PANEL DISCUSSION

Varicose Veins: Addressing Key Patient Questions

Approaches to answering questions from patients seeking varicose vein treatment, navigating challenging scenarios related to social media and Google searches, patient safety fears during the pandemic, and more.

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What is the hardest question patients seeking treatment for varicose veins ask, and why? How do you reply?

Prof. Uthoff: For me, it is always hard when patients ask if they will be cured of varicose veins after the offered treatment. It is not easy to scale down patient expectations and confess that there is currently no treatment that definitively cures varicose veins. I then try to explain that varicose veins and associated symptoms are clinical manifestations of a predominately genetically determined disease. Although I cannot offer "final cure by gene therapy," I assure the patient that by using the latest minimally invasive, state-of-the-art treatment options, we can effectively reduce symptoms (ie, leg heaviness), control the risk of complications (ie, ulcer), and improve aesthetic aspects as needed. Of course, some patients are disappointed to hear there is no final cure. Nevertheless, in my experience, explaining the true "nature" of varicose vein disease and its realistic treatment options builds trust and facilitates a good long-term doctor-patient relationship, even in the setting of recurrent varicosis.

Dr. Gohel: Any discussion about treatment should include an explanation about the natural history of the disease. However, with varicose veins, it is often difficult to explain what will happen if they *do not* have venous intervention. There are few high-quality, longitudinal studies mapping the progression of disease. Therefore, questions about the risk of developing ulcers or skin changes are the hardest to answer.

I am very honest with patients about the lack of clear evidence regarding disease progression, but I explain that age and obesity are clear risk factors for developing more advanced venous disease, including ulceration.

Dr. Elias: I don't think any question regarding vein disease is hard to answer. Everything should be answered honestly. For some patients, the honest answer may be hard to hear. As The Hold Steady sings in the song "Soft in the Center," "You can't tell people what they want to hear/If you also want to tell them the truth." So, the hardest questions tend to be those such as, "Can you make these veins disappear?" or "These veins won't come back, will they?" or "What can I do to stop my veins from getting worse?" Setting expectations regarding all these questions can be "hard" at times. Vein disease is an incurable disease. We need to help patients understand this so they recognize what can be accomplished and what can't. In fact, occasionally if I get the sense that a patient has totally unrealistic expectations, I may encourage conservative treatment alone and not a procedure.

Dr. Brown: One of the most difficult questions I get in my vein clinic is from patients with recurrent venous ulceration who have been compliant with compression and have

no superficial reflux to treat. They want to know why their ulcer is recurrent despite "doing everything right." Often, these patients are overweight and sedentary. In conjunction with making sure they have no central venous occlusive disease, I have a conversation about lifestyle changes. I have had to recommend bariatric surgery to patients over the years, and these can be difficult conversations to have. One must have compassion and take time to educate the patient about venous disease. I typically let my patients know that venous disease is a chronic disease that we will have to manage throughout their lives.

Dr. Darby: One of the hardest questions I encounter from patients is, "Will treatment of varicose veins and spider veins 'fix' my problem?" Unfortunately, the development of both varicose and spider veins is secondary to genetics, as well as lifestyle situations such as jobs that require standing or sitting for prolonged periods. Treatment will help with current superficial venous issues as well as cosmetic spider veins, but I always remind patients they may potentially develop varicose and spider veins later in life. Treatment is not always permanent, and they may need additional treatments in the future. I encourage patients to follow-up with me every 1 to 2 years to evaluate their legs and any changes that may occur. I also encourage using compression stockings even after treatments to prevent the progression of new varicose veins, especially if they stand or sit for prolonged periods.

The second hardest question is regarding permanent skin discoloration and hyperpigmentation secondary to untreated, long-standing superficial venous insufficiency and history of venous ulcerations. Unfortunately, when skin discoloration happens, it is likely permanent and unlikely to completely improve once superficial venous insufficiency has been addressed. There may be improvement in the discoloration, but complete resolution is unlikely. I try to discuss realistic long-term treatment goals with my patients at the initial visit.

What are one or two questions every patient should ask before having their varicose veins treated?

Dr. Elias: Every patient should ask, "How much will this procedure help me?" and "How long will it take for me to feel and/or see results?" These two questions echo my answers to the first question. If they don't ask these questions, I tell them the answers anyway. Almost any intervention we do takes at least 6 weeks and up to 3 or 4 months for the full effect to occur. Some patients may improve sooner, but this time period applies to most patients. Even though we treat the main underlying pathology (saphenous incompetence, iliac vein compression, etc), all the other affected veins in the leg and pelvis have been "stretched" for years, and it takes time for them to regress. Patients should ask these questions and see if the vein specialist answers them honestly. Treatment results never achieve perfection (I tell patients to expect a 75%-80% improvement at best), but if done for the right reasons on the right patient by the right doctor, the patient and doctor will be happy with the results.

Dr. Gohel: Patients should ask the surgeon what they expect in terms of recovery and cosmetic appearance of the leg after any intervention. When a patient is unhappy with their treatment, there has often been an expectation mismatch between the physician and patient.

Dr. Darby: Pretreatment, patients should ask questions regarding how many treatments may be required for their desired end result and what is involved for treatment. Patients sometimes have expectations of immediate results and improvement, which is not the case with venous procedures. Most venous procedures take at least several weeks, and sometimes months, to notice visual improvement. Veins will actually look worse and turn brown and discolored before disappearing. Having clear communication in regard to the timeline of vein resolution healing is important. Many symptoms associated with venous insufficiency, such as leg swelling, can take months before resolving.

Prof. Uthoff: Every patient should ask which alternative treatment options exist and what to expect when the offered treatment is delayed/declined. If in doubt of the diagnosis and offered treatment, patients should ask for a copy of the written ultrasound report before any treatment; the reported findings are essential and should mirror the offered treatment plan.

Dr. Brown: Every patient seeking venous care should ask about all options of venous care. They should know about all their options, including conservative versus surgical or endovascular treatments. They should also understand the risks and benefits of each treatment, the recovery and follow-up expectations, why those treatments are being suggested, and what outcomes they can expect. Be wary of guarantees or promises of a "quick fix."

What should prompt a patient to seek a second opinion?

Dr. Darby: A patient should look for a second opinion if they are not comfortable with the physician they see or the treatment that is recommended. If at any time a patient

feels "uncomfortable" with their care or what a provider suggests, that may be an indication to get a second opinion. Most venous procedures are elective, noninvasive, with limited downtime, and I always encourage my patients to feel completely comfortable before proceeding with any intervention.

Dr. Brown: I recommend that patients listen to their "gut." In other words, if you are suspicious, feel uncomfortable, or just can't communicate well with your physician, get a second opinion. If you can't get your questions answered or aren't given enough time or opportunity to understand your treatments, get a second opinion. If you feel you aren't being listened to, get a second opinion. The bottom line is, if you think things aren't going the way you feel comfortable with, you should get a second opinion.

Any physician who is doing the right thing will not mind if you get a second opinion, and if your provider gets upset when you ask for another opinion, then you don't want to be with that provider in the first place. Just because you get another opinion doesn't mean you have to go with it. You can still go back to your original provider if you wish.

Dr. Elias: Second opinions should be considered when something doesn't "feel right." I have had patients come to me saying these exact words, or that they were treated as an object and money was the main driver. We also now have good data from studies and registries that most patients average somewhere between 1.5 to 1.8 superficial venous procedures to help them.[1] Patients should seek a second opinion if a physician is laying out a care plan that involves much more than this. We've all seen the patient who has been told they need both great saphenous veins and small saphenous vein treated, excision of varicosities, and multiple sclerotherapy sessions. Patients should also seek a second opinion if the vein specialist doesn't take the time to try to understand what the patient wants accomplished. If they don't listen to the patient and the vein specialist does most of the talking, patients should consider a second opinion.

Dr. Gohel: Treatment of venous disease is much more than a technical activity. The treating clinician needs to have a good understanding of the severity of symptoms, appreciate the impact on the patient's life, and be able to communicate the different management options (including conservative measures). If a patient ever feels pressured into having an intervention, that should prompt a second opinion.

Prof. Uthoff: I would strongly recommend a second opinion when the proposed treatment plan is not discussed based on the results of a dedicated ultrasound workup or if the physician claims there is only one treatment option (ie, due to the large vein diameter only a surgical option is possible). This is never true. In experienced hands, there are always several treatment options, and pros and cons must be discussed.

Have you encountered a scenario in which you disagree with how "Dr. Google" (ie, the top search result) answers a question? What was it?

Dr. Gohel: Dr. Google can be very unhelpful, and I frequently disagree with information that patients have found on the internet. For example, searching for "What is the best treatment for varicose veins?" returns a website advocating sclerotherapy. It can take some time in the consultation to communicate the complexity of treating superficial venous reflux, particularly if patients arrive with a preconception of the gold standard treatment.

Dr. Brown: I haven't come across this scenario exactly, but there are times when I disagree with the treatment plan another physician has outlined for a patient I am seeing for a second opinion. This frequently has to do with how aggressive the physician is regarding treatment, often in a very elderly patient. Typically, I fully explain my rationale to the patient, while clarifying that the other physician's plan was not wrong, but that there are often multiple options when it comes to treating venous disease.

Dr. Elias: The internet is filled with a lot of information, and in general, I encourage patients to google. As Sy Syms, the founder of SYMS discount clothing chain said, "An educated consumer is our best customer." Knowledge empowers people and engenders conversation. In general, I find that Dr. Google focuses on the image and not the patient. Therefore, the question I tend to disagree with most is the one that focuses on a test result and not the patient. Patients will say they have been told they have venous insufficiency or iliac vein compression, and if they don't fix it something bad will happen, such as an ulcer or deep vein thrombosis (DVT). There is a lot on the internet about the terrible things that can happen. For almost all patients with venous disease, we have no data that treatment is required to prevent something. It takes some discussion to dispel this when patients bring up what they have read. Dr. Google doesn't really focus on quality-of-life issues. This type of information may be what venous societies should focus on by appropriate internet messaging.

Prof. Uthoff: Once in a blue moon, patients have read about some less well-established but "incredible, effective, all-natural" alternative treatment option (eg, leech therapy

for varicose veins). Fortunately, discussing the open topics in person is unbeatable. At least in my experience, patients still trust real doctors' opinions and arguments more than those of Dr. Google.

Dr. Darby: This happens frequently as patients try to diagnose and self-treat their problems. In this instance, I remind the patient that the results from typing in key words into a computer don't look at the entire patient or understand and know their ultrasound results and anatomy. Physician experience can never be replaced over self-diagnosis.

How concerned are you with what patients find when they Google you before that first visit? Often, they'll find a Healthgrades or similar rating site or an institution biography with ratings. What effects does this have on how you manage patient discussions?

Dr. Brown: I am not really all that concerned. My hospital does have someone who monitors these sites and disputes comments that are not true. This doesn't affect how I discuss treatments with patients. I try to make sure the patient understands my thought process fully before embarking on a treatment plan.

Dr. Gohel: In general, I support greater transparency in reporting outcomes and patient experiences from treatment. In the United Kingdom, it is mandatory for vascular surgeons to report outcomes after all arterial operations, and this information is publicly available. However, outcomes after venous interventions are difficult to measure. Much like restaurant and other reviews, ratings websites are often biased by selective reporting. I invite patients to judge the service based on their personal experience rather than what they may have read.

Similarly, how do you approach your publicly available profile, such as social media, with prospective patient searches in mind?

Dr. Gohel: Although social media and other online portals may seem private, we must remember that these activities all leave an online footprint that may be used to form judgment of medical professionals. We cannot be naive in this regard. The same professionalism and decency that we display in our hospitals or offices should also be present in social media posts. The online profile also offers an important opportunity to reach out to patients with additional clinical information.

Dr. Darby: Our hospital system is currently working on enhancing social media options for prospective patients. In the past, we have posted videos of our bios and specialty fields of medicine and practice that patients regularly review. I have had numerous self-referrals from new patients who "watched my videos online and were impressed" and "Googled me to look at community reviews." I think it is important to recognize that social media will be an important platform going forward to reach out to the community as well as prospective patients.

Dr. Brown: I don't interact a lot on social media, so I don't have a huge presence. I do try to avoid any posts that could be misconstrued, but that has more to do with my family seeing what I post than anything else!

When it comes to safety during COVID-19, what are patients most concerned about?

Dr. Elias: Obviously, patient concerns during COVID-19 center around safety from contracting the virus. My main office is physically located in the hospital but not anywhere near inpatients. At the onset of COVID-19, we only saw urgent patients (DVT, pulmonary embolism), but we were fully back by mid-May. Since that time, our hospital, my staff, and I have reinforced the message that coming to the hospital for an office visit is safer than food shopping. Everyone (including staff and visitors) has a temperature check and wears a mask. Social distancing is enforced, and surfaces are cleaned. At this point, patients are rarely reticent about coming to see me.

Where we have seen some negative logistical impact is in scheduling and doing procedures. Every patient who will have a procedure at the hospital needs a COVID-19 negative test within 6 days of the procedure. A few patients have tested positive, and their procedure was postponed. Pre-COVID-19, it would be much easier to move someone into that slot, but now there is the impediment of scheduling another patient for a COVID-19 test and obtaining results fast enough to fill that spot. Overall, most of the hospital staff are vaccinated, and many patients will be soon. We hope to never need to deal with this pandemic again and that these questions will never need to be asked again.

Prof. Uthoff: Over time, many patients are less concerned than they were at the start of the pandemic. Patients recognize the established safety precautions in the office and in my experience, very seldom feel the need to wear an FFP2 face mask rather than a normal mask as an additional personal precaution measure.

Dr. Brown: I think patients are most concerned that the appropriate personal protective equipment (PPE) and

social distancing are being followed. Like most practices, we have altered our workflow to minimize the number of patients in the waiting rooms, and we make sure to provide and wear the appropriate PPE. Most of our patients are grateful to finally get their veins treated after we shut down for several months early in the pandemic.

Dr. Gohel: In the United Kingdom, we have had several waves of COVID-19, and patient emotions and concerns have changed over time. The initial widespread fear remains to an extent, but an increasing number of patients are more concerned about the delays to medical treatment for non–COVID-19–related conditions, including venous disease. One of the biggest challenges we face is the safe and efficient restarting of normal clinical services, with appropriate prioritization of severe cases. There is likely to be significant disparity between regions and hospitals depending on the severity of the local COVID-19 case load.

Dr. Darby: Patients are concerned about COVID-19 exposure when coming to doctor visits and appointments. Our hospital institution has many screening measures in place to protect both the providers and the patients. We call the day before with screening questions. Patients have temperature checks and are screened before being allowed to enter our building. We limit visitors and guests as well, and most patients must come alone to our office. All providers, staff, and patients are required to wear masks in the office. We space out chairs in the front lobby as well to maximize social distancing between patients. We have used telehealth visits for patients with possible exposures or those that may be high risk if exposed to COVID-19. I have used FaceTime and other sources to simultaneously communicate with patients and their family members who can't be physically present in the office.

During the pandemic, I think patients are most concerned about coming into contact with staff or other patients who may have unknown COVID-19 exposure. Most are trying to stay home, limit contact, and social distance. However, the distancing and screening measures in place make going to our office safer than going to the grocery store. For the most part, patients have continued to come to office appointments and treatments, but again, our staff and hospital have clearly defined the safety measures we have in place to the community, which reassures most patients. Those still not comfortable with in-office visits either have the option of telehealth visits, phone assessment, or moving their appointment to a later date.

As we cross the 1-year threshold, how would you summarize the impact COVID-19 restrictions have had on your practice, particularly patients' willingness and ability to come to the office for their care?

Dr. Brown: We have made some changes in workflow to minimize the number of people interacting with patients and the number of patients in the waiting rooms. Some patients are postponing vein treatments until the pandemic is over, but most are grateful to get treatment and relief from their symptoms. As time has gone on, patients seem to be more comfortable with masking, handwashing, and seeking treatment. Our volume remains slightly lower than prepandemic, but I believe that is somewhat due to patient reluctance to be seen as well as economic circumstances. We saw a similar decline during the recession, and I expect that volume to come back as economic circumstances improve.

Prof. Uthoff: In spring 2020 during the first lockdown in Switzerland, all practices were obligated to cancel nonemergency treatments. Whereas some patients appreciated this measure because the course of the pandemic and effective safety precautions were largely unclear, many patients would have preferred to have their veins treated due to the quality-of-life impairments they experienced daily.

Fortunately, the established safety precautions have been shown to be effective, and we are now allowed to treat patients during the second lockdown in spring 2021. Patients recognize the professional implementation of safety precautions and appreciate the opportunity to see their doctor.

Dr. Gohel: The impact of COVID-19 on venous practice, both personally and generally in the United Kingdom has been catastrophic. This is primarily because the majority of superficial venous interventions are delivered in hospitals, and both public and private hospitals have been overwhelmed in the pandemic response. Patients have been very understanding, but the growing burden of advanced venous disease, particularly ulceration, is becoming increasingly clear.

However, it may be that despite adversity, we can innovate and develop new models of care for patients with venous disease. The greater use of treatments delivered outside hospitals will be essential as we try to get a grip on the enormous backlog left by a year of inactivity in terms of venous treatments. ■

1. Masuda E, Ozsvath K, Vossler J, et al. The 2020 appropriate use criteria for chronic lower extremity venous disease of the American Venous Forum, the Society for Vascular Surgery, the American Vein and Lymphatic Society, and the Society of Interventional Radiology. J Vasc Surg Venous Lymphat Disord. 2020;8:505-525. doi: 10.1016/j.jvsv.2020.02.001