Commissioning Policy
Varicose Vein Referral Guidelines

December 2010

This commissioning policy applies to patients within:
South Worcestershire Clinical Commissioning Group (CCG)
Redditch & Bromsgrove Clinical Commissioning Group (CCG)
Wyre Forest Clinical Commissioning Group (CCG)

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<td>Ratified by (name of Committee):</td>
<td>Commissioning Executive – April 2010, Policy Working Group December 2010 (minor) 1st April 2013 – this policy was formally adopted by: NHS South Worcestershire Clinical Commissioning Group NHS Redditch &amp; Bromsgrove Clinical Commissioning Group NHS Wyre Forest Clinical Commissioning Group</td>
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<tr>
<td>Date ratified:</td>
<td>April 2010 (Revised December 2010)</td>
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<tr>
<td>Date issued:</td>
<td>August 2004, April 2007, December 2010, April 2013</td>
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<td>Expiry date: (Document is not valid after this date)</td>
<td>Any revisions to the policy will be based on local and national evidence of effectiveness and cost effectiveness together with recommendations and guidelines from local, national and international clinical professional bodies. Minimum 3 yearly.</td>
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<tr>
<td>Review date:</td>
<td>April 2016</td>
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<tr>
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<tr>
<td>Target audience:</td>
<td>NHS Trusts, Independent Providers, GP’s, patients</td>
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<tr>
<td>Distribution:</td>
<td>NHS Trusts, Independent Providers, GP’s, patients, Public &amp; Patient Involvement Forum</td>
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<tr>
<td>Equality &amp; Diversity Impact Assessment</td>
<td>12th November 2009, Endorsed April 2010</td>
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**Key individuals involved in developing the document**

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<tr>
<td>NHS Worcestershire Policy Working Group</td>
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<td>Patient and Public Representatives</td>
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1. Definitions

1.1 Exceptional clinical circumstances are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional. This will usually involve a comparison with other patients with the same clinical condition and at the same stage of development of that clinical condition and refer to features of the particular patient which make that patient out of the ordinary, unusual or special compared to other patients in that cohort. It can also refer to a clinical condition which is so rare that the clinical condition can, in itself, be considered exceptional. That will only usually be the case if the NHS commissioning body has no policy which provides for the treatment to be provided to patients with that rare medical condition.

1.2 A Similar Patient refers to the existence of a patient within the patient population who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. When the treatment meets the regional criteria for supra-CCG policy making, then the similar patient may be in another CCG with which the Commissioner collaborates. The existence of one or more similar patients indicates that a policy position is required of the Commissioner.

1.3 An individual funding request (IFR) is a request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment.

1.4 An in-year service development is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Commissioner agrees to fund outside of the annual commissioning round. Unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

1.5 Exceptional refers to a person who demonstrates characteristics, which are highly unusual, uncommon or rare.

2. Scope of policy:

2.1 This policy should be considered in line with all other Worcestershire Commissioning Policies. Copies of these Commissioning Policies are available on the Worcestershire’s local website at the following address:
3. **Background:**

3.1. NHS principles have been applied in the agreement of this policy.

3.2. The following guidelines are intended to assist GP’s in making an appropriate decision to refer a patient with varicose veins for definitive treatment and to try and achieve consistency of referral. As there is a finite budget available to treat varicose veins we request the assistance of GP’s in helping to focus interventions on those patients who have the greatest clinical need. It is clear that patients with varicose veins of cosmetic concern only, or with minimal symptoms, should NOT be referred for an NHS specialist opinion.

3.3. It is universally accepted that patients who have suffered complications - ulceration, bleeding, thrombophlebitis - or have objective clinical evidence of venous insufficiency - skin damage (lipodermatosclerosis, varicose eczema), thrombophlebitis or ankle oedema SHOULD be referred with a view to intervention.

4. **Relevant National Guidance and Facts**

4.1. Most patients with varicose veins can be managed in primary care. Patients in whom varicosities are present or suspected should, however, be referred to a specialist vascular service. The Guidelines herein provide graphical illustrates to aide the classification of varicose veins to ensure appropriate referrals are made to secondary care.

4.2. NHS treatment for varicose veins will concentrate on providing the most cost-effective solution for truncal vein incompetence, to reduce severe symptoms and reduce the risk of complications, NOT to provide a perfect cosmetic result. This approach will allow providers to provide care for as many patients as possible who have the greatest clinical need for intervention.

5. **Commissioning Policy**

5.1 The Commissioner considers all lives of all patients whom it serves to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to the patient’s clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

5.2 Unless a clinically exceptional case\(^1\) is presented, the Commissioner will not fund secondary care for the treatment of:

- Grade 0: Thread/Flare veins
- Grade I: Minor/moderate varicose veins
- Grade II: Moderate or symptomatic varicose vein

5.3 The PCT will fund specialist advice and surgery if appropriate for the following:

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\(^1\) Refer to Page 2 of this policy for definition of exceptional clinical circumstances.
- Grade III: Extensive or severely symptomatic varicose veins
- Grade IV: Severe signs of venous insufficiency
- Grade V: Active leg ulceration

For more information relating to the clinical appearance and presentation of these various grades of varicose veins, please see Appendix 1.

6. Clinically Exceptional Circumstances

6.1 If there is demonstrable evidence of a patient's clinically exceptional circumstances, the referring practitioner should refer to the Worcestershire’s local “Individual Funding Request Policy” document for further guidance on the process for consideration.

For a definition of the term “clinically exceptional circumstances”, please refer to the Definitions section of this document.

7. Documents Which Have Informed This Policy

- Worcestershire’s local: Individual Funding Request Process
- Worcestershire's local: Prioritisation Framework for the Commissioning of Healthcare Services
- West Midlands Strategic Group Commissioning Policy 1: Guiding principles and considerations to underpin priority setting and resource allocation within collaborative commissioning arrangements
- West Midlands Strategic Group Commissioning Policy 4: Use of cost-effectiveness, value for money and cost effectiveness thresholds
- West Midlands Strategic Group Commissioning Policy 16: Prior Approval
- West Midlands Strategic Group Commissioning Policy 9: Individual funding requests
Appendix 1: Varicose Vein – Referral Guidelines

Grade 0: Thread / Flare veins
Telangectasias are small red / blue venular flares. Reticular veins are easily visible small blue veins (less than 3mm diameter), not associated with large vein valvular incompetence.

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

Grade I: Minor / moderate varicose veins
Truncal varicosities which may be associated with large vessel valvular incompetence but are asymptomatic.

Surgical treatment for patients with grade I varicose veins is not available on the NHS and they should not be referred to NHS vascular clinics.
Grade II: Moderate or symptomatic varicose veins
This group includes patients with obvious varicose veins that remain asymptomatic and those with moderate veins that cause mild symptoms such as itching, mild oedema and aching.

Lifestyle advice and reassurance may be given and graduated compression stockings may be advised / prescribed.

*NHS surgical treatment for patients with grade II varicose veins is not routinely available and they should not usually be referred to NHS vascular clinics.*

NICE recommends that patients may be referred if there is evidence of a significant reduction in quality of life resulting from the varicose vein symptoms.

Grade III: Extensive or severely symptomatic varicose veins
Patients presenting with gross varicose veins merit a specialist opinion if they request it. Surprisingly, a number will remain asymptomatic and may well be effectively managed with lifestyle advice and compression stockings. Patients who have had obvious thrombophlebitis, bleeding from varicose veins or present with objective evidence of venous hypertension – pitting oedema, lipodermatosclerosis or varicose eczema – should normally be referred for specialist advice.
Surgical treatment on the NHS is available for patients with Grade III varicose veins and patients should be referred to NHS vascular services if they request this.

Grade IV: Severe signs of venous insufficiency
This group includes patients with healed varicose ulcers, inflamed lipodermatosclerosis, infected varicose eczema and severe extensive thrombophlebitis. Initial management may include compression stockings, anti-inflammatory drugs and antibiotics as appropriate and should commence in primary care.

Prompt referral to NHS vascular services is recommended for patients with Grade IV varicose veins and these patients should be given clinical priority in vascular clinics.

Severe thrombophlebitis may be associated with DVT. Aspirin or subcutaneous low molecular weight heparin should begin prior to referral.

Grade V: Active leg ulceration

Patients who develop leg ulcers should ideally be referred to specialist community-based ulcer clinics where arterial disease can be excluded.

Venous ulcers may then be treated by four layer bandaging.

Those ulcers not responding or recurring despite prophylaxis using compression stockings require assessment in a vascular clinic.

NHS treatment is obviously available for patients with ulcers caused by superficial venous incompetence, but intervention is ideally performed once the ulcer has healed.
Appendix to varicose vein referral guidelines

Telangectasia and reticular veins 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 for most, though pulsed light therapy is effective for very small red telangectasia. Laser and microwave do not appear to be as successful and electrolysis is ineffective on leg veins.

Patients with varicose veins not eligible for NHS surgical intervention may seek treatment elsewhere or be managed conservatively:

- **Lifestyle advice** may include weight loss, encouraging exercise and leg elevation on resting.

- **Reassurance** can be given that unless severe symptoms or signs of venous insufficiency are present then serious complications such as leg ulceration are very unlikely in the short to medium term. Should the clinical situation change then referral is obviously possible.

- **DVT risk** is not significantly increased by uncomplicated varicose veins but precautions when flying, including compression stockings, aspirin, avoiding dehydration and regular exercise would seem sensible.

- **Graduated compression stockings** control most symptoms attributable to varicose veins, including aching and ankle swelling in addition to reducing the risk of ulceration. Stockings are available on FP10 or can be purchased from pharmacists. **Class one** stockings are suitable for mild symptoms whilst significant ankle oedema or prevention of ulcer recurrence requires a **class two** stocking. Below-knee stockings are usually effective but some patients find them uncomfortable or ineffective if varicosities are in the thigh. Thigh-length stockings may be prescribed but many patients report difficulty keeping them up. Suspender belts are effective and some manufacturers now offer graduated compression stockings with “stay-ups”.

- **Varicose eczema** may require emollients and topical steroids are effective if severe or inflamed.

- **Thrombophlebitis** usually responds to leg elevation, topical or systemic NSAID’s and stockings. Antibiotics are occasionally required for secondary infection.

- **Conventional surgical intervention** for varicose veins involves removing the varicosities (phlebectomies or avulsions) combined with removing their cause – valvular incompetence. This commonly requires long saphenous vein (LSV) stripping, short saphenous vein ligation or perforator ligation. Specialists, performing large numbers of these procedures using modern techniques ensures that they are performed with reduced morbidity / invasiveness and an acceptably low complication and recurrence rate. Pre-operative evaluation using combined Doppler and ultrasound (Duplex) scanners ensures that the correct operation is performed.

**New Treatments for varicose veins** have received much publicity lately, including VNUS Closure radiofrequency ablation of the LSV, Endovenous Laser Ablation of the LSV and Ultrasound –Guided Foam Sclerotherapy. All are now NICE-approved.

**VNUS Closure** is a minimally invasive alternative to LSV stripping and has obtained NICE approval. It is expensive and not available on the NHS locally.
**Endovenous Treatments** for varicose veins are now well established, of proven efficacy and NICE-approved. They include radiofrequency ablation (RF), endovenous laser ablation (EVLA) and ultrasound-guided foam sclerotherapy. They are an extremely effective minimally-invasive alternative to stripping and are performed under local anaesthetic. Foam sclerotherapy is less reliable at occluding large truncal veins but is useful in some situations when the truncal vein is tortuous or there are recurrent veins with a complex pattern of recurrence.

Endovenous Laser allows outpatient LSV ablation under local anaesthetic. Varicose veins feeding into the LSV may shrivel post-operatively or may require subsequent sclerotherapy.

**Foam Sclerotherapy** potentially allows outpatient obliteration of the truncal veins (eg: LSV, SSV) and varicosities. More than one session may be required.

Both these techniques have potential advantages of reduced morbidity and cost compared to conventional surgery but none of these interventions are without disadvantages and patient selection by a specialist with a working knowledge of all alternatives is crucial.

Endovenous laser, ultrasound-guided foam sclerotherapy and minimally-invasive conventional day-case surgery are all available in Worcestershire.
Equality Impact Assessment Report Template

Your Equality Impact Assessment Report should demonstrate what you do (or will do) to make sure that your function/policy is accessible to different people and communities, not just that it can, in theory, be used by anyone.

1. Name of policy or function: NHS Worcestershire Varicose Veins Referral Guidelines Commissioning Policy
2. Responsible Manager: Helen Bryant
3. Date EIA completed: 12th November 2009
4. Description of aims of function/policy: To provide referral guidelines to clinicians in both primary and secondary care on the appropriate management of patients with Varicose Veins.
5. Brief summary of research and relevant data: Not Applicable
6. Methods and outcomes of consultation: Not Applicable

Results of Initial Screening or Full Equality Impact Assessment

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7. Decisions and or recommendations (including supporting rationale) Not Applicable
8. Equality action plan (if required) Not Applicable

Monitoring and review arrangements (include date of next full review)

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</tr>
<tr>
<td>Director</td>
<td>Simon Hairsnape</td>
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<tr>
<td>Report produced by and job title</td>
<td>Helen Bryant, Commissioning Manager</td>
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<tr>
<td>Date report produced</td>
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