

# The Vein Institute of Blue Bell

## Fort Washington Radiological Associates

721 Arbor Way, Suite 103 • Blue Bell, PA 19422

Office: (267) 416-9534

### POST RADIOFREQUENCY(RF) ABLATION PATIENT INSTRUCTIONS

1. You have had a RADIOFREQUENCY ABLATION procedure of your **RIGHT / LEFT** leg.
2. Recovery from RF ABLATION is usually trouble-free. It is normal to feel a tightening sensation in your leg after a couple of days, and it may last for a few days. Your thigh may also be slightly tender to touch for a few days. It is also normal to experience the following symptoms during the next 2-3 days:
  - a. Mild pain
  - b. Cramping
  - c. Bruising
  - d. Swelling
3. The treated area may be somewhat tender, discolored (red-purple) and you may have some bruising lasting 2-3 weeks.
4. You may have numbness or tingling at the treated site. This should only affect the skin and not the muscle function of your leg. This usually resolves, but can last for several months.
5. Your leg was wrapped with a compression bandage, absorbent pads, and ACE wraps. **Please remove compression bandages and pads and put your compression stocking on prior to going to bed tonight.**
6. Starting the following day, you should wear your compression stockings while upright during normal daily activities for 3 weeks. You may take them off to shower and when in bed at night. During this time, continue to avoid hot tub baths.
7. You should keep your leg elevated when sitting or lying during this 48 hour period. You may also apply ice to the leg to help with swelling/discomfort.
8. You can take Motrin or similar ibuprofen every 6 hours as needed for discomfort.
9. During the next 3 weeks, avoid prolonged periods of standing. It is better to walk or sit.
10. **Walking every day is very important.**
  - a. You should walk a minimum of 30 minutes per day. However, you **should avoid** hot tub baths, vigorous exercise, jogging, sit ups, leg lifts, squats, or lifting over 15 pounds for 7 days following the procedure. This could cause the vein to re-open.
  - b. You should walk **twice per day for 30-minute periods** for the **first week**.
11. If you have received sedation for the procedure, do not drive a car or make any important decisions for 24 hours after the procedure. Someone needs to stay with you for 24 hours post-procedure.

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12. You may resume your normal medications. However, if you take any blood thinning medications, such as anticoagulants, aspirin, or NSAIDS (*unless directed by us*), refrain from taking them for 24 hours post procedure.
13. It is advised that you do not travel on an airplane until you have completed your post procedure Ultrasound. If there is an emergency and you must fly prior to your ultrasound, please call the office immediately.

**Notify your primary physician and/or Radiologist IMMEDIATELY if any of the following occur:**

- **Fever of 100 ° F (38 ° C)**
- **Lightheadedness, dizziness, or feeling faint**
- **Difficulty breathing, shortness of breath, pain with breathing, or chest pain**
- **Increasing pain in leg**
- **Persistent bleeding or excessive swelling in the leg**
- **Progressive area of redness, warmth, blisters, or drainage in the leg**
- **Persistent itching or rash in leg**
- **Lump formations**
- **Leg numbness**
- **Blue or cold feet**

### **Follow-up Care:**

You will be asked to get an ultrasound one week following the procedure and then again one month after the procedure with an office visit.

### **Physician Contact Information**

- **If you have a problem that requires immediate attention, you should go to the emergency room, either at Abington Memorial Hospital or the closest hospital, or call 911.**
- Our office is open Monday through Friday (except major Holidays) from 7:30 AM to 3:00PM. We can be reached at 267-416-9534.
- If you are unable to reach our office and you have an urgent need, please call **215-481-2000** and ask the hospital operator to contact the Interventional Radiologist on-call.

These post operative instructions were reviewed with me prior to discharge, and I understand the expectations of my physician. I understand I must call the office immediately if any unexpected side-effects arise.

**Patient Signature** \_\_\_\_\_

**Staff Signature** \_\_\_\_\_

**Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Time** \_\_\_\_\_