AN INTERVIEW WITH…

Ellen D. Dillavou, MD, FACS

Dr. Dillavou shares her thoughts on tackling some of the challenging areas of venous care and her experience thus far with the HUMANITY trial.

What would the ideal tool look like for tracking venous ulcers? What measures would be most helpful to record in order to refine treatment guidelines?

I think total ulcer volume over time is the most helpful way to track ulcers and to think about in terms of ulcer care guidelines. This is difficult, but there is software available. The hard part is building this tool into the electronic medical records so that the effort that goes into wound management is billed. This also enables other providers to see wound progress and minimizes duplication of work.

What is the greatest challenge to getting patients with pelvic congestion syndrome and accompanying varices to the appropriate care provider? How much of a role does reimbursement play here?

I think the most difficult part is the appropriate referral of patients, as this disorder is not well recognized and many patients who could get significant relief suffer for years instead. Coding needs to be carefully done to ensure that the work performed is appropriately reimbursed.

In your opinion, what is the most promising option for treating this presentation? What factors do you consider during diagnosis and when offering individualized treatment for patients?

When seeing a patient with possible pelvic congestion, I try to separate symptoms into pelvic versus those attributable to labial varices. I treat labial varices directly with foam sclerotherapy. For pelvic symptoms, I start with iliac and renal venography. I perform contrast sclerotherapy into the internal varices below the pelvic brim and coil embolize the ovarian vein or refluxing internal iliac branches as needed. Of course, it is paramount to rule out May-Thurner compression, and intravascular ultrasound is the gold standard for this assessment.

What would the optimal trial design look like for further assessment of techniques for treating pathologic perforator veins?

Big question! Perforators are especially challenging because after treatment, they can recanalize or new ones can appear in the same areas. Constructing maps of the leg to track this process is vital to studying methods of closure and will help our understanding of venous ulcer pathology. Another challenge in this area is that these closure methods can be technically difficult, and there is no closure method that is ideal for all anatomic variants. I think the percutaneous technologies are superior to any type of open surgery, and so I would plan a trial concentrating on these technologies.

Can you give us an update on the current activity in the HUMANITY trial, the phase 3 study of a human acellular vessel for end-stage renal disease patients who are not candidates for fistulas? What has your experience been so far?

The HUMANITY trial has reached its enrollment goals, and we are eagerly awaiting results! In my experience, the trial was very well run, and the graft was great to handle and sew. A very promising technology!

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Are there unique roles and indications for both arteriovenous fistulas and arteriovenous grafts, or do you think that one will ultimately prove itself to be the best option for most patients?

I think we are parsing this question out and are discovering that grafts may be superior in the short term, and fistulas are best for long-term use. We are also learning more about specific populations, such as the fact that elderly women have very high failure rates for radiocephalic fistulas, so these are generally not the best choice for this population. The use of grafts for people older than 80 years is looking to be a great first choice, and the immediate-use grafts seem like a good solution to minimize catheter days.

If you were to design and organize a meeting of your choosing, what topic of venous care would it focus on, and what types of sessions or activities would it include?

I would love to have a venous meeting that touched on all aspects of superficial and deep venous care and would try to focus these topics on the appropriateness of interventions and making sure that we all perform the procedures that will really make a difference in patients' lives.

What area of vascular care for women do you find to be most lacking?

I think chronic abdominal pain and pelvic congestion is still a difficult area. More multidisciplinary work may help many women feel better. ■

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