Diagnosis Starts with the Basics: Mapping, Drawing, Ultrasounds

Visual examination, thorough documentation and ultrasound proficiency were topics covered by speakers on Thursday morning.

Jan Sloves, RVT, RCS, FASE, looked at the role that venous duplex mapping plays in patient documentation. He stressed the need for this to be done correctly – and identified four components that make up the venous map:

- Protocol;
- Technique;
- Anatomy; and
- Documentation.

Dr. Lowell S. Kabnick, left, chats with Jan Sloves, RVT, RCS, FASE, during the Venous Diagnostics session on Thursday morning.

He took the audience through the steps that need to be included in the exam, including patient positioning and the ways a machine can be used to streamline the distal augmentation process.

Sloves was not the only speaker to encourage attendees to become proficient with ultrasound scanning. "You need to know the inner workings of your ultrasound system," he said.

He also noted the need to become familiar with the IAC Standards for Vein Center Accreditation, which will require a minimum of 16 images of documentation per protocol.

Moving on to the approach, the exam should begin with the deep venous system, before moving on to the superficial. He also recommended pre-scanning of the nerves. "You should be looking for them, and anything noteworthy should be included in the vein map."

IVC Course Director Jose Almeida, MD, presented "Clinical Findings Do Not Match Duplex Ultrasound: What Do You Do?" This presentation had been prepared by Timothy Liem, MD, who experienced travel delays.

Mapping and drawing are key, according to Dr. Almeida.

"You have to go by IAC standards," he said. "But there's so much anatomical variation that makes mapping and drawing so important. Venous anatomy is complicated. It's much more difficult to interpret than arterial anatomy."

He also recommended that the time of day be noted, as heat and temperature cause changes in reflux patterns.

"After you've done your drawings and sketches, you have to scan the patient yourself," he stressed. "If you're going to work on veins, you have to do the scans yourself. You have to know the anatomy, and know how to hold the probe in one hand and get access in the other. You must connect the reflux source with the pathology."

When mismatches do occur, Dr. Almeida recommends taking a step back to look at other potential causes, such as cardiovascular disease, and then determining what further testing might be needed.

Kandy Hammond, RN, BSN, meanwhile, discussed whether an ultrasound should be performed on patients with C1 disease (spider veins).

Hammond considered the typical patterns of spider veins, which include lateral subdermal plexus, medial aspect of the thigh and posterior leg. Recognizing these patterns is important, she said, as it could indicate some truncal insufficiency.

She said she wants to educate patients and provide them with realistic expectations of what is going to be done.

One alternative to an ultrasound is the quick scan, which she said could be performed by a physician, nurse practitioner or physician assistant in less than three minutes. The scan is performed purely to gain knowledge.

"And there is no charge for this exam," she said. "It's important to be knowledgeable so you can prepare the patient for the potential outcomes."

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