

number of measuring being 33. The average age of patients was 53,9. The patient's severity state was quantified by APACHE II score, the average being 15,9. The measurement of intra-abdominal pressure (IAP) was performed by indirect method – urinary bladder pressure measurement. Results: The leading causes of IAH were: intraperitoneal surgical pathology in 68% (n=15), retroperitoneal pathology in 27%(n=6) and one case of ventral hernia cure complicated by IAH. The average of IAP was 15,58 mmHg, the highest value was recorded at the patients with retroperitoneal pathology. Carrying on analysis of systemic effects of IAH was marked tachypnea at the patients whose IAP exceeded the value of 15mmHg. Signs of pulmonary shunt was found in 84,85% cases, the ratio of PaO₂/PAO₂ being 0,47. Comparing IAP values at the patients who had signs of pulmonary shunt and competitor group was noted a negligible difference. At the patients with IAH was noted a slight tendency to tachycardia, the average heart rate being 93.64±15.91 per min. False high values of central venous pressure (CVP) have been recorded at the patients whose IAP exceeded the value of 20mmHg. The average level of serum creatinine in the single group was 111,44 μmol/dl. Higher serum creatinine values were recorded at the patients with increased values of IAP as impairment of kidney function. Discussion and conclusions: Abdominal hypertension is a more common phenomenon in intensive care unit than seems to be at first sight. Causes leading to elevated intraabdominal pressure are diverse, but unified according to certain principles can be separated into 3 anatomical large groups: intraperitoneal, retroperitoneal pathology and those related to abdominal wall. Elevated intraabdominal pressure has systemic reflexion. Prevalence of pulmonary shunt at the patients with IAP<15 mm Hg versus those with IAP>15mmHg can be explained by other origins than intraabdominal hypertension when IAP value doesn't exceed 20mmHg. Hemodynamic effects are manifested by high false CVP value, which is a surrogate of preload and reflects indirect volemic state. Intra-abdominal pressure less than 20mmHg had minimal systemic effects while IAP exceeding 20mmHg is responsible for the compromising of at least one organ system.

Safety and Effectiveness of Ultrasound-Guided Foam Sclerotherapy for Varicose Veins

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The aim of this study is to compare NICE guidance recommendations to the outcome of a series of patients with varicose veins managed by ultrasound-guided foam sclerotherapy (UGFS), thereby assessing UGFS's safety and effectiveness. Methods: Between April 2008 and December 2009, 16 outpatients (9 males and 7 females), mean age 48.1 years, with varicose veins were treated with UGFS at the Queen Elizabeth Hospital. An audit support tool provided by NICE was used to collect data relating to three criteria: consent, safety and effectiveness. Results: Consent was sought in 100% of cases. Colour-flow Doppler ultrasound testing showed that 92% of limbs were completely occluded with no reflux at the saphenofemoral junction, whereas only 1 patient showed occlusion with reflux at the saphenopopliteal junction. None of the patients reported recurrence of varicose veins. No serious side-effects were reported. 31% had pigmentation post-procedure, 25% suffered from bruising, but only 6% reported a skin ulcer post-treatment. 75% of patients were happy and satisfied with the results, while the rest (25%) were unhappy due to persistent skin pigmentation (12.5%), pain (6%), or lack of symptom improvement (6%). The AVVQ scores show that 86% of patients have an improved quality of life post-treatment. Our results are in accordance with the NICE guidance. The outcome of the 16 patients suggests that UGFS is an efficacious and safe procedure short term. Nonetheless, a study with a larger sample size and a longer follow-up is needed to confirm our findings, yield more statistically significant results and establish long term efficacy.