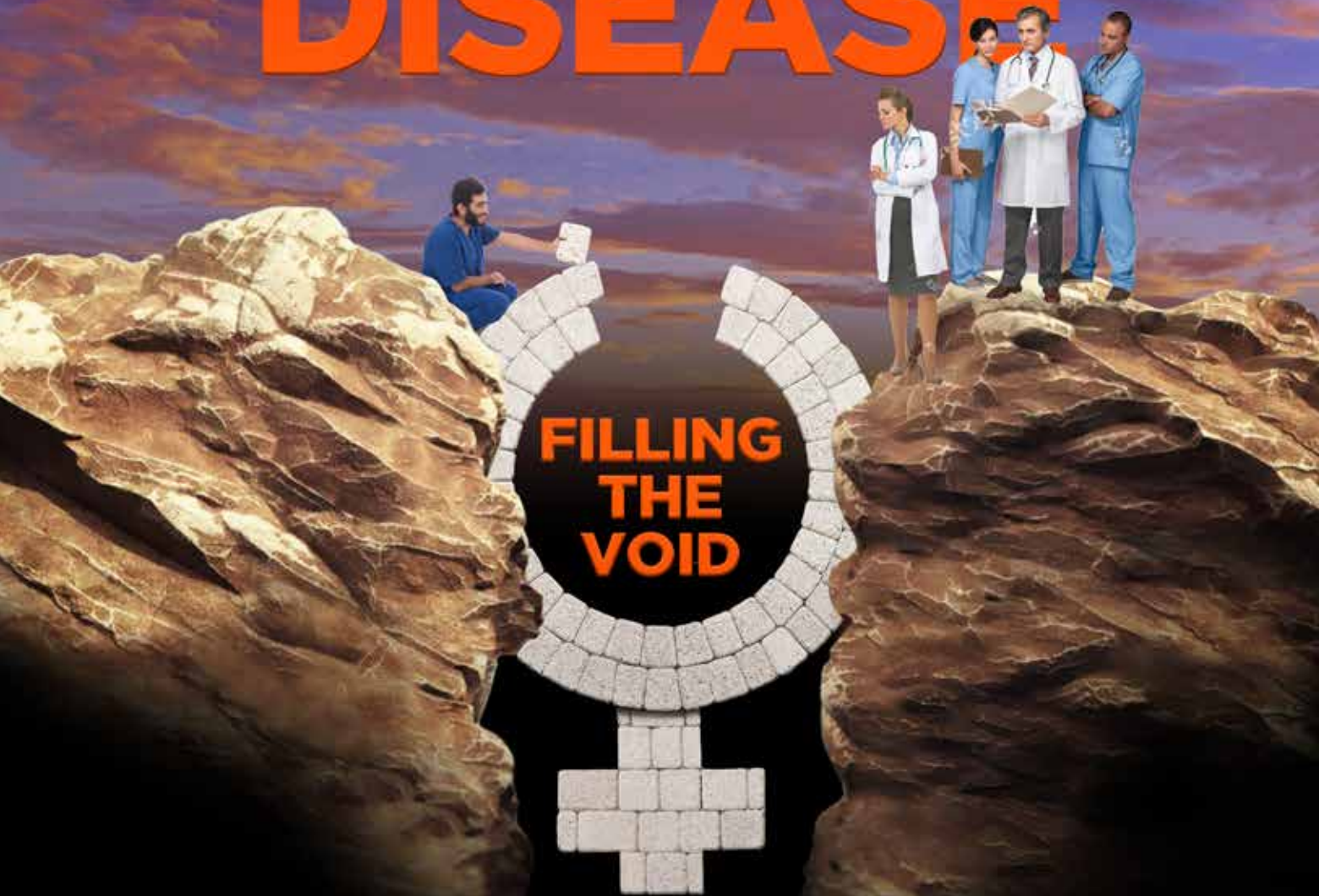


PELVIC VEIN DISEASE



A roundtable discussion with Dr. Meredith Englander, Dr. Tony Gasparis,
Dr. Neil Khilnani and Dr. Mark Meissner
Moderated by Dr. Steve Elias

Steve: Today we're talking about the management of pelvic vein disease, and I want us to think about every single aspect of diseases that can originate from the pelvis--whether it affects the pelvis, the legs, or both.

Let's start with referring physicians; they see people coming with relatively nebulous complaints and they don't put two and two together to think maybe something is going on. Meredith, regarding the referring physicians, what do you feel the impediments are to get the right patient to you?

Meridith: We've done outreach to gynecologists to let them know that if they see visible varicosities, or if they notice varicosities on the internal exam, that's something we can treat. In the past, I'm sure they have just assumed that was untreatable.

We've tried to let our diagnostic radiologist partners know that when they see pelvic varices on cross-sectional imaging, they need to comment on it and say that this could be suggestive of pelvic congestion syndrome. If the study was to evaluate for pelvic pain in a woman, those comments could trigger a referral to our office.

Gynecologists might not even know that there's a vascular solution for pelvic pain. We have been trying to educate.

Tony: Do you encounter resistance?

Meridith: They're skeptical, but we have a solid core of gynecologists in different practices in our community who have been relatively responsive in sending us new patients.

We have been treating uterine fibroids with embolization for years, so we see a lot of pelvic pain patients, and we have that relationship with the gynecologists already. When we say we can also treat patients who have pelvic varicose veins, they are on board. They already know we can treat fibroids, and now we can address other pelvic problems too.

Steve: Neil, are the physicians who refer patients mostly OBGYN?

Neil: The patients who have the lower extremity varicose veins and who end up having pelvic origin varicose veins are coming from a large group of physicians, or are self-referring, probably not recognizing that their problems originate in the pelvis in the first place.

Another large number of patients are women who have had children and who are coming to us from the gynecologist. For the most part, that particular pathway follows the same referral pattern as our lower extremity varicose veins do. Perhaps there are enlightened physicians who recognize pelvic origin veins and refer patients, but that is a small minority.

It's an entirely different referral pathway for the patients who come with chronic pelvic pain. With those patients, we don't see the same broad spectrum of physicians who refer. Most of the time those patients come from physicians who we've had contact with and who we've discussed the issue of pelvic venous disorders with. In our local area, it's chronic pain physicians, usually physiatrists, and pelvic pain specialists who have a considerable presence in the New York City area. Increasingly we see referrals from those specific types of physicians for the chronic pelvic pain patients.

Steve: Mark, which physicians refer your pelvic pain patients?

Mark: I would say 80 percent of my patients are self-referred. It's probably not optimal. I wish we got more from gynecologists.

Steve: Who harbors most of these types of patient—gynecologists or chronic pain physiatrists or pain physicians?

Mark: Gynecologists clearly see most of the patients with chronic pelvic pain, some of whom have a primarily venous etiology to their pain. Pain specialists are clearly underutilized in this patient population. I do think there are multiple pathways that lead to chronic pelvic pain and just addressing an underlying venous problem may not afford complete relief of the patient's



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symptoms. Ultimately a lot of this is a chronic pain problem that requires a pain specialist’s involvement.

Neil: There’s some interesting literature that shows these women, particularly those with undiagnosed chronic pelvic pain, see many physicians over an extended period. They go and see a doctor, they start a workup, it doesn’t go anywhere, and it doesn’t solve their problem. They disengage from health care then come back and go to a different doctor, sometimes in a different specialty. Sometimes they still don’t get relief for their problem; sometimes they’re told there’s nothing wrong with them. They disengage from the diagnostic cycle again and they live with this pain for a long time.

Many of these patients are seen by different types of physicians. I imagine most of them are seen by at least one gynecologist (if not more) along the way. So that’s probably where most of the chronic pelvic pain women get their primary attention. But ultimately many will start to see physicians in different specialties.

Steve: Tony, what has been your experience with the people who do refer, and those with whom you’re having trouble making inroads in educating?

Tony: I would say 90 percent, or more, of the patients I see are self-referred. I’ve tried reaching out to OBGYN’s-- going and giving lunch and learns-- but it’s tough. I think it’s a matter of educating physicians during medical school, or even during their residencies, for them to understand the role of pelvic venous insufficiency or pelvic vein disease and the development of pelvic pain.

I’m sure a majority of patients with pelvic pain (unless they’re having GI symptoms or something entirely different) have seen at least one gynecologist at some point.

Mark: It’s a two-way street. There’s a lot that vein specialists who don’t understand about chronic pelvic pain, and there are many things that gynecologists don’t understand about venous disease. Most current efforts are focused on one-on-

one discussion with each gynecologist. However, the best long term plan is to increase the dialogue both ways. The international pelvic work group has started to do that with some of the pelvic projects, such as the development of a descriptive classification, which we have been working on.

The pelvic working group has been well received by both the American College of Obstetricians and Gynecologists (ACOG), as well as the International Pelvic Pain Society. They have been very well engaged in the working group and there has been a lot of learning in both directions between pelvic pain and venous specialists.

I’ve learned a lot about chronic pelvic pain from the gynecologists and pelvic pain specialists and vice-versa. In the long run, an organized back and forth educational approach is probably the best solution. Engaging individual gynecologists may be successful for our individual practices, but for patient care in a broad sense, it involves engaging the entire gynecologic community on a scientific basis.

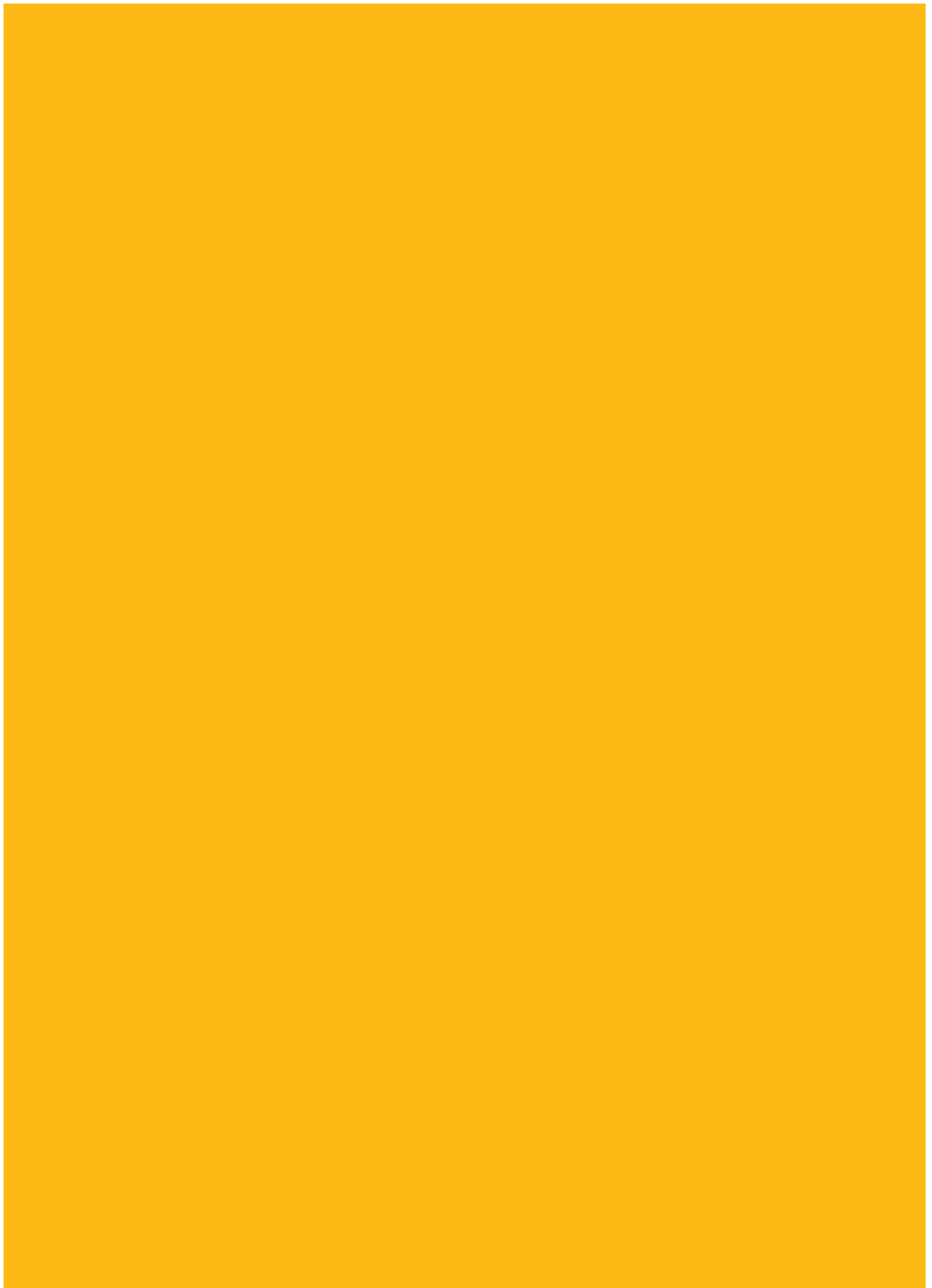
Meridith: In our community, there’s a uro-gynecologist who started a pelvic pain consortium that involved colo-rectal surgery, gynecology, urology, pain management, vascular interventional radiology, and physical therapy. This group was trying to address pelvic pain from a multi-specialty approach.

It seemed like a great approach, and my practice was involved. Unfortunately, the urologist who started it left our hospital and the consortium faltered. Something like that seems to have promise, so patients can be seen by the right specialist.

A Multidisciplinary Approach for a Multifactorial Condition

Steve: Mark, what can vascular specialists learn from OBGYN?

Mark: A lot of chronic pelvic pain is multifactorial. Women may have ovarian vein reflux or common iliac vein compression have pelvic varicosities, but



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when you’ve taken care of enough patients, you realize that you don’t wholly cure most patients of their pelvic pain. You may make them much better, but some other things are going on that need to be addressed as well, and a multidisciplinary approach is what a lot of these women need.

That involves a gynecologist, a vein specialist, and a pain physician. There are some pretty robust data from the neurofunctional imaging of women with chronic pelvic pain; you really do get some cerebral changes. When you have long-standing pelvic pain you get a decrease in gray matter. That reads in pain processing pathways and some other things. All of that has to be addressed. I think that’s what I’ve learned a lot from our GYN colleagues that specialize in pelvic pain. Even though they may recognize venous disease as one of the causes of pain, in many cases, there are other dimensions to be considered besides just the pelvic varices.

Steve: So there are OBGYN who are pelvic pain specialists, so to speak.

Neil: Just like there are vein specialists who are not true venous experts but who care for an occasional patient with venous disease, there are gynecologists who do general gynecology and don’t really deal with more complicated patients with chronic pelvic pain. So they are not comfortable, and certainly not as experienced at doing the appropriate workup. (Now we’re talking specifically about patients with chronic pelvic pain only. This is just a subset of pelvic venous disorder patients.)

They rely more on imaging and laparoscopy than they do on physical exams and history taking. The gynecologists who Mark and I have worked with on our committees are the first to recognize the fact that there isn’t a robust training pathway for physicians who are interested in chronic pelvic pain.

Consequently, there are not very many residency programs that stress the need for a thorough evaluation of chronic pelvic pain, and there aren’t that many skilled people in the community who can do so.

There are people who self designate themselves as chronic pelvic pain specialists. They are probably better at evaluating chronic pelvic pain patients than the standard gynecologist. Then there are members of those organizations like the International Pelvic Pain Society who are more committed to this and they’re the ones we should work with.

Tony: We have a women’s health center that was just put together about two years ago. When this was put together, our vascular team wasn’t even asked to be part of it or asked what we could offer.

Even after even reaching out to a couple of the people who work there and showing interest in going there to see patients whom they think could have a pelvic venous disorder, I still never got a phone call back. It’s pretty interesting.

Steve: What percentage of chronic pelvic pain is venous in origin?

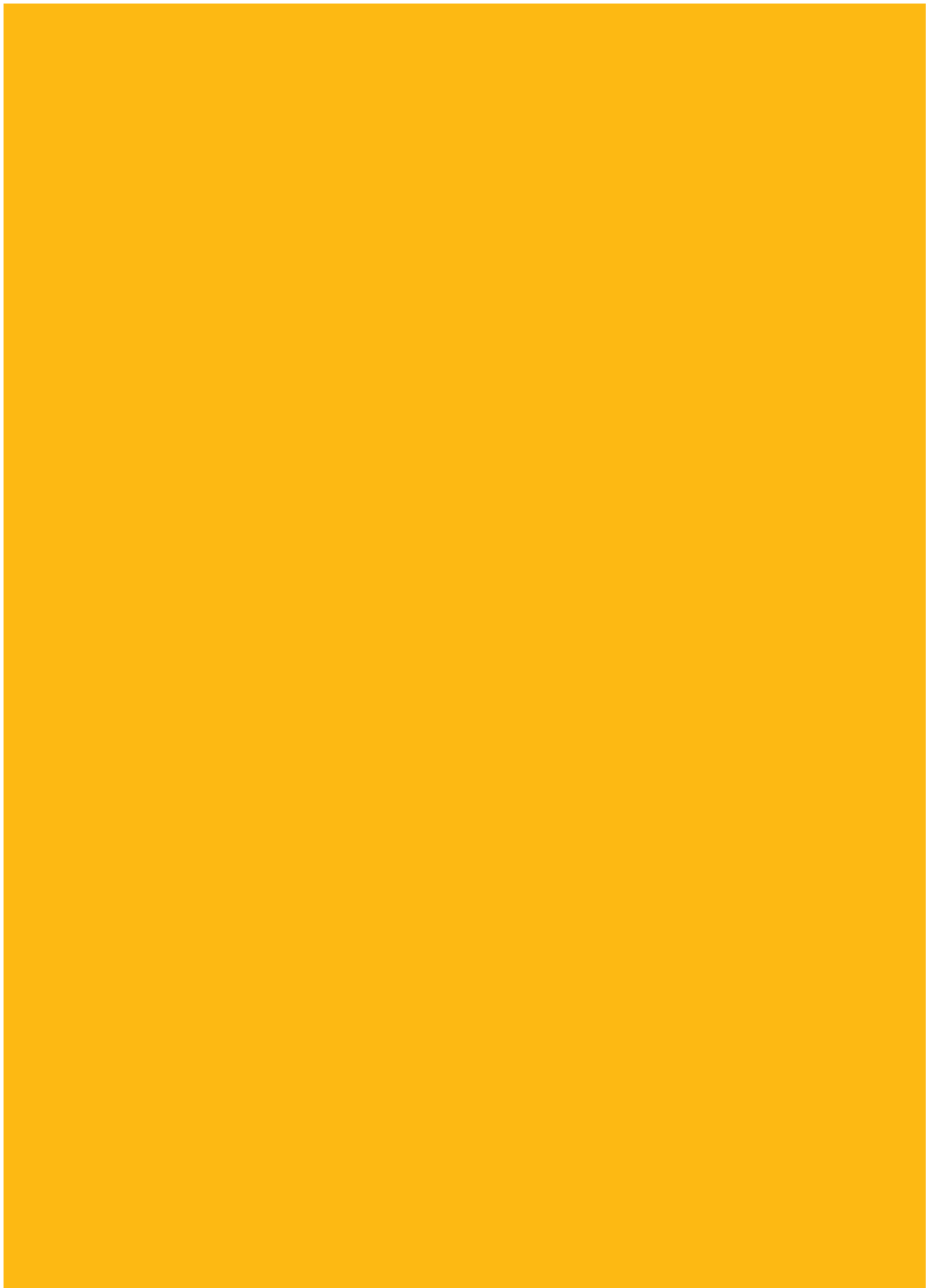
Mark: The literature generally shows about 30 percent of chronic pelvic pain will have a venous component to it.

It’s a little hard to sort out whether that means of the women who present with chronic pelvic pain, 30 percent of them will have varicosities (I think that’s what it refers to), or if a venous disorder is the primary or sole cause of their pelvic pain in 30 percent of patients. That’s a little harder to get to.

Steve: This sounds like the wound center problem. We know that of patients who present to a wound center, 30-40 percent of them (some people think even more) will have wounds that are venous in origin and yet the wound centers don’t recognize that venous is a component, and they don’t get an evaluation by a vein specialist.

Tony: I have two gynecologists in our area who actually send me patients. When they work them up and they don’t have anything that they can find, it’s





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a pretty high percentage of the ones who come to me who actually do have a pelvic venous disease.

A Cycle of Cynicism

Neil: In the GYN community there is a lot of cynicism about venous disease leading to chronic pain. Maybe it’s not very prevalent but some have said about radiologists promoting treatment, there they go again, trying to do another procedure to make money. In women with pelvic pain, even the chronic pelvic pain doctors who recognize that at least a certain fraction of the patients they’re seeing have a clinically important pelvic venous etiology question whether there is causality. They still have questions about it.

The data linking venous disease and symptoms is not strong, and then even more of an issue, they also raise questions about the success of our treatment. They have made the point that many promising treatments for chronic pelvic pain in the past have been abandoned with RCT data proving that they were not as effective as those who were performing them thought. An often-cited example is laparoscopic lysis of adhesions.

They have some valid concerns. It may date back to biases held by those who taught them. A lot of these patients develop secondary problems as a result of long term pain, like depression and anxiety, which then become the dominant problem for the patient. The patient may not present to you until late and that’s what you see by the time you see the patient. You don’t see the pelvic varicosities and very quickly the average gynecologist will conclude that this chronic pelvic pain, that can’t be explained by laparoscopy in the Trendelenburg position and ultrasound and cross-sectional imaging, may be some sort of psychological problem that needs to be addressed and not a pelvic condition at all.

We all see these patients who clearly have a dominant venous problem and symptoms that can’t be explained by anything else. They haven’t gotten the attention. It seems so simple to us; it’s just not something that’s on other physicians’ radars, and that’s what we need to address as a group of venous specialists.

We’ve been working on this issue at a society level, and dealing with the gynecology experts. The next stage is to get ourselves in front of the audience of practicing gynecologists. Not just self-invited to their grand rounds, which we’ve done and has been minimally productive, but to be invited by leaders in the OBGYN community to speak about what we have. We need to hear the criticism, and be prepared to defend our position with data that will hopefully become more robust as time goes on.

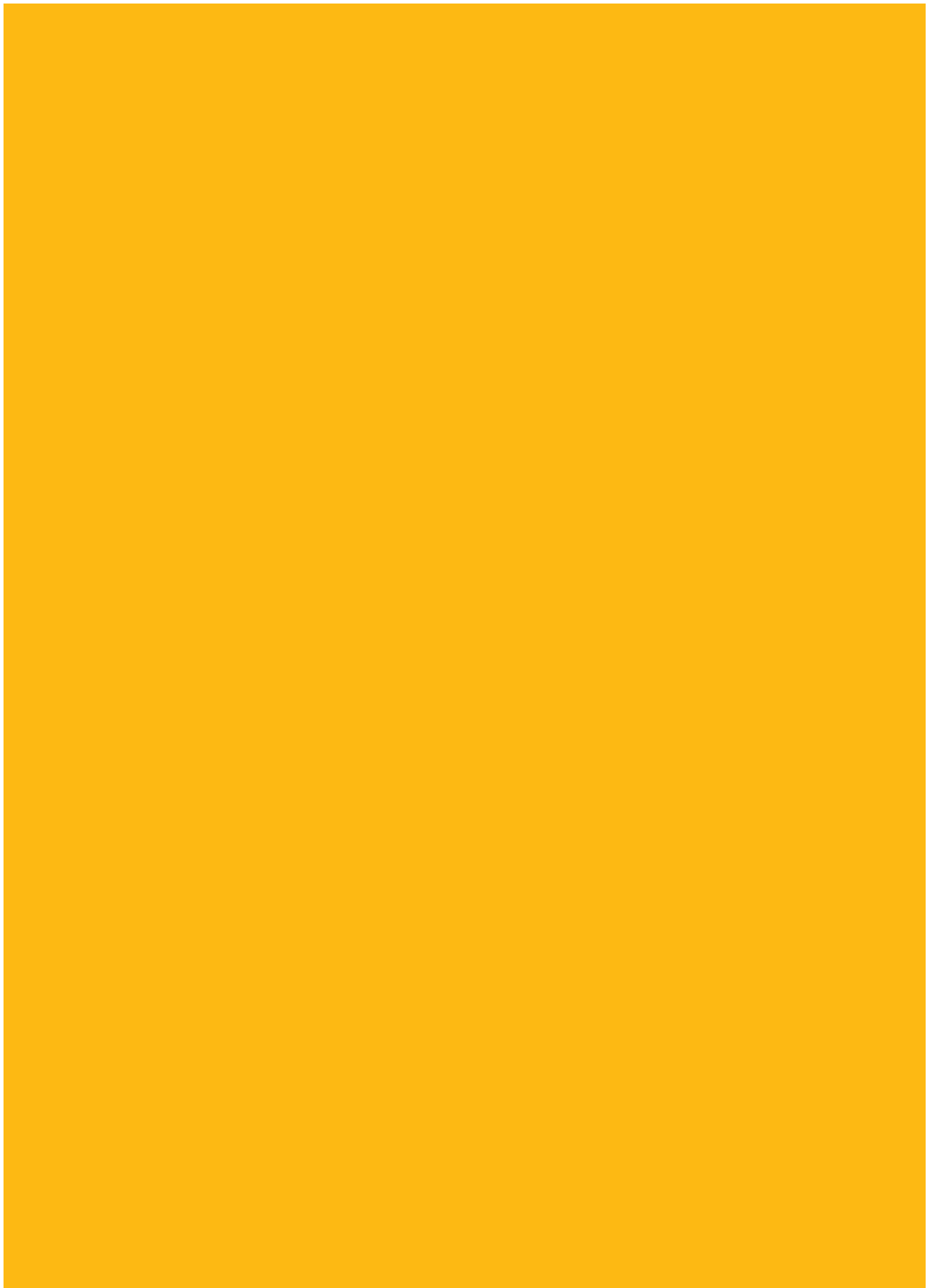
Meridith: When uterine artery embolization was a new procedure, it was a challenge to get the gynecologists to see there was a non-operative solution for what always has been a disease that’s been treated with hysterectomy. Pelvic venous disease is a very similar entity in that there’s a new way to think about a problem.

Steve: What do you think is the push back from the general practicing gynecologists regarding both fibroid treatment and treatment for pelvic venous disease?

Meridith: With fibroids, the push back was that they didn’t want to lose their cases, right? They were doing hysterectomies on all these women and interventional radiologists were proposing a non-operative procedure. With chronic pelvic pain, it’s probably more cynicism because these patients don’t have surgical options. They can do a laparoscopy to look in and see what the problem is, or maybe put them on some medications, but they have very few options. It’s getting over that ‘Show me that this works, show me that this is real.’ That’s the biggest obstacle in this case.

Steve: The literature is muddy in terms of whether these people get better. When someone has pelvic vein disease, it’s not clear that it is the cause of all their pelvic pain problems. There’re multiple factors that become confounding. So it’s hard to get good data that says, do this procedure and this happens. We cannot blame OBGYN for being cynical since there isn’t great data that gives a clear cut answer that if you intervene you’re going to get 85 percent improvement.

Meridith: Also, we can’t convince the insurance companies because there’s no clear cut data. Sometimes we get patients in and we can’t even treat them.



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Steve: You can treat them, but maybe not get paid for it.

Neil: It gets back to an even more elementary level; we don’t even have a good set of diagnostic criteria for the disease. What are the criteria? How do you precisely define pelvic venous disorders? And when you define it, how do you categorize it? And then how do you measure how patients’ symptoms change after treatments? What’s the natural history of this disease?

All of these metrics are not well developed at this point; the criteria being used are not homogeneous. There are a variety of different definitions out there, a variety of different metrics being used to evaluate outcomes that aren’t necessarily precise. You may be looking at more noise than signal when you’re trying to measure how patients are doing after treatment because you don’t ask the right questions or measure the right things. So, there are still a lot of foundational things that need to be done to move this literature forward, and it is understandable that there are some questions about it.

From listening to the gynecologists I learned a lot about some of the things that could coexist in women with chronic pelvic pain who have no other standard physical exam, laparoscopic or imaging abnormality, other than veins, that could be responsible for the pain and that we don’t typically think about or evaluate. Pelvic pain patients are optimally evaluated in a multidisciplinary way by physicians who have broad expertise. There’s no question that pelvic pain specialists or the routine gynecologist is considering the pelvic venous component.

Mark: It’s not only that there may be more than one cause of pelvic pain in individual patients. Everybody who takes care of these patients knows there may be more than one venous cause of pelvic varicosities in a given patient (for example primary ovarian vein reflux, left common iliac vein compression, left renal vein compression).

A patient may have some primary ovarian vein reflux; they may have a little bit of left common

iliac compression; they may have a some degree of renal vein compression. It’s not uncommon to see a patient with multiple potential venous pathologies.

Deciding which of those is primary can be difficult, and contributes to the poor results. There’s this historical concept of pelvic congestion syndrome, which really doesn’t mean much, and if you’re going to treat every patient who has pelvic congestion syndrome with ovarian vein embolization, the results are going to be less than perfect as is documented in the literature.

What really needs to be done is to build a whole framework to understand this problem before we even get to the point of doing randomized trials.

You have to have the framework first to understand it. Then you have to have the outcome measures that are specific to it, and then study it.

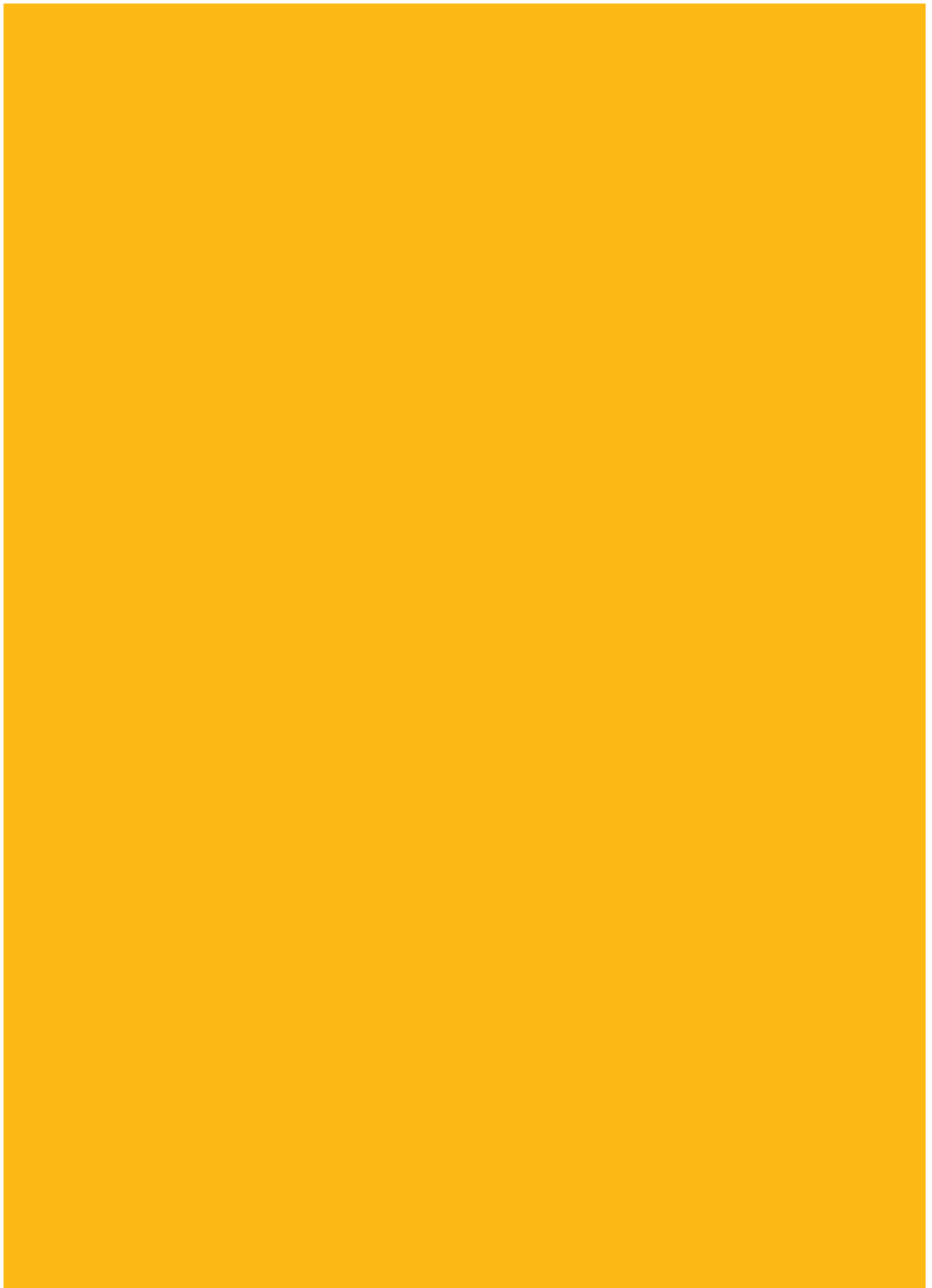
Tony: How do you even start something; look into it and do all the stuff we’re talking about when you’re limited even in the ability to offer treatment to get some of this data. The industry has no interest, at least so far, because the treatment options are pretty inexpensive from an industry perspective, so getting that support is out of the question.

Mark: Robust data may be a few years off, but thorough evaluation of the data and presenting it correctly is the role of guidelines and advocacy. That hasn’t really yet been done for pelvic venous disease—a thorough look at the data with its positives and its negatives and saying based on what’s out there now, these are the guidelines for how it should be treated. Then using advocacy to get that word out.

Tony: It’s similar to your venous ulcer patient where you have multifactorial pathology. Some of the data on some of the treatment options is questionable, and how do you measure? Is it the reflux in the saphenous vein? Is it the perforator? Is it the compression?

There are multifactorial causes to get a good answer with a pelvic disorder patient, just like with the venous ulcer patient.

Steve: I tend to agree with Tony in that we’re not even going to be able to get the data in the modern



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era if nobody is being paid to do the procedure; it’s hard to get the kind of data that we want.

Neil: Ultimately we’re going to have to do this through grants and we’re going to have to do randomized trials in order to be able to prove it and get broader acceptance of these treatments. There’s obviously a heterogeneous population. There are different presentations and different physiologies when it comes to pelvic venous disease. We are going to have to take discreet portions of that population and study them individually and do it very objectively with comparison populations, and not just case series where somebody presents the last 50 patients that they treated.

It has to be done the right way where you are comparing it to some other treatment that would be considered the standard of care at that time and then see the outcome. That’s the only way we are going to move this needle.

Steve: A lot of studies have been done in the past, basically industry-funded studies, because there was a semi-soft interest and they wanted to seem like they were being altruistic for patient care. We don’t have this in the pelvic venous insufficiency or the pelvic pain world, where we can go to one or two people in the industry and say we’d like to have you fund some study.

If we’re not going to get paid to do the procedures, then you’re narrowing yourself down to certain institutions where the physician gets paid whether the procedure is reimbursed or not. For people who are working in a situation where if they don’t get paid for something, they’re not making any money and, in fact, losing money, it’s going to be hard to get some of this data. It’s a catch-22. You want the data to show insurance that they should pay for it, and yet your insurance will not pay for anything to get the data. How do we break the cycle?

Neil: What we need is good data, not just data. We’ve had 15 years of case series on this and they show a trend, but the quality of the data, the strength of the

evidence, is not enough to sway the payers, nor the referring physicians who are the gatekeepers of these.

Mark: I’m not sure that I entirely agree with that because the first thing that’s needed is a dispassionate look at the literature with true, unbiased, evidence-based guidelines as a starting point. It’s going to come out with a lot of low-grade, low quality of evidence recommendations, but that will move the needle a little bit—as long as it’s done in a proper fashion. I don’t think we have to wait for randomized trials to start saying, “experts in the field who are knowledgeable in the literature think that the best treatment in 2018 is…” This is the data that’s lacking, and this is the data that we need to accumulate to move up the level of the recommendation.

Neil: I suspect that may be a little bit of, ‘we’ll build it and they will come’ kind of philosophy. It may make things go a little bit faster. However, unless we create those guidelines with thought leaders and influential members of communities that care for these patients and unless we get them to participate in developing those guidelines and get them to advocate for the positions in those guidelines, we may be building guidelines just like we built venous leg ulcer guidelines that the wound community just doesn’t pay attention to.


Mark: Any guidelines for pelvic venous disorders have to include the gynecologists and the pelvic pain specialist. Absolutely.

Getting to Guidelines: A Group Effort

Steve: Where do we stand now? Who is working to put together guidelines?

Neil: We have gotten representatives from different societies to participate. We contact the societies and the societies recommend a particular person to participate, but when they participate, they are doing so by themselves.

Our hope is that by working with us they find the relationships to be productive and leading



somewhere, and that eventually they will bring us and what we're talking about back to their professional communities and, at some point, begin to endorse some of our positions and work with us to develop the actual guidelines. We are working with representatives of the International Pelvic Pain Society and ACOG at this point.

Steve: Who in the vein world is leading these discussions? Under what aegis?

Neil: It's a group of vascular physicians who are part of a few societies, and we have the support of the societies that we are part of. So Mark and I are part of the American Vein and Lymphatic Society (AVLS), the American Venous Forum (AVF) has been supportive, the Society of Interventional Radiology (SIR) has been supportive both in logistics and financially and, at least in the sense of interested in working with us and sending us representatives, the International Pelvic Pain Society and the American College of Obstetrics and Gynecology.

Steve: What kind of meetings have you all had? Where do you stand at this moment?

Mark: Neil organized a project with SIR to look at critical issues in pelvic venous disorders. There were a number of projects that came out of that, one of which has been taken on primarily by the AVLS, with the SIR's help, which is the development of a descriptive instrument for pelvic venous disorders analogous to the CEAP classification for lower extremity venous disorders. That's an international multidisciplinary group that includes representatives from AVLS, AVF, SIR, ACOG, International Pelvic Pain Society, European Venous Forum, CIRCE in Europe, the Asian Venous Forum, and we're going to add the Latin American Venous Forum.

A one day retreat was held at the end of July 2018 with representatives from each of these societies. This multidisciplinary group has developed a draft instrument for the classification of pelvic venous disorders that is now undergoing revision.

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The second project that the AVLS is doing is guidelines for the management of pelvic venous disorders, which will also involve invited participants from other societies. This project started with a one day retreat addressing the fundamentals of generating evidence-based guidelines. Gordon Guyatt, from McMaster University in Canada, came and presented a primer on how to write guidelines. We are now just beginning to generate the initial guidelines.

Considering the Procedures

Steve: An important question to ask ourselves is do we have good enough procedures to treat a patient if the majority of the patient’s problems in the pelvic area point to pelvic venous disease?

Mark: It depends on what that problem is between the diaphragm and the inguinal ligament.

I think for a multiparous patient with primary ovarian vein reflux and classic symptoms, pelvic venous embolization is a good procedure when done right and done correctly.

On the other hand, if you have a patient with even classic renal vein compression symptoms of pain and hematuria, treatment for that is not optimal, whether it’s surgical or endovascular. A lot of that has to do with our misunderstanding of what the problem really is and all of the procedures that we have devised to treat it may not really even address the problem.

Steve: Meridith, who is the patient with pelvic venous disease that makes you think, “I just can’t wait to take care of this patient, they’re going to be so happy”?

Meridith: When they have huge refluxing ovarian veins, I just know this is going to be a slam dunk and I don’t have to think about it—they are going to feel better. When they have really tight iliac stenosis and I know that I’m going to put a stent in there and open it up, I know they will get relief. It’s where the veins are small, and there’s reflux, and you can see that there’s a small plexus of varicose veins in the pelvis, or maybe their pain has lateralized to one side, but they have reflux on both sides, or they have generalized pain and a unilateral abnormality, it isn’t always obvious

that what you’re doing is going to fix their problem.

Neil: It’s a patient who has primary reflux disease in the ovarian veins, and she has big pelvic varicosities, and she has pain that just fits perfectly with the description you would expect from venous hypertension in her pelvis. Those are the patients that you know are going to get better.

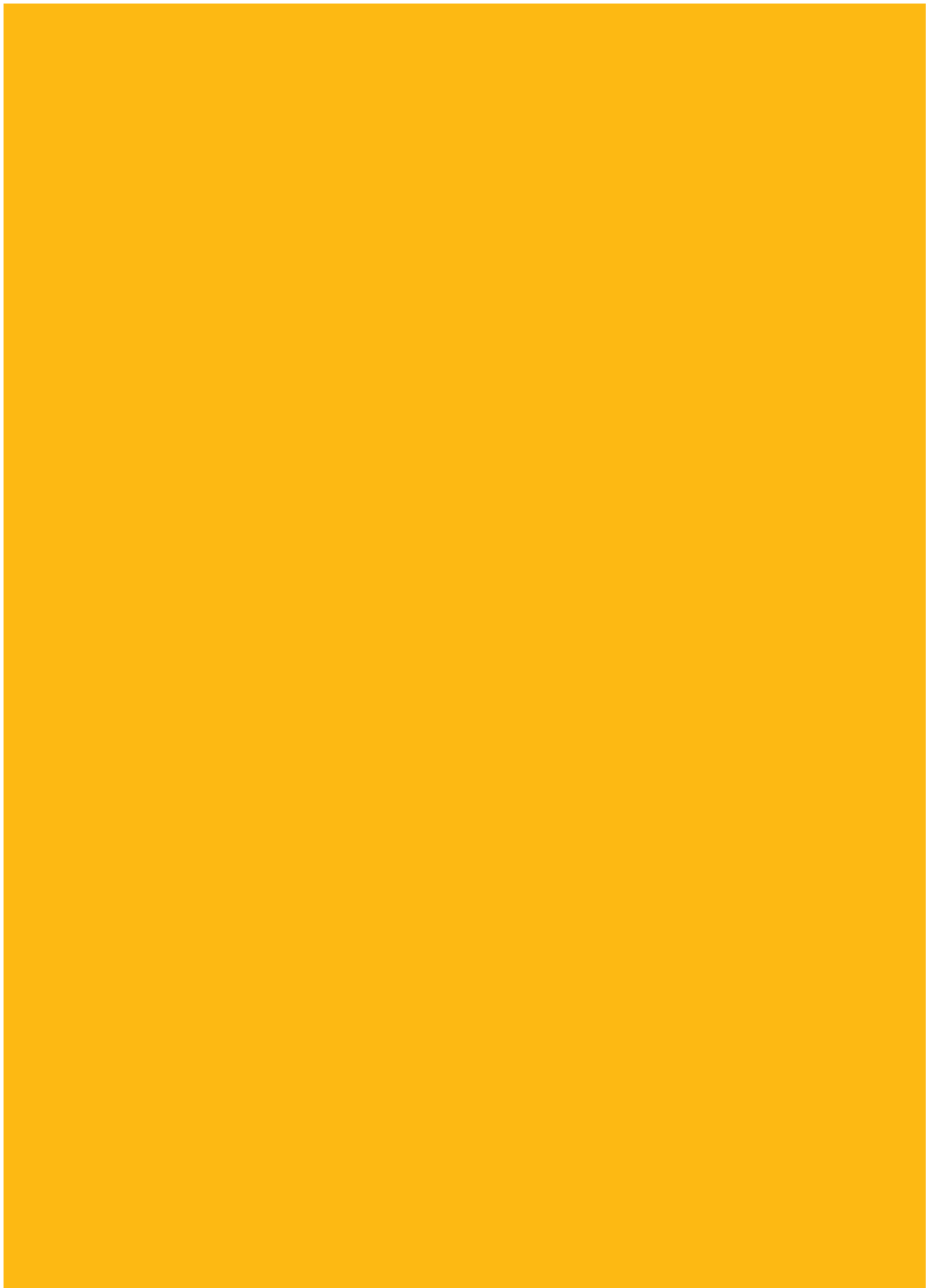
The other group is the patient who has big pelvic varicosities and has a very significant left common iliac obstruction. Those patients usually do really well when they get the appropriate treatment.

Steve: Who is the one that causes you to say, “This one I’m not quite sure about.” Who are those patients, who make you say, “You know what, I’m going to do this, but I’m not quite sure this is going to help?”

Meridith: When their clinical presentation just isn’t convincing. Their pain is not necessarily at the end of the day. They are just always in pain. Sometimes they just don’t feel right. It’s just too vague, I don’t know, there are definitely patients where you’re like, well, they have the abnormality, they have the symptoms. I’ll talk to the patients and say you can try ... They’ve usually tried everything, so at a certain point I say we can try this and, if it works, great, and if it doesn’t then we have to think about the next thing.

Neil: The patient who comes in with a chart that is six inches thick are usually the ones who you should start to worry you may not be able to help simply. A lot of chronic pelvic pain patients present like this. They come with tons of data from multiple prior physicians since they have been looking for a solution for a long time, and sometimes it’s a venous problem, sometimes it’s not. So those are the ones that make us sweat.

Tony: I find the ones who I figure out have pelvic symptoms, but who don’t come with that diagnosis, or they’re complaining about it, but you can figure out based on their lower extremity anatomy that it’s coming from the pelvis, and you start asking questions and they say, “oh, yeah, I saw my OBGYN and they said it’s nothing, but I just live with it.” Actually, those are the ones who end up having the best results.



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The Reimbursement Paradox

Steve: Going forward, what impediments should we focus on overcoming first, second and third?

Tony: Reimbursement.

Mark: I say reimbursement.

Neil: I think ultimately reimbursement is going to be important if we want the access for the patients to be able to get the treatment, but I think we’re going to have to do the hard work, whether it’s starting with guidelines and at the same time, more importantly, moving to trials where we can prove that what we’re doing works. I think that’s where the ultimate answers will come from.

Meridith: We have to get reimbursement to do the procedures. But we also have to prove that it works.

Steve: That’s the catch-22. If you don’t get paid to do what you’re doing, you’re not going to do it.

Mark: It’s a very misogynistic sort of environment. The women who have these problems need an advocate against the payers. I don’t know the best way to do that other than having the patients themselves get involved. There are certainly lots of women who could be helped who aren’t being helped.

Neil: If we can get the gynecologists to support this, then a lot of this negativity regarding these procedures will improve. When we got this whole interdisciplinary project started, I spoke to a recent president of ACOG first. I went up to her and brought up the concept and said we’d like to begin to explore some of this stuff together as a group. She said, “Well, you know, many of us in the gynecologic community just don’t believe in this. It’s not a real entity.” So it’s not purely like guys telling women that their problems don’t exist. Women gynecologists also don’t believe it, so ultimately if we can get them to advocate for us to do this, even if the data isn’t so much stronger than it is now, we would get a little more traction with the reimbursement issue. Right now, they’re against us as a community.

Mark: I’ve never done a peer to peer review with a female gynecologist for a pelvic congestion syndrome; it’s usually with a male medical director.

Neil: That may be because most of the medical directors are retired men.

Meridith: I’ll tell you when I’ve talked to female medical directors and explained what the patient’s problem is, the female medical directors are always like, “oh my, of course, we have to fix that.” So...

Neil: And also, being a female doctor helps, too.

Tony: Neil, as far as insuring that it works or not works, look at varicoceles in men.

Neil: You can feel a varicocele and you can see it’s there.

Steve: Right. And when you’re a male medical director you can imagine a varicocele, and you say, “Yeah, I’m going to do that,” but when you’re a male medical director and you can’t see it and can’t feel it, and you don’t have pelvic pain, you kind of say, “what’s the big deal?” I do believe that is an issue.

Tony: When I spoke to the Empire medical director. It was actually a nurse, it wasn’t even a medical director. Her comment to me was, “When they see the code for embolization, the CPT code, they automatically deny it. It doesn’t matter what the hell the reason is for,” which is pretty interesting. It’s almost like a red flag, that automatic denial.

Steve: So these are obviously a significant amount of problems, but I do think the more we engage with the vein societies, and plus what you all have said, with OBGYN, we can hopefully get some more reimbursement. What scares me, though, and I don’t want it to get out of hand, if these things become reimbursed, there will be more people just throwing coils down ovarian veins for the wrong patient, just because they have a dilated vein or something. What’s the literature then going to show? It’s going to show that a lot of people don’t get better because the wrong patient is being done. Mark? Mr. Skepticism?

Mark: As we know from the saphenous veins, it doesn’t even have to be a dilated vein to put the coil down.

Steve: Exactly. So we need reimbursement so we can get data, yet it would be better if we could get data before reimbursement, and then who are the people

who will be doing this? Who is going to be putting coils in? Who is going to be putting stents in?

Tony: It's not the medical directors of these insurance companies who should be coming up with the policy of reimbursement, because that's how the abuse starts.



It should be straight criteria based on at least what we know or the specialists who deal with this knowledge, as far as indications for treatment.

Steve: It is easy for someone who goes to an IR fellowship to put a coil in an ovarian vein and to put a stent in an iliac vein. So this is going to be the problem. If you now are going to get reimbursed to do something like that, and you're facile enough to minimize your complications, we're going to wind up with patients being treated for the wrong reasons, and then we're going to get data that's going to show that these people

do not improve as much as we would think.

Meridith: There will probably be an explosion like we've seen in iliac vein stenting.

Tony: I was going to say, because of the lack of reimbursement for embolization right now, a lot of patients are getting stents because that pays.

Steve: Can we conclude this with anything positive at all? In all seriousness, I do think the summary is that the cooperation between vein specialists and OBGYN and doctors who see chronic pelvic pain is really a very good start.

Reimbursement, there's positives and negatives to it, and social media may or may not be the way to go at this point.

It is a problem that needs to be solved, and it's a good step to get everybody together. Reimbursement is going to be hard going forward until we have some of these guidelines and everything that this multi-specialty group can hopefully come up with. **V**