ASK THE EXPERTS

Contemplating the Gaps in Superficial Venous Care

Identifying the crucial needs to address in the identification, workup, and treatment of superficial venous disease.

With Teodora Bochnakova, MD; Chelsea Dorsey, MD, FACS, RPVI; Nasim Hedayati, MD, MAS, FACS, DFSVS, RPVI; and Kathleen Ozsvath, MD, FACS

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Treatment of superficial veins has the potential to significantly impact a patient's quality of life (QOL), especially in more severe stages of venous disease (eg, CEAP [clinical, etiology, anatomy, pathophysiology] 4-6). However, there are critical gaps in diagnosing and managing coexisting pathologies, such as lymphedema and fluid overload, as well as in providing diligent wound care. Identifying a lymphedema specialist, ensuring close primary care follow-up, engaging a wound care clinic in your health care community, and working together in a multidisciplinary approach are all essential to eliminate these gaps.

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With respect to the identification and workup of patients with superficial venous disease, we are undoubtedly falling short in providing this care to some of our most vulnerable patients. Patients with a lower socioeconomic status and those who come from disadvantaged racial and ethnic minority groups often present with more advanced venous disease at initial presentation. For many providers, our venous practices are composed of a large subset of patients who self-refer and thus, in many ways, already have the knowledge and means to find the care they require.

Venous care should not be reliant on self-selection but instead requires a paradigm shift where at-risk patients are identified earlier and provided with the education and resources to curb the progression to more advanced forms of venous disease. As we all know, venous problems at this stage can be incredibly costly and lead to significant deficits in QOL for patients who are likely juggling myriad complex social factors. Screening programs should not only be expanded but specifically targeted at communities with higher proportions of at-risk patients in an effort to reduce delays in diagnosis and improve outcomes.

Ultimately, it is incumbent on providers to reacquaint lawmakers with the financial burden placed on the health care system, which is made worse by managing advanced disease that in many cases was preventable. Perhaps at that point, some pressure can be placed on insurance providers to rethink their reimbursement strategy, which has historically not placed equity at the forefront.

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Most physicians who treat superficial venous disease understand the importance of having excellent vascular laboratory support to obtain a venous reflux duplex ultrasound. This is crucial in putting together a treatment plan when evaluating symptomatic patients. Unfortunately, as we see an increasing number of patients with prior interventions and complex anatomies, recommended treatments often are not straightforward. The gap in treatment comes from private and government payer denials for simple to complex superficial venous interventions for these patients. Often, the policies are based on old data. Lobbying on behalf of physicians who treat these patients falls on the shoulders of societies, such as the American Venous Forum, Society for Vascular Surgery, and American Vein & Lymphatic Society. We need to do a better job at supporting these organizations to fight on our behalf for policy change.

Another superficial venous treatment area where we have a gap is options for sclerotherapy. For decades, our main primary sclerosants have been polidocanol and sodium tetradecyl sulfate. Both have their own benefits and drawbacks. However, with all the advances in minimally invasive treatments for superficial venous disease in the last 2 decades, no new sclerotherapy agents have ever been introduced into the market. Is there an agent out there without any risk of hyperpigmentation or telangiectasia matting? Perhaps, one with quicker results so some patients do not have to wait for months to see improvements.

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Venous disease is more prevalent than arterial disease, and it affects a broad age range. It can present as lower extremity aching, pain, itching, bleeding varicosities, and restless legs. Skin changes ranging from skin discoloration to lipodermatosclerosis can affect the lower legs. In the worst cases, patients have ulceration that is painful, debilitating, and socially embarrassing. Additionally, the cost burden on the health care system is staggering.

One of the critical issues that affects care is the lack of knowledge among the physicians who attend to these patients in the community.

The identification of venous disease is of paramount importance. Venous pathophysiology is glossed over in medical school curriculums. Surgical training programs have historically not placed emphasis on venous education for trainees. Once a patient is identified as having venous disease, they may not be able to find a venous specialist to consult with to provide the best care. Some patients have socioeconomic or access issues that impede their ability to seek appropriate care.

To properly assess venous insufficiency, advanced skills in ultrasonography are paramount. Studying the superficial and deep veins of the lower extremities is the gold standard to learn the venous pathology of these venous systems. Skilled technologists understand the venous anatomy and know what maneuvers are needed to elicit the most accurate physiologic results.

Technology has evolved very fast, and the research to support this new technology and provide the much-needed data to understand when, how, and in what anatomic distribution the technology is best applied has not been published quickly enough. Technology has also been extended to practitioners of varied specialties, and many lack focused training in vascular disease.

There is no one, quick solution to these issues. However, education is the starting point. Patients should be educated to ask the right questions and seek help from specialists in this field. Health care providers must develop relationships with venous specialists to help bridge the gap in treatment and access to care. Health care providers who are interested in treating venous patients need educational opportunities to learn the anatomy and physiology of venous disease as well as the appropriate treatment of venous patients. Training programs must address these deficits in knowledge as well. Academic societies should provide training opportunities and support research in venous disease. Guidelines and appropriate use criteria need to be published and updated. Responsible distribution and sale of products and technology should be undertaken by industry partners in the venous space.

As we teach our patients, colleagues, and trainees about the pathophysiology and treatment of venous patients, we improve QOL and venous health. ■