Conclusions: All patients demonstrated an associated improvement in both clinical outcomes (CEAP class, VCSS) and PROs. There was no significant difference in the improvement in CEAP class and VCSS between patients younger and older than 65 years, although PROs did improve more in the younger population. Given these findings, patients older than 65 years appear to benefit equally from varicose vein interventions as younger patients.

Mechanochemical Ablation Improves Venous Ulcer Healing Compared With Thermal Ablation

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Background: We aimed to compare mechanochemical ablation (MOCA) and thermal ablation (radiofrequency ablation and endovenous laser therapy) in venous ulcer healing of patients with clinical class 6 chronic venous insufficiency.

Methods: Electronic medical records were reviewed of patients with venous ulcers who underwent truncal or perforator ablation between February 2012 and November 2015. These records contained history of venous disease and ulcer history, procedures, complications, follow-up, method of wound care, and current status of the ulcer. The patients were grouped according to the method of ablation for comparison.

Results: Eighty-two venous segments were treated in 66 patients, 29 with thermal methods and 53 with MOCA (Table); 16% of patients had prior venous intervention. Before ablation, three patients in the thermal group had a history of deep venous thrombosis compared with seven in the MOCA group. On average, patients treated with MOCA were younger (MOCA, 57.2 years; thermal ablation, 67.9 years; $P = .0003$). Ulcer duration before intervention ranged from 9.2 months for thermal ablation to 11.2 months for MOCA (P = NS). In total, 74% of patients treated with MOCA healed their ulcers compared with 35% of those treated with thermal methods ($P = .001$). The mean time to heal was 4.4 months in the thermal group compared with 2.3 months with MOCA ($P = .01$). The mean length of follow-up was 12.8 months after MOCA and 7.9 months after thermal ablation ($P = .02$). Both age ($P = .03$) and treatment modality ($P = .03$) independently affected ulcer healing on multiple logistic regression analysis, with only 14% of the variance in wound healing attributable to younger age. All but two patients were treated with an Unna boot after venous ablation. Complications included readmission of two patients with non-access-related infections, one nonocclusive deep venous thrombosis and one late death unrelated to the procedure second to pneumonia in the setting of advanced colon cancer. There were three recurrent ulcers at 1 week, 2 months, and 7 months after MOCA that rehealed with Unna boot and continued compression.

Conclusions: MOCA is safe and effective in treating chronic venous ulcers and appears to provide superior results to methods that rely on thermal ablation. Younger age and use of MOCA independently favored wound healing. Both the time to heal and the overall healing rates were better in patients treated with MOCA. Randomized studies are necessary to further support our findings.

Table. Patient characteristics

	Thermal	Nonthermal	Total
No. of patients	25	41	66
No. of venous segments	29	53	82
	Thermal	**Nonthermal**	***P* value**
Age, years	57.20 ± 13.51	67.92 ± 11.58	.0003
Ulcer duration, months	9.16 ± 13.93	11.17 ± 14.38	.5414
Prior intervention	5 (17.24)	11 (20.75)	.7011
History of DVT	3 (10.34)	7 (13.21)	.7049
Time to heal, months	4.43 ± 4.92	2.27 ± 2.33	.0110
Follow-up, months	12.81 ± 13.04	7.93 ± 5.85	.0220
Healed	10 (34.48)	39 (73.58)	.0006
Perforators treated	2 (6.90)	13 (24.53)	.0483
Multiple segments	5 (17.24)	29 (54.72)	.0010

DVT, Deep venous thrombosis.
Categorical variables are presented as number (%). Continuous variables are presented as mean ± standard deviation.

Fig.

Characteristics of First Vein Center Facilities Accredited by the Intersocietal Accreditation Commission

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Background: The Intersocietal Accreditation Commission (IAC) has been accrediting vascular testing facilities since 1991. In 2014, the IAC launched a new program to accredit vein centers performing sclerotherapy, ambulatory phlebectomy, saphenous vein ablation, and wound care. The accreditation process comprehensively evaluates a facility's daily operation, with quality determined by compliance with the IAC Standards for Vein Center Accreditation: Superficial Venous Evaluation and Management. These Standards represent the minimum requirements for staff qualification, training, resources, and outcomes that a facility must meet to become accredited and are based on published guidelines of 11 sponsoring professional medical societies.

The accreditation process comprises two steps. First, facilities complete a detailed application and submit three case studies Once an acceptable level of compliance is determined, the facility is granted accreditation for 1 year, and within that year, the facility must undergo a site visit. Based on the findings of the site visit, if the facility is in substantial compliance with the Standards, accreditation is granted for the remaining 3 years. If areas of noncompliance are identified, accreditation is delayed until all deficiencies are rectified.

Little is known about the initial IAC-accredited vein centers. The aim of this study was to describe in detail characteristics of facilities applying for IAC vein center accreditation.

Methods: This is a retrospective study of all facilities applying for accreditation from January 2014 to September 2016. The IAC database was used to extract facility and staff characteristics along with the results of the site visit.

Results: During the 3 years, 136 facilities applied for accreditation, with accreditation granted for 121 (Table). A majority were located in the Northeast (44.1%), followed by the South (29.4%; Fig). Most facilities were non-hospital based (85.3%). Saphenous vein ablation was the most common procedure, with 54,038 performed at 134 facilities. There were 41,405 sclerotherapy procedures performed at 125 facilities.