

# Varicose Vein Interventions

## Scope

This policy covers the treatment of Varicose Veins.

Treatment for varicose veins will not be offered for cosmetic reasons. In accordance with NICE clinical guidance 168, patients with confirmed varicose veins and truncal reflux should be offered endothermal ablation (first line option). If endothermal ablation is unsuitable, patients should be offered ultrasound guided foam sclerotherapy (second line option). Surgery (third line option) should only be offered if both first and second line options are unsuitable. Where complete treatment requires any combination of foam/endothermal/surgical interventions this is at the discretion of the surgeon and where possible should be delivered during the same treatment spell. It is accepted that where this is not possible, funding for treatment includes approval of funding for the second stage/spell of treatment.

## Policy

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Interventions for varicose veins, other than where specified in this policy, are considered to be a low priority and will only be commissioned by the NHS on an exceptional case basis and clinicians need to apply to the Exceptional Cases Panel (ECP) for approval of funding by completing the Varicose Vein Interventions referral proforma. Referral proforma should be attached to the patient notes to aid the clinical audit process. *Click [here](#) to access the CCG clinical policies web page: select the Varicose Vein Interventions Policy drop down option to access the referral proforma.*

**Where patients have the following signs of venous disease funding for varicose vein surgery is routinely funded and no exceptional or prior approval is required:**

1. significant bleeding from a varicosity that has eroded the skin and patient is at high risk of rebleeding; **OR**
2. intractable ulceration secondary to venous stasis that has not healed within 2 weeks or healed venous leg ulcers; **OR**
3. recurrent superficial phlebitis (2 or more episodes) WITH severe and persistent symptoms such as pain requiring at least daily analgesia that is significantly affecting the quality of life (but excludes occupational factors). Evidence of the signs and symptoms of thrombophlebitis include pain, redness, cord like veins, ankle or foot oedema and leg pain and this should be evidenced in the referral.

**Where patients have the following signs and symptoms these conditions are a low clinical priority and prior approval from the Exceptional Cases Panel is required before the patient can be listed for surgery**

1. significant and/or progressive skin changes including varicose eczema, lipodermatosclerosis with moderate to severe oedema; **OR**
2. severely symptomatic patients with chronic venous insufficiency which in the opinion of the vascular specialist can be reversed or significantly improved by the treatment. Typically, these patients would also suffer from swelling and pain requiring analgesia, significant enough to interfere with normal day to day activity; **OR**
3. any other symptoms not covered above.

**The GP may apply for funding prior to referral to the specialist if the clinical evidence to support severity is available. The GP may also apply after the patient's initial specialist opinion, using the clinical evidence in their records and the specialist opinion letter to substantiate the claim of severity. Clear clinical descriptions of the eczema/lipodermatosclerosis such as the effects they have on the patient, extent, treatments used and their effectiveness required, and clinical measures of pain (degree/duration/management requirements), and oedema (circumference measures/ duration, response to treatment) are the basis of the ECP decision and should be provided in as much detail as possible.**

Note 1: The diagnosis of varicose veins and the extent of truncal reflux should be confirmed using duplex ultrasound.

Note 2: Endothermal ablation includes either radiofrequency ablation or endovenous laser treatment of the long saphenous vein.

Note 3: Incompetent varicose tributaries should be treated at the same time where possible.

Note 4: Compression hosiery to treat varicose veins should not be offered unless interventional treatment is unsuitable. If offering compression hosiery for use after interventional treatment, do not use for more than 7 days.

Note 5: Do not carry out interventional treatment for varicose veins during pregnancy other than in exceptional circumstances. Consider compression hosiery for symptom relief of leg swelling associated with varicose veins during pregnancy.

Note 6: Varicose vein interventions should only be carried out by clinicians with specific training and in organisations where arrangements exist for clinical governance, consent and audit.

Note 7: Patients who smoke should be advised to attempt to stop smoking and referred to smoking cessation services – see [smoking cessation policy](#)<sup>1 & 2</sup>.

## Evidence and Rationale

Varicose veins are tortuous, distended or dilated, superficial veins (varicosities) beneath the skin of the legs. Varicose veins occur because of incompetent valves in the affected vein, which results in reflux of blood and increased pressure in the vein distally<sup>3</sup>.

For most people, varicose veins are mainly a cosmetic concern, however, they can cause symptoms; most commonly: aching legs, discomfort or itching over the veins, and swollen feet and ankles. Varicose veins can become inflamed and thrombosed (thrombophlebitis). Increased venous pressure in the leg can lead to skin damage (skin pigmentation, venous eczema, lipodermatosclerosis, and venous ulceration). Bleeding can rarely occur after trauma to the vein or if it erodes through the skin, which can be life threatening<sup>3</sup>.

Varicose veins are a common condition, estimated to affect 20–30% of adults. Risk factors for developing varicose veins are unclear, although prevalence rises with age and they often develop during pregnancy<sup>3</sup>.

NICE reviewed evidence on the diagnosis and management of varicose veins (July 2013<sup>3</sup>) and noted that overall the quality of evidence was of low to very low quality. The review noted the following:

- Endothermal ablation was the only treatment judged to have any clinical advantage over any other intervention.
- Results of economic modelling found endothermal ablation to be the most cost-effective treatment strategy, with foam sclerotherapy ranked second and surgery third.
- Interventional treatments are more cost-effective than compression therapy.
- Data from the trials of interventional procedures indicated that the rate of clinical recurrence of varicose veins at 3 years after treatment is estimated to be between 10-30%.

Treatment for varicose veins may improve quality of life. Studies indicate that this improvement is more likely to be short-term rather than long-term (the rate of clinical recurrence of varicose veins at 3 years after treatment is estimated to be between 10-30%).

There is a risk of some complications either during or following varicose vein interventions

## References

1. C Furlong. Preoperative Smoking Cessation: A Model to Estimate Potential Short Term Health Gain and Reductions in Length of Stay. A report by London Health Observatory. September 2005.
2. S Hajioff, M Bhatti. Pre-operative smoking cessation therapy in NCL. A case of short-term gain for long-term gain? September 2005.
3. National Institute for Health and Clinical Excellence. Clinical Guideline: Varicose veins in the legs; the diagnosis and management of varicose veins; July 2013. Accessible on-line: <http://guidance.nice.org.uk/CG168>

## Glossary

<b>Eczema:</b>	Symptoms typically include itching, dryness or cracking and, occasionally, soreness of the skin.
<b>Endothermal ablation:</b>	Using energy either from high-frequency radio waves (radiofrequency ablation) or lasers (endovenous laser treatment) to seal the affected veins. These procedures are explained briefly below.
<b>Endovenous laser treatment:</b>	Intervention where a catheter is inserted into the vein and using an ultrasound scan to guide it into the correct position. A tiny laser is passed through the catheter and positioned at the top of your varicose vein. The laser delivers short bursts of energy that heat up the vein and seal it closed.
<b>Lipodermatosclerosis:</b>	Hardening of the fat layer of the skin.
<b>Oedema:</b>	An abnormal accumulation of fluid beneath the skin, or in one or more of cavities of the body.
<b>Phlebitis:</b>	Inflammation of a vein.
<b>Radiofrequency ablation:</b>	Radiofrequency ablation of a varicose vein involves using radiofrequency energy to heat the wall of the vein so that it collapses. This causes the vein to close and seal up. Blood is redirected through nearby healthy veins as a result.
<b>Subcutaneous:</b>	Anything pertaining to the loose cellular tissue beneath the skin.
<b>Truncal reflux:</b>	The flowing back of blood in a vein.
<b>Ultrasound-guided foam sclerotherapy:</b>	Intervention whereby special foam is injected into the affected veins which scars the veins and seals them closed. The injection is guided to the vein using an ultrasound scan.
<b>Varicose vein surgery:</b>	Most surgeons use a technique called ligation and stripping, which involves tying off the vein in the affected leg and then removing it.
<b>Venous insufficiency:</b>	Normally blood flows from the subcutaneous tissues to the superficial veins which drain via perforating veins into the deep veins of the leg. This flow, back towards the heart, is aided by valves within the veins. When the valves fail this is called venous insufficiency. This results in increased pressure within the vessels leading to dilatation known as varicose veins.

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