

# Setting Patient Expectations for Venous Disease Treatment

Establishing realistic expectations is the first step toward satisfied patients and favorable outcomes.

BY STEVE ELIAS, MD, FACS, FACP<sup>H</sup>

*"You can't tell people what they want to hear, if you also want to tell them the truth."<sup>1</sup>*

The majority of patients who seek treatment for venous disease have early-stage disease: spider veins, reticular veins, or varicose veins. Only approximately 5% of patients present with advanced disease: skin changes, ulcers, etc. In general, the earlier the disease state, the higher the patient's expectations. A patient with spider veins would like them to disappear and never recur. A patient with an active ulcer wants it to heal and understands that it may recur. An arterial patient doesn't request to have his 6.4-cm abdominal aortic aneurysm repaired or his asymptomatic 85% carotid stenosis fixed. We tell arterial patients what treatment they need; only with claudicants might we investigate the goals and expectations of the patients.

## EXPECTATIONS OF VENOUS PATIENTS

Venous patients tend to be the opposite of arterial patients; we need to understand their expectations. Rarely do we need to tell a venous patient that he needs to take care of his venous issues because if not, problems will arise. For those patients with advanced disease, acute deep vein thrombosis, or complications such as recurrent phlebitis, bleeding, etc., we may be more forceful and suggest treatment. Later issues may only occur with advanced disease patients, acute deep vein thrombosis patients, or patients with complications such as recurrent phlebitis, bleeding, etc. For arterial patients, 95% of the time we tell them what they need. For venous patients, 95% of the time we need to know what they want to accomplish. If you don't know what they want, you can't set proper and achievable goals.

Most venous patients consider themselves relatively healthy, active people who have a problem they want fixed

so they can get back to their lives. Most are not chronically ill, and most do not have significant comorbidities. They have some veins that they want treated because they don't like how they look, they don't like how they feel, or a combination of the two. Remember, I am speaking about the majority of patients that practitioners see and not advanced disease patients that comprise the minority.

## ASSESSING POSSIBLE OUTCOMES

Before you can set your patient's expectations, you must assess what type of results you can realistically achieve with your choices of interventions. Conceptually, veins can be considered as coming in three sizes: small, medium, and large (see *Examples of Vein Sizes* sidebar). Know what you can and can't achieve with each of these vein types. In my practice, I tell patients that for small veins, they can expect to look about 65% to 70% better. Medium veins have better "expectation" rates—around 80% to 85% for both symptom and cosmetic improvement. For large veins when treating for acute deep vein thrombosis, chronic occlusion, or pelvic insufficiency, I believe realistic improvement rates are approximately 60%, meaning patients should feel that their symptoms have improved by 60%. These rates are based on past patient-reported improvement.

Others surgeons may believe that they can offer better expectation rates, but I have found that patients can relate to these numbers and after intervention usually feel that they are improved by these percentages. This is all based on doing the right procedure for the right patient after you, your staff, your literature, your Web site, and anything else related to treatment have set realistic expectations.

## EDUCATING YOUR STAFF AND PATIENTS

The setting of expectations should begin before you see the patient. Your staff that answers the initial phone call will

often be asked about procedures and results. Most of us understand how vital staff is to the success of a practice. It is important to educate your staff about your philosophy when treating venous patients. Have the nonmedical staff view procedures and speak with the patients after these procedures. They will have a better understanding and appreciation of what patients go through. Questions about insurance do have an impact on patient expectations, and your staff will be asked to deal with these matters.

### Insurance Considerations

This takes us back to discussing small, medium, and large veins. Small veins are usually cosmetic and not covered by insurance; because this does not fit the criteria of medical necessity, you should not try to get small vein procedures covered. Medium veins tend to be covered by insurance depending on the patient's symptoms. Large veins are usually covered. If a patient is paying out of pocket, his expectations generally start higher. How many times has a patient asked, "Is this covered by my insurance?" If it is, he breathes a sigh of relief. Keep this in mind when speaking to a patient that may be paying for three or four sclerotherapy sessions.

### Educational Tools for Patients

Your and industry's Web sites and printed literature are excellent tools for educating patients about your practice, venous disease, treatment, etc. Make sure there is mention of results and expectations that will then be echoed when the patient comes to your office. Some of the available before and after pictures may be not typical but can border on the extraordinary. Patients love before and after pictures; however, few interventionists will show images with less-than-perfect outcomes. I advise including pictures of less-than-perfect treatments to keep expectations realistic. For instance, patients should know what matting or pigmentation looks like and what may occur after sclerotherapy. Patients should understand that not every visible varicose vein disappears after endovenous ablation.

## SELECTING AND TREATING THE RIGHT PATIENT

The aforementioned topics can occur before the patient enters your office. Once in the office, the mantra continues by you and your staff. You are the venous expert, and if anyone can get the best results, you can—but the best results are not perfection. Perhaps there are a few doctors who believe they can achieve perfection; most of us realize we can't in venous disease treatment. We can, however, attain very good results with very satisfied patients if we do the right thing for the right patient.

Properly selecting patients means asking them what they want to achieve. We have all seen the patient with huge

### EXAMPLES OF VEIN SIZES

Small Veins	Medium Veins	Large Veins
<ul style="list-style-type: none"> <li>• Spider veins</li> <li>• Telangiectasias</li> <li>• Reticular veins</li> <li>• Small varicose veins</li> </ul>	<ul style="list-style-type: none"> <li>• Great saphenous vein</li> <li>• Small saphenous vein</li> <li>• Varicose veins</li> </ul>	<ul style="list-style-type: none"> <li>• Iliac veins</li> <li>• Inferior vena cava</li> <li>• Superior vena cava</li> <li>• Subclavian vein</li> <li>• Axillary vein</li> </ul>

varicose veins who has no symptoms but is concerned if the veins are a health issue. When this patient is reassured, he thanks you and leaves. This patient doesn't need treatment, even though we could. We have also seen the patient with a body mass index of 30 who is bothered by small spider veins; this is not the right patient to treat either.

### Patient First, Veins Second

It is important to treat the patient first and then treat the veins. It is always tempting to treat the image whether the image is a large refluxing great saphenous vein seen on ultrasound in the first patient example previously or the visual image of spider veins in the second patient. Don't chase the image—treat the patient. In general, the more something bothers a patient, whether symptoms or appearance, the happier he will be after treatment. This I believe is key to setting patient expectations. Beware of the patient who asks you, "What do you think?" I tell this patient that it is his legs and not mine, so the decisions are his.

Once you have identified what the patient wants to achieve, you can set realistic goals. Many patients are very excited and want treatment immediately. I would recommend not treating at the first encounter if it is for small veins. Send those patients home with some literature, your Web site, etc., and ask them to return if they want treatment. The patients who return have already preselected themselves, and hopefully they have more realistic expectations. You may treat fewer small vein patients but a greater percentage of them will be satisfied. This has a great impact on the future of your practice, because once you reach "critical mass," a large majority of new referrals will come from satisfied previous patients.

### Knowing When Not to Treat

You don't need to treat every patient or vein. Start with what bothers the patient the most. Let the patient know what you can achieve and perhaps more importantly what you can't. There are some patients that you should be wary of treating, such as patients who come to you after previous treatment and were not happy with the results. It is important to have a discussion as to why

they were not satisfied. Perhaps their expectations were not realistic.

Beware of patients who say, "You are the best; I know I will be happy." Patients who have had multiple plastic surgeries are always a challenge. A change in life circumstance such as divorce or weight gain is sometimes a reason that patients seek treatment, which may be the wrong reason. They may expect your treatment of their venous disease to solve other problems, and they may not be pleased with the outcomes. A distorted body image can be a particular challenge, such as the spider vein patient with a body mass index of 30. Have a very in-depth discussion of expectations and results with these patients or perhaps opt not to treat.

### Improvement Takes Time

Once you have decided to treat a patient, continue to reinforce expectations during treatment and follow-up. Most venous procedures do not yield immediate results. Patient-perceived results take time, whether for sclerotherapy, endovenous ablation, or iliac stenting. Encouraging patience can be the biggest challenge; I tell patients that it is a process. The veins have been abnormal for a while, and it will take time to improve to the percentages previously mentioned.

### SUMMARY

Set expectations before seeing a patient. If you and your staff reinforce realistic expectations once the patient is evaluated, you don't need to treat every patient or every vein. Be selective and let the patients preselect themselves. Know when to stop treating; patients can always come back in the future. By setting reasonable expectations, you may treat fewer patients but the great majority will be happy with your care, and future patients will be referred. As Dylan sings, "The moral of the story, the moral of the song, is simply that one should never be where one does not belong."<sup>2</sup> ■

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2. Dylan B. The Ballad of Frankie Lee and Judas Priest. John Wesley Harding. Columbia Records. 1967.

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