SHORT COMMUNICATION

General understanding of saphenous vein

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INTRODUCTION

The extraordinary saphenous vein (GSV, on the other hand, "long saphenous vein") is an enormous, subcutaneous, shallow vein of the leg. It is the longest vein in the body, running along the length of the lower appendage, returning blood from the foot, leg and thigh to the profound femoral vein at the femoral triangle [1]. The extraordinary saphenous vein begins from where the dorsal vein of the enormous toe (the hallux) converges with the dorsal venous curve of the foot. Subsequent to passing before the average malleolus (where it frequently can be imagined and touched), it runs up the average side of the leg. At the knee, it runs over the backline of the average epicondyle of the femur bone. In the proximal foremost thigh three to four centimeters anterolateral to the pubic tubercle, the incredible saphenous vein plunges down profound through the cribriform sash of the saphenous opening to join the femoral vein. It shapes a curve, the saphenous curve, to join the normal femoral vein in the district of the femoral triangle at the saphenous-femoral intersection [2]. A few veins join the extraordinary saphenous vein, yet every one of them is absent in each person. A large portion of them goes along with it close to its intersection with the normal femoral vein (CFV), at different normal good ways from this intersection [3]. At the lower leg, the mind-boggling saphenous vein gets branches from the underside of the foot through the normal fringe vein; in the lower leg it anastomoses straightforwardly with the little saphenous vein, conveys by perforator veins (Crockett perforators) with the foremost and back tibia veins and gets numerous cutaneous veins; close to the knee it speaks with the popliteal vein by the Boyd perforator, in the thigh it speaks with the femoral vein by perforator veins (Dodd perforator) and gets various feeders; those from the average and back pieces of the thigh as often as possible join to frame an enormous frill saphenous vein which joins the principle vein close the saphenous-femoral intersection. [3].

Pathology of the extraordinary saphenous vein is somewhat normal, however in confinement commonly not dangerous.

- Varicose veins: The extraordinary saphenous vein, like other shallow veins, can become varicose; enlarged, wound and protracted, and for the most part viewed as unattractive. Varicose veins are not hazardous and different treatment choices are accessible. Notwithstanding, when the breadth of the vein is excessively enormous for the valves inside it to cover totally, the subsequent condition, persistent venous inadequacy, can bring about skin shading changes in the calf and ulcers that might continue for quite a long time if the vein isn't removed. [4].
- Thrombophlebitis: The GSV can apoplexy. This kind of phlebitis of the GSV is generally not hazardous in confinement; be that as it may, if the blood coagulation is situated close to the saphenous-femoral intersection or almost a perforator vein, a coagulation section can relocate to the profound venous framework and to the pneumonic course. Additionally, it very well may be related with, or progress to a profound vein apoplexy (incapacity resulting from a cerebral haemorrhage or stroke) which should be dealt with expeditiously. [4].

CONCLUSION

The extraordinary saphenous vein is the conductor of decision for vascular specialists, when accessible, for performing fringe blood vessel sidestep activities The saphenous vein might go through vein join disappointment after engraftment, yet it has better long haul patency thought about than engineered unites (PTFE, PETE (Dacron)), human umbilical vein unites or biosynthetic unions [Omni flow]. Regularly, it is utilized in situ (set up), in the wake of tying off more modest feeders and annihilation of the venous valves with a gadget called valvulotome (a medical device used to destroy the venous valves in especially the great saphenous vein to allow for arterial flow), for example, Lemaitre's valvulotome.

REFERENCES

1. Franceschi, C, Zamboni P. Principles of Venous Hemodynamics. Nova Biomed Books Pp. 2009;98(5):1112–23.
2. Mühlberger T, Dominic R, Morandini L, et al. Venous valves and major superficial tributary veins near the saphenofemoral junction. J Vasc Surg. 2009;49(6): 1562–1569.
3. Jong C, Sun H. Clinical course and risk factors for visual field progression in normal-tension glaucoma with myopia without glaucoma medications. Am J Ophthalmol. 2012;53(4):403-12.
4. Lucas A, Glen P, Donna M, et al. Influence of bruch's membrane opening area in diagnosing glaucoma with neuroretinal parameters from optical coherence tomography. Am J Ophthalmol. 2019;45(4): 410-56.

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