Conclusions: Short procedural time, fast patient recovery, and small recidive rate, were main advantages considering ablation of GSV by FAST RF catheter, due to saphenous reflux.

V10-6

ENDOVENOUS LASER COMBINED WITH MINIPHLEBECTOMY FOR TREATMENT OF VENOUS VARICOSE VEINS: OUR FIRST 625 PROCEDURES

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Objective: Varicose veins and reflux of the saphenous vein (GSV) are traditionally treated with conventional surgical. In recent years, minimally invasive alternatives such as the endovenous laser to surgical treatment have been developed with promising results. Aim of the study is to investigate the safety and efficacy of EVLT and Miniphlebectomy in patients with varicose veins.
Methods: Four hundred and forty-two patients with varicosities due to primary saphenofemoral- popliteal junctions and saphenous vein reflux underwent out-patient EVLT (980 nm diode laser) and Miniphlebectomy.
Results: The mean energy applied per length of GSV during the treatment was 77.5 J±17. Average follow-up was 22±9 months. There were two patients with thrombus exention into femoral vein after EVLT. Recanalization was noted 3% of the patients. Ninety-seven percent clinical improvement was achieved.
Conclusions: Endovenous laser ablation technique are rapidly replacing surgery as the treatment of treatment of saphenous vein reflux, because it is very effective and safe.

V10-7

HEPARIN-INDUCED THROMBOCYTOPENIA IN PATIENTS WITH DEEP VEIN THROMBOSIS

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Objective: HIT is a prothrombotic drug reaction caused by platelet-activating antibodies that recognize multimolecular complexes of platelet factor 4

V10-8

MODIFIED ENDOVENOUS LASER TREATMENT (EVLT) OF LOWER LIMBS' VARICOSE VEINS: OUR EXPERIENCES

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Objective: We assessed the safety and efficacy of modified endovenous laser treatment (EVLT) of the saphenous vein combined with a surgical strategy for treatment of deep venous insufficiency in the lower extremity, based on experience.
Methods: Since September 2007 to December 2009, 512 endovenous laser treatments of great and small saphenous vein and extra-saphenic veins have been performed. These operations are performed by a diode laser with 980 nm of wavelength by a kit that includes optical fibre of 600 micron; 400 micron fibers for small extra-saphenic veins have been used (Eufoton, Italy). Laser power is variable regarding veins diameter from 6 to 12 W set in semi-continous mode and the energy supplied is personalized to morphologic vein characteristics: 50-80 J/cm for vein diameter of 1.5-3.5 mm; 80-100 J/cm for vein diameter of 3.5-6 mm; 100-140 J/cm for vein diameter of 6-8; up to 140 J for vein over 8 mm of diameter. Power is always personalized to echographic vein patterns (diameter, wall thickness, anatomic deep). In the 82% of all patients have been associed other technique.
Results: In all cases (100%) has been detected the subjective symptomatology's fading, with an objective improvement of symptomatology after one month of the operation. At three months after operation, in the 99.9% of all cases has been detected a complete obclusion of vein treated, and in the 0.01% of cases has been detected an early recanalization of Saphenous vein (initial learning curve only). At six months after operation has been detected a recanalization of saphenous vein in the 1.5% of 145 operated patients. At 12 months after operation has been detected a long regurgitation without usual relapses in the 0.46% of 32 operated patients. In the 74% of patients we observed that vein treated disappear after six months.
Conclusions: The endovenous laser treatment (EVLT) of saphenous and extra-saphenic veins is a minimally invasive surgical intervention, that is performable by a Day-Surgery ever under ultra-sound guide and by a topical anesthesia. It can ensure good clinical and aesthetic results by a short time

of convalescence. The laser treatment efficacy is linked to the standardization of preoperative and operative clinical procedures. Interventions must be standardized for the part that pertains to the methodology, but it must be personalized to the patient's vein. Combined techniques if indicated permit to obtain the best results and the best satisfaction of patient.

V10-9

COMBINATION TECHNIQUE OF TUMESCENT ANESTHESIA DURING ENDOVENOUS LASER TREATMENT OF SAPHENOUS VEIN INSUFFICIENCY

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Objective: Endovenous laser therapy (EVLT) is one of the many minimally-invasive procedures that have been developed in recent years for the treatment of saphenous vein insufficiency and varicose veins. Use of general/regional anesthesia or intravenous sedation may increase the risk of deep vein thrombosis because the patient will not be able to stand and walk immediately. Tumescent anesthesia technique is the most popular way for the patient's anesthesia. However, during the EVLT, the patients can suffer from the procedure and feel discomfort; especially if the tumescent anesthesia is inadequate. For this reason, we performed tumescent anesthesia before and continuous way during the procedure. This study aimed to evalu-

Methods: We performed this retrospective study in order to evaluate the effectiveness of different surgical methods in the treatment of inguinal vascular infections. Twenty consecutive patients underwent surgical treatment of such infections from 1997 through 2009 in our clinic. The mean age was 53±12 years. Twelve of the 20 patients underwent emergency operation due to bleeding or acute ischemia. The events that caused inguinal infection were synthetic graft implantation in 16 patients, vascular trauma in 2, arterial catheterization in 1, femoropopliteal saphenous vein bypass operation in 1. The most common infecting pathogen was *Staphylococcus aureus*. Thirty-one operations were performed in 20 patients. These operations included lateral femoral bypass (6), autologous great saphenous vein tailored graft to replace an infected prosthetic graft-in situ position (6), obturator bypass (5), revascularization with homograft (2), autovenous extra-anatomic femorofemoral bypass (3), arterial reconstruction with TEA and autologous great saphenous vein patch (5), only removing the infected prosthetic graft without further arterial reconstruction (4).
Results: All inguinal infections were completely cured after surgery. Early complications included poor wound healing (6 patients), amputation (3 patients), and extension of infection to the distal anastomosis and false aneurysm formation (3 patients). Late complications were graft occlusion (thrombosis) of a bypass reconstruction (3 patients). There was no operative mortality, late mortality is 10% (2 patients). All patients were followed-up for a mean of 48.1±24.7 months. We encountered three patients with reinfection with aneurysmal degeneration and rupture during follow-up.