VENOUS REFLUX AUDIT MEETING 03/11/16 – Present: AC, PG, CR, MY, JB

Apologies- SM

Technique

- Tippy couch used by some staff not all, weight limit for couch is 25 stone. Some patients may need to be asked their weight to ensure that they are not too heavy for their own safety on the couch.

- Another technique used by PG is to have the patient standing with the examination couch raised behind them. The sonographer sits on the double step facing the patient and the patient can hold on to the handle for support.

- Some staff have the patient "perched" on the edge of the couch for their scan.

Dressings

- The current patient leaflet clearly states that full dressings cannot be redressed however a temporary dressing can be applied until the patient is able to get to their GP.

- It was discussed that if reflux is obtained with dressings in situ on the leg then there is no necessity to remove them, however if reflux is not obtained and the referral infers that the ulcer is from a venous cause then dressings should be removed.

Protocol

- Our current protocol states that reflux is reverse flow in the vein lasting longer than 0.5 seconds.

- It is also recognised that if after flow has been augmented in the vein a small response has been produced but the reverse flow is similar in size and duration that this is also classed as reflux.

- MY to change protocol as it was discussed that determining reflux at the SFJ can sometimes be difficult therefore it is easier to measure reflux approximately 2-3 cm distal to the junction.

- There is a function on the EPIQ that assists in measuring the duration of reverse flow in the vein called TIME/SLOPE.

- Valsalva can be used, but AC reported that recent literature has questioned its place – therefore use with caution.

Perforators

- Currently the vascular surgeons at QAH do not treat incompetent perforators; they are to be examined if there is no other source of reflux in the limb.

- MY stated that at Chertsey perforators are treated so their location and diameter if incompetent is reported.

REPORTING

- It was agreed to keep depicting reflux with a ↓ and competent vein with a ↑ on our paper reports.

- It was agreed that if reflux is demonstrated in the CFV when there is SFJ reflux that this should be commented on in the paper report- e.g. "CFV reflux noted, due to SFJ incompetence".

- PG &CR to audit venous reflux reports as part of the QA programme.

Valves

There are no veins in the IVC and CIV and the majority of the population have no valves in the EIV or CFV. There is usually a valve at the origin to the SFV and an average of four to five valves along the length of the SFV and popliteal vein to the level of the knee.
There is a valve in the below knee popliteal vein in the majority of people that is sometimes referred to as the "gatekeeper" as it prevents venous reflux into the proximal calf. (Taken from "Peripheral Vascular Ultrasound, How, Why and When", Abigail Thrush and Tim Hartshorne).

AC – re-label LSV as GSV on ultrasound machines and source an extra step for reflux scanning.

3.11.16.