

Dr Simka's letter to the Canadian Parliament

pubblicata da ms-ccsvi-uk il giorno martedì 31 agosto 2010 alle ore 10.28

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June 15, 2010

To the Canadian Parliamentary Subcommittee on Neurological Diseases

I represent the centre that I believe has performed the largest number of endovascular treatments for chronic cerebrospinal venous insufficiency (CCSVI) in the world. Although we only began those treatments in October 2009, we currently perform about 20 procedures per week, and total number of people who have been treated is now around 400. It is important to point out that the interventions for CCSVI in our Department have been approved by the Bioethical Committee of the Regional Silesian Board of Physicians in Katowice, Poland. Because we collect all data regarding patients' history, clinical status and the characteristics of the venous lesions that have been diagnosed, the analysis of this dataset has enabled us to draw some conclusions regarding links between CCSVI and multiple sclerosis.

First, CCSVI has been found to highly correlate with multiple sclerosis. Only 3% of the MS patients we have seen were not diagnosed with CCSVI (using color Doppler sonography, magnetic resonance venography and standard intraoperative venography).

Second, localisation and severity of venous lesions have been found to significantly affect the clinical course of MS. For example, injury to the optic nerves were found more often in the cases with unilateral lesions in the internal jugular vein, while bilateral stenoses in the internal jugular veins correlated with a less frequent ocular pathology. More disabled MS patients were found to suffer from bilateral and/or severe occlusions of the internal jugular veins and the patients with stenosed azygous vein presented with the most aggressive clinical course of MS. These findings, in addition to preliminary observations that a substantial percentage of MS patients improved after endovascular interventions for CCSVI, favour the idea that surgical treatments for those venous obstacles should be an important part of the management of MS.

The most important question regarding treatments for CCSVI, however, regards the safety of such a management of venous outflow blockages. Such a management strategy is actually recommended by the Consensus Document of the International Union of Phlebology for the diagnosis and treatment of venous malformations. However, although similar endovascular procedures for the treatment of other venous pathologies are known to carry very low risk, an actual rate of complications related to such treatments for CCSVI remains undetermined, mainly because these procedures are not yet routinely performed in these cases. Moreover, recently in some neurological papers it has been claimed that surgical treatment for CCSVI can be dangerous. Interestingly, these statements were based only of the beliefs of the authors, and not on the body of evidence. Contrary to those opinions, in our clinic we have demonstrated that these procedures are safe and usually well-tolerated by the patients.

In brief, 347 CCSVI patients with associated multiple sclerosis have undergone a total of 587 endovascular procedures: 414 balloon angioplasties and 173 stent implantations were performed during 361 interventions. There were only few, rather minor and occasional complications or technical problems related to the procedures. These included: i. life threatening complications: death - 0, major hemorrhage - 0; cerebral stroke - 0; stent migration - 0; ii. major complications: early stent thrombosis - 2 (1.2%); postoperative false aneurysm in the groin - 2 (0.6%); surgical procedure (opening of femoral vein) to remove angioplastic balloon - 1 (0.3%); injury to the nerves - 0; iii. minor complications: transient cardiac arrhythmia - 2 (0.6%); minor bleeding from the groin - 2 (0.6%); minor gastrointestinal bleeding - 1 (0.3%); postprocedural lymphatic cyst in the groin - 1 (0.3%); problems with the removal of angioplastic balloon or delivery system - 5 (0.9%).

Therefore, in our opinion, precise preoperative diagnostics and selective use of the stents (if balloon angioplasty was not successful) can make the endovascular management of CCSVI free of significant complications and, in terms of restoring the proper venous outflow, more efficacious than performing balloon angioplasty in all cases. However, the actual impact of the endovascular treatments for venous pathology on the clinical course of multiple sclerosis warrants more clinical studies and long term follow-ups.