Determining and Applying "Appropriate Use" of Venous Care

A conversation with Drs. Ozsvath and Masuda about appropriate and inappropriate venous application and how the 2020 AUC document on venous disease came to be.

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For those unfamiliar, can you briefly explain the RAND Corporation/University of California, Los Angeles (RAND/UCLA) appropriateness method and how the appropriate use criteria (AUC) authors used this to determine the current criteria?[1]

Dr. Masuda: AUC is a rating of appropriateness that combines the best available evidence with the collective judgment of experts. The method features a structured, quantitative technique that is based on the RAND/UCLA method of rating appropriateness. RAND/UCLA is a modified Delphi method that was originally developed to measure overuse and underuse of medical and surgical procedures. This methodology has been validated and applied to numerous procedures, including carotid endarterectomy, dialysis access procedures, bariatric surgery, and coronary revascularization. On the basis of the ratings, some groups have identified cases of substantial underuse, overuse, or inappropriate use of procedures. Clinical scenarios that are encountered by venous specialists were posed to the panelists, who individually rated the treatment options on a scale ranging from appropriate to never appropriate. The data were anonymously collected, then reviewed and shared with the panelists for two rounds of ratings.

What makes venous procedures particularly susceptible to inappropriate application?

Dr. Ozsvath: CEAP (clinical, etiology, anatomy, pathophysiology) classification allows for practitioners and insurance companies to categorize venous disease ranging from spider veins to venous ulceration. CEAP 2 (pain) and CEAP 3 (swelling) can have signs or symptoms that are difficult to measure objectively, making it easier to manipulate "need" for gain.

Based on your research, in which venous applications is overuse or inappropriate application most prevalent?

Dr. Ozsvath: It is most prevalent in venous ablations in C2 or C3 disease, which are the most common indications for ablation. Prior to the advent of endovenous interventions, the only way to remove axial superficial disease was to perform vein stripping, which requires anesthesia, is painful, and has an expected recovery period. When endovenous ablations become available, the numbers

of cases skyrocketed exponentially. The procedures are relatively simple to perform, can be done in an office-based setting, and require very little recovery time. The indications for CEAP 2 and CEAP 3 are difficult to measure objectively. This can allow for overuse or inappropriate use to occur.

Do we know how much of inappropriate application is due to lack of understanding/education versus those performing unnecessary procedures for financial gain?

Dr. Masuda: The treatment of venous disease does not have its own specialty board. Therefore, treatment can be performed by a wide variety of practitioners from differing specialties. This makes it difficult to ensure equal training of practitioners across specialties. Education is of utmost importance to become a venous specialist. There will always be a small number of practitioners doing unnecessary procedures in patients, no matter what specialty is evaluated.

For the sake of emphasis on that which is explained clearly in the AUC, which venous procedures are considered "never appropriate"?

Dr. Ozsvath: As an example: It is never appropriate to do a vein ablation on a normal vein. To determine whether or not a vein is diseased, a venous duplex ultrasound is performed, which will identify whether or not the valves are functioning correctly. If the valves are diseased, the patient will have reflux and blood will pool. In a patient with normal valves and no reflux, it is never appropriate to ablate the normal vein. An example would be a patient with no venous reflux in their great saphenous and small saphenous veins but unsightly spider veins on the thigh. There is no reason to ablate the normal axial veins. Consider a patient with unsightly veins and axial reflux who has absolutely no signs or symptoms of venous hypertension and no medical indication for venous intervention. There may be an indication to intervene for cosmetic reasons; however, aesthetic indications were not included in the AUC and should not be submitted for insurance coverage. Presently, there is no evidence to support "prophylactic" ablation of the superficial refluxing veins in an asymptomatic patient.

Beyond seeking a second opinion, what resources do patients have to determine whether a suggested course of action is appropriate?

Dr. Ozsvath: A great source is the American Venous Forum (AVF). The AVF is a premier academic society with membership that includes leading vein experts from around the world. This mission of the AVF includes education of not only venous specialists but also patients. The "Patients" section of the AVF website has great information for patients to learn more about venous disease, including an educational page designed for patients to learn more about venous and lymphatic disease and a link to find vein specialists in the patient's area. Additionally, the AVF developed an educational handbook about venous disease for patients.

The AUC is a multisociety document including the AVF, American Vein & Lymphatic Society (AVLS), Society for Vascular Surgery (SVS), and Society of Interventional Radiology (SIR). How challenging was it to get buy-in from all four groups, and what was learned from the process of gaining consensus?

Dr. Masuda: Experts from each of the societies were invited and met to discuss the project. Each panel member took the poll that had been developed and then reviewed the results. There was robust discussion on a few key points that did not have a definite answer; but ultimately, the panel members worked hard to rate the scenarios both independently and after group discussions.

With research showing a wide variety of specialty backgrounds performing venous ablation in particular, were other societies approached, such as interventional cardiology?

Dr. Masuda: There are many societies with members from different backgrounds. Those societies that are directly involved in venous treatment and education were included: SVS, AVLS, SIR, and AVF. This is an evolving field, and as other specialties become more involved in the science and understanding of venous disease, we will hopefully see an increase in participation among groups.

As dedicated venous stents come to market but are still in a relatively early phase of data development, what is your advice to practitioners who are increasingly placing stents?

Dr. Ozsvath: Stents, as with any procedure, should be placed for the appropriate indications in patients who are educated about the risks and the benefits of the procedure. Not all iliac vein obstructions need stenting. The AUC pointed out that it is not appropriate to treat iliac vein obstruction (stenosis or occlusion) for minimally symptomatic or asymptomatic disease, such as that found incidentally during imaging.

Finally, what can be done in terms of enforcement? Do the signatory societies have any specific plans for this? How would you summarize the opportunities and challenges of doing so?

Dr. Masuda: It is hard to enforce presently. Payors and accrediting organizations are doing their best. However, as payment models move from service to quality, the incentive to do "more" will no longer exist. ■

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.e4. doi: 10.1016/j.jvsv.2020.02.001