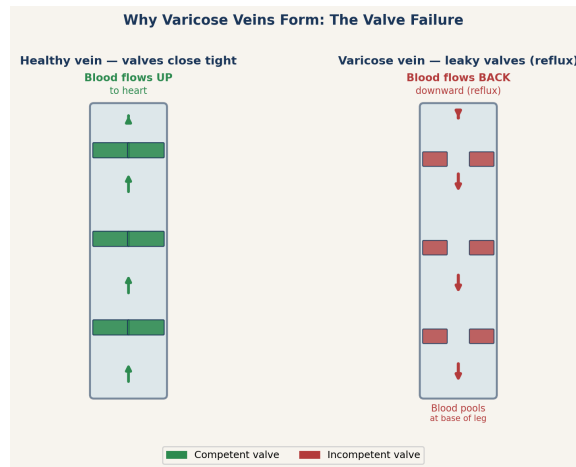


Understanding Varicose Veins

Enlarged, twisted leg veins — causes, stages, and today's minimally invasive treatments

Varicose veins are not just cosmetic. Failed valves cause real symptoms and can progress to skin damage and ulcers. Modern treatment is office-based with no hospital stay.



Online: <https://go.riasalimd.com/varicose-veins-guide>

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Names & Terms You Will Hear

Term	Meaning
Varicose veins	Enlarged, twisted veins on the legs. Leaky valves let blood pool and push vein walls outward.
Chronic venous insufficiency (CVI)	Leg veins cannot move blood back to the heart well. Valves are damaged or leaky.
Venous reflux	Blood flows backward through a leaky valve. This raises pressure in the vein.
Great saphenous vein (GSV)	The main vein from the inner ankle to the groin. The most treated vein in this disease.
Small saphenous vein (SSV)	A vein along the back of the calf. The second most common cause of reflux.
CEAP classification	A staging scale: C0 (no signs) to C6 (open ulcer). Used by all vein doctors.
Duplex ultrasound	A painless scan that shows vein shape AND blood flow direction. The first test ordered.
Endovenous ablation	A small tube closes the bad vein from inside. Uses heat (RFA, laser) or glue (VenaSeal). Done in the office.
Endovenous laser ablation (EVLA)	A thin laser fiber seals the vein wall with light energy.
Radiofrequency ablation (RFA)	A thin tube uses heat to close the vein. The ClosureFast system is the most used.
VenaSeal	Medical glue closes the vein. No heat. No numbing shots. Return to normal activity the same day.
Mechanochemical ablation (MOCA / ClariVein)	A rotating wire roughens the vein wall while foam is injected to seal it. No numbing shots needed.
Sclerotherapy	A liquid or foam is injected into a vein. The vein scars shut.
Ambulatory phlebectomy	Tiny punctures remove branch veins. Done in the office, often the same day as ablation.



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Term	Meaning
Superficial thrombophlebitis	A clot in a surface vein along a varicose vein. Painful and red. Usually not dangerous, but needs a check.

Key fact: Varicose veins affect about 1 in 4 adults. They are a vascular disease, not just a cosmetic issue. When you have symptoms and reflux is confirmed on ultrasound, most insurers cover care. **A duplex ultrasound is the first step.**



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What Is Varicose Veins?

- Varicose veins are big, twisted veins that bulge under the skin. They form when small valves inside the vein stop working.
- Valves open to let blood flow up to the heart. Then they close to stop blood from flowing back. A broken valve lets blood pool below it. The extra pressure pushes the vein wall outward.
- The great saphenous vein (GSV) runs from the ankle to the groin. It is the most common source of reflux. One leaky vein can cause branches to bulge all over the leg.
- About 23% of U.S. adults have varicose veins. They are more common in women, older adults, people who stand for long hours, and people with a family history.
- Varicose veins are part of chronic venous disease. The CEAP scale grades this from C0 (no signs) to C6 (open sore). They are not just cosmetic — they can get worse over time.



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A real example of varicose veins: a rope-like, bulging vein visible under the skin of the calf, the classic appearance caused by the valve failure shown below.



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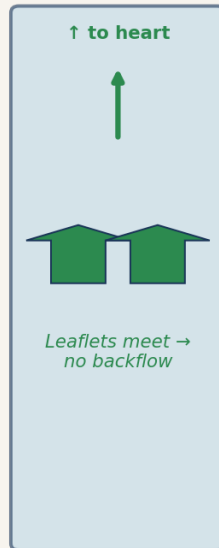
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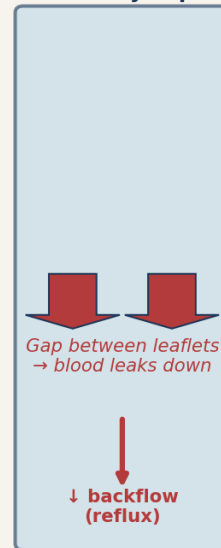
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The Valve Mechanism: Why Varicose Veins Develop

Normal valve — closes between heartbeats



Incompetent valve — stays open, blood refluxes



Left: a healthy valve closes after each heartbeat to stop backflow. Right: a leaky valve stays open — blood pools down, pressure builds, and the vein wall stretches outward.



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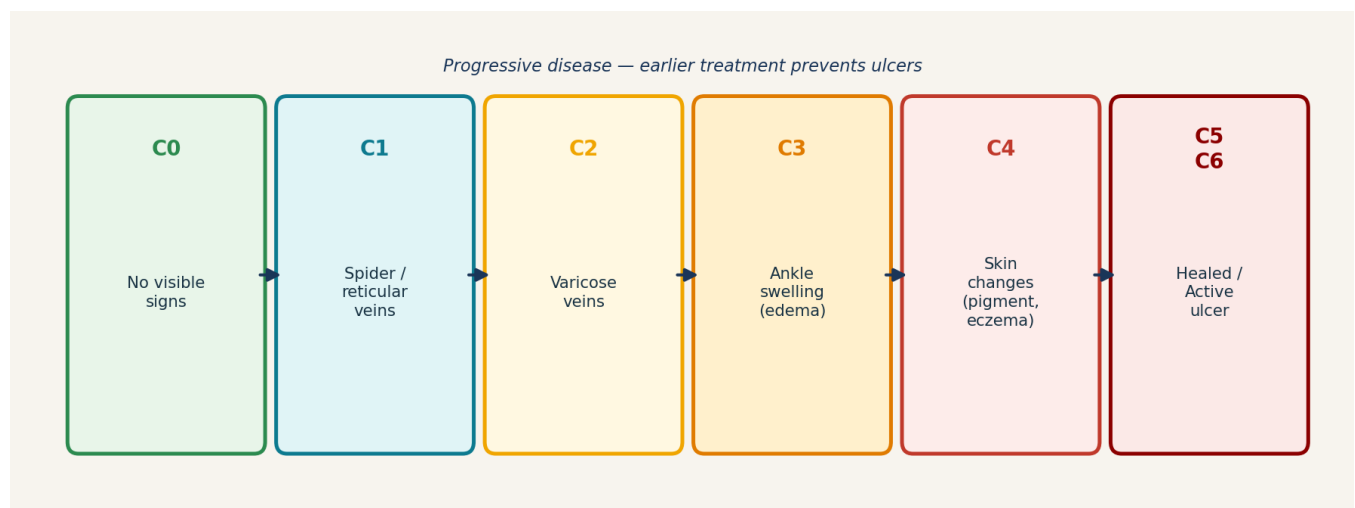
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Why It Matters

- Varicose veins are not just cosmetic. They cause aching, heaviness, swelling, and itching. These symptoms can limit daily life.
- Without care, they can get worse. Swelling at C3 leads to skin damage at C4. Skin damage leads to open sores (C5–C6) that can take months to heal.
- Venous leg ulcers affect 1–3% of adults over 65. They are a common chronic wound. Recurrence after healing is over 50% if the bad vein is not treated.
- A varicose vein can rupture and bleed after minor injury. A clot can also form in a surface vein (thrombophlebitis). Both need prompt care.
- Modern vein closure is done in the office in about an hour. No hospital stay. Same-day return to light activity. Early treatment is easier than waiting for ulcers.



CEAP stages C0–C6: varicose veins are a progressive disease. C1 spider veins, then C2 varicose veins, then C3 swelling, then C4 skin changes, then C5–C6 ulcer. See the Venous Insufficiency guide at go.riasalimd.com/vi-guide for more on the later stages.



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Risk Factors

Some patients are more likely to develop this condition. Knowing your risk helps your care team take extra precautions.

Risk Factor	Why It Increases Risk
Age	Valves weaken over time. Varicose veins are rare under 20 and very common after 50.
Female sex	Female hormones relax vein walls. Risk goes up with each pregnancy and at menopause.
Pregnancy	The growing uterus presses on pelvic veins and raises pressure in the legs. Each pregnancy adds more valve wear.
Family history	If both parents have varicose veins, the lifetime risk is over 90%.
Long hours standing or sitting	Standing or sitting for long periods raises vein pressure. This is common in nurses, teachers, and office workers.
Obesity	Extra belly weight raises pressure in leg veins and slows blood return to the heart.
Prior DVT (blood clot)	A deep vein clot can scar the valves and lead to varicose veins later.
Prior vein clot (thrombophlebitis)	A clot in a surface vein scars the wall and weakens valve function.



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Treatment Options

- Step 1 — Duplex ultrasound: shows which veins are leaking and how bad the damage is. This test is needed before any procedure.
- Step 2 — Compression stockings: 20–30 mmHg for mild disease, 30–40 mmHg for more severe. Worn daily to cut pressure and reduce swelling. Insurance often needs a 3-month trial before paying for ablation.
- Step 3 — Lifestyle: walk daily, lift your legs above heart level, lose weight if needed, and avoid long periods of standing still.
- Step 4 — Heat ablation (RFA or laser): a thin tube is placed inside the vein. Heat seals it shut. Done in the office under local numbing. Over 90% of veins stay closed at 5 years.
- Step 5 — VenaSeal (medical glue): glue is injected to seal the vein. No heat. No numbing shots. No stocking needed after. Same-day return to normal activity. 88% closed at 3 years.
- Step 6 — MOCA (ClariVein): a rotating wire roughens the vein while foam seals it. No heat. No numbing shots.
- Step 7 — Sclerotherapy: a foam or liquid is injected into smaller veins. Used to treat branch veins after the main vein is closed.
- Step 8 — Ambulatory phlebectomy: tiny skin openings remove visible branch veins. No stitches. Done in the office, often the same day as ablation.
- Surgery (vein stripping): rarely used today. Endovenous techniques work just as well with much less recovery time.



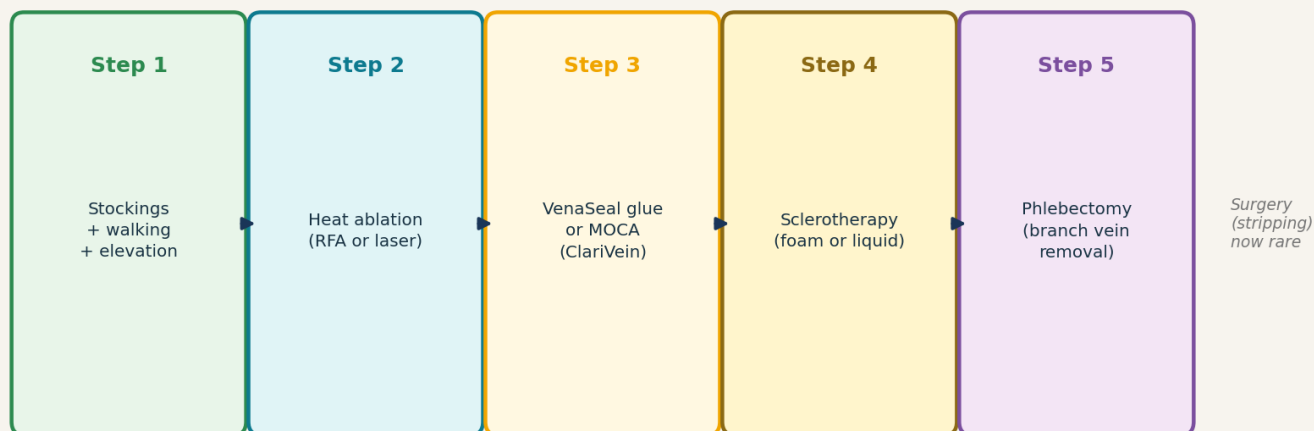
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Start conservative — escalate if symptoms persist



Treatment steps: start with stockings and walking, then escalate to RFA, laser, VenaSeal, MOCA, sclerotherapy, or phlebectomy as needed. Vein stripping surgery is now rarely used.

Procedure	What it is	Anesthesia	Recovery	Durability
RFA (ClosureFast)	Heat closes GSV/SSV via catheter	Tumescent (local)	1–3 days	>90% at 5 yrs
EVLA / Laser	Laser fiber seals the vein	Tumescent (local)	1–3 days	>90% at 5 yrs
VenaSeal (glue)	Medical adhesive closes vein	None required	Same day	88% at 3 yrs
MOCA (ClariVein)	Rotating wire + sclerosant foam	None required	1–2 days	~85% at 3 yrs
Sclerotherapy	Chemical injected into vein	None	None	Varies by size
Phlebectomy	Branch veins removed via punctures	Local	1–2 days	Permanent
Vein stripping	GSV removed surgically	Spinal/general	1–2 weeks	>90% — now rare



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Conservative Care: Compression + Lifestyle

- Wear compression stockings daily — 20–30 mmHg for C2–C3 disease, 30–40 mmHg for C4–C6. Put them on in the morning before getting out of bed.
- Walk 30 minutes a day. Each step fires the calf-muscle pump and cuts vein pressure by up to 70%.
- Raise your legs above heart level for 15–20 minutes, 2–3 times a day. Use pillows when you rest.
- Do not stand or sit still for more than 45–60 minutes. Walk or do calf raises to move blood out of the legs.
- Losing weight lowers belly pressure and reduces the pressure in your leg veins. Even 10 lbs helps.
- Most insurers need a 3-month stocking trial before they cover ablation. Keep a simple daily log of your stocking use and symptoms.



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Endovenous Thermal Ablation: RFA and Laser

- RFA and EVLA (laser) are the first-choice procedures. They replace vein stripping for most patients and are endorsed by the SVS, AVF, and NICE guidelines.
- A thin tube is placed in the vein under ultrasound. Heat seals the vein from inside. The body reroutes blood through nearby healthy veins.
- Local numbing shots are placed along the vein (called tumescent anesthesia). No IV sedation needed. Most people watch TV during the procedure.
- The visit takes about 45–60 minutes. Walk out the same day. Return to light work in 1–2 days. Avoid heavy exercise for 1 week.
- Over 90% of treated veins stay closed at 5 years (CLASS trial). Heaviness and swelling usually improve within the first week.
- Wear your compression stocking for 1–2 weeks. A follow-up ultrasound at 3 days and 1–3 months checks that the vein is closed.



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Glue Closure (VenaSeal) and MOCA (ClariVein)

- VenaSeal: a small amount of medical glue is injected along the vein. The glue hardens in seconds and seals the vein shut.
- No numbing shots — just one needle stick at the entry site. No heat. No stocking needed after. Return to normal life the same day.
- VenaSeal: 88% of veins stay closed at 3 years (Morrison 2019). Less long-term data than heat ablation. A good choice for patients who strongly dislike needles.
- ClariVein (MOCA): a small rotating wire roughens the inside of the vein while foam seals it at the same time. No numbing shots. No heat.
- MOCA results match heat ablation at 3–5 years. A light stocking is still worn for 2 weeks after. Return to work is the same as with RFA or laser.
- Rare: allergy to VenaSeal glue. Vein soreness after is common and fades in a few weeks. Tell your doctor if you have any known glue allergies.



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Risks, Benefits, and Alternatives

Every choice has trade-offs. Use this table to start the shared decision conversation.

Option	Risks	Benefits	Alternatives
Compression stockings	Hot in summer. Hard to put on with arthritis. Symptoms come back when stockings are off.	Safe, cheap, covered by insurance. Cuts swelling and heaviness. Slows disease. Most insurers need a 3-month trial first.	Endovenous ablation (closes the vein for good); watchful waiting (OK if symptoms are mild).
RFA — radiofrequency ablation (ClosureFast)	Bruising and soreness for 7–10 days. Rare: skin burn, nerve tingling, or DVT (each less than 1%). Numbing shots needed.	Over 90% of veins stay closed at 5 years. Symptoms improve in days. One-hour office visit. Walk out the same day.	Laser (EVLA) — same results; VenaSeal — no numbing shots; stockings alone — controls symptoms but does not close the vein.
EVLA — endovenous laser ablation	Similar to RFA: bruising, soreness, rare nerve tingling. Numbing shots needed.	Same long-term closure as RFA (90%+ at 5 years). Good for veins that curve a lot.	RFA — similar results; VenaSeal — no numbing shots; stockings alone.
VenaSeal — medical glue	Rare: allergy to glue. Vein soreness (common, fades in weeks). May cost more; not all insurers cover it.	No heat. No numbing shots. No stocking needed after. Return to normal life the same day. 88% closed at 3 years.	RFA or laser — more long-term data, often cheaper; stockings alone.
MOCA — mecha nochemical ablation (ClariVein)	Vein soreness along the treated area. Light stocking still advised for 2 weeks.	No numbing shots. No heat. Results equal to heat ablation at 3 years. Done in the office.	RFA or laser — more long-term data; VenaSeal — also needs no numbing shots.



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Option	Risks	Benefits	Alternatives
Sclerotherapy — foam or liquid	Brown skin staining for weeks to months. Temporary vein soreness. Very low clot risk.	Works well for branch veins, spider veins, and small leftover veins after ablation. No anesthesia. No downtime.	Phlebectomy — better for large bulging branches; watchful waiting if no symptoms.
Ambulatory phlebectomy	Small bruises at puncture sites. Brief numbness. Wear a stocking for 2 weeks.	Removes bulging branch veins right away. No stitches. Often done the same day as ablation.	Sclerotherapy — less invasive but needs more visits; observation if OK with appearance.



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Common Misconceptions

Myth	Reality
Varicose veins are just a cosmetic issue.	Not true. Bulging veins mean the valves are damaged. Over time, this leads to swelling, skin damage, and open sores. When symptoms are present and reflux is confirmed by ultrasound, many insurers cover treatment.
The only fix is painful vein stripping surgery.	Surgery is rarely used today. RFA and laser close the vein in about an hour in the office. Local numbing is used. No hospital stay, no general anesthesia. Walk out the same day.
Treated veins grow back.	They do not. Once a vein is closed, it stays closed. New varicose veins can appear elsewhere over years, but the treated vein does not reopen.
Stockings are enough — I don't need a procedure.	Stockings help, but they do not fix the leaky valve. Symptoms come back when you take them off. For C4–C6 disease (skin changes or ulcers), closing the bad vein is needed to prevent sores from coming back.
Leg swelling just means I was on my feet too long.	Venous swelling is worst by evening and gets better overnight with leg elevation. This pattern is different from heart failure or lymphedema. A duplex ultrasound can tell the difference.
If my veins were serious, they would hurt all the time.	Pain from varicose veins is worst after standing and is gone at rest. Many people have major skin damage with little pain. Pain level is not a reliable sign of how bad the disease is.
Spider veins and varicose veins are the same thing.	Spider veins are tiny, flat, and mostly cosmetic. Varicose veins are large, bulging, and mean a valve is damaged. Both can exist at the same time. Spider veins alone are treated with sclerotherapy for appearance only.



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Myth	Reality
Insurance won't cover this — it's cosmetic.	Insurance usually covers ablation when: (1) reflux is confirmed on ultrasound, (2) you have symptoms, and (3) you wore compression stockings for 3 months. Purely cosmetic spider-vein treatment is usually self-pay.

Related guides: See the **Venous Insufficiency** guide at go.riasalimd.com/vi-guide for C4–C6 disease. The **DVT** guide at go.riasalimd.com/dvt-guide explains how to spot a deep clot. The **May-Thurner Syndrome** guide at go.riasalimd.com/mts-guide covers left-leg reflux from pelvic compression.



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Possible Complications

Knowing what can go wrong helps you spot problems early. Most complications are uncommon, especially with treatment.

Where / What	What Can Happen
Venous leg ulcer (C6 disease)	The most serious risk — an open wound near the inner ankle that will not heal until the bad vein is treated. Healing takes 3–12 months. Without closing the refluxing vein, the ulcer comes back in over 50% of cases within 5 years.
Surface vein clot (thrombophlebitis)	A painful, red, cord-like lump along a varicose vein. Most heal with compression, pain relievers, and walking. An ultrasound checks that the clot has not spread to a deep vein (DVT), which needs blood thinners.
Bleeding from a varicose vein	Surface veins can burst and bleed heavily, especially near the ankle. Press firmly, raise the leg above the heart, and get urgent care. Closing the feeding vein stops this from happening again.
Lipodermatosclerosis	Long-term vein pressure scars the skin and fat of the lower leg. The leg looks narrow in the middle — like an inverted bottle. This is a warning sign of ulcer risk. Compression and ablation stop it from getting worse.
Skin staining and venous eczema	Iron from broken red blood cells turns the skin brown near the ankle. Venous eczema causes itching and weeping skin — often confused with infection. Keep the skin moist and wear compression to limit damage.
Deep vein thrombosis (DVT)	Less common, but possible after long periods of bed rest or sitting. Sudden one-sided leg swelling, warmth, and pain needs a same-day ultrasound. An untreated DVT can travel to the lungs (pulmonary embolism).



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When It Is More Than Cosmetic: Skin Changes and Ulcers

- C4 disease — brown skin staining, hardened fat, and itchy weeping skin — appears around the inner ankle when vein pressure has been high for a long time.
- At this stage, closing the bad vein is needed. This is true even when varicose veins are not large or visible. The skin damage tells us the pressure is too high.
- Venous ulcers (C5–C6) are open wounds. Each heartbeat pumps high-pressure blood backward through leaky valves. This breaks down healing tissue over and over.
- Treating a venous ulcer requires: multi-layer compression, wound cleaning, and closing the bad vein. Ablation helps the ulcer heal faster and cuts recurrence by more than half.
- See us right away for any wound near the ankle. Early care is much easier than treating a full ulcer. See also: the Venous Insufficiency guide at go.riasalimd.com/vi-guide and DVT guide at go.riasalimd.com/dvt-guide.



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Points to Know

If you remember nothing else, remember these key points.

- Walk every day. Each step squeezes blood upward and is the best defense against leg vein pressure.
- Wear your compression stocking from morning to bedtime. It is most helpful on days you stand a lot.
- Raise your legs above heart level for 15–20 minutes, 2–3 times a day. Use pillows when resting.
- Do not stand or sit still for more than 45–60 minutes. Walk or do calf raises to reset vein pressure.
- Every 10 pounds of weight loss lowers the pressure in your leg veins.
- See a vein doctor if your ankle skin turns brown, scaly, or develops any wound. Treat early — before a sore forms.
- Insurance usually covers ablation with: confirmed reflux on ultrasound, symptoms, and 3 months of compression. Keep a symptom log.
- After ablation, walk daily and wear your stocking for 1–2 weeks. Movement helps keep the treated vein closed.



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When to Call Us - and When to Call 911

If you are not sure, call. We would rather hear from you twice than miss a real problem.

- Bleeding from a varicose vein — press firmly, raise the leg, call us today.
- A sudden, painful, red lump along a vein — call us today (possible vein clot).
- New leg swelling with pain, warmth, or tightness — call us today or go to the ER (rule out DVT).
- Chest pain or shortness of breath with leg swelling — call 911 now (possible lung clot).
- An open wound near the ankle that will not heal — call us today (possible venous ulcer).
- Skin redness, weeping, or fever — call us today (possible skin infection).
- Brown or red staining spreading around the ankle — call us this week (early skin change; treat now).
- More swelling or heaviness despite wearing your stocking — call us to check fit or rule out a clot.

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Trusted Resources

The links below are the trusted resources Dr. Ali used to write this guide and that he recommends you visit for more information. Each is a clickable link in the digital version and a Short.io tracked URL on the printed version.

- [Society for Vascular Surgery — Varicose Veins](#) - Specialty-society patient resources from the vascular surgeons who set the treatment guidelines.
- [American Venous Forum — Patient Information](#) - Patient education from the specialist society dedicated to venous disease.
- [Cleveland Clinic — Varicose Veins](#) - Plain-language overview of varicose veins and modern treatment options.
- [Mayo Clinic — Varicose Veins](#) - Symptoms, diagnosis, and treatment overview from a leading academic center.
- [AHA / American Heart Association — Venous Health](#) - Heart and vascular health information including venous disease prevention.



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Sources Used to Build This Guide

Every recommendation in this guide is grounded in one or more of the studies, guidelines, or trusted resources below. Short links are tracked so Dr. Ali can see which references patients are reading; nothing personally identifying is captured.

- [Society for Vascular Surgery — Varicose Veins Patient Info](#) [Professional Society]
Primary specialty-society guidance on varicose vein evaluation and treatment (SVS Clinical Practice Guidelines 2024).
- [American Venous Forum — Patient Resources](#) [Professional Society]
AVF specialist guidance; venous disease staging and treatment modalities.
- [Cleveland Clinic — Varicose Veins](#) [Academic Medical Center]
Patient-friendly overview; symptoms, duplex ultrasound, and procedure descriptions.
- [Mayo Clinic — Varicose Veins](#) [Academic Medical Center]
Plain-language guide to varicose veins, risk factors, and treatment options.
- [NICE Guideline NG168 — Varicose Veins in the Legs](#) [Clinical Guideline]
UK National Institute evidence-based guidance endorsing endovenous thermal ablation as first-line over surgery.
- [Gloviczki P et al. — SVS/AVF Clinical Practice Guidelines on the Management of Venous Leg Ulcers \(J Vasc Surg 2024\)](#) [Guideline Paper]
2024 SVS/AVF guideline providing GRADE recommendations for venous ulcer management and ablation timing.
- [CLASS Trial — Carolan-Rees G et al. Foam Sclerotherapy vs RFA vs EVLA vs Surgery \(BMJ 2015\)](#) [Rct]
Landmark 5-arm RCT comparing RFA, EVLA, foam sclerotherapy, surgery, and foam vs surgery — informs RBA table outcome data.
- [Morrison N et al. — VenaSeal Cyanoacrylate Closure 3-Year Outcomes \(J Vasc Surg 2019\)](#) [Clinical Study]
3-year durability data for VenaSeal adhesive closure (88% closure at 36 months).
- [Whing J et al. — Mechanochemical Ablation \(ClariVein/MOCA\) vs EVLA — Systematic Review \(Cochrane 2021\)](#) [Systematic Review]
Cochrane systematic review of MOCA/ClariVein — comparable efficacy to thermal ablation with no tumescent anesthesia.
- [Rabe E & Pannier F — CEAP Classification Update 2020 \(Phlebology 2020\)](#) [Classification Paper]
Revised 2020 CEAP classification — C0-C6 definitions used in the guide's staging section.



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About This Guide

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Reviewer note: Reviewed against Society for Vascular Surgery (SVS) patient resources, American Venous Forum (AVF) pages, Cleveland Clinic, and Mayo Clinic. This guide adds: a side-by-side valve anatomy diagram, the CEAP C0–C6 progression chart with tinted severity coding, named procedural modalities (RFA, EVLA, VenaSeal, ClariVein/MOCA, phlebectomy), and cross-links to companion venous guides (Venous Insufficiency, DVT, May-Thurner).

Disclaimer

This guide is for educational purposes only and does not replace medical advice from your physician. Recommendations may not apply to every patient. Always follow the specific instructions of Dr. Ali and your care team. In an emergency call 911 or go to the nearest emergency department.



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