

COMMENTARY

“Bottom Up” Treatment for Vulvar and Lower Extremity Varicose Veins of Pelvic Origin: Keeping It Simple and Effective**Maria Katsarou ***

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Pelvic congestion syndrome is a condition characterised by chronic pelvic pain resulting from dilated and incompetent veins in the pelvic region. Symptoms often include a dull, aching pain that worsens with prolonged standing or sitting, during or after intercourse, and around the menstrual cycle. Recognised visible presentations of this syndrome are varicose veins commonly in the vulvar, perineal, posterior thigh, or upper leg areas. These develop due to venous reflux in the distal tributaries of the internal iliac veins with transmission of venous pressure to the lower extremity veins through escape points in the pelvic floor. The condition predominantly affects pre-menopausal women, particularly those who have had multiple pregnancies, probably due to increased pelvic blood flow and hormonal influences during pregnancy. The diagnosis is essentially one of exclusion, typically also involving a combination of patient history and imaging techniques, such as ultrasound, computed tomography, or magnetic resonance scanning, to identify and assess vein dilation and blood flow.^{1–6}

Treatment options for pelvic congestion syndrome range from pain management with non-steroidal anti-inflammatory drugs to minimally invasive procedures like pelvic vein embolisation, which aims to occlude the affected veins and alleviate symptoms. Concerning varicose veins of pelvic origin, there are two treatment options: a “top down” technique which involves pelvic vein embolisation or treatment of iliac and/or renal vein compression, and a “bottom up” technique to focally treat pelvic escape points and varicose veins.⁶ Interventional radiologists have traditionally performed these procedures, but they are now increasingly being managed by vascular surgeons, with a relevant bearing on the evolution of current endovascular practice.

The case report by Jaworucka-Kaczorowska *et al.* presents the bottom up technique for managing pelvic varicose veins in a young patient with extensive pelvic varices but no

associated pelvic symptoms.⁷ The authors used transvaginal ultrasound to identify pelvic escape points, followed by ultrasound guided foam sclerotherapy, achieving excellent clinical results at a two year follow up. The advantages of the bottom up technique include its limited technical complexity and elimination of the need for contrast media or radiation exposure in patients typically of reproductive age. However, potential drawbacks include procedural pain, the need for multiple follow up sessions, and complications commonly associated with foam sclerotherapy, such as hyperpigmentation, induration, and superficial vein thrombosis.

In summary, this case report revisits, and clearly illustrates with interesting figures, a useful and applicable minimally invasive technique, providing valuable insights into the treatment of a common but frequently overlooked condition and the potential to achieve favourable outcomes in appropriately selected patients. This technique represents a valid first approach in the treatment of patients without pelvic symptoms, avoiding the necessity for more invasive procedures such as pelvic and/or ovarian vein embolisation.

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