I was really starting to feel sick." She attempted to sleep, but she began to develop pain in her neck, upper back, lower back and abdomen. "It was the worst pain I've ever experienced." She got up to use the bathroom and passed out, hitting her head on the sink, "I woke up in a pool of blood." She once again called a friend who drove her to a local hospital emergency department around 7 a.m. Teri was diagnosed with a ruptured ovarian cyst. Because she had been anticoagulated, the ruptured cyst had bled profusely into the peritoneum, resulting in excruciating pain, hemorrhage and shock. Teri says, "It was absolutely terrifying; I still have nightmares about it." She was given three units of plasma, underwent emergency open laparotomy with partial oophorectomy, "I had 33 staples," she noted. Her two-week hospital stay was further complicated by pneumonia and a bowel obstruction. Years later, she continues to have pain from the incisions and adhesions.

Teri remained on warfarin for more than a year after the ruptured ovarian cyst. At that point, she decided it was time to stop anticoagulants. "Mostly I was just worried that I would get another cyst, bleed out and die." She has now been off of all anticoagulants for over six years, and had had no recurrent venous thromboembolism. She does now avoid hormonal birth control and walks frequently during long flights or sedentary activity. Asked what she would like physicians to know about her experience she says, "A lot of the care I got was compassionate and caring, but I do wish there had been more patient education, more take-home literature... more patient education would have helped."

Summary

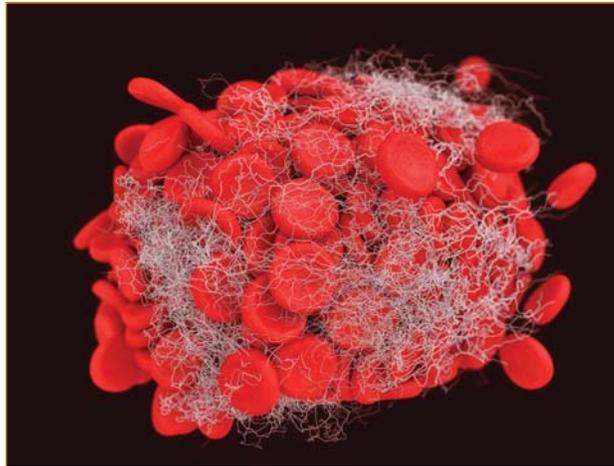
Teri's case provides an important example of why the risks and benefits of treatment must be carefully weighed. In particular the benefits of indefinite anticoagulation treatment for a single episode of provoked DVT have not been shown to outweigh

the risk of major bleeding, even for those with thrombophilia. Her case also demonstrates how multiple factors in Virchow's "triad" interact and can be present in a given instance of venous thromboembolism. Even if there are "adequate" provoking factors to explain a VTE, an underlying thrombophilia may be present. Finally, as Teri stresses, thorough and compassionate patient education can be helpful in providing information, guidance, comfort, and hope for the newly diagnosed patient.

Footnote:

1 <http://asheducationbook.hematologylibrary.org/content/2010/1/210.full>

2 <http://journal.publications.chestnet.org/article.aspx?articleID=1159453>





Announcing: Free Screening Tuesdays: “Todos los Martes”

Center for Vein Restoration is proud to announce we're expanding our service to diverse and under-served communities. Announcing: Free Screening Tuesdays, our program for our local Hispanic patients in which our staff perform free ultrasound scans every Tuesday and explain the stages and causes of vein disease in Spanish. The sessions take place in our Silver Spring/Takoma Park, MD clinic (831 University Blvd. East, # 24/25 Silver Spring).

Free Screening Tuesdays are the latest in a series of efforts in recent years to expand our service to local communities and provide information and services to people who many not ordinarily receive it. These have included our sponsorship of the Vietnamese Health Fair in Annandale, Va. and sponsoring the Asian American Medical Society meeting in Arlington, Va.

In our Free Screening Tuesday program, patients can be assured to get the information and treatment they need via Spanish-speaking doctors and staff as well as having access to Spanish speakers in our call center [(800) FIX-LEGS/ (800) 349-5347].



New Clinic: Catonsville, MD

Center for Vein Restoration is proud to announce the opening of our newest clinic in Catonsville, Md. The clinic is now taking referrals.

The Catonsville clinic is located at 1001 Pine Heights Ave., Suite 303, and can be contacted at (410) 525-1444. As with all our locations, the Catonsville clinic is under the supervision of our senior medical team: Sanjiv Lakhanpal, MD, CVR President and CEO; and Khan Nguyen, DO, CVR Corporate Medical Officer.

Our local supervising physician is Henry Meilman, MD. Dr. Meilman is Board Certified in interventional cardiology, cardiovascular diseases, and internal medicine. He is a Senior Fellow, Society of Cardiac Angiography and Interventions, a Fellow Emeritus with the American College of Cardiology, and a member of the American College of Phlebology. Dr. Meilman attended New York University School of Medicine, was a member of AOA Honor Medical Society, and was an Academic Excellence Prize Winner. He also attended Harvard, where he graduated with Honors. Additionally, he is former Chief of Cardiac Catheterization Laboratories at Union Memorial Hospital, Baltimore, Md., and State University of New York, Downstate Medical Center, Brooklyn, New York.



Meet our Newest Physicians

CVR is proud to welcome three talented physicians to our team: Shubha Varma, MD; Theresa M. Soto, MD, FACOG, FACS; and Laurence Starin, MD, FACS.

Dr. Varma has been chief of vascular surgery at Palisades Medical Center, in New Jersey for the past ten years. Formerly Dr. Varma was Assistant Professor, Department of Surgery at Columbia University in New York, and was a Clinical Instructor at the New Jersey Medical School in Newark. She attended Maulana Azad Medical College at the University of Delhi, and served a general surgery residency at the New York Hospital in Queens; she did a vascular fellowship at the University of Medicine and Dentistry of New Jersey.



Dr. Soto is Board Certified in obstetrics and gynecology and is Assistant Professor of OB/GYN at Virginia Commonwealth School of Medicine. She is former Chief of OB/GYN Services at Langley Air Force Base Hospital, in Hampton, Va., former staff and interim chief OB/GYN, 7th Medical Group (Dyess Hospital), at Dyess Air Force Base, Texas. She received her medical training at St. Bonaventure University in Alleghany, New York and Buffalo Medical School in Buffalo, New York. She was chief

resident in OB/GYN at SUNY in Buffalo.

Dr. Starin is a Board Certified physician and is assistant Clinical Professor of Surgery at the George Washington University School of Medicine. He was appointed to the Medical Executive Committee and Section Chief in General Surgery and is a former Vice Chairman of the Department of Surgery at Holy Cross Hospital. Dr. Starin was recently voted one of the "2014 Top Doctors" by Washingtonian Magazine.



Q & A

In each issue of the *Venous Review*, members of our medical team answer questions we've received from referring physicians.

This issue's guest Q & A Editors are



Mark Edelman, MD



Gautam Shrikhande, MD



Michelle Nguyen, MD

Q: *If my patient has only visible signs of spider veins (according to your CEAP chart) what's the likelihood they may have other varicosities going on?*

A: As a matter of review the CEAP system is based on clinical findings (usually on physical examination), Etiology (congenital, primary, or secondary), Anatomic findings (superficial, deep, or perforating veins), and Pathophysiology (reflux or obstruction).

It is quite common for patients to have only spider veins (C-1), but have significant underlying venous reflux that can be diagnosed by history (pain, heaviness, restless legs, itching, throbbing, etc.), and, most accurately, by diagnostic duplex ultrasonography.

In our clinical practice as phlebologists we often see patients who lack varicosities (C2), edema (C3), or skin changes (C4), BUT have significant symptoms due to their underlying superficial venous reflux, which we can diagnose and treat in our clinics.

Although there has been no specific figure published, a significant percentage of patients who only have spider veins on clinical exam have advanced symptoms and abnormal duplex ultrasound, consistent with clinically significant, superficial venous insufficiency. It is important to remember that symptoms of superficial venous reflux often develop BEFORE the patient progresses to C2 and beyond in their clinical presentation.

The medical term for spider veins is telangiectasias and, in addition to the cosmetic issues they are associated with, they can also cause symptoms such as itching, burning, dry skin, warm skin, bleeding or pain. These veins measure <1mm, while reticular veins measure from 1-3 mm, and varicose veins measure >3mm. Spider veins can either be purely a cosmetic issue, or they can be the tip of the iceberg where more significant underlying venous insufficiency may be present. Prior to treatment of spider veins, all patients should have a venous ultrasound performed for more significant

venous disease. If one simply treats the spider veins prior to treating the underlying veins, the spider veins can come back in either the same location or a different location. The proper therapy is to first perform venous ablations prior to sclerotherapy of spider veins.

Q: *I'm a physical therapist. We are trained that exercise can heal the body; how do we know when to send a patient to you if they still have leg pain and we've been working with them?*

A: As health care professionals who diagnose and treat individuals with physical impairments, physical therapists play an essential role in identifying venous disease. For those patients who do not respond to traditional intervention, it may be beneficial to inquire about:

- increased pain with prolonged standing or sitting,
- aching and heaviness, especially at the end of the day,
- restless legs,
- itching and burning, and
- swollen ankles.

These symptoms are very indicative of venous disease, and a full venous evaluation with subsequent treatment could greatly improve the patient's daily standard of living. Physical therapists also are vital in identifying those patients with pre-ulcerative

changes and lower extremity skin discoloration. Referring these patients to CVR is an essential step in preventing the development of painful, distressing venous ulcers. Improving patients' lower extremity symptoms will overall increase their ability to be active and gain the most benefit from their physical therapy sessions.

We always appreciate the hard work of physical therapists who help patients overcome pain issues. Often times, we see patients referred from orthopedic surgeons, neurosurgeons, physiatrists, and physical therapists. These patients frequently have musculoskeletal issues addressed with various treatment modalities including an intensive physical therapy regimen. The musculoskeletal symptoms can include pain localized to hip, knee, and ankle joints, shooting sciatic pain radiating from the lower back, and tightness of muscles groups. If patients continue to experience pain such as tired, achy, itchy, or heavy legs associated with swelling or pain, we feel that they should have an ultrasound evaluation to assess for venous insufficiency. Further, if patients have any visual stigmata of venous insufficiency such as spider veins, varicose veins, phlebitis, or hyperpigmentation, a venous evaluation is warranted.



Have you attended one of our CME events? Our CMEs on venous insufficiency are conducted by Center for Vein Restoration physicians and staff. When you first join us you'll notice a difference from other sessions you may have attended. First, we respect your busy schedules, so we tend to hold our CMEs in the evenings. We start with a nice dinner and networking and follow that with information on the diagnosis and treatment of patients with venous insufficiency. We discuss classification of VI, the use of duplex ultrasound to screen patients, the use of modern ablation techniques like radiofrequency and laser, visual sclerotherapy and more as part of a full spectrum of care available to your patients.

CME Courses & Events

Our attendees give us high marks for their experience – in fact, our recent event in Silver Spring Maryland broke our attendance record with 78 physicians. When surveyed, attendees gave us kudos for providing a collegial atmosphere and unbiased content, and many said the information could lead to improved health for their patients.

At the end of each presentation, participants can expect to understand the etiology, diagnosis and clinical presentations of venous disease, evaluate differential diagnosis in patients with multiple symptoms, and learn about current treatment options and disease management.

Each CME course is valued at 3.0 credits. Following are dates for Spring 2014. We look forward to seeing you or a colleague at one of these events soon.

Maryland: Rockville/Germantown • April 2, 6:30pm

Timpano Chophouse 12021 Rockville Pike, Rockville, MD 20852

RSVP: Michelle Gaynor, michelle.gaynor@centerforvein.com, (202) 320-9484



Northern Virginia: Vienna • April 24, 6:30pm

Clyde's of Tysons Corner 8332 Leesburg Pike, Vienna, VA 22182

RSVP: Matt McMahon, matt.mcmahon@centerforvein.com, (312) 498-1565



For more information, please contact Matt McMahon, Regional Sales Director [matt.mcmahon@centerforvein.com, (312) 498-1565.]



Continued from page 5

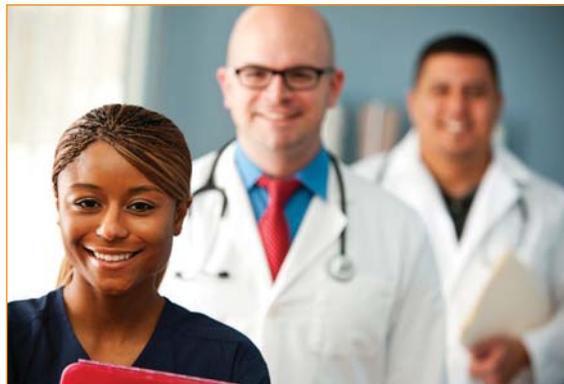
Q: Why should I send patients to a vein group when they could be treated for both the veins and arterial side with a vascular group? Do vascular groups have same capabilities for treating veins?

A: Great question. I'm glad you asked. Many vascular surgical groups do fine work in the diagnosis and treatment of peripheral arterial disease, carotid arterial disease, and abdominal aortic aneurysms, but often approach venous reflux disease as a peripheral (pardon the pun) aspect of their clinical practice. As a result, they will often focus on the catheter-based techniques that are useful in treating the refluxing great and small saphenous veins, but not focus on the diagnosis and treatment of associated refluxing accessory and tributary veins, which are often treated with ultrasound-guided foam sclerotherapy or endovenous laser.

If the patient only undergoes procedures that treat the refluxing great and small saphenous veins, the

patient will often be left with significant residual symptoms of their chronic venous insufficiency, as they have only been "partially treated".

At CVR, we pride ourselves on performing complete bilateral venous ultrasound in the standing position in order to identify ALL the refluxing veins that are responsible for the patient's clinical presentation. In addition, whenever possible, we also perform visual sclerotherapy on the residual spider veins that often also contribute to the patient's



symptoms. Furthermore, our detailed 1 month and 6 month follow-up consultations, which include standing venous ultrasound, often identify additional underlying venous reflux disease that has been "unmasked" with prior treatment or has appeared since the initial evaluation.

Finally, because we are a large physician-owned group (25 centers and counting) that focuses SPECIFICALLY on the treatment of symptomatic venous insufficiency, we have accumulated and published clinically significant data on the best treatment algorithms for these patients.

Do you have clinical questions for our team? Please let us know. Submit them to Kathleen Hart, Managing Editor [kathleen.hart@centerforvein.com.]

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Center for Vein Restoration
Sanjiv Lakhanpal, MD



Editor,
Robert C. Kiser, DO, MSPH

VENOUS Review

THE OFFICIAL JOURNAL OF CENTER FOR VEIN RESTORATION

Did you know March is DVT Awareness Month? Why devote such attention to a seemingly common problem? Because of its consequences, and the need for public education; according to the Centers for Disease Control, an estimated 60,000-100,000 Americans die of DVT/PE each year, with sudden death being the first symptom in about a quarter of people who have a PE.

We at Center for Vein Restoration put great focus on DVT awareness not just for one month, but all year long. In fact, we offer all of our referring physicians a special DVT Hotline (877) SCAN-DVT. Our Patient Services team will locate the nearest CVR clinic and arrange urgent access for a patient to have urgent access to have a DVT rule out.

In our lead article, we explore the topic of DVT awareness in hopes you and your patients can be better informed of signs, symptoms, risk factors and treatment options. Separately, we also in this edition explore vulvar varicosities – focusing attention on another, enigmatic condition to help patients see past embarrassment so they can get the medical treatment they need.

Additionally in this issue, we're happy to report on our new Free Screening Tuesdays program – free consultations and advice from our physicians, staff and call-center attendants, all conducted in Spanish (based in our Silver Spring/Takoma Park, Md. Clinic). Also, we're excited to announce we've opened our newest clinic, in Catonsville, Md., which is now taking referrals.

We hope this information is useful to you and your practice. We look forward to discussing vein health further with you and your patients soon.

Yours in good health,
Robert C. Kiser, DO, MSPH
Editor