The anterior saphenous vein. Part 1. A position statement endorsed by the American Vein and Lymphatic Society, the American Venous Forum, and the International Union of Phlebology

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ABSTRACT

Background: There is a lack of clarity regarding the terminology of the anterior accessory saphenous vein (AASV) that can impact treatment outcomes. Although use of the word "accessory" implies that the vein is a superficial tributary, evidence supports its role as a truncal vein, similar to the great and small saphenous veins, and warranting a change in terminology.

Methods: A multisocietal panel was convened by the American Vein and Lymphatic Society (AVLS), the Union International of Phlebology (UIP), and the American Venous Forum (AVF). The group was charged with reviewing the existing anatomic and clinical literature pertaining to the term "anterior accessory saphenous vein" and to consider the need for alternative terminology.

Conclusion: Based on the insights gathered from the literature review and extensive discussions, the panel recommends changing the terminology such that the "anterior accessory saphenous vein" (AASV) now be designated the anterior saphenous vein (ASV). (J Vasc Surg Venous Lymphat Disord 2024;■:101721.)

Keywords: Chronic venous insufficiency; anatomy; professional education; saphenous vein; varicose veins

It has become increasingly evident to many venous specialists that there is a lack of clarity regarding the terminology of the anterior accessory saphenous vein (AASV). Although use of the word "accessory" implies that the vein is a superficial tributary, its anatomic features, accepted treatment approaches, and clinical outcomes after treatment clearly support its role as a truncal vein, similar to the great and small saphenous veins, and warranting a change in terminology.

It should be emphasized that terminology is defined as a set of specialized terms for a specific scientific field, such as venous and lymphatic medicine, while nomenclature is a set of terms defined according to strict anatomic standards and principles.[1] Although relying on anatomic principles, the distinction between truncal and tributary veins is a clinical rather than a purely anatomic issue. The superficial veins are localized in the subcutaneous tissue, and within this tissue, the truncal saphenous veins are surrounded by a membranous envelope (the saphenous fascia), which defines a saphenous compartment.[1] Truncal saphenous veins are situated within their saphenous compartment and drain the extrafascial tributaries. Tributary veins are smaller veins, not enclosed in a fascial envelope, that drain into truncal veins and contribute to the subcutaneous venous network.

Distinguishing between truncal and tributary veins is crucial in planning superficial venous interventions, as each require different treatment considerations. Identifying the truncal saphenous vein responsible for a patient's symptoms helps determine the primary routes of venous reflux, allowing a more targeted and effective treatment strategy. Superficial venous interventions primarily focus on resolving the underlying issues related to truncal reflux with tributary treatment a secondary consideration individualized to optimize the overall truncal AASV treatment strategy. Differentiating truncal from tributary veins is therefore essential in assessing the severity of venous disease and planning treatment.

Superficial venous interventions primarily focus on treating truncal saphenous reflux with or without additional tributary treatment, based on shared decision making. While

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there is consensus that the great and small saphenous veins are anatomically truncal veins, there remains confusion surrounding the classification of the anterior accessory saphenous vein as either a truncal or a tributary vein. In large part, this comes from the inclusion of the term "accessory."

Unfortunately, this lack of clarity has significant implications for patient treatment and long-term outcomes following intervention. For example, if the AASV is mistakenly considered a tributary vein, the need for treatment could be overlooked leading to the inadequate resolution of the symptoms that led the patient to seek treatment. Additionally, patients with AASV reflux could be denied for coverage, also resulting in the same undesirable outcomes for patients. Properly identifying the AASV's role as a truncal vein is essential in developing a targeted and effective long-term intervention plan. Precise diagnosis and treatment planning ensure that interventions are appropriately targeted and resources are efficiently utilized. Misclassification may result in unnecessary utilization of resources and may divert attention from the actual source of reflux.

To address this confusion, an international, multisocietal panel was convened by the American Vein and Lymphatic Society (AVLS), the International Union of Phlebology (UIP), and the American Venous Forum (AVF). The group was charged with reviewing the existing anatomic and clinical literature pertaining to the term "anterior accessory saphenous vein" and to consider the need for alternative terminology. Panel members were selected by these societies based on their knowledge and experience in the field of venous disease and anatomy. The final panel was composed of experienced venous and lymphatic medicine professionals, vascular surgeons, members with experience in vascular ultrasonography, anatomists, and researchers from various practice settings (both academic and private practice) and geographical regions to include a global perspective. All panel members provided their voluntary consent to participate in this collaborative effort. The panel members engaged in a series of virtual meetings and communications to discuss the findings of the literature review. The process adhered to ethical guidelines for conducting expert reviews and ensured that any conflicts of interest were appropriately managed and disclosed. The panel examined the historical context, variations in terminologies across different anatomical references, and the clinical implications of using the term "anterior accessory saphenous vein."

Based on the insights gathered from the literature review and extensive discussions, the panel recommends changing the terminology such that the "anterior accessory saphenous vein" (AASV) now be designated the anterior saphenous vein (ASV). This recommendation is supplemented by three accompanying papers: Part 2: an ultrasound study of ASV anatomy in normal controls and patients with anteromedial thigh varicosities; Part 3: a systematic review of the literature regarding the ASV; and Part 4: a review of the clinical and technical considerations when treating patients with ASV reflux.

In summary, the confusion surrounding the terminology of the AASV has far-reaching consequences for patient care and resource utilization. Accurate designation of its status as a truncal saphenous vein is critical in selecting the most appropriate treatment options, improving intervention planning, and optimizing long-term patient outcomes in the management of venous disease. Collaboration among experts, thorough literature review, and consensus building are essential to resolving such uncertainties and improve patient care in vascular surgery and venous interventions. Based on this process, the panel unanimously suggests the name of the vein be changed from anterior accessory saphenous vein (AASV) to anterior saphenous vein (ASV) to more accurately reflect its anatomic features and clinical importance.

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CONTRIBUTORSHIP

MM, AG, NL, and SD conceived of the project. MM, AG, NL, EB, RD, AC, and SD all contributed to developing the articles and contributing to the analysis and conclusions. EB, RD, and AC wrote the drafts of the articles, and all parties approved of the final manuscripts.

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