

LSV. There were no deaths or stroke at time of follow up. 30-day peri-operative morbidity included myocardial infarction (1), transient hypoglossal neuropraxia (4), neck hematoma (2) and groin infection/haematoma (4). All were managed conservatively. None had evidence of restenosis on follow up duplex assessment at time of study.

Conclusion

CEA in our setting is a safe procedure and our peri-operative and mid-term mortality and morbidity figures are in par with standard figures.

OP 72

ENDOVASCULAR LASER ABLATION FOR LOWER LIMB VENOUS REFLUX DISEASE; EXPERIENCE FROM THE VASCULAR UNIT, TEACHING HOSPITAL ANURADHAPURA

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Introduction

Endovascular laser ablation (EVLA) has gained popularity over old treatment methods for venous reflux disease. This study aims to examine the outcome of 50 patients who underwent EVLA for lower limb varicose veins.

Method

53 patients underwent EVLA for Great saphenous vein (GSV) reflux disease over a period of 3 months. EVLA was delivered with 1470 nm diode laser (ELVeS). Tumescence anesthesia was delivered into peri-venular sheath under Ultrasound guidance. Maximum diameter of the vein, length of the treated vein, total energy delivered and treatment time were documented. Follow up USS were done at 1 week and 1 month to assess the outcome.

Results

Total of 53 patients were included. 32 were females and 21 were males. Mean age was 45 years. Mean length of treated vein was 32.8cm. At the end of 1 month 13 patients were lost to follow up. 5 patients had non-thrombosed (failure) veins. Mean energy concentration for successful ablation was 52.5j/cm, and the mean for failures was 32.4 j/cm. Overall the success rate was 87.5%.

Conclusion

At our center the success rate of EVLA was >85% at 1 month. An energy concentration of more than 50 j/cm is preferred to get a successful ablation. Increasing the energy concentration is likely to bring more success. We hope that this will happen with increasing experience of the operators.

OP 73

ATTENUATION OF SKELETAL MUSCLE ISCHAEMIA-REPERFUSION INJURY (IRI): COULD INSULIN BE THE ANSWER?

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Introduction

Enhanced leucocyte activity is a critical step in the pathophysiology of IRI. We hypothesize that insulin via its' anti-leucocyte activity can attenuate skeletal muscle IRI.

Methods

A randomized, blinded, placebo-controlled clinical trial was conducted on patients with skeletal muscle ischemia requiring revascularization. Treatment protocols were identical except for 'insulin' group who received an insulin infusion at 2.5U/hr. Endothelial-leukocyte activity was measured via P-Selectin and Myeloperoxidase(MPO). Their temporal evolutions were measured in the venous effluent.

Results

24 consenting patients were randomized to 'insulin' and 'Control' groups, 12 in each. The differences in the groups; Insulin vs. Controls for age(years): 64.9 v 62.3, elective surgery: 7 vs. 6, emergency surgery: 5 vs. 6, mean duration of ischemia(minutes): 119.5 vs. 180.5 (p=0.078) were similar. Mean serum insulin level was significantly higher in the 'insulin' group(p<0.01). Clinical outcomes (death, major amputation, fasciotomy, AKI, MI) between groups were similar. The increment of P-Selectin and MPO was compared at 0, 2, 4, 6, 12 hours post-reperfusion between groups (linear regression model) in the 'Control' group, P-Selectin (p<0.001) and MPO (p<0.001) demonstrated a significant increase post-reperfusion, reaching a peak at 2 hours. Increment of P-Selectin from its' baseline was significantly diminished in the 'insulin' group at the two-hour interval; 12.1%(insulin) vs. 81.2%(control)[p=0.001] and

four-hour interval; 5.6%(insulin) vs. 73.6% (control) [p=0.003]. Elevation of MPD was similarly attenuated in the 'Insulin' group at the two-hour interval; 3.9%(insulin) vs. 44.9%(control)[p=0.001] and four-hour intervals 1.4%(insulin) vs. 34.4%(control)[p=0.002].

Serum markers of white cell activation were significantly reduced with an insulin infusion at 2.5U/hr, in human skeletal muscle IRI.

OP 74

ONE-STOP, CUSTOMIZED, DAY - CASE ENDOVENOUS LASER THERAPY (EVLT) OF LONG SAPHENOUS VENOUS (LSV) SURGERY COMBINED WITH TRIBUTARY SURGERY AT THE SAME SETTING - A SAFE AND EFFECTIVE OPTION

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Objectives

Treatment of LSV varicose veins should be customized to individual disease patterns. Combination of EVLT with tributary procedure surgery, at the same setting, as a day-surgery, under local anaesthesia (LA) obviates the repeated admissions / surgeries and is beneficial for the patient and health system.

Methods

A retrospective study was carried out on 187 patients and 209 limbs with LSV incompetence from January 2013-April 2017. Treatment was customized based on clinical and duplex assessment at preoperative clinic. All patients underwent either EVLT alone or in combination with tributary surgery with phlebectomy (MSA) or sclerotherapy (ST), at the same setting, under LA. Patients were assessed pre-operatively and post-operatively with clinical and duplex assessment. Clinical and QOL outcome was assessed with CEAP and venous clinical severity score (VCSS) respectively.

Results

Majority were female (123/187), mean age of 32 years (21-68) and presented with complicated disease (C4-C6). Tributary surgery was performed in addition to EVLT in 154/209(73%) of limbs. [EVLT+MSA (72); EVLT+ST (82)] the follow up rate at time of study was 72%. There were no significant complications of EVLT, MSA or ST during the study period. Minor complications were

up. 95% had resolution of symptoms. Median VCSS improved from 8 pre-procedure to 1.2 post-procedure. 15/187 patients required revisits for ST of below-knee residual veins during follow up.

Conclusions

A one-stop, customized venous surgery clinic, performed under LA as a day case is a safe and effective option for a surgical unit in Sri Lanka.

OP 75

COMPARISON OF ENDO VENOUS LASER THERAPY (EVLT) ALONE OR IN COMBINATION WITH PHLEBECTOMY (MSA) OR CHEMICAL ABLATION (ST) FOR LONG SAPHENOUS AND TRIBUTARY VEINS - IS THERE A DIFFERENCE?

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Objectives

EVLT is the treatment of choice for incompetent long saphenous vein (LSV). Tributary veins are treated either with MSA or ST as a secondary procedure. Combination of EVLT with MSA/ST at the same setting under tumescent anaesthesia (TA) is advantageous but debatable. We compared the efficacy and safety of MSA or ST of tributary veins when combined with EVLT.

Methods

A retrospective analysis was conducted on 209 limbs with incompetent LSV varicose veins undergoing EVLT +/- ST or MSA. All surgeries were performed under TA, as a day surgery. Clinical and duplex assessment was performed pre-operatively and during follow-up treatment options were decided based on pre-operative assessment. Quality of Life (QOL) outcome was assessed using venous clinical severity score (VCSS).

Results

EVLT alone, EVLT + MSA, EVLT+ST was performed on 5%, 72 and 82 limbs respectively. 25/209 were recurrent disease following previous saphenous surgery. 177/209 limbs presented with complicated varicose veins [C4-C6; 84%; CEAP]. The need for tributary surgery was an independent predictor for healed/active ulceration (p=0.03). Mean follow-up duration was 8.4 months (1-27). There were no reports of DVT, PE or skin necrosis. Minor complications of EVLT [skin blistering (1%),