

Varicose veins: referral, assessment and treatment

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Aim of this guide

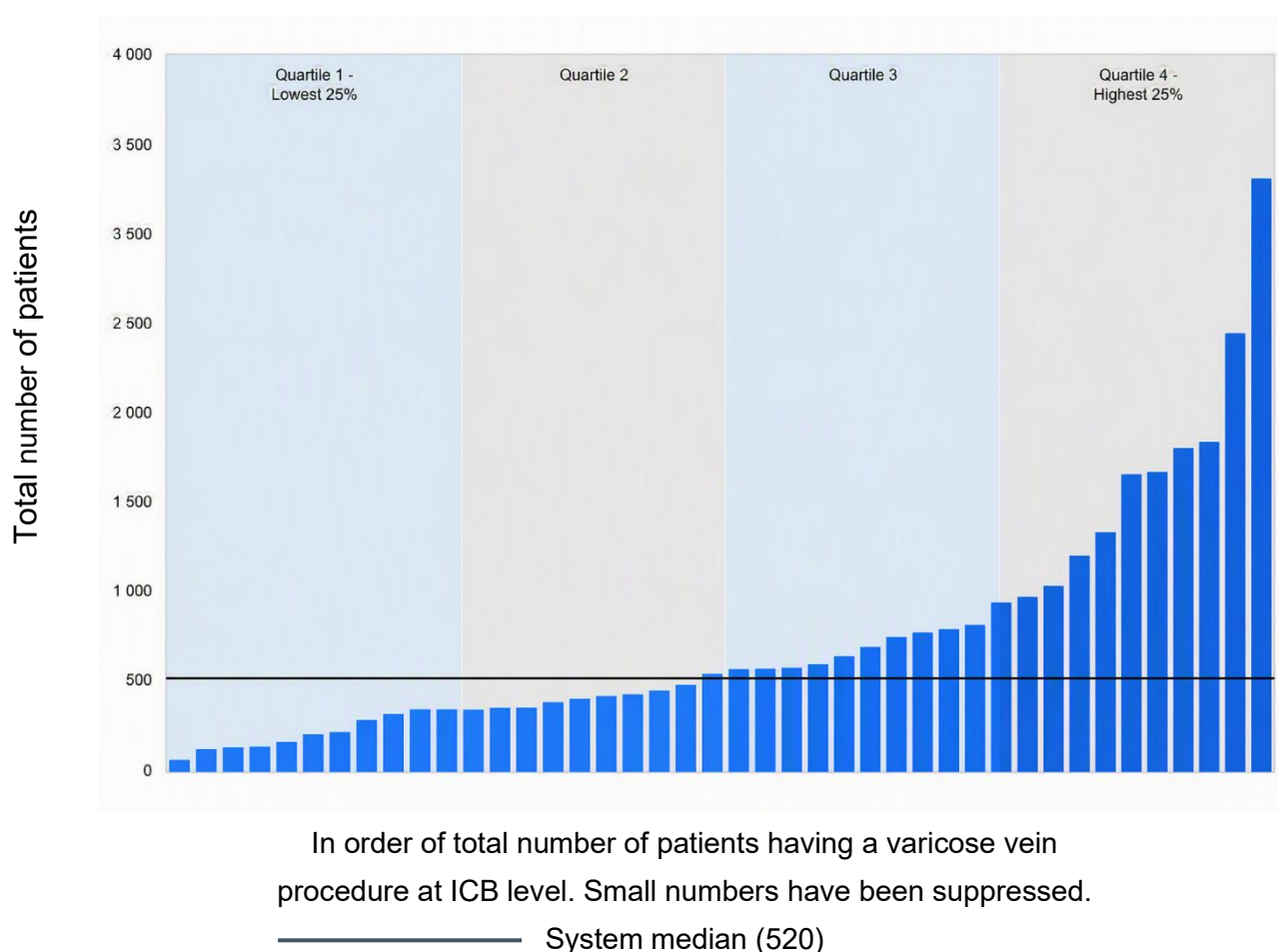
The purpose of this guide is to support primary care, vascular services and commissioners to consistently implement the Getting It Right First Time (GIRFT) varicose veins pathway. It should be used alongside local clinical judgement to inform referral decisions, prioritise urgent and routine presentations, and support appropriate management for people who do not meet the referral criteria.

1. Context

Varicose veins are common, affecting approximately 20-30% of adults, with prevalence estimates reported as high as 40%.¹ They can affect quality of life, daily activity and work, as well as causing complications such as skin changes, superficial vein thrombosis (SVT), bleeding and venous ulceration. National guidance supports referral for specialist vascular assessment where varicose veins are symptomatic or complicated, while treatment for cosmetic reasons alone is not recommended.^{2 3}

Access to assessment and treatment for varicose veins varies significantly across England (see figure 1).⁴

Figure 1: Total number of elective patients or outpatients having a varicose vein procedure under a vascular surgeon at Integrated Care Board (ICB) level (Q4 2025/26)



Data source: [Model Health System](#)

¹ National Institute for Health and Care Excellence (NICE) (2024) [Clinical Knowledge Summary on Varicose veins](#). See the Background information: prevalence section.

² Academy of Medical Royal Colleges (2024) Evidence Based Interventions Programme. [Statutory Guidance: Varicose vein interventions](#).

³ NICE guideline (2013) [Varicose veins: diagnosis and management](#)

⁴ BJS Open, Volume 6, Issue 4, August 2022. [Varicose veins treatment in England: population-based study of time trends and disparities related to demographic, ethnic, socioeconomic, and geographical factors](#).

The GIRFT vascular surgery workstream reviews have identified wide variation in local threshold policies. This leads to variation in care, with some services accepting most referrals and others requiring bleeding or active ulceration before referral or treatment is considered.

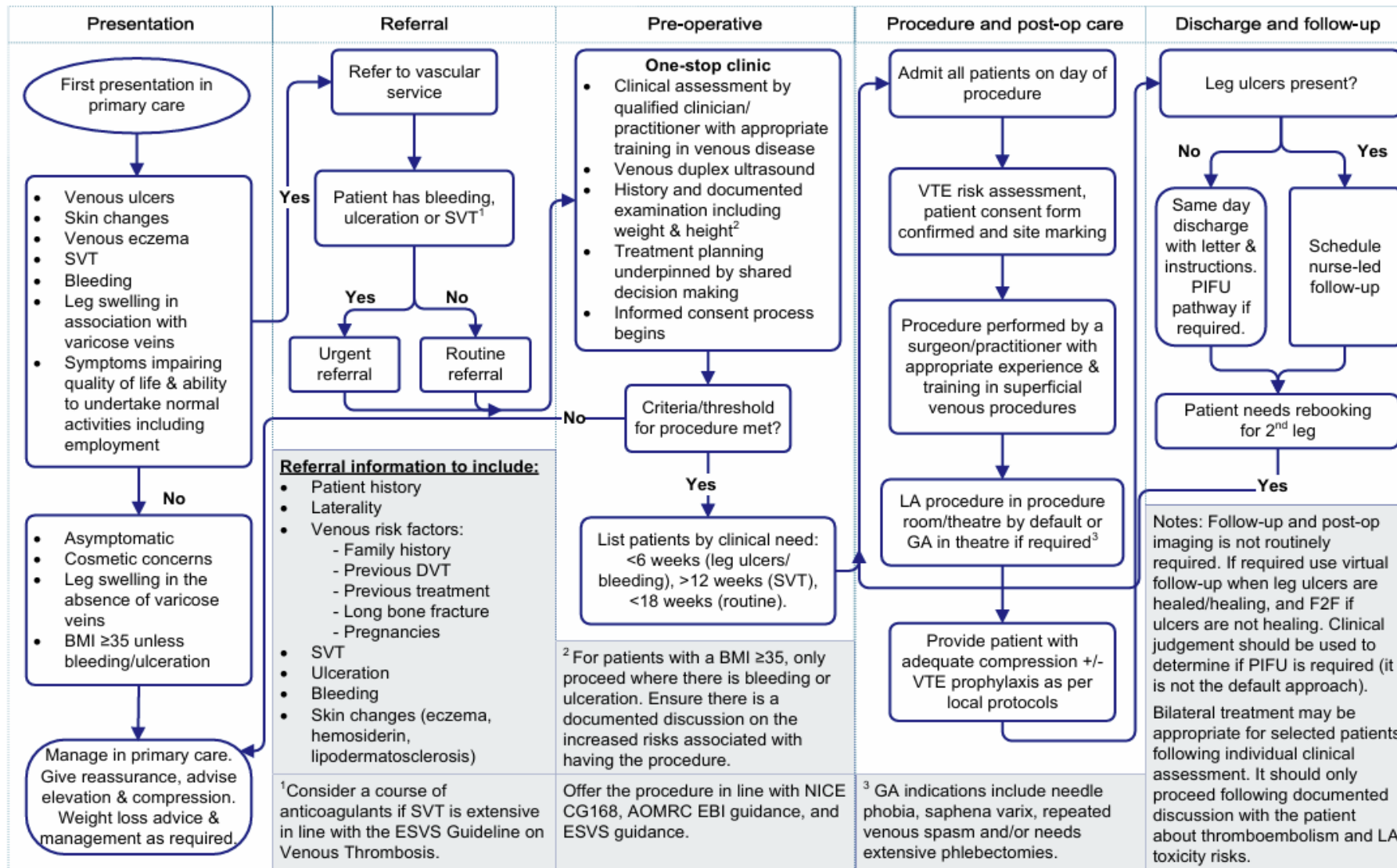
Some hospital trusts receive more referrals for varicose veins than available capacity can accommodate, which may affect their ability to prioritise more urgent life and limb-threatening arterial work. This guide therefore sets out a pragmatic middle ground: advising against referral for cosmetic or asymptomatic varicose veins, while ensuring that people with clinically significant symptoms and the greatest potential to benefit from treatment are referred and prioritised appropriately.

Clear, standardised criteria can reduce uncertainty for primary care, support consistent triage by vascular services, and reduce avoidable prior approval requests, retrospective challenge and unnecessary duplex imaging. A more consistent pathway should improve equity, reduce delays and make demand more manageable, so that patients with the greatest clinical need can be assessed and treated in a timelier way.

2. GIRFT Varicose veins pathway

2.1 The pathway

The GIRFT pathway sets out the recommended steps from initial presentation to referral, assessment, treatment and discharge.



Click [here](#) to view the full pathway.

2.2 Bilateral treatment

The GIRFT pathway advises treating one leg at a time where bilateral treatment is needed. The decision to treat both legs should be made at the initial clinical assessment, so that the procedure for the second leg can be booked when clinically appropriate without a further routine clinic appointment.

The advice to treat one leg at a time reflects consideration of potential risks associated with bilateral intervention undertaken in a single session. These risks include longer procedural time, thromboembolic complications⁵, infection and the potential for local anaesthetic toxicity.

A single-leg procedure is usually more predictable in duration. Attempting to treat the second leg in the same session can take longer, for example if the untreated leg has gone into spasm, increasing the risk of list overruns and making planned procedure capacity less reliable. Staging treatment by leg supports safer care for patients, effective discharge planning, consistent list timing and efficient use of capacity.

Bilateral treatment may be appropriate for selected patients where it can be delivered safely by an appropriately trained practitioner. It should only proceed following individual risk assessment and shared decision-making. The assessment should take account of procedural complexity, expected duration, local anaesthetic dose, VTE risk and patient preference.

⁵ Sutton, P.A., El-Duhwaib, Y., Dyer, J. and Guy, A.J. 2012. [*The incidence of post operative venous thromboembolism in patients undergoing varicose vein surgery recorded in Hospital Episode Statistics*](#). *Annals: Royal College of Surgeons of England*: 94(7); 481–483.

3. Referral criteria

3.1 Referral principles

Referral decisions should be based on clinical symptoms, signs and functional impact, rather than the presence of visible varicose veins alone. The aim is to support a consistent national approach that avoids referral for cosmetic or asymptomatic veins, while ensuring that people with clinically significant symptoms, complications or risk of deterioration are referred to a vascular service.

3.2 Information to include in referrals

Referrals from primary care to vascular services should include sufficient information to support triage and prioritisation.

Information to include in the referral

- **Relevant history**
- **Affected leg**
- **Risk factors:**
 - **Family history**
 - **Previous venous treatment**
 - **Previous deep vein thrombosis (DVT)**
 - **Long bone fracture**
 - **Pregnancy-related history**
- **Any history of bleeding**
- **SVT**
- **Ulceration**
- **Skin changes e.g. Eczema, hemosiderin or lipodermatosclerosis**
- **Swelling**
- **Pain**
- **Body Mass Index (BMI)**

3.3 Funding and approval

Where a person meets the referral criteria outlined in the GIRFT pathway and guide, an individual funding request should not be required. Requiring clinicians in primary or secondary care to complete separate funding forms for routine varicose vein referrals adds avoidable administrative burden and can delay access to assessment and treatment. Commissioners and providers should use the criteria outlined in the pathway and in this guide as the basis for referral, triage and approval decisions.

3.4 When to refer urgently

Consider urgent referral or requesting urgent advice for people with varicose veins who have:

- bleeding from a varicose vein, including a single episode of bleeding;
- active or deteriorating venous leg ulceration;
- diagnostically confirmed SVT.

Where SVT is suspected, local pathways for excluding DVT should be followed. Short-course anticoagulation may need to be considered where SVT is extensive or proximal, in line with evidence based guidelines, local policy and clinical judgement.

3.5 When to refer routinely

Routine referral to a vascular service should be considered for people with varicose veins where symptoms or signs suggest clinically significant venous disease, including:

- Pain, aching, heaviness or discomfort that affects quality of life and ability to undertake normal daily activities such as caring responsibilities or work.
- Skin changes consistent with chronic venous disease, including pigmentation, varicose eczema or lipodermatosclerosis.
- Venous leg ulceration.
- Swelling associated with varicose veins, where other likely causes of leg swelling have been excluded.

Where pain or symptoms affect function, the referral should describe the impact on the person's day-to-day life so that the vascular service can make a fair and consistent triage decision.

3.6 When to manage varicose veins in primary care

People should not be referred to a vascular service where varicose veins are cosmetic or asymptomatic, or where symptoms are unlikely to be caused by varicose veins. This includes:

- Thread veins or small superficial veins without symptoms or skin changes.
- Cosmetic concerns only.
- Leg swelling in the absence of varicose veins or leg swelling more likely to be explained by another cause, such as heart failure, reduced mobility, dependency oedema or other non-venous pathology.

People with a BMI of 35 or above should not usually be referred for vascular assessment or treatment of varicose veins unless there is a clear clinical indication, such as bleeding varicose veins or venous ulceration. There is evidence to suggest that the risk of complications increases and the potential benefits of treatment decrease when operating on patients with a BMI of 35 or above.^{6 7 8} People with a high BMI should be supported with weight loss advice and management in primary or community care.

4. Managing varicose veins in primary care

People who do not meet the referral criteria should receive clear, consistent advice in primary care. This should explain why referral is not currently indicated, what the person can do to manage their symptoms and when they should seek further review.

Primary care advice should include:

- Reassurance that asymptomatic or cosmetic varicose veins do not usually require referral to a vascular service.
- Advice on symptom management, including avoiding prolonged standing or sitting where possible, elevating the legs when resting, keeping active and maintaining mobility.
- Compression where appropriate, for example Class 2 compression stockings, taking account of clinical suitability, patient preference and contraindications.
- Healthy lifestyle and weight management advice, as weight loss may help improve symptoms for some people and may also reduce procedural risk if treatment is needed in future.
- Information on when to seek further review, particularly if symptoms progress or complications develop.
- Signposting to evidence-based patient information on varicose veins.

People should be advised to seek prompt review if they develop bleeding from a varicose vein, a new or deteriorating leg ulcer or suspected SVT.

See the [Further information section](#) for useful resources.

⁶ Vuoncino, M., Hedayati, N. and Kwong, M, 2024. [Complications of Varicose Vein Interventions in the Vascular Quality Initiative](#). *Journal of Vascular Surgery: Venous and Lymphatic Disorders*, 12 (3).

⁷ Deol, Z.K., Lakhanpal, S., Franzon, G. and Pappas, P, 2020. [Effect of obesity on chronic venous insufficiency treatment outcomes](#). *Journal of Vascular Surgery: Venous and Lymphatic Disorders*, 8 (4).

⁸ Parkin, L., Sweetland, S., Balkwell, A. et al, 2012. [Body mass index, surgery, and risk of venous thromboembolism in middle-aged women: a cohort study](#). *Circulation*, 125 (15): pp. 1897-904.

For people who remain in primary care, the aim is to provide practical advice without creating unnecessary appointments, investigations or expectations of treatment. Duplex ultrasound should not usually be requested solely to confirm varicose veins where the person does not meet referral criteria, as this can create avoidable demand and make later conversations about thresholds more challenging.

5. Conclusion

This guide and the associated pathway is intended to support more equitable access to varicose vein assessment and treatment across England. By setting out clear and consistent referral criteria, it aims to reduce unwarranted variation, avoid referral for cosmetic or asymptomatic varicose veins, and ensure that specialist vascular capacity is focused on people with clinically significant symptoms, complications or the greatest potential to benefit from treatment.

6. Further information

- Academy of Medical Royal Colleges (2024) Evidence Based Interventions Programme. [Statutory Guidance: Varicose vein interventions](#)
- NICE Clinical Knowledge Summary (2024) [Varicose veins](#)
- European Society for Vascular Surgery (ESVS) (2021) [Clinical Practice Guidelines on the Management of Venous Thrombosis](#)
- NICE guideline (2013) [Varicose veins: diagnosis and management](#)
- NHS England (2023) [Decision support tool: making a decision about treatment for varicose veins](#)
- Campbell, B., Dilley, C. and Gohel, M, 2022. [Bleeding from varicose veins: advice in primary care and referral](#). British Journal of General Practice, 72 (722); pp. 448-449.
- Circulation Foundation [Patient Information Leaflets](#)
- NHS [BMI Calculator](#)

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About GIRFT and the GIRFT Academy

Getting It Right First Time (GIRFT) is a clinically-led national programme designed to identify and minimise unwarranted variation in treatment and care delivered. It undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

The programme has the backing of the Royal Colleges and professional associations and has a significant and growing presence on the Model Health System portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency.

The GIRFT model has now been applied in more than 50 different areas of clinical practice. It consists of five key strands:

1. Data gathering – a broad data gathering and analysis exercise, generating a detailed picture of current national practice and outcomes.
2. Peer reviews – direct clinical engagement via visits or virtual meetings between clinical leads and trust teams; an opportunity to examine trust behaviour in the context of the national picture, enabling teams to understand where they are performing well and what they can do better.
3. National report and Academy resources – production of national reports that draw on data analysis and discussions with provider teams to identify opportunities for improvement, locally, regionally and nationally, alongside - clinical resources such as best practice pathways and guides.
4. Support to deliver – the implementation phase where the GIRFT team supports trusts, commissioners and integrated care systems to deliver the improvements recommended.
5. Research and development – GIRFT fellowships support resident doctors, nurses and allied health professionals to develop their research and clinical improvement skills, delivering research projects and GIRFT identified improvements in their host provider, system or region.

For the latest version of this document, please see www.gettingitrightfirsttime.co.uk or [Getting It Right First Time - FutureNHS Collaboration Platform](#)

GIRFT and a greener NHS

Climate change is one of the greatest health threats and opportunities of the 21st century. The NHS is acting now to mitigate and adapt to this threat in order to protect the health of current and future generations. Doing so will not only protect the environment but will also bring many health, social and financial benefits. As the largest employer in the UK, contributing 4.6% of national emissions, the NHS is both part of the challenge and the solution.

Through its endeavour to improve the quality of care within the NHS by reducing unwarranted variation, GIRFT can play an important role in reducing the carbon emissions associated with care delivery. Through the GIRFT model, there is the opportunity to identify changes that will help reduce the NHS carbon footprint and therefore improve patient care now and in the future.



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GIRFT is part of an aligned set of programmes within NHS England