

Glauco Bassi

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Professor Glauco Bassi

Glauco Bassi was born in Feltre on 19 December 1914 and spent his childhood and youth in Brazzano del Friuli. He graduated in medicine in Bologna in 1938 with honors and then specialized in Dermatology in Padua (Figure 1).

During the Second World War, he was interned in a Nazi concentration camp, where he contracted the lung disease that would torment him throughout his life and that would be the final cause of his death.

After the war, he went to Paris where Tournay coined the term *phlebology* and founded the first scientific society dedicated to the study of veins and their diseases. Strongly attracted by these new developments, he multiplied his stays in Paris and in the 1950's he began to go to German-speaking countries. He was fascinated by the functional approach to venous disease. To verify the scientific basis of these new concepts, Bassi became a tireless reader of angiological texts. He took, and never abandoned, the habit of writing a short summary of the most important works in big binders sorted by subject (he filled a couple of dozens of these).

From then on, phlebology became *his life and his joy*, as he often said.

In the meantime, he founded the Italian Society of Angiology together with Professor Marcello Comel from Trieste, being its Secretary for 9 years. Later on he was a founding member and then a vice-president of the *Union Internationale de Phlébologie* (UIP), an institution created with the purpose of coordinating the activities of the phlebological institutes.

In 1962, Minerva Medica published the book *The varices of the lower limbs*.¹ Five years later, an expanded and updated French translation was called *The Bible of the Phlebologist*.

In 1973 Bassi produced a totally innovative and rare instrument for that time: a color animated film exclusively made with partly humorous drawings to explain the best treatment of the saphenous veins.

In 1979 he published a peculiar book of *science-fantasy* entitled *Gl. Bassi Anno Accademico 2047 - Rapporto sulla medicina*,² a red booklet of which he was very proud, although it was boycotted by the

extreme harshness of his criticism of the defects of our medical society and its hierarchies.

In 1983 he published a book in French written with the angiologist Robert Stemmer of Strasbourg entitled *Traitements Mécaniques Fonctionnels en phlébologie*,³ which presents with great detail the scientific basis and the practical use of compression therapy in venous and lymphatic diseases.

Finally, in 1985, he published a *Compendio di terapia flebologica* (a collection on phlebology treatments) with the editor Minerva Medica, in cooperation with almost all the best European phlebology centers, where he described the *therapy of the three thirds*. This book is still considered as the basic handbook of modern phlebologists.

Glauco Bassi also contributed to the progress of phlebology in the field of research.

He began by studying the relationships between venous insufficiency and obesity. He was the first, in 1962, to present a consistent diagram of the mechanism of venous return in the lower limbs, by comparing it to a suction and pressing pump, integrated by side injection pumps.

The suction pump consists of the *vis-a-fronte*, which has the function of drawing blood into the right atrium. It is divided into the cardiac effect, which is of little relevance, and the respiratory effect, of unquestionable significance. However, having a limited range of action, this pump is of little value in orthostatism, in the venous hemokinetics of the lower limbs.

The pressing pump, the one that gives the first thrust to the reflux venous blood, consists, in the entire lower limb by the *vis a tergo* and by the foot of the plantar venous crushing.

The *vis-a-tergo*, which is regulated by complex microcirculation mechanisms that are implemented through the capillary network and the system of arterial-venous short-circuits, also has little functional importance. The squeezing of veins in the LEJARS venous insole is produced mechanically at each step when the foot touches the ground. The thrust received by the venous blood is very strong, but can be considerably reduced not only by osteoarthritic foot diseases, but also by an improper use of shoes that reduce the support surface of the foot (high heels) or that limit the elasticity of the foot vault (hard insoles).

There are many side injection pumps, some of the least importance in venous hemokinetics, such as the accentuations of the venous tone, pulsation in paravenous arteries (in depth) and skin pump (on the

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Key words: Italian Phlebology; history; Masters of the past; phlebology; lymphology.

Conflict of interests: the author declares no potential conflict of interests.

This paper is part of the monographic issue: '*Did the Masters of the past know the future? History and update of Italian Phlebology*' - Guest editor: Alberto Macciò (*Phlebology - Part I* edited by G. Agus; *Phlebology - Part II* edited by P. Bonadeo; *Lymphology* edited by F. Boccardo).

Received for publication: 30 June 2020.

Revision received: 10 July 2020.

Accepted for publication: 15 July 2020.

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Veins and Lymphatics 2020; 9:9249

doi:10.4081/vl.2020.9249

surface). Others have a high blood pushing capacity, such as the contractions of the calf muscles and the tensioning of the various limb aponeuroses, and particularly, among the latter, of those of the ankle, which are foot veins with no valvular apparatus, so they act as the first valve of the venous pump of the lower limb.

These powerful pumps, also called *vis-a-latere*, impart bidirectional thrusts to the already moving venous blood, and the valvular system, which can be defined as the *driver* of the complex system of anti-gravitational venous circulation, can make these thrusts unidirectional.

The various mechanisms of venous kinetics never act individually, but in a harmonious functional concordance game, to create a sort of operating chain that causes the venous return to take place without effort and without damaging the structures. This does not happen when any of these items is blocked because it has been injured or because it is not used. In the former case, we will have a venous insufficiency due to anatomical damage; in the latter case, we are in front of a pure functional venous insufficiency, without anatomical damage.

Later he focused on perforator veins and invented a surgical instrument called *Bassi's hook* that interrupts incontinent perforating veins, including the largest ones, with a small day surgery intervention. This

paved the way to the treatment we currently call *ambulatory phlebectomy*.

All this contributed to drawing attention to the perforating vein that is mostly responsible for external malleolar ulcers, which was later officially called *the perforator of Bassi* as proposed by Austrian phlebologists, with Wenner further proposing to also include in the definition the two upper perforator veins of the same side. A few years before his 70th birthday, Bassi was appointed as honorary member of the French and German phlebological societies and awarded the merit of the *Ordre de la Santé Publique* (Order of Public Health) of the French Republic.

Bassi belonged to that generation of phlebologists who collected, processed and improved knowledge of the pioneers' era and of empiricism, and presented them to the new guard in a strictly scientific manner.

He was an uncomfortable person to isolate because he preached a *functional phlebology*. He disdained national congresses where, in his opinion, phlebology was simplistic, schematic and too *anatomical*.

He suggested that for an accurate diagnosis to be carefully established one should perform a functional, individual and differentiated treatment of the varicose sore. He repeated that treating the disease from the outside was not enough, that even the own defenses and restoration processes of the limb had to be used.

He advocated early mobilization associated with graduated elastic compression.

He preferred treating conditions in small steps rather than with radical surgery, while waiting for natural healing processes to partly restore venous circulation.

Open to new diagnostic methods, he rejected the abuse of instruments and limited the use of invasive investigation equipment, such as the phlebograph, to a minimum.

He maintained that phlebology had to be left to phlebologists, and not divided among general vascular surgeons, angiologists, dermatologists, sclerotherapists, and so on.

He was a perfectionist; he could not tolerate carelessness and slapdash attitudes. The health of the patient was above any other consideration for him.

He died on December 17th, 1987, sadly ignored and forgotten for a long time by almost all the national medical class, and by Trieste in particular.

Here are some excerpts of his last interview, which is considered his phlebological testament.

Phlebological testament

(Excerpt from the last interview given by Glauco Bassi at the opening of the Congress of the Italian Society of Phlebology in Ostuni in September 1987.)

As far as I know, a multitude of doctors are being trained in Italy over the last few years, mostly young people, dedicated to the treatment of venous diseases. We were in great need of this, because the treatment of venous insufficiencies has always been *the poor relative* of medicine here and everywhere in the world. In fact, in Germany as in England and Scandinavia, people lament that most of these patients are being treated inaccurately or even badly.

The new phlebologists will have to be deeply grateful to those who have started them to this medical branch. Those of you who have chosen medicine by vocation, and not to fulfil the ambitions of their parents, will find the best they could wish for in this field.

It is to these people that I would like to show what they will find on their way, and particularly the obstacles they will have to overcome. I believe I can do this not only because of a personal experience of almost 40 years, but also because, over this period, many dozens, perhaps a hundred young colleagues who wanted to learn phlebology, have turned to me for advice. Then I heard news about several of them. And I can tell you, quite rightly, that the fertile ground you will find on your route has been created by the errors of your predecessors.

First of all, I would like to depict to you the charm of this medical discipline.

If you learn the craft properly, you will turn legs deformed by prominent varices into perfectly presentable, and even attractive, legs. You will heal wounds that nobody had ever managed to heal with years of treatments. You will experience the surprise of those who see the *mater familiae* return to her housekeeping after being at rest for a malleolar ulcer. You will receive all sorts of expressions of gratitude from the varicose patient who has been released in one hour, and then definitively, from an itch that had plagued him for years. You will be able to bring to an end, once and forever, the relapses of a post-phlebotic ulcer that had been considered unavoidable until then. You will see phlebotic patients who had entered your room on crutches and a retracted leg, leaving your office walking normally. And you will be able, already at the first visit, to tell your varicophlebotic patient, worried and fearing death by embolism, that his condition will be certainly cured.

Of course, the way aspiring phlebolo-

gists will have to travel before they can define themselves as such is not a short or an easy one, nor does it end in a meadow permanently in bloom.

At first, you will all pay a price for lack of expertise, then you will be subject to the risks of daily phlebological practice, even if you behave correctly and cautiously. By operating a junction of the external saphenous vein, you may regret your decision to perform that procedure. After a perfectly successful saphenous stripping followed by a persistent dysesthesia, you may find the psychotic subject convinced that you have *ruined his circulation*. Treating the varices of the external saphenous area, you may happen to have one of those frequent accidents, sometimes serious, that are typical of this venous network. At least once you will have the unwelcome surprise of finding, under an adhesive compressive bandage you applied, a vast necrosis of the skin and subcutaneous layer that will take many months to heal. In sclerosing therapy, one day or another you will certainly get an immediate allergic reaction, maybe with a swelling of the glottis. By treating reticular or dermal varices, now and then you will have disheartening aesthetic results, just as you may happen to be blamed forever for a single, small, pale residual pigmentation. And at least once you will experience the anguished drama of the accidental intra-arterial sclerosing injection - all sclerotherapists have experienced it, even those who deny it.



Figure 1. Professor Glauco Bassi.

These are, in my experience, the misadventures that move the less motivated neophytes away from phlebology, both those who take this road only to make some extra pennies compared to those paid by Mummy NHS and those who are already seeing their 15-meter cabin cruiser at the end of the road. But they will not discourage motivated phlebologists, who instead will be even more spurred to persevere. After all, the misadventures I described tend to be considered as *par for the course* by patients, who do not blame the phlebologist in those cases. That which destroys the neo-phlebologist and undermines his credibility are misdiagnoses and ill-conceived treatment plans, instead. For example, ruining with extended surgical scars or post-sclerosis pigmentation the legs of a woman who went to the phlebologist's office only with beauty purposes; asking sclerosing therapy to give more than what it can, with the result of multiplying the existing varices; prescribing unusable elastic socks because you did not take the shape of the leg into account; confusing a lumbar reticulitis for a phlebalgia; downplaying an interdigital mycosis

responsible for erysipèle or relapsing eczemas. These are some of the mistakes that will force a young phlebologist to choosing another career.

There is only one way to avoid them: to learn and get to know venous semeiotic very well and to diligently implement it. Above all, the traditional clinical examination is important: thorough questioning of the patient followed by the inspection and palpation of the limb and then tourniquet tests. Today, like yesterday, a first phlebological visit lasting less than half an hour is absolutely unacceptable. Non-invasive instrumental examinations must check and complete the clinical examination, never replace it, and - if possible - they must be carried out by the phlebologist himself with skill and expertise (that is to say, after an adequate apprenticeship). Instead, those who send their patients to vascular laboratories, perhaps without asking them accurate questions, and then do not critically analyze reports, will expose themselves to bad mistakes. This is what we have been reading in all the qualified angiological journals, which is exactly what I have been observ-

ing. With this, my preaching is over. Please, do not think that I do not know the saying *Don't give me advice, I know how to make mistakes by myself*: I did not apply it here because I know that, in phlebology, a new area of medicine, still looked at with suspicion, making mistakes will trigger all sorts of old and new sceptical reactions.

You should not even believe that I shared part of my long experience for pure missionary spirit. In fact, there is also a personal interest: I do not want anybody to end up by hurting my beloved phlebology.

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