



Fig 1. The symptoms, signs (varices), and pathophysiologic manifestations of pelvis venous disorders (PeVD) occur in four anatomic zones of the abdomen and pelvis. These are arranged in descending order from the renal veins to the lower extremities and include symptoms and varices associated with (1) the left renal vein, (2) the gonadal, internal iliac, and pelvic veins, (3) the pelvic origin extrapelvic veins arising in the pelvis and refluxing through the pelvic escape points to the genitalia and lower extremity veins, and (4) the lower extremity veins. The first three zones are included in the Symptoms-Varices-Pathophysiology (SVP) classification while the fourth zone, associated with the superficial and deep veins of the lower extremity and their tributaries, is optimally classified with CEAP and is not included. *L*, left; *R*, right.

vein, (2) the gonadal and internal iliac veins and associated pelvic venous plexuses, and (3) the pelvic origin extrapelvic transitional veins arising from reflux exiting the pelvis through recognized escape points—are included in the SVP classification. Although often communicating with zone 3, the fourth zone, the superficial and deep veins of the lower extremity and their tributaries, is optimally classified with CEAP and is not included in the SVP instrument.

Each of the three primary domains—symptoms (S), varices (V), and pathophysiology (P) with its 3 subdomains—is discussed in this section.

Symptoms (S). Pelvic venous classification begins with the patient's clinical symptoms (S) designated by

subscripts from 0 through 3 (Table II). As discussed elsewhere in this article, responses are arranged in descending anatomic zones from the renal veins to the lower extremities. Although some complaints may occur in either sex, others such as pelvic pain and varicocele occur predominantly or exclusively in one sex. Venous origin extrapelvic symptoms (S_3) are further subdivided into those involving the external genitalia, those related to pelvic origin nonsaphenous varicosities of the leg (posteromedial thigh and sciatic/tibial nerve), and those of venous claudication.

The pelvic origin extrapelvic veins of the thigh may communicate with the superficial and deep veins of the lower extremity and be associated with any of the manifestations of C_2 through C_6 disease. Although