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VENOUS FORUM OF THE ROYAL SOCIETY OF MEDICINE

## Recommendations for the referral and treatment of patients with lower limb chronic venous insufficiency (including Varicose Veins)



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## Background

Lower limb chronic venous insufficiency (CVI) affects up to 50% of the adult population and, not surprisingly, is a frequent cause for referral from primary to secondary care within the NHS.

Patients seek treatment for CVI for a wide range of reasons:

1. physical symptoms such as pain and itching
2. prevention and treatment of complications such as
  - a. bleeding
  - b. superficial thrombophlebitis
  - c. deep vein thrombosis (DVT)
  - d. chronic venous ulceration (CVU)
3. cosmetic concerns

As well as the burden imposed by CVI upon the health related quality of life (HRQL) of the nation, the socio-economic impact upon the UK is significant.

In recent years, explicit and implicit rationing by purchasers and General Practitioners (GP) has led to a decrease in the number of interventions performed for CVI by the NHS; at present the figure stands around 35,000 annually in England and Wales (HES data).

Few of the many existing referral guidelines are evidence-based and "localism" in decision-making perpetuates the injustice of the "post code lottery".

The Venous Forum of Royal Society of Medicine believes that the resulting current situation is unsatisfactory and that all UK citizens should have fair and equal access to evidence-based treatment of CVI within the NHS.

## Aim

To offer an evidence-based, expert view as to how those NHS resources made available for the treatment of CVI might be used in the most clinically and cost-effective manner.

## Classification of Venous Disorders

The CEAP grade represents an internationally accepted classification system for patients with CVI<sup>1</sup> (Table 1). We recommend that the "C" (clinical) class of CEAP is used when describing indications for referral or treatment.

Table 1. CEAP (Clinical-Etiology-Anatomy-Pathophysiology) clinical classification

C <sub>0</sub>	No visible or palpable signs of venous disease
C <sub>1</sub>	Telangiectasias or reticular veins
C <sub>2</sub>	Varicose veins; diameter >3mm
C <sub>3</sub>	Oedema
C <sub>4</sub>	Changes in skin and subcutaneous tissue: pigmentation, eczema, lipodermatosclerosis or atrophie blanche
C <sub>5</sub>	Healed venous ulcer
C <sub>6</sub>	Active venous ulcer

## Treatment of CVI

There is ample published evidence to show that, when patients are correctly selected, treatment for CVI, both conservative and interventional, can:

1. significantly improve disease specific and generic HRQL
2. relieve a wide range of troublesome lower limb symptoms
3. delay and prevent the onset of complications of CVI
4. represent a highly cost-effective use of NHS resources

The current options for the treatment of CVI comprise:

1. Conservative therapy, of which the mainstay is compression
2. Surgery
3. Endovenous thermal ablation (LASER (EVLA) or radiofrequency (RFA))
4. Ultrasound guided foam sclerotherapy (UGFS)

RFA, EVLA and UGFS have a number of potential benefits over surgery; for example, they:

1. can be performed as a day-case or in the out-patient setting under local anaesthesia
2. are associated with significantly less morbidity
3. allow a significantly earlier return to activity
4. can be provided at a materially lower cost<sup>2</sup>

Guidance on the use of specific techniques has been set out in recent publications from the National Institute for Clinical Excellence and the Royal Society of Medicine Venous Forum (Venous Intervention Project).<sup>3-6</sup> On-going research will continue to refine our understanding of which techniques are optimal for different clinical indications.<sup>7</sup>

## **Recommendations for referral and treatment of CVI in the NHS**

### **Uncomplicated C1-C3 disease**

1. Most such patients can be managed in primary care with reassurance, advice on exercise, weight loss, elevation and the use of compression hosiery.
2. Patients whose primary concern is cosmetic should not normally be offered treatment in the NHS; such patients are well catered for in the private sector.

3. Those patients:

A) troublesome lower limb physical symptoms that:

- i. are impairing HRQL
- ii. are likely to be due to CVI
- iii. have not responded to conservative therapy in primary care

B) Oedema (C3)

Should be:

- i. referred to a vascular surgeon for clinical and duplex ultrasound assessment
- ii. offered intervention if deemed appropriate by the surgeon and the patient

4. We endorse the current NICE referral guidelines<sup>8</sup> that support urgent referral for patients with:

1. superficial thrombophlebitis
2. bleeding from varicosities
3. complicated (C4-6) disease (please see below)

It is anticipated that most such patients will benefit from and should receive treatment aimed at the eradication of superficial venous reflux.

### **Complicated (C4-C6) disease**

The ability to reliably predict which patients with uncomplicated (C1-C3) CVI will go on to develop ulceration remains elusive. However, it is clear that the development of skin changes (C4 disease) is associated with a significantly increased risk of CVU. These observations strongly suggest that withholding treatment for patients with C4 disease will increase the future burden of CVU.

We recommend that:

1. All C4 patients and all patients with history of suspected CVU (C5 patients) should be referred to a vascular surgeon for a full clinical and duplex ultrasound assessment supported by other diagnostic tests as deemed appropriate<sup>9-10</sup>

# Recommendations for the referral and treatment of patients with lower limb chronic venous insufficiency (including Varicose Veins)

2. All patients with a break in the skin below the knee that has failed to heal within 2 weeks (potential C6) patients should be referred urgently (within 2 weeks) to a vascular surgeon

It is anticipated that most patients so referred will benefit from and should receive treatment aimed at the eradication of superficial venous reflux.

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