Humber Coast and Vale

Varicose Vein Commissioning Policy

Intervention	**Interventional treatments in acute care**
OPCS Codes	L882 Radiofrequency Ablation of Varicose Vein of Leg L862 Ultrasound guided foam sclerotherapy for varicose vein of leg L881 Percutaneous transluminal laser ablation of long saphenous vein L849 Unspecified combined operations on varicose vein of leg L848 Other specified combined operations on varicose vein of leg L871 Stripping of long saphenous vein L873 Stripping of varicose vein of leg NEC L851 Ligation of long saphenous vein L861 Injection of sclerosing substance into varicose vein of leg NEC L874 Avulsion of varicose vein of leg L853 Ligation of recurrent varicose vein of leg
For the treatment of	**Varicose Veins**
Background	Humber Coast and Vale CCGs do not routinely commission treatment in secondary care for varicose veins. This commissioning policy clarifies the care pathway and the criteria that must be met before interventional treatment or surgery is commissioned, and is based on the recommendations in the NICE Clinical Guideline CG168 (July 2013) *Varicose Veins in the legs – Diagnosis and Management*[1]. The Clinical Guideline is only a recommendation and the CCG has identified grading / severity of varicose veins to support the criteria. Requests for surgical treatment outside the criteria outlined below and outside the pathway must be considered via the Individual Funding Request (IFR) Panel.
Commissioning position	**Exclude Red Flag Symptoms** Deep vein thrombosis (DVT) should be excluded in any patient presenting with a red, hot swollen leg with use of the Well's criteria and d-dimer testing. Superficial vein thrombosis above the knee should be discussed with the vascular team as admission is sometimes indicated for high tie and/or anticoagulation as there is a significant potential for clot migration and PE Bleeding varicose veins which have caused significant blood loss and/or will not stop with direct pressure may require admission. **All Other Cases** Prior to referral to acute care vascular services, a minimum of six months of conservative management needs to be clinically evidenced as unsuccessful, for patients in the C5 to C6 Clinical, Etiological, Anatomical and Pathophysiological (CEAP) classification (1), detailed below: • C0 no visible or palpable signs of venous disease • C1 telangectasia or reticular veins • C2 varicose veins • C3 oedema • C4 changes in skin and subcutaneous tissue: eczema, lipodermatosclerosis or atrophie blanche • C5 as C4 but with healed ulcers

	• C6 skin changes with active ulcers venous insufficiency ulceration Conservative management in primary care may include advice on: • Walking and exercise • Avoidance of activities that exacerbate symptoms e.g. prolonged sitting or standing • Elevation of the legs when sitting down to increase venous return • Losing weight, if appropriate • Compression hosiery to relieve leg swelling associated with varicose veins (especially in pregnancy) Humber Coast and Vale CCGs will commission referral to a secondary care vascular service for patients with classification C5 to C6 (above) **with** any of the following symptoms that indicate a higher likelihood of disease progression: • Bleeding varicose veins (immediate referral required) • Symptomatic primary or recurrent varicose veins that are causing severe pain, aching, discomfort, swelling, heaviness or itching • Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency • Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence • An active or healed venous leg ulcer. Interventional treatment for varicose veins in pregnancy will not be commissioned unless exceptional circumstances apply and agreement is sought via the IFR Panel. Humber Coast and Vale CCGs will not routinely commission Transilluminated Powered Phlebectomy or Endovenous Mechanochemical Ablation (NICE IPG435 and IPG37) to treat varicose veins, due to inadequate evidence on the safety and efficacy of these techniques. Humber Coast and Vale CCGs will commission surgical treatment for varicose veins if the pathway has been clinically evidenced as being followed and after clinical assessment and the use of duplex ultrasound to confirm the diagnosis of varicose veins and the extent of truncal reflux (venous blood flowing backwards due to valves not working properly), is classified as severe.
Summary of evidence / rationale	Varicose veins are dilated superficial veins in the leg caused by incompetent venous valves. About a third of the population are affected by visible varicose veins in the legs; prevalence increases with age and they often develop during pregnancy. Asymptomatic present as a few isolated, raised palpable veins with no associated pain, discomfort or any skin changes. Moderate varicose veins present as local or generalised dilatation of subcutaneous veins with associated pain or discomfort and slight ankle swelling.

	Severe varicose veins may present with phlebitis, ulceration and haemorrhage. About 3-6% of people who have varicose veins will go on to develop ulcers. There is some evidence that the clinical severity of venous disease is worse in obese persons so advice on weight loss may help reduce symptoms and would make any intervention safer. Because most varicose veins do not cause serious health problems, treatment is not usually needed on medical grounds.
Date effective from	December 2017
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References:

1. NICE Clinical Guideline 168 (July 2013) Varicose veins in the legs: the diagnosis and management of varicose veins
2. NICE Care Pathway
3. NICE IPG 8 (2003) Radiofrequency ablation of varicose veins.
4. NICE IPG 52. (2004) Endovenous laser treatment of the long saphenous vein.
5. NICE IPG 440. (2013) Ultrasound-guided foam sclerotherapy for varicose veins.
6. NICE IPG 37 (2004) Transilluminated powered phlebectomy for varicose veins.
7. NICE IPG 435 (2013) Endovenous mechanochemical ablation for varicose veins