TREATMENT OF FEMALE EXTERNAL GENITAL VARICOSITIES
Speaker and consultant for Merit Medical since April 2023
INTRODUCTION
Pelvic congestion syndrome is commonly associated with the presence of vulvar, perineal, and less commonly inguinal and buttocks varicose veins whether alone or associated with lower limbs varicosities.
INTRODUCTION:

• Vulvoperineal varicosities can occur due to various reasons including refluxing intrapelvic veins, venous obstruction, increased venous pressure, and venous insufficiency.
The prevalence of vulvar varices in the general population is still unknown. In a series of over 4,000 female vein clinic patients, the incidence of vulvar varices was about 4 – 5 %, as described by Hobbs.

The incidence rises to up to 40% in patients with PCS, who are typically multiparous, women between 20 and 45 years of age.
RELEVANT ANATOMY
The anatomy of the pelvic venous system in women is rather complex.
Studies described six parietal escape points through which pelvic reflux can cause external genitalia and/or gluteal or inguinal varices or transmitted to lower limbs and cause varicose veins.
Pelvic leak points reflux can spread either in the ipsilateral or contralateral sides due to the fact of lack of valves of all the pelvic veins except for the ovarian vein.
DIAGNOSIS
SIGNS AND SYMPTOMS: MOSTLY PELVIC CONGESTION SYNDROME PLUS:

01 Pain: Coital ache, Vulvar and perianal pain and heat

02 Visible vulvar and perineal varices (Appears on standing or straining)

03 Hip pain

04 Continuous genital arousal and discomfort

05 +/- LL varicosities
LEAK POINTS AND LL VARICOSITIES:

Leak points:

• Should always be suspected when finding extraaxial LL varicosities especially if no SFJ reflux and if present Pelvic varices should always be treated first.
IMAGING: VULVOPERINEAL VARICES:

Vulvar, perineal and gluteal ultrasound should be thoroughly done to patients with PCS before and 2 weeks after gonadal embolization.

Ask the patient to strain to assess reflux.
TREATMENT OF VULVOPERINEAL VARICES
TREATMENT OPTIONS:

YOU MUST TREAT GONADAL AND ILIAC REFLUX FIRST
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YOU MUST TREAT GONADAL AND ILIAC REFLUX FIRST FOLLOWED BY:

01 Surgical ligation

OR

02 Sclerotherapy which can be ultrasound guided alone
TREATMENT OPTIONS:

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01 Surgical ligation

02 Sclerotherapy which can be ultrasound guided alone
TREATMENT OPTIONS:

YOU MUST TREAT GONADAL AND ILIAC REFLUX FIRST FOLLOWED BY:

01 Surgical ligation

OR

02 Sclerotherapy which can be ultrasound guided or our new combined ultrasound fluoroscopy technique
ELEVATE

A corporation is a form of organization that has an existence independent of its owners. Corporations have powers and liabilities separate and distinct from those of its owners. They can be organized for many purposes and can come in many types. For example, a municipal corporation is a city, county, or town operating under a corporate charter granted by the state, while a public corporation is owned and operated by the government. This lesson will focus on corporations that are engaged in business.

TECHNIQUE

- Anesthesia
- Tools and sclerosant
- Procedure
- Post procedural care
Patients with planned vulvar punctures should US guided have pudendal block of the affected side using lidocaine hydrochloride 2% infiltration with a maximum dose of 300mg (4.5 mg/kg).
Consequently, in patients who need perineal, gluteal, or inguinal punctures subcutaneous lidocaine 2% injection with no need for a pudendal block is sufficient.
TOOLS AND SCLEROSANT

01 18G Cannula

02 2% Polidocanol 1:4 foam
PROCEDURE:

• A case of bilateral vulvoperineal varices in a 31-year-old patient suffering from marked genital heaviness and continuous arousal.
**POST PROCEDURE CARE:**

- Vulvar compression for 3 to 5 minutes after the procedure is very important.

- Patients are advised to wear tight underwear for 1 week and applying hot fomentation for 3 days.

- Patients can be discharged directly after the procedure with no specific medication post-procedure except for any analgesic medications if needed.
Follow-up is done 1 week, 2 weeks, 6 months, and 12 months after the treatment session by doing a US examination for the vulvar and perineal varices along with monitoring the symptoms.
Direct Fluoroscopic-Guided Sclerotherapy for Vulvoperineal Varices: An Experience in 70 Patients

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OUR RESULTS

• Technical success was seen in all cases (100%).
• All the patients reported improvement in their symptoms with the disappearance of the related pain and swelling of the labia.
• A second session was done for 14 (20%) patients who had residual varices at the 2-week follow-up revealed by US examination.
• No minor or major complications were reported.
• All patients underwent a control US of the pelvic veins with no signs of thrombosis.
• No cases of hyperpigmentation, allergic reaction, or skin necrosis were found.
OUR RESULTS

• All patients on venography of the draining veins showed drainage of the vulvar varices and/or the perineal veins into the pelvic veins mainly the internal iliac veins through mainly perineal veins and internal pudendal veins.
• Ovarian venous drainage was not seen since they were embolized in a previous session in all the patients.
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Vulvar LL connection
OUR RESULTS

• Several preliminary punctures revealed an isolated venous blowout not communicating to pelvic veins.
• External iliac communication as well as the isolated blowouts show the value of fluoroscopic guided injection.
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