Uncomplicated varicose vein surgery in the UK – a postcode lottery?

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ABSTRACT

INTRODUCTION Recent research confirms that uncomplicated varicose vein surgery provides significant benefits in terms of quality of life compared to conservative treatment at a relatively small cost. There appear to be major variations in indications for treating varicose veins across the UK and this seems to be based mainly on financial restraint imposed by local Primary Care Trusts (PCTs). This survey was aimed at quantifying this variation.

MATERIALS AND METHODS An E-mail questionnaire was sent to 245 surgical members of the Vascular Society of Great Britain and Ireland across the UK. The main questions asked were aimed at finding out whether surgeons were having any restrictions imposed on them by their local PCTs with regard to treatment of varicose veins.

RESULTS A total of 109 surgeons replied (44% response rate). Of these, 64% of surgeons had restrictions set upon them by their local PCTs; however, 62% of surgeons under restrictions still offered surgery for symptomatic uncomplicated varicose veins. Restrictions varied from 100% to 0% across different regions in the UK.

CONCLUSIONS Many patients are denied surgical treatment for their symptomatic uncomplicated varicose veins according to where they live in the UK regardless of their symptoms.

KEYWORDS

Varicose vein surgery - Audit – E-mail survey

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A significant proportion of the adult population in industrialised countries is affected by varicose vein disease. The Edinburgh Vein Study, a cross-sectional survey of a random sample of the Edinburgh population, showed that 40% of men and 30% of women aged 18–64 years had varicose veins.¹ In the UK, the treatment of varicose veins and their complications used to consume about 2% of the total NHS budget.²

Health rationing began in the mid-1990s with some common treatments being singled out for exclusion, including the treatment of varicose veins (10 out of 129 health authorities in England, Scotland and Wales).³ Exclusion criteria varied widely between areas.³ The presence of varicose veins rarely presents as a significant medical problem; despite this, their presence can have a significant impact on quality of life.⁴ Two recent trials showed that surgery for uncomplicated varicose veins provides significant benefit over conservative treatment in terms of health status, quality of life and patient satisfaction at a relatively small cost.^{5,6} Therefore, should surgical treatment be rationed and, if there

is rationing, to what degree is this taking place across the UK? The aim of this study was to answer these questions.

Materials and Methods

An E-mail questionnaire was sent to 245 surgical members of the Vascular Society of Great Britain and Ireland. Members residing in the Republic of Ireland (because of differences in the provision of healthcare), retired surgeons and those with no traceable E-mail address (78 surgeons) were excluded. The E-mail addresses were obtained from the 2005 Year Book of the Society. Two E-mail reminders were sent to non-repliers.

The questionnaire was a simple 'Yes' or 'No' questionnaire designed to enquire about the surgeons' NHS practice in terms of treating uncomplicated symptomatic varicose veins (unsightly or aching) and veins with complications (ulcers/bleeding/recurrent phlebitis/skin changes). Surgeons were also asked if any restrictions were imposed

Table 1 Regional details

Region	Hospitals	Surgeons	Surgeons reporting restrictions	Surgeons agreeing to restrictions	Surgeons performing sclerotherapy	Surgeons performing uncomplicated vein surgery
Eastern	11	11	10 (91)	6	0	3 (30)
London	7	9	7 (78)	2	2	6 (67)
North Ireland	3	4	0 (0)	0	0	4 (100)
North West	7	9	0 (0)	0	4	9 (100)
Northern and Yorkshire	8	12	2 (18)	1	7	10 (83)
Scotland	5	7	4 (57)	3	2	4 (57)
South East	12	12	11 (91)	2	1	5 (45)
South West	12	16	16 (100)	3	2	6 (33)
Trent	8	11	7 (70)	2	1	6 (45)
Wales	5	9	5 (62)	4	2	9 (100)
West Midlands	6	9	8 (89)	2	0	6 (67)
Total	84	109	70 (64)	24 (34)	20 (18)	68 (62)

Figures in parentheses are percentages.

by their local Primary Care Trusts (PCTs). If there were any restrictions, the surgeon was asked whether she or he agreed with these restrictions.

Results

A total of 109 surgeons replied (44% response rate). The surgeons represented 84 hospitals across the 11 UK health regions. All surgeons operated on complicated varicose veins with no restrictions. Seventy surgeons (64%) reported restrictions on interventional treatment (surgery or sclerotherapy) for uncomplicated varicose veins imposed by local PCTs. Of these surgeons, 24 (34%) thought that these restrictions were justified.

The presence of restrictions for the treatment of uncomplicated symptomatic varicose veins varied considerably across the UK ranging from no restrictions at all in the North West and Northern Ireland to 100% of surgeons reporting restrictions in the South West. Despite these restrictions, 62% of surgeons under restrictions would still consider operating on uncomplicated symptomatic varicose veins depending on the particular patient. Regional details are presented in Table 1.

Discussion

There are no published E-mail surveys relating to vascular surgery. Previous research into the response rate of E-mail

surveys of healthcare professionals range from 9% to 94%, reaching higher response rates with up to five follow-up reminders.⁷ A response rate of 44% in this study was considered reasonable since all the regions were evenly represented.

There has been no survey, to date, investigating the presence of rationing as pertains to varicose veins or, indeed, if rationing is present, except for a postal survey for the indications of sclerotherapy,⁸ and whether rationing has changed surgeons' practice when it comes to uncomplicated symptomatic varicose veins.

It is obvious from this survey that rationing of treatment of uncomplicated varicose veins is wide-spread across the UK. The National Institute for Health and Clinical Excellence (NICE) guidelines for varicose vein referral are flexible enough for general practitioners (GPs) to exert some clinical judgement as to when to refer patients for surgery,⁹ but this is determined more by the local PCTs protocols. GPs may, however, actively promote symptoms such as phlebitis in order to get the patient seen in secondary care due to patient pressure. It is then down to the surgeons themselves to enforce the restrictive practice laid down by the PCT protocols. It is also obvious from this survey that some surgeons try to work around these restrictions according to the clinical need of the patient, as evident from the percentage of surgeons still performing surgery for uncomplicated varicose veins in regions where rationing has occurred.

There has been continuing research into the relevance of symptoms attributed to uncomplicated varicose veins and the benefits attained by surgery over conservative measures in their treatment. A number of studies, including two recent well-constructed randomised trials, provide some re-assurance that standard surgery for uncomplicated varicose veins provides significant benefit in terms of quality of life at a relatively small cost.^{5,4,10–15}

Conclusions

On the basis of this E-mail study, rationing of treatment for uncomplicated symptomatic varicose veins is wide-spread, and is regionally dependent. It seems inappropriate that this diversity of treatment depends on which area of the country one lives. Surely, it is time for a nationally agreed policy on NHS treatment of symptomatic varicose veins, and that this should be accepted by the PCTs and not altered for local financial reasons.

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