*Extract from the below named document for ICS Implementation purposes;* [*Microsoft Word - EBI consultation response statutory guidance 11 Jan 2019 FINAL v2.0 CLEAN + cover sheet.docx (aomrc.org.uk)*](https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/ebi-statutory-guidance.pdf)

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Varicose vein interventions

Updated description of the intervention

NICE has published detailed guidance on what treatment should be considered for varicose veins and when interventions for varicose veins (endothermal ablation, sclerotherapy or surgery) should be offered. Surgery is a traditional treatment that involves removal of the vein, patients can get recurrence of symptoms which may need further treatment. Treatments like endothermal ablation or ultrasound-guided foam sclerotherapy are less invasive than surgery and have replaced surgery in the management of most patients. However surgery is the most appropriate in some cases. Patients with symptomatic varicose veins should be offered treatment of the varicose veins. Compression hosiery is not recommended if an interventional treatment is possible.

Updated clinical criteria

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| Summary of intervention |
| There are various interventional procedures for treating varicose veins. These include endothermal ablation, ultrasound guided foam sclerotherapy and traditional surgery (this is a surgical procedure that involves ligation and stripping of varicose veins) all of which have been shown to be clinically and cost effective compared to no treatment or treatment with compression hosiery. Varicose veins are common and can markedly affect patients quality of life, can be associated with complications such as eczema, skin changes, thrombophlebitis, bleeding, leg ulceration, deep vein thrombosis and pulmonary embolism that can be life threatening. |
| Number of CCG interventions in 2017/18 |
| 28,846 |
| Recommendation |
| Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery.  Refer people to a vascular service if they have any of the following;-  Symptomatic \* primary or recurrent varicose veins.  Lower‑limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.  Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.  A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks).  A healed venous leg ulcer.  \*Symptomatic: “Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).”  For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment  Refer people with bleeding varicose veins to a vascular service immediately.  Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable  For further information, please see:  https://[www.nice.org.uk/guidance/qs67](http://www.nice.org.uk/guidance/qs67)  https://[www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-](http://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-) veins/300594.article  https://[www.nice.org.uk/guidance/cg168](http://www.nice.org.uk/guidance/cg168) |
| Rationale for recommendation |
| International guidelines, NICE guidance and NICE Quality standards provide clear evidence of the clinical and cost-effectiveness that patients with symptomatic varicose veins should be referred to a vascular service for assessment including duplex ultrasound.  Open surgery is a traditional treatment that involves surgical removal by 'stripping' out the vein or ligation (tying off the vein), this is still a valuable technique, it is still a clinically and cost-effective treatment technique for some patients but has been mainly superseded by endothermal ablation and ultrasound guided foam sclerotherapy.  Recurrence of symptoms can occur due to the development of further venous disease, that will benefit from further intervention (see above). NICE guidance states that a review of the data from the trials of interventional procedures indicates that the rate of clinical recurrence of varicose veins at 3 years after treatment is likely to be between 10–30%.  For people with confirmed varicose veins and truncal reflux NICE recommends:  Offer endothermal ablation of the truncal vein.  If endothermal ablation is unsuitable, offer ultrasound‑guided foam sclerotherapy.  If ultrasound‑guided foam sclerotherapy is unsuitable, offer surgery.  Consider treatment of tributaries at the same time  Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.  Complications of intervention include recurrence of varicose veins, infection, pain, bleeding, and more rarely blood clot in the leg. Complications of non-intervention include decreasing quality of life for patients, increased symptomatology, disease progression potentially to skin changes and eventual leg ulceration, deep vein thrombosis and pulmonary embolism. |
| References |
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