

2013

Commissioning guide:

Varicose veins



Sponsoring Organisation: Vascular Society of Great Britain and Ireland

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NICE has accredited the process used by Surgical Speciality Associations and Royal College of Surgeons to produce its Commissioning guidance. Accreditation is valid for 5 years from September 2012. More information on accreditation can be viewed at www.nice.org.uk/accreditation

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Introduction

This guide is designed to assist clinical commissioning groups (CCGs) to make decisions about appropriate healthcare for specific clinical circumstances and fulfil their obligation to commission healthcare for their population that meets the five domains in the NHS Outcomes Framework.

The high value care pathway contained within this guide aims to provide patients, the public, health and social care professionals, commissioners and service providers with a clear description of what constitutes a high quality service for varicose veins.

For more information about the development of this guide please visit the [Royal College of Surgeons](#) website.

Varicose veins are dilated, tortuous, subcutaneous veins most commonly found in the legs. Around a quarter of the population may be affected by varicose veins at some time in their lives. Varicose veins may cause a range of symptoms such as pain, aching, itching and swelling and have a significant adverse effect on quality of life (QoL). Complications of varicose veins include skin damage (such as eczema and pigmentation), bleeding (which can be life-threatening), superficial thrombophlebitis (SVT), and deep vein thrombosis (DVT). Up to 3-6% of patients with varicose veins go on to develop chronic venous ulceration.

The treatments for varicose veins recommended in the [NICE guidelines for varicose veins in the legs](#) are as follows:

- Endothermal ablation is offered first if suitable;
- Ultrasound-guided sclerotherapy is offered as a second choice; and
- Surgery is offered if the other two procedures are not suitable.

These treatments are likely to reduce the likelihood of disease progression and improve quality of life by reducing symptoms.

Between 30,000 to 35,000 surgical or endovenous interventions were performed for varicose veins or venous ulceration in the NHS in England in 2012 with a greater than 90-fold variation (5 to 430 procedures per 100,000 population) observed between different CCG areas (see Figure 1).

Prior to the NICE guidelines for varicose veins in the legs there was no established framework for the diagnosis and management of varicose veins and this resulted in the wide regional variations in the management of varicose veins in the UK.

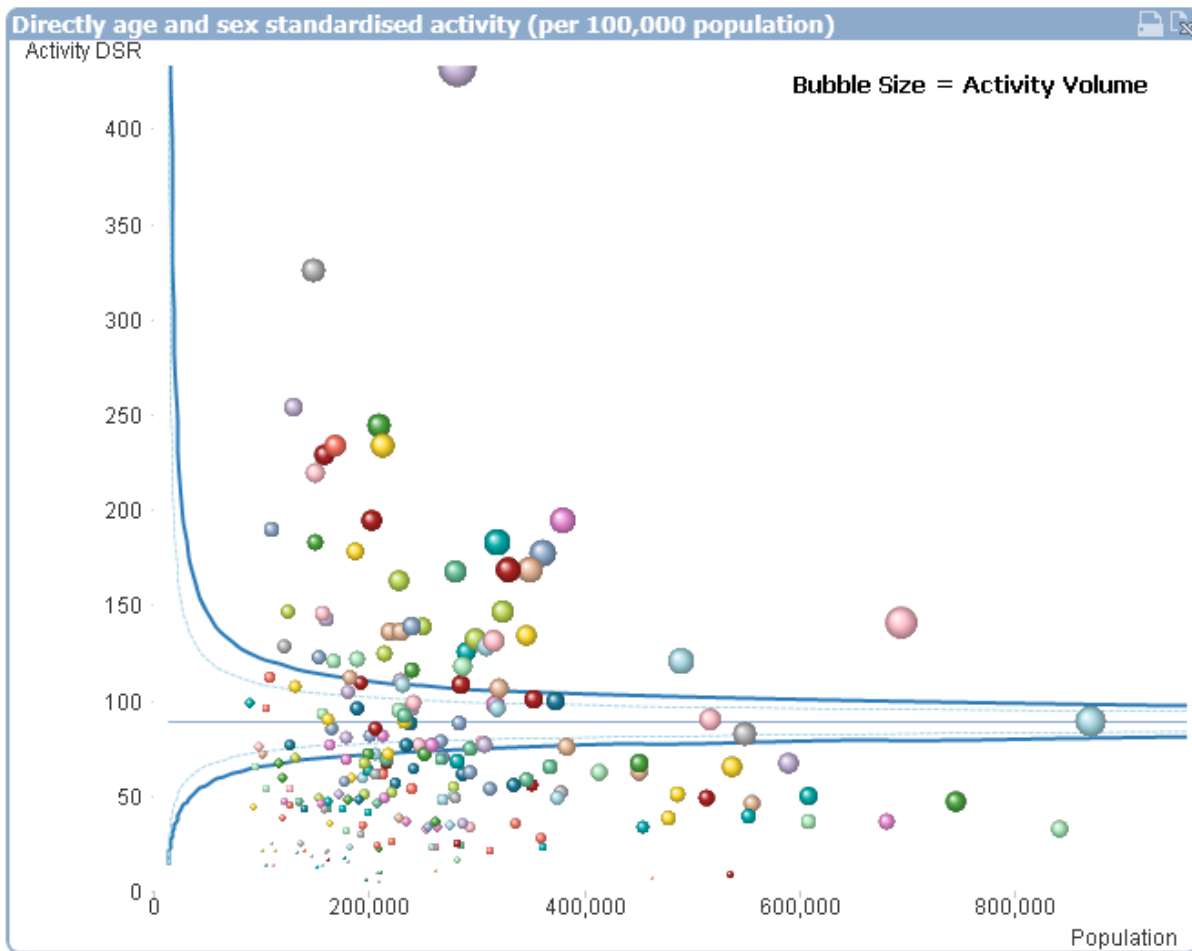


Figure 1: Age and sex standardised rate of surgical and endovenous interventions performed in England in the NHS to treat VV or venous ulceration per 100,000 population in 2012 (each bubble represents a CCG).

The data used to create Figure 1 were derived from individual patient activity. The patient’s GP practices were grouped into relevant CCGs, allowing pre April 2013 data to be displayed at CCG level.

The size of each bubble represents the raw count of actual activity. Individual CCG can be viewed either in the ‘Activity DSR’ metric on the dashboard or the ‘Activity Variation’ tab on the Procedure Explorer Tool.

1 High Value Care Pathway for Varicose Veins

1.1 Primary Care

Asymptomatic varicose veins

Offer people information and explanation:

- This should include information on the likelihood of developing symptoms as well as complications such as skin changes, leg ulcers, bleeding, thrombophlebitis and deep vein thrombosis
- Lifestyle advice should be offered that encourages people to maintain a healthy weight, undertake moderate physical exercise and avoid prolonged standing

Symptomatic varicose veins

People with varicose veins (primary & recurrent) should be referred to a vascular service¹ if they have:

- Symptoms; for example pain, swelling itching and cramps
- Lower limb skin damage thought to be due to venous insufficiency
- Superficial thrombophlebitis (hard, painful, thrombosed superficial veins)
- Past history of leg ulceration
- A leg ulcer thought possibly to be due to venous (with or without arterial) disease (an ulcer is defined as a break in the skin below the knee that has failed to heal within 2 weeks)

Patients should be referred *immediately* to vascular service if they have:

- Bleeding varicose veins

Varicose veins can develop during, or be exacerbated by, pregnancy. Interventional treatments are not indicated in pregnancy except in exceptional circumstances. Information should be supplied and compression hosiery offered for symptom relief.

¹ A team of health care professionals who have the skills to undertake a full clinical and duplex ultrasound assessment and provide a full range of surgical and endovenous treatments for VV and venous ulceration.

1.2 Secondary Care

- Duplex Doppler ultrasound is recommended in all patients with lower limb symptoms thought possibly to be due to venous disease as it is necessary to confirm the diagnosis and plan treatment
- Compression hosiery should only be offered if interventional treatment is not suitable or declined by the patient
- Patients with symptomatic varicose veins and truncal reflux should be offered initially endothermal ablation (ETA); if not suitable for ETA then ultrasound-guided foam sclerotherapy (UGFS), or if not suitable for ETA, UGFS then conventional surgery. Patients' suitability and preferences do need to be considered.
- Symptomatic tributaries and varices should be treated by phlebectomy or sclerotherapy. This should generally be performed at the same time as the truncal reflux treatment but may be deferred if thought appropriate.
- Compression hosiery or bandaging is usually only required for a maximum of 7 days after ETA and surgery but may be indicated for a longer period after UGFS.
- For more information, please see the NICE [guidelines](#), [pathway](#) and [costing report](#).

2 Procedures explorer for Varicose Veins

The Procedures Explorer Tool (PET) is available via the [Royal College of Surgeons](#) website.

PET enables CCGs to see whether they are under- (or over-) commissioning treatments for varicose veins compared to their counterparts.

Users can access further procedure information based on the data available in the quality dashboard to view how individual providers are performing against the indicators.

This will identify any providers who appear to be "outliers" from the indicators of quality that have been set and allow improvements to be implemented.

3 Quality dashboard for Varicose Veins

The quality dashboard provides an overview of activity commissioned by CCGs from the relevant pathways, and indicators of the quality of care provided by surgical units

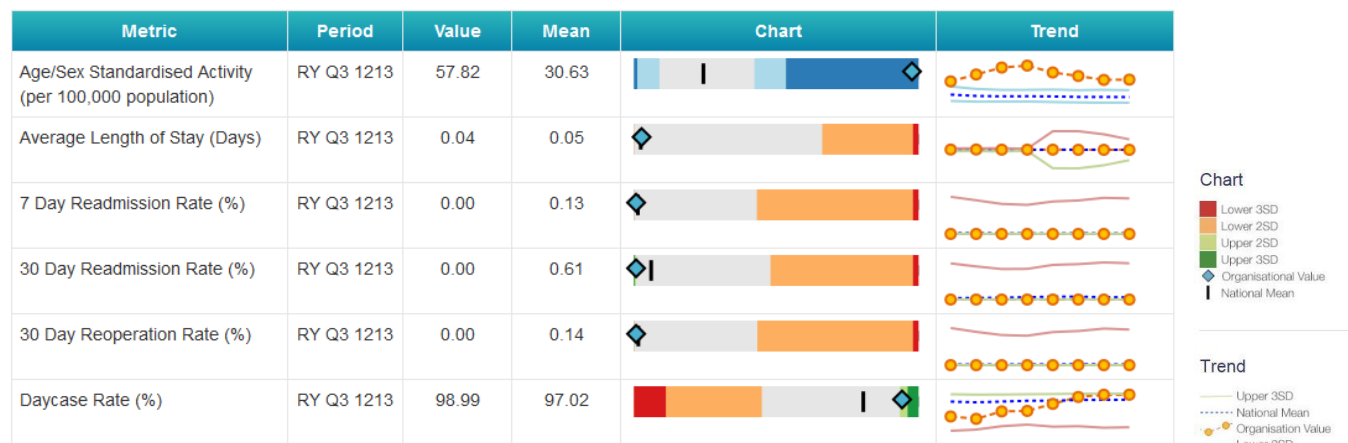
The Quality Dashboard is available via the [Royal College of Surgeons](#) website.

Example Quality Dashboard for Quarter 2 2012/13:

NHS HAMMERSMITH AND FULHAM CCG

Vascular surgery-Varicose Veins

Endothermal without Ulcer (Unilateral)



4 Levers for implementation

4.1 Audit and peer review measures

The following measures and standards are those expected at primary and secondary care. Evidence of adherence to these measures and standards should be made available to commissioners if requested.

	Measure	Standard
Primary Care	Referral	Do not refer people with asymptomatic varicose veins
	Patient Information	People should be directed to appropriate information, such as that contained within the NICE pathway and Circulation Foundation
	Referral	Refer all people with symptomatic primary or recurrent varicose veins, healed or current CVU to a vascular service. Refer patients with superficial thrombophlebitis to a vascular service. Patients with bleeding varicose veins should be referred immediately.
	Audit	Providers should be able to provide evidence of regular local audit, for example Morbidity and Mortality meetings, and compliance with NICE national guidelines

4.2 Quality Specification

Measure	Description	Data specification (if required)
Day Case Rates	Providers should be able to demonstrate close to 100% day case rate. Non-day-case procedures should be justified on an individual case basis	Data available from HES
VTE within 90 days	Providers should be able to identify a 90 day symptomatic VTE rate of <1%	
Unplanned readmission within 30 days for any reason	Provider demonstrates a rate of 1%	
Patient Reported Outcome Measures	Provider demonstrates 90% submission rate and demonstrates use of data	

5 Directory

5.1 Patient Information for Varicose Veins

Name	Publisher	Link
NICE pathways: varicose veins in the legs	NICE	http://pathways.nice.org.uk/pathways/varicose-veins-in-the-legs
NICE information for the public	NICE	http://publications.nice.org.uk/varicose-veins-in-the-legs-ifp168
Circulation Foundation patient information	Circulation Foundation	http://www.circulationfoundation.org.uk/help-advice/veins
Vascular Society patient information	Vascular Society of Great Britain and Ireland	www.vascularsociety.org.uk

5.2 Clinician information for Varicose Veins

Name	Publisher	Link
Varicose veins in the legs: the diagnoses and management of varicose veins (CG168)	NICE	http://www.nice.org.uk/guidance/index.jsp?action=byID&o=14226

6 Benefits and risks of implementing this guide

Consideration	Benefit	Risk
Patient outcome	<ul style="list-style-type: none"> Ensures that people have equitable and timely access to modern, effective interventional treatments for varicose veins and leg ulcers Improves symptoms of people with varicose veins Improves quality of life of people with varicose veins 	None
Patient safety	<ul style="list-style-type: none"> Reduces the risks of people developing venous ulceration and improves healing and recurrence rates in people already affected by ulceration 	None
Patient experience	<ul style="list-style-type: none"> Improves access to patient information about treatment choices available 	None
Equity of Access	<ul style="list-style-type: none"> Improves access to effective procedures Modernisation of venous treatment 	None
Resource impact	<ul style="list-style-type: none"> Reduces unnecessary referral and intervention Provides more cost effective treatment 	Training required for specialists not familiar with endothermal and sclerotherapy techniques

7 Further information

7.1 Research recommendations

- This group agrees with the [research recommendations](#) coming out of the NICE guidance on varicose veins in the legs (CG168).

7.2 Other recommendations

- The prevalence of leg ulceration in the community is recorded in community-based records but these data are not accessible. This group recommends that the data relating to prevalence of leg ulceration become available nationally to assess the impact of venous intervention on the burden of leg ulceration.

7.3 Evidence base

1. Venous Forum of the Royal Society of Medicine. *Venous Intervention (VEIN) project*. 2009. http://www.rsm.ac.uk/academ/downloads/veg102_apr09.pdf
2. NICE. *Varicose veins in the legs: the diagnoses and management of varicose veins (CG168)*. 2013. <http://www.nice.org.uk/guidance/index.jsp?action=byID&o=14226>
3. Additional search carried out by Bazian Ltd, May 2013

7.4 Guide development group for Varicose Veins

A commissioning guide development group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email and teleconferences.

Name	Job Title/Role	Affiliation
Mr Ian Franklin	Consultant Vascular Surgeon	Vascular Society of Great Britain and Ireland Chairman of Circulation Foundation
Mr David Berridge	Consultant Vascular Surgeon	President of the Venous Forum, RSM
Professor Andrew Bradbury	Professor of Vascular Surgery	Past President of Venous Forum, RSM, Member of NICE Guidelines Committee
Professor Alun Davies	Professor of Vascular Surgery	Past President of Venous

		Forum, RSM Chairman of NICE Guidelines Committee
Dr Mark Vaughan	GP, Meddygfa Avenue Villa Surgery, Llanelli	Member of NICE Guidelines Committee
Mr David Evans	Patient representative	Member of NICE Guidelines Committee
Ms Joyce Calam	Patient representative	Member of NICE Guidelines Committee
Dr Raj Krishna	GP, Argyle Surgery	Ealing CCG

7.5 Funding statement

The development of this commissioning guidance has been funded by the following sources:

- Department of Health Right Care funded the costs of the guide development group, literature searches and contributed towards administrative costs.
- The Royal College of Surgeons of England and the Vascular Society of Great Britain and Ireland provided staff to support the guideline development.

7.6 Conflict of Interest Statement

Individuals involved in the development and formal peer review of commissioning guides are asked to complete a conflict of interest declaration. It is noted that declaring a conflict of interest does not imply that the individual has been influenced by his or her secondary interest. It is intended to make interests (financial or otherwise) more transparent and to allow others to have knowledge of the interest.

The following interests were declared by members:

Name	Job Title/Role	Interest
Professor Alun Davies	Professor of Vascular Surgery	<ul style="list-style-type: none"> • Attended and lectured at Turkish Vascular Society, European Society of Vascular Surgery, European Venous Forum, ARAB vein meeting (Saudi Arabia). The meeting organisers paid expenses but no monies were given for lecturing. The organisers would have had multiple healthcare related

sponsors.

- Expenses paid for attending and lecturing at Veith symposium (USA). The meeting organisers paid expenses but no monies were given for lecturing. The organisers would have had multiple industrial sponsors.
- Attended academic meeting of CACVS (Controversies and Updates in Vascular Surgery) in France and received expenses for registration, travel and accommodation from meeting organisers, who would have had industrial sponsorship.
- Research department was awarded a grant from Venous Forum UK.
- Attended American Venous Forum (USA) with registration paid for by meeting organisers who would have had industrial sponsorship.
- Met with Sapheon to investigate commencing a trial in the UK on vein ablation with a novel glue technology. A grant has been awarded from Sapheon to Imperial College for which Professor Davies is the principal investigator.
- A grant was awarded to the research department from Clarivein (novel vibrating technology for varicose vein treatment), for which Professor Davies is the principal investigator.
- A grant was awarded to the research department from Geko to fund a trial looking at

an electrical stimulation tool for the prevention of VTE.

- Organised and attended major meeting (Charing Cross Symposium) with multiple industrial sponsors and attended meal.
- Received a bursary to cover travel and accommodation expenses from Australasian College of Phlebology (ACP) to attend and lecture at their annual meeting (Australia). The meeting organisers would have had industrial sponsorship.
- Attended a meeting with Servier (Paris) to discuss Daflon, a pharmaceutical treatment of varicose veins. Servier paid travel expenses.
- Received expenses for travel, registration and accommodation to the European Vascular Course (Belgium) from the meeting organisers. The meeting organisers would have had industrial sponsorship.
- Attended vascular meeting in India funded by the Indian vascular society and VASCUTEK.
- Attended the Veith Vascular Symposium as a guest speaker and gave 7 talks. Flights were funded by VASCUTEK UK and the meeting was sponsored by multiple companies.
- Attended the ISVS Miami, AVF Phoenix and CX Symposium – all meetings has commercial sponsorship from many organisations.

Professor Andrew Bradbury	Professor of Vascular Surgery	<ul style="list-style-type: none">• Attended as part of the faculty the European Venous Forum (EVF) Hands-On Workshop (HOW) in Vienna in November 2011. Travel and accommodation costs were covered by the EVF and those funded were obtained from a range of different companies who manufacture materials and equipment used for the treatment of venous disease.• Department did some research which was funded by British Biotechnology Group (BTG) Ltd, who are trying to make a commercial foam, looking at the evaluation of a novel health-related quality-of-life (HRQL) instrument administered via a Palmtop Application Device (PAD). The funds were used to pay the salary of a research nurse. No personal payment received.• Had a discussion with the Chief Executive of STD pharmaceuticals (who make a chemical called STS which can be used to make foam for the treatment of varicose veins) during dinner at the European Venous Forum annual meeting in Florence in June 2012. During that dinner the application of a European licence for STS foam was discussed.• Attended a faculty of Charing Cross Meeting – expenses paid by Charing Cross – no personal fee.
Mr Ian Franklin	Consultant Vascular	<ul style="list-style-type: none">• Runs independent private

	Surgeon	practice with venous specialty interest
Mr David Evans	Patient representative	<ul style="list-style-type: none">Mr Evans holds shares with Astrazeneca and Glaxo Smith Kline
Dr Mark Vaughan	GP, Meddygfa Avenue Villa Surgery, Llanelli	<ul style="list-style-type: none">Agreed to speak at the National Primary Care Conference in May 2013