VDM VASCULAR DISEASE MANAGEMENT

INTERVIEW

The American Vein and Lymphatic Society Position Statement on Mechanical Occlusion Chemically Assisted Ablation of Varicose Veins for Venous Insufficiency

An Interview With John Blebea, MD, MBA

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At the 2024 VEITH Symposium, vascular surgeon John Blebea, MD, MBA, from the Central Michigan University College of Medicine in Saginaw, Michigan, presented information on the latest position statement of the American Vein and Lymphatic Society (AVLS) on mechanical occlusion chemically assisted ablation (MOCA). The position statement provides recommendations for the appropriate use of MOCA for patients with venous insufficiency. *Vascular Disease Management* spoke with Dr Blebea about this technique and its role in the treatment of superficial venous insufficiency.

Click here to read the AVLS position statement on MOCA.

How does MOCA compare to traditional thermal techniques?

MOCA has the major benefit of not requiring tumescent anesthesia, therefore it is faster and there is less pain associated with it compared to thermal ablation techniques. Because of the lack of thermal energy that needs to be applied there is also less of an incidence of injuring the nearby nerves, so it can also be used in situations where that could be much more of a hazard, below the knee and in treating the small saphenous vein.

What factors determine the appropriateness of MOCA for a specific patient? Are there particular anatomical or clinical considerations?

As the position statement has summarized, one of the difficulties of MOCA is the fact that there is a significantly higher rate of recanalization. This becomes more prominent after 2 years and certainly by 5 years. Associated with that, the report by Witte et al (“Long-term results and predictors of failure after mechanochemical endovenous ablation in the treatment of primary great saphenous vein incompetence,” *Phlebology*, 2024;39(1):9-19) suggests that there is an increased recurrence of symptomatic disease for these patients and they may require additional reinterventions. As the position statement concluded, MOCA would be appropriate in situations where patients may not be appropriate for thermal types of treatments or the use of cyanoacrylate.

Since the AVLS emphasizes safety in its position statement, could you elaborate on the potential risks or complications unique to MOCA, and how these compare to other minimally invasive procedures?

One of the advantages of MOCA is the lack of potential for thermal injury and no need for tumescent anesthesia. As such, there is nothing particularly problematic about MOCA except the rare, reported instances where the tip of the rotating wire can snag in small vessels, tributaries, or if there are synechiae from prior episodes of thrombosis. Snagging is a rather unique complication, but it is

quite infrequent.

Given the AVLS position on the use of MOCA, what steps do you think should be taken to ensure standardization of training and technique among practitioners?

There is not an active process of standardization of the technique for this procedure, and given the relative infrequency of its use, at least in the United States, I am not aware of any standard teaching requirements. Endovenous ablation techniques, including MOCA, are taught in most vascular interventional residency and fellowship programs.

Is there anything else you wanted to say about the position statement?

Position statements are different than society-sponsored guidelines. Guidelines are very in-depth and detailed, but they are also expensive and can take 2 or more years to develop. Position statements are an alternative wherein they represent the consensus of an expert panel or a professional society to give quicker, more timely updates to professionals in the use of specific techniques and their indications. As such, there is a very useful role for both position statements and guidelines. ■