NHS
Devon
Clinical Commissioning Group

Clinical Policy Committee

Referral for Varicose Veins: Commissioning Policy and Referral Guidance

Commissioning Policy

The National Institute for Health and Care Excellence (NICE) has issued a clinical guideline on the management of varicose veins (CG168, July 2013). This policy is broadly consistent with criteria for referral recommended by NICE with the exception that referral for patients with symptomatic primary or symptomatic recurrent varicose veins without complications is not routinely commissioned. A rationale for this decision is given below. Patients with symptomatic varicose veins without complications may be referred only if they meet the criteria for exceptional funding (see guidance on exceptionality overleaf).

Referral will not be routinely commissioned for patients with:

- Grade 0: Thread/Flare/Reticular veins
- Grade I: Varicose veins without symptoms
- Grade II: Varicose veins with symptoms such as pain, aching, heaviness or swelling

Referral for specialist advice and surgery, if appropriate, will be routinely commissioned for patients with:

- Grade III: Varicose veins with complications, including bleeding, recurrent phlebitis or eczema
- Grade IV: Signs of venous insufficiency – lipodermatosclerosis or healed ulceration
- Grade V: Active leg ulceration

Rationale for the decision

NHS England Evidence-Based Interventions programme guidance recommends the commissioning of varicose vein interventions in line with NICE CG168 (varicose veins in the legs). This recommends referral for all patients with symptomatic varicose veins (typically pain, aching, discomfort, swelling, heaviness and itching).

NHS Devon Clinical Commissioning Group commissions referral for specialist opinion and surgical intervention for patients who have varicose veins that are causing complications. There is no good evidence to identify patients with symptomatic varicose veins whose condition might deteriorate and who should be prioritised for treatment in the absence of complications.

Varicose vein procedures are effective in alleviating the symptoms of varicose veins but the costs of the increased number of referrals and procedures performed would be substantial if the recommendation to refer all patients with symptomatic varicose veins was implemented. Referral for all patients with symptomatic varicose veins was considered to be a low priority for investment given the requirement to balance resources with healthcare needs.

Guidance notes on exceptionality

Where the circumstances of treatment for an individual patient do not meet the criteria described above exceptional funding can be sought. Individual cases will be reviewed by the appropriate panel of the CCG upon receipt of a completed application from the patient's GP, consultant or clinician. Applications cannot be considered from patients personally.

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Varicose Veins – Referral Guidance

1. Description of service/treatment

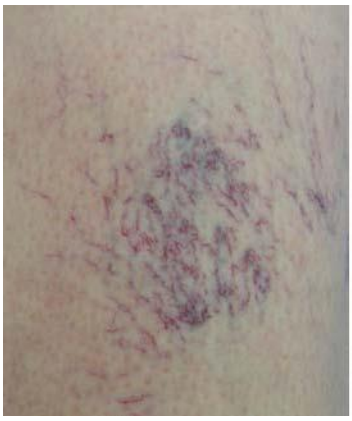
1.1 Most patients with varicose veins can be managed in primary care. Section Two of these guidelines provide graphical illustrations to aid the classification of varicose veins to ensure appropriate referrals are made to secondary care. Those in whom varicose veins are causing complications – including any skin changes or eczema – should be referred to a specialist vascular service. Section Three provides information on the management of patients.

2. Classification of varicose veins

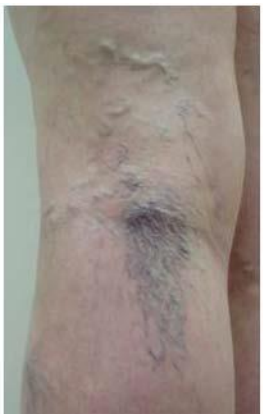
2.1 **Grade 0: Thread / Flare/ Reticular veins**

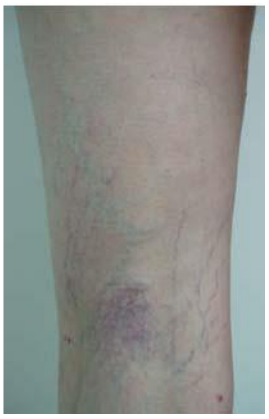
Red/blue spider veins or flares are all forms of telangiectasia.

Reticular veins are easily visible small blue veins (less than 3mm diameter), not associated with valvular incompetence of superficial venous trunks (e.g. long or short saphenous veins).



TELANGECTASIA



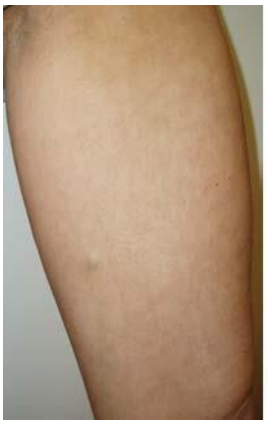


TELANGECTASIA AND RETICULAR VEINS

Telangectasia and reticular veins may be unsightly but are of cosmetic concern only. Treatment is **NOT** available in the NHS and patients with such veins should **NOT** be referred to NHS vascular clinics.

2.2 **Grade I: Varicose veins without symptoms**

Varicose veins which may be associated with long or short saphenous valvular incompetence but are asymptomatic may cause cosmetic concerns or needless worries about possible harm they might cause.



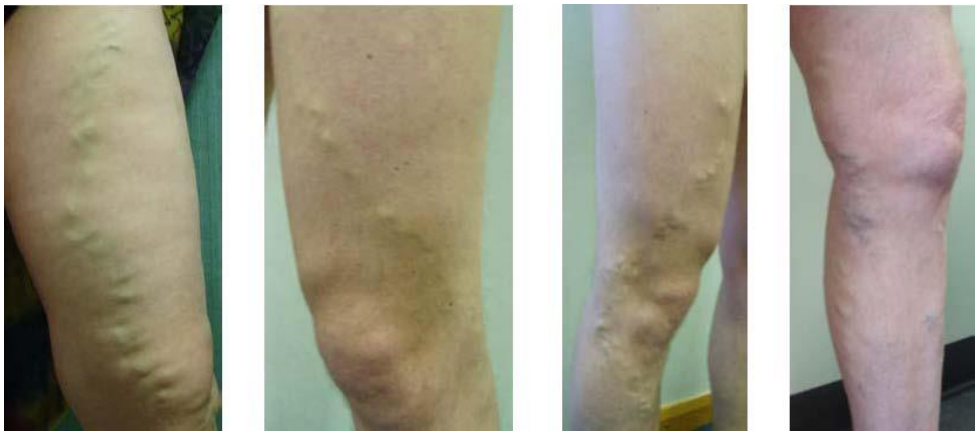
GRADE I VV'S THIGH – LSV INCOMPETENCE

GRADE I VV'S CALF SSV INCOMPETENCE

Specialist treatment for patients with Grade I asymptomatic varicose veins is **NOT** available in the NHS and they should **NOT** be referred to NHS vascular clinics.

2.3 **Grade II: Varicose veins with symptoms such as pain, aching, heaviness or swelling**

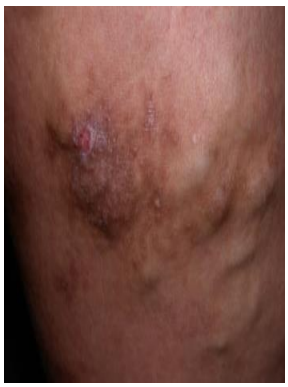
These symptoms are common among people with varicose veins. Varicose veins may also cause itching (not associated with eczema or skin changes). Other causes of pains in the legs should be considered: varicose veins do not cause severe or sharp pains or pain on movement.



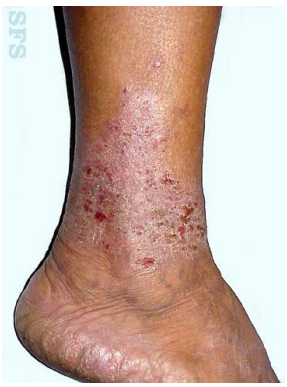
Specialist treatment is **NOT** routinely available in the NHS for patients with Grade II varicose veins.

2.4 **Grade III: Varicose veins with complications, including bleeding, recurrent phlebitis or eczema**

- Patients who have had bleeding associated with varicose veins should be referred urgently.
  Patients with eczema near the ankle or associated with varicose veins below the knee should be referred for specialist advice.
- Patients with recurrent thrombophlebitis and persistent varicose veins may be referred, especially if phlebitis has affected veins above the knee.



VARICOSE ECZEMA



STASIS GRAVITATIONAL ECZEMA

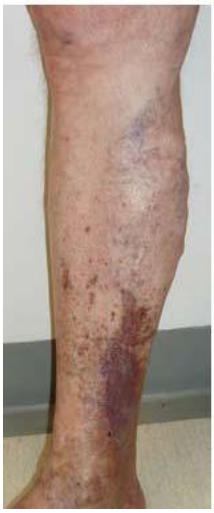
These patients should be referred to a vascular surgical service for consideration of treatment for their varicose veins. Treatment is available in the NHS.

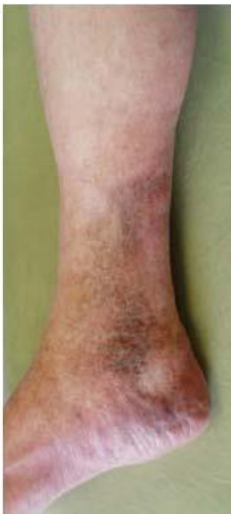
2.5 **Grade IV**: **Signs of severe venous insufficiency – lipodermatosclerosis or healed ulceration. These patients are at risk of developing ulcers and should be referred**

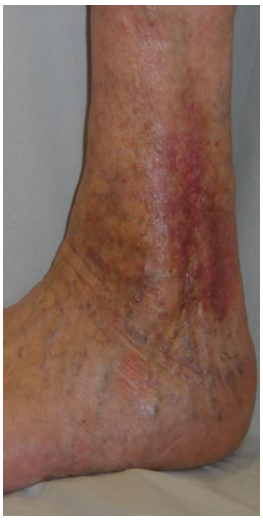
Prompt referral is recommended and these patients should be given clinical priority in vascular clinics.

Lipodermatosclerosis is important to recognise because it is the condition that precedes ulceration: it is progressive and largely irreversible. Treatment of varicose veins can stop lipodermatosclerosis from progressing and so prevent venous ulcers. Features of lipodermatosclerosis are:

- Dark/brown/purple/red discolouration of the skin in the gaiter area of the leg.
- Hardness of the subcutaneous tissues (“liposclerosis”). The subcutaneous fat may shrink, to produce a contracted, indrawn area.
- The whole area may become red, hard, inflamed and sometimes very painful. This is “inflammatory liposclerosis” (not phlebitis).
- Small areas of pearly, white discoloration called “atrophe blanche” may develop and represent an advanced stage of lipodermatosclerosis.



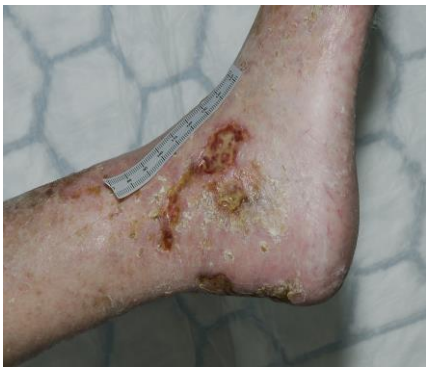


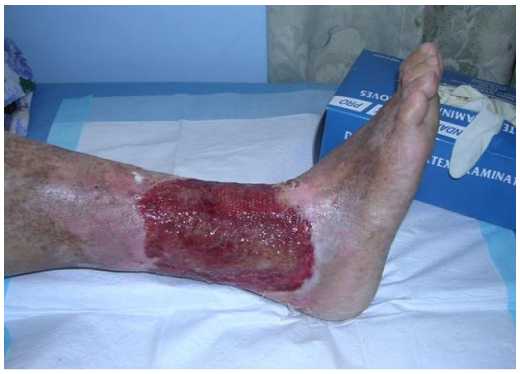


2.6 Grade V: Active leg ulceration

Patients who develop leg ulcers should initially be seen in specialist community-based ulcer clinics where arterial disease can be excluded and venous ulcers may then be treated by four layer bandaging.

Most venous ulcers are associated with superficial venous disease and if this is treated the risk of further ulceration is reduced. There should be a low threshold for referring patients with ulcers to a specialist vascular service, especially if they have arterial disease, painful ulceration or obvious varicose veins.





3. Management of patients

3.1 Grade 0: Telangectasia and reticular veins

These are understandably a cause of significant cosmetic concern and sufferers may seek advice on treatment outside the NHS. The most effective treatment remains microinjection sclerotherapy. Laser or pulsed light therapy may be effective for red telangectasiectatic blushes.

3.2 Grade I and II: Varicose veins without symptoms or with symptoms such as pain, aching, heaviness or swelling

These patients who are not eligible for specialist intervention in the NHS may seek treatment elsewhere or be managed conservatively. Conservative management includes:

- **Reassurance** that varicose veins are not harmful from a medical point of view unless they start to cause skin damage. They may or may not worsen. Just because varicose veins are large or extensive is not a reason to be worried about them or to treat them.

- **Lifestyle advice** includes advice to lose weight if obese and to elevate the legs on resting to relieve symptoms.

  Graduated compression stockings control many symptoms attributable to varicose veins, including aching and ankle swelling (in addition to reducing the risk of ulceration in people with skin changes). NICE CG168 recommends that compression hosiery is not offered to treat varicose veins unless interventional treatment is unsuitable. This recommendation is based on a cost-effectiveness analysis comparing compression stockings with interventional treatments. Compared with no treatment or lifestyle advice, compression hosiery has been shown to result in clinical benefit. In the context of patients with symptomatic varicose veins who do not meet the criteria of this policy for referral, it is reasonable to offer compression hosiery for relief of symptoms.

  Stockings are available on FP10 or can be purchased from pharmacists. Class 1 stockings or support tights are suitable for mild symptoms. Class 2 stockings are more appropriate for patients with severe symptoms or significant ankle oedema. If symptoms are mainly below the knee then below-knee stockings are usually effective. For symptomatic varicose veins above the knee, thigh-length stockings may be required: for patients who have difficulty keeping these up, suspender belts or stockings with “stay-ups” may be useful.

- **DVT risk** is not significantly increased by uncomplicated varicose veins but precautions for long haul flights seem sensible, including compression stockings, avoiding dehydration and exercising the legs.

3.3 **Grade III: Varicose veins with complications, including bleeding, recurrent phlebitis or eczema**

- **Varicose eczema**. Advice to moisturise regularly should be routine. Steroid cream should be prescribed to settle inflammatory eczema – but for use for a few days only until the eczema has settled. Below knee Class 2 compression stockings should be considered.

- **Thrombophlebitis.** This usually responds to leg elevation, topical or systemic NSAID's and stockings. Antibiotics are not required. Sometimes thrombophlebitis causes veins to thrombose permanently and to pose no further problems or risks. When, very rarely, thrombophlebitis affects the long saphenous vein above the knee and extends towards the groin, emergency referral is appropriate.

- **Bleeding.** Emergency control is by elevation and pressure. A protective pad and bandage should then be applied pending the advice of a vascular specialist.

3.4 **Grade IV: Signs of severe venous insufficiency – lipodermatosclerosis or healed**

Initial management in primary care should include advice to moisturise the skin and prescription of Class 2 below knee compression stockings. Inflammatory lipodermatosclerosis should be treated by anti-inflammatory drugs and analgesics, not antibiotics.

Types of specialist treatment for varicose veins. These include conventional surgery, foam sclerotherapy, and the use of laser or radiofrequency ablation (often in combination with surgical phlebectomies or foam sclerotherapy). There is evidence that all these treatments are effective. One may be more appropriate than another for an individual patient and further evidence on their relative clinical and cost effectiveness has been published since NICE CG168 was issued, so practice may vary between hospitals.