

Flebedema Factor Alleged of Chronic Venous Insufficiency - Clinical and Evolutionary Implications - Study on a Total of 305 Cases

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ABSTRACT Flebedema is the first and most important symptom of venous circulation insufficiency and usually precede or accompany other manifestations induced of cutaneous venous circulation and/or lymphatic system decompensation. Having as aim the identification of the clinical-evolutional aspects of edema in chronic venous insufficiency we have undertaken a study on 305 patients. **Results** In the group of patients: prevalence of leg edema of venous origin was 26%; edema of venous origin diagnosed are swelling about 82%; the most frequent risk factors are sedentary life style (33%) and family history of disease (31%); approximately 64% of patients with venous edema are treated.

KEY WORDS chronic venous insufficiency, edema, evolution

Introduction

Flebedema is the first and most important symptom of venous circulation insufficiency and usually precede or accompany other manifestations induced of cutaneous venous circulation and / or lymphatic system decompensation.

The accompanying symptoms that are generally suggestive but the diagnosis is not always set right from the beginning. Perimaleolar debut is affecting the lower third of leg and back leg. It emphasizes on prolonged standing and is reabsorbed at night and then to be permanent. It is a white, painless, non-inflammatory, located unilaterally in approximately 60% of cases or bilaterally, but asymmetrically [1].

In addition to these objective signs always present, the vast majority of cases are accompanied by rich subjective symptoms which should be carefully investigated, often labeled as "functional disorders".

Among these needs are met:

- Pain is usually located on the path of large veins or disseminated throughout the leg, followed by local feeling of constriction.
- Feeling of weight in legs that appears more intense at the end of the working day or after prolonged physical effort and standing
- Painful muscle cramps, which occur frequently during the night, and more rarely on day.
- Paresthesia as tingling, the alternate with numbness or burning sensations in the legs veins located.

- Restless leg syndrome at night, characterized by a sense of compression, tension and gravity, which forces the patient to rub legs to change their position.
- Local itching (venous pruritus) is located on the affected leg, sometimes on the route of dilated veins. It is an important sign, because the presence and persistence predicts the occurrence of trophic skin disorders [2].

As the first manifestation of venous stasis, flebedema recently associated with some or other of stasis dermatitis lesions. Virtually all cases of stasis dermatitis is accompanied by swelling, but swelling is ignored in these cases, in the foreground as skin lesions: eczema, purpura, hypodermatitis, phlebitis and ulcers [3].

Postflebitic flebedema worth pointing out that failure is often accompany of lymphocytic and fibrous organization that is faster than secondary varicose veins flebedema.

In some cases the lymphatic circulation change is severe, by setting up pachydermia. It forms the fibrous skin papules, warts, papillomatosis. Transverse folds appear at the root of the fingers and the front of the tibio-tarsus joint [4,5].

Patients and method

Within two years time we considered it useful and important for the medical practitioner to examine the prevalence of leg edema like often crucial element in advance of further development of trophic lesions induced by chronic venous insufficiency.

This study also included patients in the city of Craiova by participating family physicians. We selected a total of 305 study patients. Detailed clinical examination of patients in our study showed the presence of edema of venous origin in 94 patients (30.8%), noting that 56 of them had no previous diagnosis.

Results

Data about subjective symptoms we have confirmed the importance of a thorough case history and to some extent targeted highlighting details usually overlooked also of the patient and the doctor in the territory

We found statistically significant differences between the spontaneous responses and those offered after physician suggestion (Chart 1). The same but with larger differences are observed in highlighting the objective symptoms (Chart 2).

Underline the significant difference between women and men about the presence of the well (Chart 3). We were also interested in the distribution of new patients in the study group compared with the duration of venous edema (Chart 4) and edema type: morning, evening or continuously (Chart 5)

In this study we can conclude:

- prevalence of leg edema of venous origin was 26%
- edema of venous origin diagnosed are swelling about 82%
- the most frequent risk factors are sedentary life style (33%) and family history of disease (31%)
- approximately 64% of patients with venous edema are treated.

Discussions

Since flebedema is one of the first signs of chronic venous insufficiency, whose diagnosis is important for both patient and physician practitioner we consider useful to present still disorders that differ:

- cardiac edema - is symmetrical, legs fully achieve. There is hepatomegaly, splenomegaly, ascites, cardiomegaly, tachycardia and fatigue. Non-invasive tests as echocardiography may be helpful in the diagnosis of heart failure. Heart exam quickly clarifies the cause of edema. In general it is irreducible cardiac insufficiency, the patient can not relax than sitting in an armchair, with both legs hanging in this way is increasing edema during the night rather than reduced. Edema reduction can not be obtained only by

fair treatment of heart failure, plus venous tonic and supine.

- edema in obesity - is often bilateral, approximately equal to the two legs with varicose veins less visible (most of them are hidden under fat). Edema in these individuals is hard, infiltrated skin, which often takes the appearance of "orange peel". It is difficult to distinguish flebedema. However, lipid deposits developed on the inside of the thighs embarrassed lymphatic circulation and worsen edema [6].
- edema in hypothyroidism - is associated with bradycardia, bradipsiie, bradilalie, increased cholesterol, decreased basal metabolism, hypotension. Skin is pale, rough, with little hair growth.
- renal edema - often debut eyelid. There we found oliguria, hypertension, nitrogen retention, changes in urine. Patients with edema due to renal failure generally have signs of pulmonary congestion on chest radiography, cardiomegaly noted before, but usually do not develop orthopnea. Patients with chronic renal disease may also develop edema due to sodium and water retention primary.
- congenital lymphedema - occurs from birth to 20 years or until the onset of the dorsal fingers and feet. It can be associated with hyperkeratosis, papillomatosis and warts that progressively worsened, reaching elephantiasis [7,8].
- compression edema - is unilateral, soft, uniform, white and inflammatory. It quickly spread to the entire leg. It progressively worse rather rapidly. Occurs by blocking abdominal or intrapelvine lymph channels in malignant proliferative processes.
- edema in cirrhosis - ascites and clinical and biochemical evidence of liver disease (collateral venous circulation, jaundice, spider veins), characterized by edema of hepatic origin. Ascites is often refractory to treatment, because it occurs as a result of the combination of the lymphatic circulation obstruction, portal hypertension and hypoalbuminemia. Edema can occur in other parts of the body as a result of hypoalbuminemia. Furthermore, a noticeable accumulation of ascites fluid may increase abdominal pressure and impede venous return from lower extremities, leading to accumulation of fluid in these regions.
- edema in pregnancy - is bilaterally equal association with veins or general fluid

retention, and the link to pregnancy is obvious [9,10].

Coclusions

1. To prevent recurrence, the patient after discharge must perform elastic retainers during standing and to surgically treat varicose disease. You must correct the predisposing factors (obesity, physical inactivity, prolonged static standing, diabetes mellitus).

2. The large number of patients studied and gained experience allows us to conclude that the multitude of therapeutic means and methods used to date in the chronic venous insufficiency, especially in venous ulcers, elastic contention is about 50% of successful therapy.

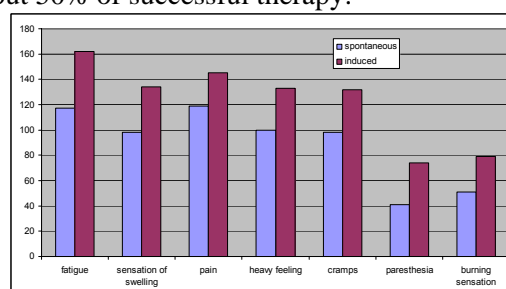


Chart 1 Distribution of patients after subjective signs of venous disease

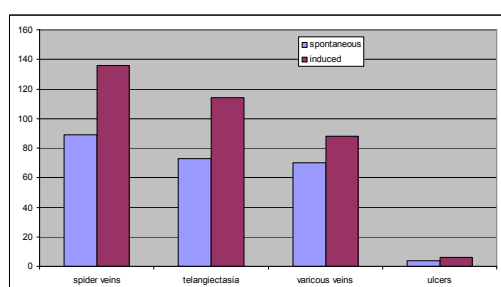


Chart 2 Distribution of patients after objective signs of venous disease

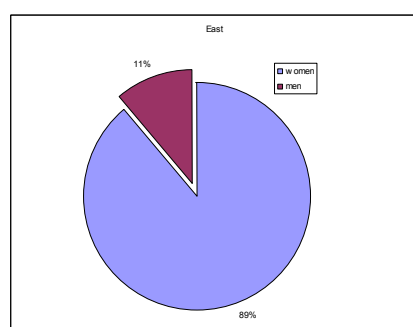


Chart 3 Distribution of patients by the presence of the well in patients with edema of venous origin

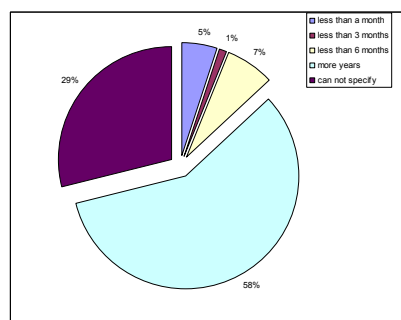


Chart 4 Distribution of patients after the onset of edema in patients with edema of venous origin

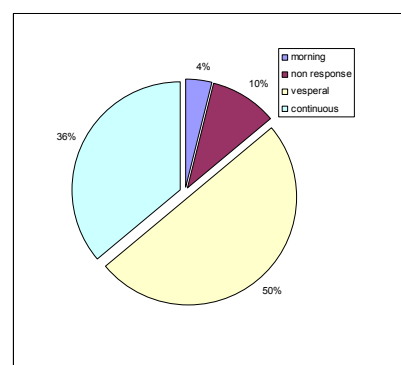


Chart 5 Distribution of patients by the character of edema in patients with edema of venous origin

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