



## Appendix 7c

### Varicose Veins Task and Finish Group meeting, 3 May 2018

#### Notes of key discussion points

#### Task and Finish Group members

Attendees:		
Stella Vig	Vascular Consultant Surgeon & Clinical Director for Surgery	SWL
Sophie Renton	Consultant Vascular Surgeon	NWL
Vimple Bhalani (Chair)	GP and Clinical Lead Bexley CCG	SEL
Clare Jarman	GP and Clinical Lead Hammersmith and Fulham CCG	NWL
Nikesh Dattani	GP and Clinical Lead, Barnet CCG	NCL
Andrew Rixom	Consultant in Public Health, Barking & Havering	NEL
Priscilla Baines	Board member and Co-vice-chair, Lambeth Patient Participation Group Network	SEL
Apologies		
Dino Pardhanani	GP and Clinical Lead Sutton CCG	SWL

#### Also in attendance:

Stephen Black	Consultant Vascular Surgeon	SEL
Joseph Shalhoub	Consultant Vascular Surgeon	NWL
Taha Khan	Post-CCT Deep Venous Fellow	SEL
Jane Halpin	Director	Deloitte
Ronen Gordon	Senior Consultant	Deloitte
Danny Batten	Acting Director of Transformation and Delivery (NEL)	NHSE (London)
Mandip Korotana	Programme Manager	Healthy London Partnership
Kunle Awosanya	Project Manager	Healthy London Partnership

#### 1. Welcome from Vimple Bhalani, Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair confirmed:

- The meeting was quorate.
- It was noted that Vimple Bhalani has a private aesthetic clinic treating various cosmetic issues not related to varicose veins.
- Joseph Shalhoub declared that he was a vascular surgeon treating individuals with venous disease.

## 2. Presentation of the evidence review from Jane Halpin and Ronen Gordon

Colleagues from Deloitte presented the draft evidence review which had been circulated in advance to Task and Finish Group members. They confirmed that it is not a NICE level review, it is a review of the available evidence and existing policies in London, to support the development of a common approach across London. NICE guidelines (2013) on the management of varicose veins, reviewed in 2016, and the evidence behind these guidelines were reviewed, alongside any recent evidence.

The core search questions for the evidence review, as agreed by the Task and Finish Group are:

- What are the key clinical criteria (e.g. eczema, ulcers, infection) for which the evidence shows value treating the varicose vein?
- Does the evidence describe specific parameters of these criteria where therapeutic value is achieved? (e.g. length of time for ulcer to heal, number of episodes of thrombophlebitis)
- Are there any comorbid conditions that would indicate varicose vein intervention?
- Does the evidence document an appropriate scoring system for severity of varicose veins within clinical practice?
- Does the evidence document the most appropriate treatment pathway i.e. endothermal ablation, followed by sclerotherapy?

## 3. Discussion on the evidence: is it robust and of high quality?

The key discussion points were as follows:

- A new Level 1 trial was published last week in the NEJM (Gohel et al) on venous leg ulcers and should be incorporated into the evidence review.
- There is some research on a correlation between venous leg ulcers and obesity, so advice on weight management should be offered.
- There is conflicting evidence on treatment and vein diameter. There are patients with large varicose veins without any symptoms and vice versa. The Group agreed that there is too much variability and diameter is not a good indicator or marker for treating varicose veins. It is not used in clinical practice by surgeons when treating varicose veins.
- NICE recommends duplex scanning and there was no further evidence on this in the 2016 NICE review. Discussion clarified that duplex scanning was an important part of planning surgical treatment but was unlikely to be of benefit in primary care management of varicose veins.
- There is a lot of subjectivity around 'pain' and 'function', and the definitions for these symptoms are not standardised across the evidence base reviewed.
- The Group agreed that it can be difficult to identify those patients who are having significant quality of life issues so they can be treated, as opposed to patients who want treatment for varicose veins for cosmetic reasons.
- It was highlighted that East Midlands has had a policy in place for a decade that restricts referral and intervention to essentially CEAP C4/5/6. This has not been associated with an increase in varicose ulcers. There were differing views on whether sufficient follow up had been carried out on those not being treated.
- The Group acknowledged that there are a range of different scoring systems in use to assess severity which have been developed in order to support research trials. All have limitations in

measuring quality of life. The most commonly used are CEAP, VCSS and AVVQ and the most frequently used of these is the CEAP classification.

- Different parts of London are using different approaches to scoring systems, and have also adapted these to try and tackle the quality of life issue.
- It was also noted that some scoring systems are quite onerous as they have been developed for use in research, rather than in clinical practice.
- Given this, the Group agreed, that in the absence of a proven “best” approach, they would support the use of the relevant descriptors from the “Clinical” scale from CEAP (grading from 1-6) alongside criteria developed from standard good practice, in order to support appropriate access to treatment.
- The treatment hierarchy in NICE guidelines is widely accepted and not disputed.
- There is some evidence to suggest endothermal ablation could be superior, but not enough randomised control trials to support this at present.

The Group agreed that they were satisfied with the evidence review, subject to the inclusion of the recently published research, and happy to proceed on this basis given there was a need for consistency across London. It was noted that there were limitations to the available evidence in some areas.

#### 4. Drafting the London policy

In terms of the **presentation of the policy**, the Group discussed and agreed the following:

- The referral criteria should be clear and easy to implement and abide by.
- The language used should be commonly understood across primary and secondary care.
- It should be made clear that the policy is about treatment criteria as well as referral criteria.
- Referral criteria need to be clear so that only patients appropriate consideration of surgical treatment are referred to secondary care, as patient expectations are difficult to manage if they have to be referred back to primary care.
- The relevant descriptors of the CEAP scoring system should be put into words as this is more accessible for primary care clinicians.
- The policy should include a general guideline on lifestyle management such as smoking and BMI, in line with the other London policies being drafted.

In terms of the **clinical criteria**, the Group discussed and agreed the following:

- An appropriate scoring system:
  - There was concern that any scoring system should not exclude people who have disabling symptoms that prevent them from working or carrying out their caring responsibilities.
  - It was agreed that there should be a simple scoring system that includes quality of life criteria, and was not overly onerous.
  - The Group agreed that CEAP is the most easily applicable tool and widely used classification. The “C” element (Clinical) is easy and quick to apply, straightforward and reproducible.

- The Group agreed that C of CEAP would be added to the policy to accommodate quality of life.
- The threshold for treatment using the C of CEAP score:
  - The Group agreed that those with a C of CEAP score of 4 or above should receive treatment, and clinical judgement was required for those patients with a C of CEAP score of 2 or 3, as this is when quality of life factors come into play.
- The Group agreed that CCGs will fund treatment for varicose veins when the patient meets the following criteria:
  - Patient presents with varicose veins with skin changes (CEAP score of 4 or above) which includes varicose eczema, lipodermatosclerosis or a venous ulcer (which is a break in the skin below the knee that has not healed within 2 weeks) or a previously healed venous ulcer  
OR
  - Patient presents with varicose veins with oedema (CEAP score of 2 or above) AND they have ALL THREE of the following:
    - Oedema above the ankle in the affected leg(s)
    - Severe daily pain affecting activities of daily living (including aching, heaviness, soreness and burning)
    - Varicose veins involving the calf and thigh
 OR
  - Patients have one documented episode of superficial thrombophlebitis above the knee [referred urgently] or two documented episodes of superficial thrombophlebitis below the knee.  
OR
  - Patients experiencing spontaneous bleeding should be referred urgently.
- The issue of lifestyle factors was discussed. Some members stated that there is no evidence to support that recurrence of varicose veins after surgery differs between patients of normal weight or above; however obesity is associated with higher rates of progression to ulceration. There are risks associated with smoking related to surgery given that general anaesthetic is used. It was acknowledged that some CCG policies refer to BMI and weight management. It was therefore agreed that the pan-London policy should indicate offering support as follows:
  - Advice is offered for people with varicose veins including: weight loss (if they have a BMI >30), light to moderate physical exercise, avoidance of factors that make symptoms worse and when to seek further medical help.
  - Smokers considering surgical treatments encouraged to attend smoking cessation services, ideally to be able to quit at least 12 weeks prior to surgery.
- The Group agreed that CCGs should not fund treatment in the following circumstances:
  - Patients with no symptoms or skin changes associated with venous disease
  - Patients whose concerns are cosmetic including telangiectasia and reticular veins
  - Patients with mild symptoms including itch, ache, mild swelling, minor changes of skin eczema and haemosiderosis
  - Pregnant women presenting with varicose vein should be given information on the effect of pregnancy on varicose veins. Interventional treatment for varicose veins during

pregnancy should not be carried out other than in exceptional circumstances.

Compression hosiery should be considered for symptom relief of leg swelling associated with varicose veins during pregnancy.

- It was agreed that duplex scanning should happen in secondary care, before treatment, as follows:
  - Duplex Doppler ultrasound is recommended in all patients with lower limb symptoms thought possibly to be due to venous disease as it is necessary to confirm the diagnosis and plan treatment. Offer endothermal techniques e.g. endothermal ablation and endovenous laser treatment of the long saphenous vein as a first line treatment;
  - If endothermal ablation is unsuitable, then offer ultrasound-guided foam sclerotherapy;
  - If ultrasound-guided sclerotherapy is unsuitable, offer surgery.
- There was a discussion about whether there should be reference to whether one leg is treated during one procedure or whether both legs can be treated at the same time. It was agreed that there should be no reference made on treating both legs within the same procedure, as there are multiple factors that impact on this clinical decision.
- The role of glue in treatment was also discussed, but the group did not feel this needed to be added to the policy at this stage.

## **5. Review of the draft policy (statements above) against the ethical application sheet**

The statements and process were reviewed against the key principles and considerations of the ethical framework. The group agreed that decisions were:

- Rational: within the limits of the available evidence
- Socially inclusive: the draft policy does not discriminate any particular groups. Patient information materials were also discussed.
- Clear and open to scrutiny
- Economic factors had not entirely been taken into account. There is not a lot of evidence on cost, and it was acknowledged that this policy may increase costs for some CCGs who currently have stricter criteria. The Group discussed the difference between cost effectiveness and affordability.
- Promote health: the policy will include information on lifestyle factors. The group acknowledged that NICE stipulates that the patient should be engaged in the shared decision making and informed about the treatment, risks and lifestyle.

## **6. Next steps**

The draft policy and notes of the meeting will be circulated, for final comment and virtual sign off.