NHS
Scarborough and Ryedale
Vale of York
Clinical Commissioning Groups

Dear Colleague

Changes to Varicose Vein Commissioning Criteria

NHS Vale of York and NHS Scarborough and Ryedale CCGs have harmonised and updated their Commissioning Statement for Varicose Veins and this is available on the RSS website at the following links:

NHS VoYCCG – http://www.valeofyorkccg.nhs.uk/rss/index.php?id=primary-care-procedures-not-routinely-commissioned
NHS SRCCG - http://www.scarboroughryedaleccg.nhs.uk/rss2/surgery-vascular/

Commissioning statements start with an assertion that the NHS does not routinely commission treatment in secondary care for varicose veins; this means the CCGs do commission treatment in a specific and subsequently defined way and not in an open, unspecified way. The new commissioning statement is attached. It is important that all GPs are familiar with these, as they will influence your practice and advice you give to patients. Familiarising yourself with CCG commissioning policies and referral guidance is easily evidenced CPD.

The significant changes are:

1. **In the absence of skin damage or an imminent risk to skin integrity**, primary care clinicians should only refer and surgeons should only undertake surgery, where there is a clear justification for clinical benefit and use of NHS resources. In light of financial position and capacity issues within the local health economy in 2018 referral for, and surgery for, symptomatic varicose veins without skin damage is not regarded as a priority for use of NHS resources.
2. Where **clinical signs are mild, conservative management should be undertaken for at least six months** prior to referral into the hospital vascular team, where clinicians believe that such an approach is clinically appropriate, and in the patient's best interest, and that there is **no urgency for surgical intervention**. Patients should be advised to report any worsening of their symptoms.
3. GPs should fully inform patients about conservative management (see statement for details)
4. **The *routine* removal of superficial varicosities (phlebectomies) is not commissioned**. This is based on a NICE acknowledged lack of evidence for what is the best practice.
   Most patients who have truncal (deeper) vein endothermal ablation or foam sclerotherapy will see a shrinking of superficial varicosities and an improvement in their skin health in time. If skin health subsequently deteriorates varicosity surgery will be commissioned.
5. **All patients are expected to be treated under local anaesthetic** unless there are clinical reasons why this is not appropriate. Patient preference for general anaesthesia without exceptional factors, as agreed by IFR, is not an appropriate use of NHS resources

Patients should be informed that if they do not fulfil the specific situations where phlebectomies are commissioned, they will not have the superficial varicosities treated on the NHS. Patients who have a preference for general anaesthesia and are not considered by IFR Panel (or who do not wish to be considered) as exceptional may wish to have surgery privately.

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New Referral Form
There is a new referral form specific for Varicose Veins that GPs will need to complete where you know the patient meets the specific commissioning criteria.

This will enable the CCG to assign a pre-authorisation code (PAC) to ensure swift processing of the referral where we know the patient meets the commissioned criteria. The new form will be sent to your administration team via the RSS team and please note that these forms will be subject to clinical audit.

As a reminder the local NHS does not commission treatment for

- telangiectasia,
- reticular veins,
- asymptomatic varicose veins,
- varicose veins without other clinical skin signs
- treatment for cosmetic or aesthetic reasons
- surgical treatment for varicose veins in pregnancy

The Health Optimisation (BMI and smoking) thresholds still apply. The health optimisation delays to surgery run simultaneously with initiating conservative management, from the time of first presentation, when GPs should record lifestyle counselling (or such like) to establish a 'time zero'. Lower limb ulceration is an exclusion to the application of the BMI and smoking thresholds.

Note - in York patients can be referred after six months of conservative management, as per the threshold, but should be warned that the BMI and smoking thresholds apply.

If you have any queries, please do not hesitate to contact the CCG.

Yours faithfully

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NHS Scarborough & Ryedale CCG

Intervention	**Interventional treatments in the management of Varicose Veins**
OPCS Codes	L832 – Subfascial ligation of perforating vein of leg L841 – Combined operations on primary long saphenous vein L842 – Combined operations on primary short saphenous vein L843 – Combined operations on primary long and short saphenous vein L844 – Combined operations on recurrent long saphenous vein L845 – Combined operations on recurrent short saphenous vein L846 – Combined operations on recurrent long and short saphenous vein L858 – Other specified ligation of varicose vein of leg L859 – Unspecified ligation of varicose vein of leg L875 – Local excision of varicose vein of leg L876 – Incision of varicose vein of leg L883 – Percutaneous transluminal laser ablation of varicose vein of leg NEC L888 – Other specified transluminal operations on varicose vein of leg L889 – Unspecified transluminal operations on varicose vein of leg 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	This commissioning policy clarifies the care pathway and the criteria that must be met before interventional treatment or surgery is commissioned. The policy takes into account NICE Clinical Guideline CG168 (July 2013) *Varicose Veins in the legs – Diagnosis and Management*[1] and *NICE Surveillance report 2016 – Varicose veins in the legs (2013) NICE guideline CG168*[2] The NICE Clinical Guideline is only a recommendation and in this statement the CCG has defined the grading / severity of varicose veins for what is felt to be an appropriate use of NHS resources. 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	**The NHS does not routinely commission treatment in secondary care for varicose veins.** **The NHS does not commission treatment for** • **telangiectasia,** • **reticular veins,** • **asymptomatic varicose veins,**

- **varicose veins without other clinical skin signs**
- **treatment for cosmetic or aesthetic reasons**
- **surgical treatment for varicose veins in pregnancy**

Clinicians should exclude Red Flag Symptoms which are not covered by this statement

- **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 pulmonary embolism.
- **Bleeding varicose vein** which has caused significant blood loss and/or will not stop with direct pressure may require admission.

NICE detail symptoms from varicose veins as pain, aching, discomfort, swelling, heaviness and itching. Patients along with their primary care clinicians and surgeons should be aware that these symptoms are subjective and not specific just to varicose veins. Other causes should be considered and excluded prior to referral to the secondary care vascular services.

Clinical signs of varicose veins that <u>may</u> justify surgical treatment include

- oedema,
- changes in skin and subcutaneous tissue such as eczema, lipodermatosclerosis or atrophie blanche,
- healed or active ulceration of the skin in the absence of other causes of ulceration.

The severity of varicose vein induced skin damage or imminent risk to skin integrity and any subjective symptoms should be a guide for general practitioners and vascular surgeons in prioritizing patients for NHS surgery. Conservative management should still be encouraged to prevent or delay the need for, or support the success of, subsequent surgery.

In the **absence of** skin damage or an imminent risk to skin integrity, primary care clinicians should only refer for an opinion, and surgeons should only undertake surgery, where there is a clear justification for clinical benefit and use of NHS resources.[3]

In light of financial position and capacity issues within the local health economy in 2018 referral for, and surgery for, symptomatic varicose veins without skin damage is not regarded as a priority for use of NHS resources.

Where **clinical signs are mild, conservative management should be undertaken for at least six months** prior to referral into the hospital vascular team, where clinicians believe that such an approach is clinically appropriate, and in the patient's best interest, and that there is **no urgency for surgical intervention**. Patients should be advised to report any worsening of their symptoms.

Conservative management in primary care should include advice on

- the causes of varicose veins,
- the likelihood of progression and possible complications (NICE in 2013 stated "the evidence review for the guideline showed a *lack of high-quality evidence on the progression of varicose veins* from [mild] (CEAP[9] stage C2 or C3) to more serious varicose veins disease[1])
- Patient Reported Outcome Measures for Varicose Vein Surgery. In 2013/14 nationally only 52% of patients reported an improvement in their health status as measured by the EQ5D tool; although 84% reported improvement using the Aberdeen Varicose Vein Questionnaire, only 40% reported improvement using the EQ-VAS score.
- The following should be recommended for those who do not have signs of skin damage or those who do not wish to undergo surgery.
    - Increasing activity such as walking and more vigorous exercise when possible
    - Weight loss where needed, aiming to achieve a BMI of 20-25
    - Avoidance of activities that exacerbate symptoms e.g. prolonged sitting or standing
    - Elevation of the legs when sitting down to increase venous return
    - A trial of compression hosiery to relieve oedema (leg swelling) associated with varicose veins (especially in pregnancy). In 2013 NICE recommended research was needed to ascertain the clinical and cost effectiveness of compression hosiery versus no compression for the management of symptomatic varicose veins[1].

Vale of York and Scarborough and Ryedale CCGs commission referral to a secondary care vascular service for patients with

- Symptomatic primary or recurrent varicose veins **and** clinical signs such as oedema (in the absence of other causes), changes in skin and subcutaneous tissue: eczema, lipodermatosclerosis or atrophie blanche, healed or active venous ulcers

NHS Vale of York and Scarborough and Ryedale CCGs do not routinely commission Transilluminated Powered Phlebectomy or Endovenous Mechanochemical Ablation (NICE IPG37 and IPG435) to treat varicose veins, due to inadequate evidence on the safety and efficacy of these techniques[4, 5].

NHS Vale of York and Scarborough and Ryedale CCGs commission surgical treatment for varicose veins as detailed above if

- the pathway has been clinically evidenced as being followed and there is justification for prioritising NHS resources for treatment and

- after clinical assessment including duplex ultrasound confirmation of the diagnosis of varicose veins and presence of truncal reflux (venous blood flowing backwards due to valves not working properly),

NHS Vale of York and Scarborough and Ryedale CCGs only commission the following surgical treatment:

1. First line: endothermal (radiofrequency) ablation **without** removal of varicosities[6, 7].
2. Second line: Ultrasound guided foam sclerotherapy **without** removal of varicosities[8].

Surgery to remove superficial varicosities (phlebectomies) is NOT routinely commissioned. NICE stated in 2013 'There is limited evidence on the use and timing of tributary treatments after truncal endothermal ablation. There is a need for practice to be based on empirical evidence from a large and sufficiently powered RCT comparing all 3 main intervention options (no tributary treatment, concurrent tributary treatment and delayed tributary treatment). NICE reviewed studies published between 2013 and 2016 and reported that none of the new evidence considered in surveillance of [the 2013] guideline was thought to have an effect on current recommendations[1, 2].

Removal of varicosities (phlebectomies) are commissioned when:

- there has been a history of significant bleeding from the varicosities **OR**

- there is anterior thigh vein incompetence and the incompetent trunk is too tortuous for endothelial ablation. Where possible patients should have proximal ablation and sequential avulsions if skin complications are present **OR**

- large (>1cm) varicosities are present in association with truncal incompetence and perforator disease in the calf or thigh. Ultrasound measurement of varicosities, demonstration of truncal incompetence, and presence of perforators needs to be recorded and stored for medico-legal and audit purposes.

All patients are expected to be treated under **local anaesthetic** unless there are clinical reasons why this is not appropriate, e.g.

- Three or more truncal veins require treatment
- For high tie and stripping of a Saphena Varix or a large (>2cm) Greater Saphenous Vein where radiofrequency ablation and foam sclerotherapy are not suitable.
- Patients in whom a large number of phlebectomies are needed AND the phlebectomies are commissioned (as defined above) AND the use of local anaesthesia would risk toxicity.

Treatment in all other circumstances is not routinely commissioned and should not be referred unless clinical exceptionality is demonstrated and approved by the Individual Funding Request

	panel. Patient preference for general anaesthesia without exceptional factors, as agreed by IFR, is not an appropriate use of NHS resources
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 ones 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	September 2018
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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. Surveillance report 2016 – Varicose veins in the legs (2013) NICE Guideline CG168 (published 4/2/16)

3. Paragraph 18 GMC Good Medical Practice, 2013

4. NICE IPG 37 (2004) Transilluminated powered phlebectomy for varicose veins

5. NICE IPG 435 (2013) Endovenous mechanochemical ablation for varicose veins

6. NICE IPG 8 (2003) Radiofrequency ablation of varicose veins