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UK's neglect of venous disease must be reversed

Better access to cost effective treatments would improve many lives ***[OK? We need a short declarative title/subtitle combination summing up your arguments]***

Bruce Campbell,[1] honorary consultant, Daniel Carradice, senior lecturer

[1]Royal Devon University Healthcare Trust, Exeter, UK

[2]Hull York Medical School, Hull, UK

Correspondence to: B Campbell bcam13wr@gmail.com

High quality evidence clearly supports the treatment of common venous diseases. Treatment of symptomatic varicose veins improves quality of life and is highly cost effective,[1-4] while early treatment of venous leg ulcers speeds healing, reduces recurrence, and potentially reduces costs.[5-8] Despite this strong evidence, and National Institute for Health and Care Excellence (NICE) guidance recommending referral of people with symptomatic primary or recurrent varicose veins,[2] access to treatment for symptomatic varicose veins is restricted in much of the UK and people who develop leg ulcers experience delay in getting the treatment they need for underlying venous disease.[9 10]

Preventing and treating leg ulceration is perhaps the most pressing issue. The importance of early referral and specialist treatment was highlighted in the 2019 report of the All Party Parliamentary Committee on Vascular and Venous Disease, *Venous Leg Ulcers: a Silent Crisis*.[10] Community treatment of venous leg ulcers costs the NHS £1bn-£2bn annually, much of which could be saved by correcting the causative venous hypertension in underlying varicose veins.[8] Recognising venous skin damage—eczema, lipodermatosclerosis, pigmentation—and treating the veins before ulcers develop is recognised as particularly important,[11] and guidance from the Venous Forum of the Royal Society of Medicine recommends that anyone who develops a leg ulcer should be seen by a vascular specialist within two weeks.[12]

Unfortunately, no meaningful progress has been made on meeting the parliamentary committee's 2019 recommendations, or those in its 2023 report,

Future of Venous Disease: Growing Problems, Shrinking Workforce.[13] The recommendations include developing an appropriate vascular workforce plan, with more vascular trainees; delivering education programmes in primary and community care; and ensuring that local NHS providers prioritise staff and resources to diagnose and treat **[diagnose and treat?]** venous disease.

Similar problems exist for symptomatic varicose veins. An estimated 40 000 people a year in England were unable to access NICE recommended treatment for symptomatic varicose veins during 2017-9, with an estimated net cost to the health economy of £164-174m.[9] Access to treatment varied widely across England. Restrictions and delays in treatment have been worsened by the covid-19 pandemic.

Once referred to a vascular service, patients have clinical assessment and imaging of their veins by duplex ultrasonography. Treatment is almost always "minimally-invasive," sealing off incompetent truncal veins using thermal energy (radiofrequency, laser); foam sclerotherapy; or bioadhesive glue. All are possible under local anaesthetic, as is concomitant removal of varicose veins (phlebectomies). These treatments are all supported by high quality randomised controlled trials.[2-5 14 15]

Improving access

In a health service beset by financial difficulties and delays, providing clinically and cost effective treatments should be a priority. This is especially true for venous ulcer disease, for which treatment is highly cost effective over one year and cost saving beyond this.[16 17] Uncomplicated but symptomatic varicose veins are more of a dilemma, because they are so common: difficulty balancing cost effectiveness against the affordability of treating large numbers of people is the key reason for current restrictions in referral and treatment.[9 18] Vascular services are commonly overstretched, with life and limb threatening arterial disease taking priority over venous disease.

One possibility is to train more specialist nurses to treat superficial symptomatic varicose veins, and a recent report from the Society for Vascular Nurses[19] details the training and governance required. Controversy continues about the benefits and risks of this option, however, especially in accountability for adverse events, and the potential adverse effect on vascular surgical training. Published evidence about the outcomes of vein treatment by non-medical practitioners is currently lacking.

Alternatively, greater capacity for managing the whole spectrum of venous disease, including an increased focus on deep veins (such as stenting of iliac veins,[20-22] and endovenous thrombectomy or thrombolysis for deep vein thrombosis[24 25]) could be achieved by appointing more vascular specialists, encouraging more to develop a "special interest" in venous disease, and requiring all vascular surgeons to devote part of their job plans to venous disease. Finally, a new discipline devoted to venous disease ("phlebology") could also be considered, as in many other countries such as Germany and France **[correct?].**

The burden of venous disease and the challenges in tackling it are considerable. Over one third of adults have varicose veins; treatment of venous ulcers currently costs the NHS at least £1bn annually; and many people with occlusive disease in their deep veins do not have access to treatment. All these conditions reduce patients' quality of life and could be avoided or successfully treated by improvements in the delivery of venous services.

Policy makers, healthcare commissioners, and clinical leaders should urgently review and implement the recommendations in both All Party Parliamentary reports. Increased awareness in community settings about when to refer and improved service design in secondary care are needed, supported by the required funding, to tackle the serious, longstanding, and well documented deficiencies in the care of people with venous disease and widespread variations in their access to treatment.

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Please check order of refs

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