SURGERY

SURGICAL ASPECTS OF VARIX OF THE LOWER LIMBS.

By Raymond Russ, M.D., in *Surgery, Gynecology and Obstetrics*, July, 1908.

Varix is to be distinguished from simple dilatation. The former only is discussed. There are from one per cent. to four per cent. of applicants for police and army service, showing the condition. The cause of the condition is not fully settled. Most cases of the author's one hundred are males. This is substantiated by many other writers. Constipation and abdominal cysts and tumors have influence on etiology. Seven of the patients first noticed the veins after fractures in the lower extremities. Russ thinks heredity is overestimated. In only three instances has he treated more than a single member of a family. Pregnancy produces dilation, which usually disappears. If there are numerous conceptions varix often results.

Trendelenburg's test is advised as the most valuable physical sign from the surgeon's standpoint. Often it is not visibly present, but on release of pressure at saphenous opening, a thrill will be felt, showing valvular insufficiency.

Standing for a long time or habitually sitting long in one position, especially if the muscles of the arms are brought into play, bicycle riding, all are frequent causative factors.

The age of onset in the majority is between the 20th and 30th years. Average of Russ' cases was 36. Venous supply is much more than the average demand. The contracting muscles assist flow of blood in deep veins, cessation throws extra work and pressure on superficial ones, as seen in the athlete after running. The long saphenous valves are always intact in the fetus and gradually become insufficient. At twenty-five, seventeen per cent., at fifty, forty per cent., at seventy, eighty per cent show insufficiency. Internal saphenous averages three to nine valves; it has superficial branches and deep anastomosis, and it communicates freely with the external saphenous.

Clinical grouping: (1) Limbs enlarged, possible ulcers, edema, eczema and pigmented spots, the long vein shows little or no varicosity; there are small dilated veins on dorsum of foot and on ankle and a few clumps between ankle and knee at the point of anastomosis, with deep veins. (2) Marked varix, little or no enlargement. Internal saphena prominent, especially in the leg, with hard, tortuous branches, phlebitic spots, and phleboliths present—Trendelenburg's test present. (3) Isolated patches of varix in thigh and leg, little or no enlargement. Internal vein may be palpable at points. Trendelenburg's test absent. If the deep veins are involved, as they frequently are, in 1 and 3, the general and skin appearances may be large relative to the dilation of the superficial veins. The most obstinate ulcers often occur with little surface dilation.

Symptoms are pain increasing during the day, numbness, cramps, itching, edema, and tropic changes, skin little resistant to infections and may be thick and brawny, muscles relaxed and atrophic, flat-foot is often seen. Violent exercise makes them worse; moderate exercise is helpful unless complications are present.

Treatment in group 1, operation is valueless, here only palliative measures are helpful. In group 2, is the best field for operation, which is best done by total extirpation of the long saphenous; seventy-five to eighty per cent. are cured.

In group 3, operation is precluded except where iminent rupture is feared, or where the pressure of the varicosities are annoying the patient.

(W. A. B.)