Sonographers Meeting

Add as much info as possible to reports to aid with planning of treatment and allocation of list time (eg: estimate number of HH or Kebab TRLOPS required, whether there are US guided phlebs and if so are these extensive etc.).

Do not refer patients for TV scan if pelvic component is not considered significant, or if patient is elderly or has had a full hysterectomy.

We are no longer routinely scanning post PVE.

Discussion around what data to collect for the TV and Abdo scans - ask surgeons.

Email management re: TV lists in Bristol.

Computer date error - rectify this by creating a PDF for all patients from July-October 2017 (Check) and then delete the Word File.

Surgeons Meeting

No blood release appointment for BUPA patients. These will need a separate post-op sheet. Insurer is indicated on the daily patient lists.

AJ to investigate the possibility of a PHD placement from University of Surrey to analyse the pelvic patient data. In the interim continue to collect most of the complete data set.

Devise a symptom questionnaire for the male PCS patients.

MSW

1940 laser has advantages at low power for aesthetic small calibre veins.

Veinsense - stocking research project underway in Guildford.

PCS compression RCT - compression shorts vs PVE to control symptoms. Bauerfend. NB: PVE may improve symptoms but will not always abolish them completely. Some patients have temporary improvement then some recurrence of symptoms (reflect in consent process).

Difficult patients - always report to clinical govenrance.

3 steps - anti-reflux; anti-recurrence; cosmetic

Risk of DVT - sub-cut heparin at Tx and for subsequent 7 days. No phlebs OR keep to a minimum and patient stays for 3 hours post -op and warn about risk of bleeding.

On anti-coagulation => Do not stop anticoagulation but do no phlebs. (* check with O A-B patient with cosmetic veins on anticoagulation)

PTS occurs in patients with recurrent DVTs or with major DVT where treatment was delayed. Most PTS patients have obstructive patterns => MRV /IVUS => stent.

SVT => anticoagulation if thrombus in truncal veins and within 5-7cm of DV junction. Wait until vein clears then treat with EVLA.

Unprovoked DVT => 10% chance of occult malignancy.

Antibiotics - ulcer patients => one dose if ulcer clean. 1 week course if infected - applies to EVLA or foam. If no allergies use co-amoxyclav.

Numbing cream - no effect (other than psychological) if applied 20 mins prior. Minimal effect if applied 2-4hours prior. May be a benefit for labial foam applied 1 hour prior with clingfilm.

MOT scan only if patients think nothing is wrong (IE: to check). Any problems then repeat diagnostic with consult.

Venous Registry - includes patient feedback and outcomes.

Varixo (MSW)

Inject 1ml 1%; switch on; select gas, concentration; mix; ready; extract (video on WhiteleyShare). Can use low concentration polydocanol for threads with yellow needle - inject SLOWLY.

Male Pelvis (JH)

56 patients; 51 successful diagnosis. Only 3 with a classical upper to lower abdo to testicle pattern. 20 with a posterior scrotum to proximal thigh pattern. 18 with involvement of vessels on the abdominal wall. 41 pelvis to leg communications. 18 ascending patterns. 5 obstructive/thrombotic.

Hypochlorous Acid (CF)

Dressing for ulcers. Suitable for patients who can redress their ulcers independently and daily. Trial in Guildford.

Review Platforms (CC)

Influencers are critical. Encourage Doctify and TrustPilot reviews.