

PREOPERATIVE DIAGNOSIS:, Varicose veins.,POSTOPERATIVE DIAGNOSIS: , Varicose veins.,PROCEDURE PERFORMED:,1. Ligation and stripping of left greater saphenous vein to the level of the knee.,2. Stripping of multiple left lower extremity varicose veins.,ANESTHESIA:, General endotracheal.,ESTIMATED BLOOD LOSS: , Approximately 150 mL.,SPECIMENS: , Multiple veins.,COMPLICATIONS:, None.,BRIEF HISTORY:, This is a 30-year-old Caucasian male who presented for elective evaluation from Dr. X's office for evaluation of intractable pain from the left lower extremity. The patient has had painful varicose veins for number of years. He has failed conservative measures and has felt more aggressive treatment to alleviate his pain secondary to his varicose veins. It was recommended that the patient undergo a saphenous vein ligation and stripping. He was explained the risks, benefits, and complications of the procedure including intractable pain. He gave informed consent to proceed.,OPERATIVE FINDINGS:, The left greater saphenous vein femoral junction was identified and multiple tributaries were ligated surrounding this region.,The vein was stripped from the saphenofemoral junction to the level of the knee. Multiple tributaries of the greater saphenous vein and varicose veins from the left lower extremity were ligated and stripped accordingly. Additionally, there were noted to be multiple regions within these veins that were friable and edematous consistent with acute and chronic inflammatory changes making stripping of these varicose veins extremely

difficult.,OPERATIVE PROCEDURE: ,The patient was marked preoperatively in the Preanesthesia Care Unit. The patient was brought to the operating suite, placed in the supine position. The patient underwent general endotracheal intubation. After adequate anesthesia was obtained, the left lower extremity was prepped and draped circumferentially from the foot all the way to the distal section of the left lower quadrant and just right of midline. A diagonal incision was created in the direction of the inguinal crease on the left. A self-retaining retractor was placed and the incision was carried down through the subcutaneous tissues until the greater saphenous vein was identified. The vein was isolated with a right angle. The vein was followed proximally until a multiple tributary branches were identified. These were ligated with #3-0 silk suture. The dissection was then carried to the femorosaphenous vein junction. This was identified and #0 silk suture was placed proximally and distally and ligated in between. The proximal suture was tied down. Distal suture was retracted and a vein stripping device was placed within the greater saphenous vein. An incision was created at the level of the knee. The distal segment of the greater saphenous vein was identified and the left foot was encircled with #0 silk suture and tied proximally and then ligated. The distal end of the vein stripping device was then passed through at its most proximal location. The device was attached to the vein stripping section and the greater saphenous vein was then stripped free from its canal within the left lower extremity. Next, attention was made towards the

multiple tributaries of the varicose vein within the left lower leg. Multiple incisions were created with a #15 blade scalpel. The incisions were carried down with electrocautery. Next, utilizing sharp dissection with a hemostat, the tissue was spread until the vein was identified. The vein was then followed to T3 and in all these locations intersecting segments of varicose veins were identified and removed. Additionally, some segments were removed. The stripping approach would be vein stripping device. Multiple branches of the saphenous vein were then ligated and/or removed. Occasionally, dissection was unable to be performed as the vein was too friable and would tear from the hemostat. Bleeding was controlled with direct pressure. All incisions were then closed with interrupted #3-0 Vicryl sutures and/or #4-0 Vicryl sutures.,The femoral incision was closed with interrupted multiple #3-0 Vicryl sutures and closed with a running #4-0 subcuticular suture. The leg was then cleaned, dried, and then Steri-Strips were placed over the incisions. The leg was then wrapped with a sterile Kerlix. Once the Kerlix was achieved, an Ace wrap was placed over the left lower extremity for compression. The patient tolerated the procedure well and was transferred to Postanesthesia Care Unit extubated in stable condition. He will undergo evaluation postoperatively and will be seen shortly in the postanesthesia care unit.