

Disorders of hemostasis, 3rd edition

Oscar Ratnoff and Charles Forbes; Philadelphia; 1996;
W. B. Saunders; 563 pages; \$140.

This book is the third edition of a classic text in hemostasis. The book briefly reviews current knowledge and history of coagulation, but the real strengths of this text are the chapters devoted to each hemostatic problem. By design, each chapter functions as a self-contained review of the problem at hand. For example, the chapter on von Willebrand's disease consists of a state-of-the-art summary of the biology of von Willebrand's protein, a discussion of the often-confusing nomenclature of von Willebrand's disease, and precise guidelines for therapy.

Several chapters particularly stand out. As a *cognoscenti* of hemostasis I enjoyed the first chapter on evolution of knowledge of hemostasis. This historical background is not only interesting in its own right but helps lead to understanding about the sometimes arcane terminology of hemostasis.

For many readers the chapter by Craig Kitchens on surgery and hemostasis will prove invaluable. It contains an excellent discussion of performing surgery on hemophiliacs, a comprehensive discussion of screening patients for hemostatic defects, certain operations and their effects on hemostasis, evaluation of postoperative hemorrhage, and finally operating on patient on chronic anticoagulants. This chapter should be mandatory reading for all surgical residents.

This book also contains chapters on topics not often found in other texts. The chapter on psychogenic bleeding is invaluable for those who have to consult on these difficult patients. Snake envenomation is not a usual problem in most physicians' practices, but this book includes a good review. The chapter on vasculitis and vascular disease provides a broad discussion of purpuras and similar lesions.

Since the appearance of the first edition, I have used this book as a valued reference for a variety of hemostatic problems. For those who consult on a large number of patients with bleeding disorders, I would highly recommend purchase of this book. For those who occasionally see such patients, one should ensure quick access to this text either by owning it or ensuring the hospital library owns one.

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Ambulatory phlebectomy: Practical guide for treating varicose veins

Stefano Ricci, Mihael Georgiev, and Mitchel Goldman; St. Louis; 1995; Mosby-Year Book; 223 pages; \$129.

The book is written by two European phlebologists with the collaboration of an American dermatologist. Dr. Goldman's comments to some selected book sections are appropriate and add a balanced point of view in areas

where it is needed. In the Preface, the authors candidly state that their objective is not to present a textbook of phlebology but to describe their personal technique to perform ambulatory phlebectomy, and the book is intended for those practitioners who wish to include the procedure in their phlebologic practice. The book has an attractive overall appearance. It contains numerous line drawings and color illustrations of excellent quality, reproduced on fine paper. The book has 223 pages and is divided into four parts and four appendices. The appendices are largely a summary of the documents used in the dermatologic practice of Dr. Goldman in California. Among them are: the consent form, preoperative and postoperative instructions, a description of the surgical procedure, and Nursing instructions. References are adequate in some sections and scarce or nonexistent in others. The table of contents is comprehensive, and the index is adequate.

The authors' main objective in writing this book was achieved. The technique of vein hook excision of varicose veins is described in detail and with an abundance of descriptive illustrations. The section on Anatomy is one of the strongest of the book. It contains a good anatomical-clinical correlation that reveals the large experience of the authors. Although the technique of ambulatory phlebectomy and its socioeconomic value are easy to understand and will be accepted by the majority of the readers, this reviewer has important concerns regarding the controversial approach described by the authors.

There is practically no selection of patients for this procedure. All patients with varicose veins are considered candidates for phlebectomy with exception of the gastrocnemius veins, saphenofemoral junction (SFJ) ligation, and recurrence of varicose veins in the SFJ area. Patients with coronary heart disease, cardiac arrhythmias, and advanced occlusive arterial disease are accepted for ambulatory phlebectomy under local anesthesia as long as the anesthetic is administered without Epinephrine (page 56). Rather than using a surgical criteria for the selection of patients, the authors use the American Society of Anesthesiologists selection criteria (page 208). The amount of anesthesia tolerance is the determinant factor in the selection of the patients. For this reason, surgery is performed in multiple sessions to limit anesthesia and operative time to 1 hour or less. For example, a typical greater saphenous vein incompetence needs three surgical sessions, 3 to 7 days apart beginning distally (page 58). In an effort to perform cosmetically acceptable surgery through 1 to 3 mm incisions, the authors perform saphenofemoral junction ligation through a 3 cm incision and consider "unnecessary and harmful" the exposure of the femoral vein above and below the junction. The lesser saphenous vein is "hooked" at the popliteal space and not a flush saphenopopliteal ligation, but "high ligation" is performed without a subfascial dissection. Saphenopopliteal ligation is done through a 3 to 4 mm incision. These concepts are contrary to the principles of varicose vein surgery, which have been hard learned during the last 50 years. An insufficient exposure at the

saphenofemoral and saphenopopliteal junctions is recognized as one of the most important sources of recurrence of varicose veins. Associated to these comments is perhaps one of the most controversial statements of the authors. In Part IV, there is a section on "Setting Up A Varicose Vein Surgery Practice" (page 207). In answering the question, "Who should perform office varicose vein surgery?", the authors state that "phlebectomy is simple enough to be performed by a physician who has manual dexterity but no general surgical training." They continue to say that "unlike phlebectomy which may be performed by a 'beginner' without general surgical training, high ligation and division of the greater saphenous vein must be performed by an expert surgeon. Therefore, since a patient may need both phlebectomy and greater saphenous vein ligation, the operation may be performed either by one surgeon with adequate surgical experience or by a team of phlebologists and surgeons."

This book comes at a time in which we recognize that the traditional stripping is not necessary in all cases. It is also recognized that varicose vein surgery can be performed in an ambulatory setting with the patient under

locoregional anesthesia and that the method is both cost-efficient and well accepted. However, the reviewer considers that this book's value lies on its well-described surgical technique of vein hooking and the excellent section on Anatomy. The authors' approach to patient selection, management of the saphenofemoral and saphenopopliteal junctions, the use of multiple surgical sessions, and minimal surgical training to perform the procedure should be viewed by our readers with a great deal of concern. The price of \$129 for an attractive book where the reader will expand his/her anatomical knowledge and learn how to use the crochet vein hooks is a high price. There are other, less-expensive sources of information on the subjects.

To whom should the book be recommended? Well-trained general and vascular surgeons who wish to learn how to use the crochet hooks and read a good section on venous anatomy and pathology may find this book of interest.

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Ambulatory Phlebectomy is the surgical removal of visible varicose veins, through keyhole incision. The procedure eliminates varicose veins through a series of small punctures (as tiny as 1mm) made in the skin adjacent to the vein. The varicose vein is then removed in small segments. The veins are detected both visually and through the use of Doppler ultrasound. Ambulatory phlebectomy is performed on an outpatient basis under local anaesthesia. The procedure can be performed in just a few minutes depending on the location and amount of varicose veins. Recovery is relatively quick with patients returning to work the day following the procedure. Ambulatory phlebectomy is often performed in conjunction with sclerotherapy. With ambulatory phlebectomy one cannot treat all varicose conditions; venous telangiectasia are best treated with sclerotherapy, and GSV incompetence with high ligation, division; and endoluminal laser or radio frequency ablation. To provide a complete practical guide for office-based surgical treatment of varicose veins, our technique for L&S of the GSV is also described. This book is not a textbook of phlebology. The physiology, pathology, investigation, and diagnosis of the venous disorders of the lower limb, as well as the available wide range of nonsurgical, surgical, and sclerotherap

KEYWORDS: Varicose vein, phlebectomy, stab avulsion, vein treatment.

Objectives: Upon completion of this article, the reader should be familiar with (1) the ambulatory phlebectomy procedure and the equipment needed to perform the procedure, (2) the indications and contraindications of the procedure, (3) the complications from this. Ambulatory phlebectomy is a safe and economical procedure that has proven to be an effective method for treating tributary and other incompetent veins. Through a small number of skin punctures, undesirable veins can be permanently removed with minimal scarring or adverse effects. Today, patients are able to undergo this procedure using local anesthesia with little or no recovery time.