Sunday
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CCSVI Debate on Alberta Primetime - Simka's Response

Sunday, April 18, 2010 at 6:21PM

Last week, **Alberta Prime Time** had a debate between Alberta Neurologist Brad Stewart and False Creek Surgical Center's Clinic Director, Mark Godley.

Dr. Marian Simka, who has treated around 250 patients for CCSVI in his clinic in Poland, has responded to this debate as follows:

"Dr. Stewart emphasized that published results from Italy (Zamboni's initial study) show that many patients do not improve after the surgery. These are real facts. But in going into the details of this article we will find that early stage patients (relapsing remitting), in general, improve. Progressive patients stabilize (that is not bad, but not as good as an improvement). The issue of chronic fatigue was not discussed, yet - it is perhaps not necessary to point how important this problem is for the patients. Anyway, knowing that the earlier that venous obstacles are removed, the better the result, an approach of "just wait for more evidence, unless there is no option for you" makes no sense. **On the contrary, the treatments should be performed immediately after the first symptoms appear.**

And now I am going to Dr. Godley's statement. In short, "Forget MS, is is vascular problem. MS should be managed by neurologists, while narrowing of blood vessels belong to vascular surgeons". You know, being a surgeon, I would never discuss a doseage of neurologic drugs, for example. **So, why are the neurologists discussing which type of surgery should or should not be performed?** Have they ever held a lancet?

The whole discussion about stent migration is ridiculous. All are saying: "Don't perform stenting because of the risk of migration". Nobody is discusing: "How to perform the procedure to avoid this complication". In Poland, we have spent hours discussing this issue. And it is only a

technical problem that CAN be solved and HAS been solved. It is the problem of proper preop diagnostics, proper intraop tactics and proper choice of the stent. The stent should be tailored to the vein. And such a stent CANNOT migrate. And if you cannot tailor the stent, or stenting is just not necessary - you simply perform ballooning. But Zamboni's statistics show that in 50% of the patients ballooning is not enough. Consequently, either you will require repetitive balloon angioplasty (most likely not very successful), or you will have progression of MS. Or - you should use stent. (In Latin: Aut, aut, tertium non datur)

What about safety. In our department we have already performed ~250 procedures, in over 100 patients we have applied stents. Serious complications: ZERO. Yet, in some patients, anticipating potential risks, only balloon angioplasty was done.

Another problem. Many doctors say: "We should establish the actual link between MS and CCSVI, and having these data we can perform treatments". Is such an approach correct? No !

Imagine, after some 3-5 years we have those data. They will be, most likely (I am nearly sure, since I already have the results), somewhere in between Zamboni's and Zivadinov's findings: ~90% MS patients and ~10-20% healthy people will have CCSVI. Another association, like EB virus, Actually, no argument for surgery.

And now forget MS. You have compromised blood flow in the most important organ of human's body (tens of articles on that, only an explanation was missing). This disturbed blood flow is manifested by many symptoms, not even mentioned in the criteria for MS, like: fatigue, "brainfog", headaches, etc. It has been already demonstrated in Zamboni's study that these symptoms dramatically improve after restoring the proper blood flow (anyway, it seems logical, but if anyone were asking for data - here they are). Unblocking obstructed veins is rather a simple procedure and a safe procedure (much safer than leaving those "diabolic" strictures). The real problem actually is: how to perform preop diagnosis (Zamboni's protocol is very far from ideal). What about other test (we are very proud of our MRV protocol (some images are at: **ccsvimri.blogspot.com**). Which endovascular equipment should be used (a very technical problem, but can be solved). What about postop medication (we know that oral anticoagulants are not a good

option, but what about other drugs?). Those are real topic for clinical trials.

In Poland we say: Dogs are barking, but they will not stop the caravan."

Update on Tuesday, April 20, 2010 at 5:10PM by **Colleen O'Shea**

Dr. Marian Simka has replied to some of the comments as follows:

The comment that reads: THANK YOU Colleen, finally a vascular Dr has spoken...MS is not the problem, vascular anomalies are...this is what we stand on when approaching our fight for testing/txment. we know our next step!!!! That's exactly what must be done - to change the context of CCSVI. As long as it is within (a) neurologic context, it will struggle. (But) not within a vascular context. Actually, at this point it is rather semantics than medicine that will decide.

To the comment: when is says "But in going into the details of this article we will find that early stage patients (relapsing remitting), in general, improve." does that mean that if you are stable with remitting relapsing ms but have had it for 30 years, that one should expect less improvement than someone only diagnosed 3 or 4 years ago? I meant the degree of disability. There are some progressive MS patients with rather short history and, on the contrary, RR patients with long history (interestingly, the first (group) are usually found (with) complete occlusions, while the latter (have) mild abnormalitiesof the valves); most likely, after some time neurodegeneration becomes the prevailing pathologic process and this cannot be reversed neither by immunomodulating drug, nor by "liberation". Therefore, most of the patients have very limited time to wait for the results from detailed trials; **I think we can spoil good scientific data for the price of less wheelchaired people, can't we?**