COMMENT ON

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AG Edwards, S Baynham, T Lees, DC Mitchell. Management of varicose veins: a survey of current practice by members of the Vascular Society of Great Britain and Ireland. *Ann R Coll Surg Engl* 2009; **91**: 77–80

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Changing practice from conventional surgery to endovenous treatments produces excellent results for both long and short saphenous varicose veins

SHIVA DINDYAL, KENNETH R WOODBURN

Department of Vascular Surgery, Royal Cornwall Hospital NHS Trust, Treliske, Truro, UK

CORRESPONDENCE TO

Shiva Dindyal, Department of Vascular Surgery, Royal Cornwall Hospital NHS Trust, Treliske, Truro, Cornwall TR1 3LJ, UK
E: doctordindyal@hotmail.com

This questionnaire study revealed a rationing of access to care of symptomatic varicose veins and that the majority of responders performed conventional surgery on the NHS. We agree with the findings of this study that endovenous treatments of superficial venous reflux are not yet widely available in NHS practice.

We have established an NHS day-case local anaesthetic endovenous service. Our initial experience with these techniques and their outcomes have consequently changed our venous practice overall.

All patients undergoing endovenous surgery (endovenous laser ablation [EVLA], radiofrequency ablation [VNUS closureFAST], or ultrasonography-guided foam sclerotherapy) by a single surgeon were entered into a venous database. Post-procedure clinical and venous duplex assessments were undertaken following treatment for all of our patients.

A total of 280 patients (334 limbs) underwent endovenous surgery and follow-up from April 2006 to June 2008. There were 227 women (81.1%) with a mean age of 57 years (range, 24–88 years). Of the study cohort, 144 had EVLA (110, long saphenous vein [LSV]; 34, short saphenous vein [SSV]), 153 had VNUS (123, LSV; 26, SSV; four perforators) and 37 had ultrasonography-guided foam sclerotherapy alone or in combination (26, LSV; 7, SSV; four perforators).

Clinical and duplex follow-up at a median of 24.3 weeks (range, 5–48 weeks) confirmed successful ablation in 96% of LSV and 97.3% of SSV and 100% of perforators treated. Twelve of 334 (3.6%) limbs required repeat treatment. Two patients had a presumed embolic phenomenon, a transient visual disturbance and a headache.

These preliminary results confirm the early success of endovenous treatment of the long saphenous system (96% success) and indicate that these results can be replicated in the short saphenous system (97.3% success). These data support the view that endovenous treatment of varicose veins is superior to the reported results for conventional surgery in the short-term; long-term data are awaited.

Consequent on establishing an endovenous service, we have observed a large increase in the number of patients whose venous disease meets locally agreed criteria being referred for treatment. Preliminary costings, however, indicate that endovenous treatments generate a financial surplus when re-imbursed at tariff (Q11), as a result of reduced requirement for anaesthetic and theatre resources, with consequent cost benefits for our NHS trust. It remains to be seen whether or not this increased demand for a successful ambulatory treatment for a condition that is frequently perceived to be low priority by primary care trusts, will result in further restriction of access to these treatments for NHS patients.

COMMENT ON

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I Mitra, T Malik, J Homer, S Loughran. Audit of clinical coding of major head and neck operations. *Ann R Coll Surg Engl* 2009; **91**: 245–8

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Improving clinical coding accuracy

ESMOND CARR, ASHA PILLAI

Department of ENT Surgery, West Middlesex Hospital, Middlesex, UK

CORRESPONDENCE TO

Esmond Carr, Department of ENT Surgery, West Middlesex Hospital, Twickenham Road, Isleworth, Middlesex TW7 6AF, UK
E: esmond@doctors.org.uk

This audit highlights three main areas of concern under the new Payment by Results system – the inaccurate coding, the overly complex coding system and the inappropriate HRG rating for some procedures. We were, however, disappointed that the authors did not have any intervention to suggest to improve things. We feel that it is the clinicians' responsibility to make sure that their activity is properly coded and the NHS trust's responsibility to make sure that changes happen to make sure that there is appropriate payment for procedures.

In a previously published audit,¹ we increased the accuracy of coding from 69% to 95% in a single cycle. This was done by:

1. Agreeing between consultants and the coding department on how different procedures should be coded.

2. Educating clinicians on the importance of coding and making them responsible for coding their procedures.
3. Weekly meetings between the coding department and a clinician to discuss difficult cases and educate the department on different procedures.

By addressing these fundamental areas of coding, we were able to produce a significant difference in coding accuracy.

Reference

1. Carr ERM, Pillai A. Audit of coding of operations. *Clin Governance Bull* 2007; 6: 20–1.

AUTHOR'S RESPONSE

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INDU MITRA

CORRESPONDENCE TO

Indu Mitra, E: indu_miyta@hotmail.com

We agree with the suggestion of close co-operation and communication between surgeons and clinical coding administrative staff for improved accuracy of clinical coding systems. The findings of their audit are reassuring. However, of note, is the issue of the increased time commitment required on the part of the surgeons in fulfilling these suggestions.

COMMENT ON

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C Brown, AR Naylor. Improving the provision of carotid endarterectomy in line with UK Government targets requires more than just motivated surgeons. *Ann R Coll Surg Engl* 2009; 91: 326–9

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Improving access to expedited carotid endarterectomy

KATIE J ADAMS, ALOK TIWARI, JONOTHAN REFSON, AHMED ABIDIA
Department of Vascular Surgery, Princess Alexandra Hospital,
Harlow, Essex, UK

CORRESPONDENCE TO

Katie J Adams, Department of Vascular Surgery, Princess Alexandra Hospital, Harlow, Essex CM20 1QX, UK
T: +44 (0)1279 444455; F: +44 (0)1279 827071;
E: kjadams@btinternet.com

We would like to highlight that, although the new UK National Institute for Health and Clinical Excellence (NICE) guidelines for reducing waiting times aim for a 2-week

turnaround time, many primary care trusts, including ours, have shortened this time further, in line with the national stroke strategy guidelines,¹ to only 48 h from time of symptoms to surgery. This will require a more co-ordinated process of disease detection and surgical provision, beyond that suggested in this article.

In our trust, we have started to run a transient ischaemic attack (TIA) clinic every day with ring-fenced duplex slots. If a patient has a significant stenosis, our stroke physicians will admit the patient on that day, organise an MRI (also ring-fenced) and refer immediately to us for assessment. This reduces any delay in booking patients for admission through the normal channels. Carotid endarterectomy is then performed in emergency theatres. This avoids knock effects for 18-week targets for patients who would otherwise be cancelled. Although we realise that this model needs to be improved upon, it provides a way to move towards attaining the 48-h target for treatment.

Reference

1. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062 [Accessed 6 May 2009].

AUTHOR'S RESPONSE

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A ROSS NAYLOR

Department of Cardiovascular Sciences, Leicester Medical School,
Leicester Royal Infirmary, Leicester, UK

CORRESPONDENCE TO

A Ross Naylor, Consultant Vascular Surgeon, Leicester Medical School, Leicester Royal Infirmary, PO Box 65, Leicester LE2 7LX, UK
T: +44 (0)116 2523252; F: +44 (0)116 2523179;
E: ross.naylor@uhl-tr.nhs.uk

As the authors will have noted, the concluding section of the discussion section in our paper anticipated most of the beneficial changes in practice you highlight, including daily TIA clinics, immediate transfer of patients to the surgical unit, inter-consultant transfer of patients, *etc.* The only difference seems to be your preference for performing expedited carotid surgery in the emergency theatre, while we prefer to allocate two 'ring-fenced' half-day lists per week in the vascular theatre. The latter ensures access to experienced vascular anaesthetists and theatre staff. Since our paper was published, approximately 75% of all symptomatic patients currently undergo surgery within 14 days of the index event.

A much bigger problem is that there is still much public ignorance about the importance of presenting early. The best way of addressing this issue would be to have someone