



Vascular HealthCare

Leading the way.

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The Guide Wire

The team at Vascular Health Care are excited to announce the official opening of our new vascular health care centre at Gateshead. In this issue you will get a chance to meet new staff and keep up to date with the latest information in vascular health care.

The official opening of Vascular Health Care

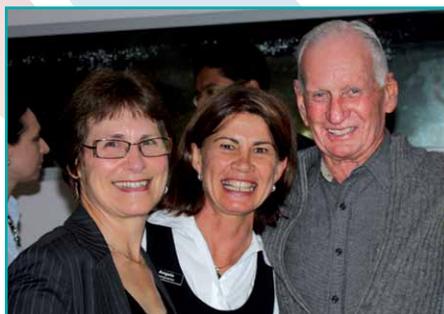
On Tuesday 25th October, John Pitsonis CEO, Lake Macquarie Private Hospital, officially opened our new Vascular Health Care head office at Gateshead. The night was a success, with delicious food and flowing French champagne, our guests had a chance to view our dedicated vascular imaging and consultation centre. We now look forward to a successful future ahead working together with you and your patients.

Clockwise from top left: Dr Naomi Hunter, Bernard Callaghan and Dr Alan Bray; John Pitsonas (CEO LMPH); New office at Gateshead; Directions to get to our new office; Ruth Keech, Angela Carruthers and Bernard Callaghan; Dr Matthew Sebastian and Enid Scott.

Christmas Hours

Vascular Health Care will be closed over the Christmas and New Year period from Friday 23rd December and reopen on Tuesday 3rd January 2012.

We would like to take this opportunity to wish you all a Merry Christmas and prosperous and healthy New Year.



Meet The Staff



Mathew G Sebastian
Vascular Surgeon

Mathew Sebastian is a graduate of the National University of Singapore. He completed both his Basic and Advanced Specialty Training in General Surgery, primarily at the Singapore General Hospital (SGH). After exit certification in General Surgery, he trained in Vascular Surgery in SGH for a year before doing an ACGME-accredited Vascular Surgical Fellowship at the Carolinas Medical Center in Charlotte, North Carolina, USA. He received specific training in Endovascular Therapy in particular aortic stent-grafting for aneurysmal disease as well as lower extremity and renal interventions.

Mathew worked as a vascular surgeon in Singapore from 2002 to 2009, when he emigrated to Australia. His time in Singapore included being Sub-specialty Chief for Vascular Surgery as well as directing the non-invasive vascular assessment lab in SGH. He held academic appointments in two medical schools and is still on the faculty of the Duke-NUS Graduate Medical School, Singapore. After coming to Australia, he obtained his FRACS (Vascular Surgery) in January 2011 and is currently a Staff Specialist Vascular Surgeon at the John Hunter Hospital.

Mathew's interests are in the endovascular management of aortic aneurysms as well as endovascular interventions in limb salvage, particularly diabetic foot disease. He has recently obtained private practice rights and will be consulting at Gateshead.

Calf Vein DVT – article by Nicole Organ



Treatment is controversial and can range from repeat duplex scanning at regular intervals for 1-2 weeks, low dose low molecular weight Heparin, to three months of Warfarin therapy.

It was previously thought that calf vein thrombosis was a benign condition, however it has a small but significant rate of extension of the thrombus into the popliteal and femoral veins and also of pulmonary embolism. Various studies have revealed extension of thrombus into larger veins in 4-30% of patients that are not anticoagulated and a PE rate reported to be 5-20% for untreated symptomatic calf vein thrombosis¹⁻⁴.

The definition of a calf vein is also debatable. It includes the paired venae comitantes that run with the arteries. That is anterior tibial, posterior tibial and peroneal veins. It could also include the soleal and gastrocnemius veins as these are subfascial. It is reasonable to consider treatment for these deep veins as well though the risk of thromboembolic disease is less it may still be clinically significant (20% extension and 4% PE in one large series⁵ though much less in others.)

The American college of chest physicians guidelines for treatment of thrombotic disease recommends 3 months of Warfarin therapy, covered initially with low molecular Heparin until Warfarin is therapeutic. This is for both provoked or unprovoked first episode of calf vein DVT.

There is no recommendation for testing for prothrombotic conditions

and this would have to be tailored to individual patients.

When deciding on treatment the patients bleeding risk would have to be weighed with the risk of treatment³. Others have recommended serial US scanning with treatment only if there is extension of the thrombus into the popliteal vein¹⁻². This would require a follow up venous duplex ultrasound at days 3, 7 and 14 as a minimum if the thrombus has not resolved and treatment with standard anticoagulation if there was progression of the thrombus.

Repeat duplex ultrasound is useful before completion of therapy to establish the burden of residual clot. This will provide a comparison for future scan if the patient develops any new symptoms.

1. The Natural History of Calf vein thrombosis: Lysis of thrombi and development of reflux. Masuda et al. *Journal of Vascular Surgery*. 1998. 28(1). 67-674.
2. Need for long term anticoagulation treatment in symptomatic calf vein thrombosis. Lagerstedt et al. *Lancet*, 1985. 326(8454). 515-518.
3. American College of Chest Physicians: Guidelines for treatment of thrombotic disease. CHEST. 2008.
4. Hirsh. In Bernstein (Ed). *Vascular Diagnosis* 1993.
5. Isolated gastrocnemius and soleal vein thrombosis: should these patients receive therapeutic anticoagulation? Lautz et al. *Annals of Surgery*. 2010. 251(4). 735-742.

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