IJCRT.ORG ISSN : 2320-2882

INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

Phlebectomy In The Management Of Varicose Veins: A Case-Based Review.

[1]Dr. Akshay Haribhau Devarkar

[2]Dr. Dhanraj Gaikwad

[1] PG Scholar, Department of Shalyatantra, Tilak Ayurved Mahavidyalaya, Pune

[2] Associate Professor, Department of Shalyatantra, Tilak Ayurved Mahavidyalaya, Pune

Abstract

Varicose veins represent a common chronic venous disorder resulting from venous valve incompetence and venous hypertension. Patients commonly present with dilated tortuous veins, pain, limb heaviness, and cosmetic concerns. Surgical phlebectomy remains a time-tested and effective method for the management of symptomatic superficial varicosities, especially in the presence of incompetent perforator veins.

This article presents a detailed case-based review of a 50-year-old male patient with bilateral lower limb varicose veins managed surgically by ligation, stripping, and phlebectomy, emphasizing clinical features, investigations, operative management, and outcome.

Keywords: Varicose veins, Phlebectomy, Perforator incompetence, Chronic venous insufficiency

Introduction

Varicose veins are permanently dilated, elongated, and tortuous superficial veins of the lower limb caused by venous valve incompetence and reflux. Persistent venous hypertension leads to symptoms such as pain, limb heaviness, edema, skin pigmentation, and in advanced cases, venous ulceration.

Management options range from conservative therapy and sclerotherapy to endovenous ablation and surgery. Among surgical methods, ligation, stripping, and phlebectomy remain reliable, particularly in patients with large bulging varicosities and perforator incompetence.

Case Report

Patient Profile

Age / Sex: 50-year-old male

Occupation: Laborer (prolonged standing)

Chief Complaints

Dilated veins over both lower limbs since 2–3 years

Pain and heaviness in both lower limbs, aggravated on prolonged standing and walking

History of Present Illness

The patient was apparently asymptomatic 2–3 years prior to presentation. He gradually developed dilated, tortuous veins over both lower limbs, initially more prominent on the right side and later involving the left. Over time, he experienced dull aching pain and heaviness in both legs, aggravated by prolonged standing and relieved by rest and limb elevation.

There was no history of sudden limb swelling, redness, fever, trauma, bleeding from veins, or venous ulceration. There was no history suggestive of acute thrombophlebitis. Due to progressive symptoms affecting daily activities, the patient presented for surgical management

Past History

K/C/O

Diabetes mellitus – on treatment

Not a known case of hypertension, ischemic heart disease, or bronchial asthma

M/H/O

No history of deep vein thrombosis

S/H/O

History of umbilical hernioplasty

No previous surgery for varicose veins

Drug History

On oral hypoglycemic agents

Allergy History

No known drug or food allergies

Personal History

Occupation involving prolonged standing

Mixed diet

Occasional alcohol intake

Family History

Father: Diabetes mellitus

Mother: Diabetes mellitus

Brother: Diabetes mellitus and hypertension

Clinical Examination

General Examination

Patient conscious and oriented

Afebrile

Pulse: 80/min

Blood Pressure: 160/90 mmHg

No pallor, icterus, cyanosis, clubbing, or pedal edema

Local Examination (Both Lower Limbs)

Inspection

Dilated, tortuous superficial veins over medial and posterior aspects of both lower limbs

Varicosities more prominent on the right side

Veins become prominent on standing

Mild skin pigmentation present

No active ulceration or eczema

Palpation

Veins soft, compressible, and non-tender

No local rise of temperature

Peripheral pulses palpable and symmetrical

No calf tenderness

Special Tests

Trendelenburg test: Suggestive of superficial venous incompetence

Multiple tourniquet test: Positive for perforator incompetence

Investigations

Duplex Doppler Study

Bilateral varicose veins, right side more severe

Incompetent perforators located approximately 10 cm above ankle and below knee

Reflux present in great saphenous vein segments

Saphenofemoral and saphenopopliteal junctions competent

No evidence of deep vein thrombosis

Laboratory Investigations

Hemoglobin: 10.4 g/dL

Renal function tests: Within normal limits

Coagulation profile: Normal

Diagnosis

Bilateral lower limb varicose veins with perforator incompetence

Management

Indications for Surgery

Symptomatic varicose veins

Doppler-proven perforator incompetence

Absence of deep vein thrombosis

Failure of conservative management

Surgical Procedure (Ligation, Stripping and Phlebectomy)

After informed consent and pre-anesthetic evaluation, the patient was taken up for surgery under spinal anesthesia.

Preoperative marking of varicosities and perforator sites was done in the standing position. The patient was placed supine, and the limb was prepared and draped.

Small incisions were made over the marked perforator sites (approximately 10 cm above ankle and below knee). Incompetent perforator veins were identified, doubly ligated, and divided to interrupt abnormal venous reflux.

Where indicated, the great saphenous vein was exposed, ligated proximally, and the refluxing segment was stripped using a vein stripper.

Multiple small stab incisions (2–3 mm) were then made along the course of superficial varicosities. Using Muller/Oesch hooks, the varicose vein segments were gently extracted in small sections with minimal tissue trauma.

Meticulous hemostasis was achieved. Stab incisions were left unsutured or closed as required. A firm compression dressing was applied from foot to thigh.

Post-operative Care

Compression bandaging for 48–72 hours

Early ambulation encouraged

Analgesics and anti-inflammatory drugs administered

Avoidance of prolonged standing for 1–2 weeks

Compression stockings advised for 6–12 weeks

Outcome

The post-operative period was uneventful. The patient showed marked reduction in pain and limb heaviness. No complications such as infection, hematoma, or thrombosis were observed. The patient was discharged with advice regarding compression therapy and follow-up.

Discussion

Phlebectomy remains an effective surgical option for patients with localized superficial varicosities and perforator incompetence. It provides excellent cosmetic results, minimal invasiveness, early recovery, and durable symptom relief. In this case, surgical intervention was justified due to symptomatic disease and Doppler-confirmed venous reflux.

Conclusion

This case highlights the effectiveness of ligation, stripping, and phlebectomy in the management of varicose veins with perforator incompetence. Early diagnosis and timely surgical intervention result in symptom relief, improved limb function, and prevention of long-term complications.

References

1. Bailey & Love's Short Practice of Surgery, 27th Edition

2. Schwartz's Principles of Surgery, 11th Edition

3. Sabiston Textbook of Surgery, 21st Edition

4. Browse NL et al., Diseases of the Veins, 2nd Edition

5. Rutherford RB, Vascular Surgery, 8th Edition