Multi-detector computer tomography venography (MDCTV) as a diagnostic tool in the management of patients with atypical, complicated and/or recurrent varicose veins

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Aim. To evaluate the role of multi-detector computer tomography venography (MDCTV), compared with conventional venography, as a diagnostic tool in the management of patients with atypical, complicated and/or recurrent varicose veins.

Materials and methods. Retrospective review of 21 patients who had undergone both MDCTV and conventional transfemoral or transpopliteal venography between January 2008 and April 2011 for the management of recurrent varicose veins and/or chronic venous ulcers. MDCTV was performed using a 16-slice CT scanner. Spiral acquisition was commenced 180 seconds after intravenous injection of 150 ml of 350 mmol/l iodinated contrast medium. A reconstruction interval of 1.5 mm was used. Conventional venography was performed by the resident vascular surgeon and was followed by stenting or coiling where appropriate.

Results. MDCTV and venography were compared in 21 patients (6 male, 15 female; average age 55 years, range 33 - 78 years); 8 also underwent endovascular iliac vein stenting. The area under the receiver operator curve (ROC) for percentage iliac vein stenosis determined on MDCTV versus venography was 0.75. Four (19%) false-positive iliac vein stenoses were reported on MDCTV. Ten patients underwent gonadal vein coil embolisation. Gonadal vein size >5.2 mm (range 1 - 11 mm) on MDCTV predicted significant venographic reflux requiring coil embolisation. Three (30%) patients who underwent embolisation did not have gonadal vein enlargement on MDCTV.

Conclusion. MDCTV plays an important adjunctive role in the diagnostic workup of patients with complex venous disease. The findings at MDCTV correlate well with conventional venography.

calibre measurements were performed and stenotic segments were measured on the reconstructed images.

Readers were blinded to the findings from the conventional venography datasets. Secondary imaging outcomes were to identify anatomical anomalies, pelvic masses or compression of venous structures by native vessels. Conventional venography was performed by the resident vascular surgeon. After a diagnostic flush, endovascular stenting (Figs 1 and 2) or coiling was performed if a significant stenosis was verified or significant venous reflux was demonstrated.

Results
MDCTV and venography were compared in 21 patients (6 male, 15 female; average age 55 years, range 33 - 78 years); 8 also underwent endovascular iliac vein stenting. The area under the receiver operator curve (ROC) for percentage iliac vein stenosis determined on MDCTV versus venography was 0.75. Four false-positive (19%) iliac vein stenoses were reported on MDCTV. Aetiologically, these stenoses were attributed to post-phlebitic changes in 6 patients, May-Thurner syndrome in 1 patient, and were idiopathic in 1 patient (Fig. 3). Ten patients underwent gonadal vein coil embolisation. Gonadal vein size >5.2 mm (range 1 - 11 mm) on MDCTV predicted significant venographic reflux requiring coil embolisation. Three (30%) patients who underwent embolisation did not have gonadal vein enlargement on MDCTV.

Conclusion
Currently, limited data exist on the use of MDCTV and its role in complex varicose venous disease. We present a small cohort of cases where MDCTV findings correlate well with conventional venographic findings. Our study focuses on a subset of patients with complex venous disease where the underlying causative lesions are above the level of the inguinal canal and involve mainly the common/external iliac veins or gonadal veins. The mainstay of imaging was to reveal pathology that could be managed endovascularly either by iliac vein stenting or gonadal vein coil embolisation. Preoperative evaluation of varicose veins must reveal the primary cause of varicosity, secondary reflux, and the distribution of varicosity, including perforating veins.

Handheld Doppler and duplex sonography have become the modern non-invasive gold standard. Sonography can evaluate haemodynamic information and anatomical data; its main limitation is the lack of adequate visualisation above the inguinal ligament.

MDCTV provides excellent information on the deep venous system above and below the inguinal canal. Multiplanar reformations and volume rendering provide both an assessment of venous compression and overall varicosity distribution. The major limitation of MDCTV is the lack of dynamic venous flow information, limiting the interrogation of points of reflux. Furthermore, MDCTV requires contrast medium administration and ionising radiation (1.6 - 3.9 mSv) and no insight to venous valvular function can be gained.
A clinical scoring system documenting the severity of venous disease is described by Eklöf et al. (Fig. 4). In our study, patients with clinical stage C6 venous disease were more likely to require iliac stenting. It was in this group that an almost 20% false-positive rate was recorded at MDCTV. In light of the clinical severity score, these patients may still benefit from diagnostic conventional venography with the adjunctive use of endovascular ultrasound to delineate potential stenoses missed at both conventional catheter venography and MDCTV. Patients with C4 disease were more likely to require gonadal vein coiling. Selecting the latter group of patients purely on MDCTV findings is not recommended.

Varicose venous disease is a complex entity; careful patient selection and intervention is required for successful and curative management. This study indicates that, although MDCTV contributes to the multi-modality approach in venous disease, more extensive work needs to be done before it can play a larger role in definitive interventional decision making.


Fig. 4. Clinical disease severity index.

**Correction notice**

We regret that an error occurred in the diagnostic algorithm on page 119 of the September 2012 issue (Vol. 16 No. 3) of the SAJR. The phrases ‘No air-trapping on exp. HRCT’ and ‘Air-trapping on exp. HRCT’ in the 2nd and 3rd columns of the centre row were inadvertently transposed. The corrected image has been placed in the online version of the journal (URL http://www.sajr.org.za/index.php/sajr/article/view/769/621). We apologise for this error.