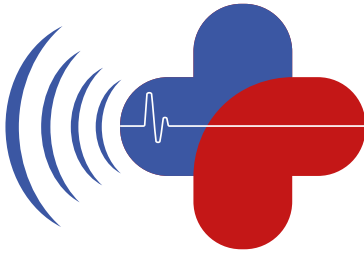


Advancing non-invasive vascular diagnostic services by promoting training and research in Vascular Science.



CSVS

THE COLLEGE AND SOCIETY
FOR CLINICAL VASCULAR SCIENCE
Great Britain and Ireland

SUMMER
2026



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President's Message



As summer draws to a close, I hope you have had the opportunity to take some well-deserved rest and recharge. This period can be particularly challenging across the NHS, with annual leave and caring responsibilities often placing additional pressure on already stretched teams. Despite this, it has been an exceptionally productive few months for the College and Society.

One of our most significant achievements has been the launch of the Recognition of Prior Learning (RPL) route for STP Equivalence, developed in partnership with the Academy for Healthcare Science (AHCS). The recent webinar highlighted how this new process can streamline the journey towards obtaining a Certificate of Equivalence by mapping the Accredited Vascular Scientist (AVS) programme to the Good Scientific Practice framework. The recording will soon be available on the CSVS website, and I strongly encourage eligible members to explore this opportunity. We also anticipate a growing need for registered Clinical Scientists to act as STP Equivalence Assessors, so if this interests you, please contact the AHCS.

We have also strengthened our operational support by formalising our long-standing relationship with the British Medical Ultrasound Society (BMUS). Whilst the overall cost remains unchanged, the new contract moves us from reliance on a single individual to support from a dedicated team, ensuring greater resilience, continuity, and responsiveness across Society activities.

Alongside this, discussions continue regarding the future governance of CASE. A proposal is being explored to establish CASE as an independent limited company, with member organisations, including the CSVS, becoming shareholders. This structure would provide stronger legal protection and improved financial accountability. Recruitment for an independent Chair is also expected shortly, helping to shape the organisation's future strategic direction. We will keep members informed as these plans develop.

I am also saddened to report that the University of Gloucestershire has paused recruitment to its undergraduate vascular science programme whilst undertaking a strategic review. Financial pressures across the higher education sector continue to present challenges, particularly for specialist programmes with smaller student numbers. The CSVS is working closely with the University to explore sustainable solutions, and further discussions are planned for September. We remain committed to supporting the future vascular science workforce and will share updates as they become available.

The National School of Healthcare Science has begun the retendering process for Higher Education Institution delivery of both the Scientist Training Programme (STP) and Higher Specialist Scientist Training (HSST) programmes. Whilst lengthy, this process is essential to securing high-quality education and long-term investment in the future healthcare science workforce.

The CSVS Council have also appointed a new Chair to the newly formed Humanitarian Committee. Following an onboarding process and agreement to early plans, the ambition is to grow this arm of the CSVS so watch out for updates in due course.

Finally, I want to highlight the upcoming ASM in Liverpool. The conference team has an exciting agenda lined up and a gentle reminder that early bird rates end on the 27th September.

Due to the volume of achievements made over recent months, you will see a separate section to this message where the subcommittees will give their own update with key dates for your diary.

Thank you for your continued support of the CSVS and for the outstanding contribution you make every day to patient care, education, research, and service development. Once again, thank you to Jeny Anton for their sterling work as newsletter editor.

Dr Steve Rogers

President, College and Society for Clinical Vascular Science

| Committee Updates

Professional Standards Committee (PSC)

The PSC continues to make excellent progress in supporting professional standards and service development across vascular science.

Updated Professional Practice Guidelines

The following guidelines have recently been updated:

- Duplex Ultrasound Examination Pre-Creation of Dialysis Arterio-Venous Fistulas (AVF) and Arterio-Venous Grafts (AVG)
- Duplex Ultrasound Examination Post-Creation of Dialysis Arterio-Venous Fistulas (AVF) and Arterio-Venous Grafts (AVG)

New CSVS Position Statement

The Society has published a new position statement:

Use of Artificial Intelligence (AI) in Vascular Science Diagnostics

National Coding Initiative

The PSC is working with the NHS NICIP Coding and Clinical Terminology Development Team to update and expand coding for vascular science investigations. A batch submission was made in June and is currently under review. Once approved, this work will support standardised coding of vascular science procedures across the UK. Guidance will be released to members following approval.

Work-Related Upper Limb Disorders Guidance

Work is also underway to update the Society's guidance on work-related upper limb disorders, including repetitive strain injury and recommendations relating to ambidextrous scanning practice.

Research Committee Update

The Research Committee continues to support research activity across the profession.

- CSVS research grants are now open year-round, allowing members to submit applications at any time.
- We currently have a vacancy on the Research Committee and would welcome expressions of interest from members who wish to contribute to the Society's research agenda and activities.

Venous Forum Conference 2026

The Venous Forum Conference took place at the Royal Society of Medicine from 15-17 June 2026 and provided an excellent platform for multidisciplinary learning and discussion.

Day 1 featured practical workshops led by the CSVS, focusing on venous ultrasound techniques, alongside presentations covering lipoedema, lymphoedema, compression therapy, and perforator vein treatment. The programme also included presentations exploring the role of vascular scientists in lower-limb venous imaging and the assessment and surveillance of deep venous disease.

Day 2 focused on deep venous outflow obstruction, upper-limb and pelvic venous disease, and venous malformations.

Overall, the conference was highly informative and particularly valuable for those with an interest in venous disease and intervention.

Education Committee Update

The Education Committee has been exceptionally busy over recent months.

Practical Examination Review

Following analysis of the membership survey conducted earlier this year, a task-and-finish group has now been established to review the practical examination and revalidation process. The aim is to introduce an updated framework in 2027 that maintains the high standards expected of CSVS accreditation whilst ensuring consistency nationwide.

Accredited Vascular Scientist (AVS) Programme

A reminder that the new research component within the AVS programme will be introduced from 1 September.

Advanced Vascular Practitioner (AVP) Pathway

A dedicated task-and-finish group has also been formed to support the development of the new AVP pathway.

CPD Audit

The annual CPD audit process is now underway. Members are encouraged to ensure that their CPD records and membership portfolio are fully up to date.

Educational Events

Finally, both the Fundamentals Study Day and the Revision Study Day were extremely well received earlier this year. Thank you to everyone who contributed to their success.



Bitesize Research: Deep Venous Reconstruction and the Future of Chronic Venous Disease Management

Author: Emily Morgan, Clinical Scientist, Cardiff and Vale University Health Board

Deep venous reconstruction remains a highly specialised area of vascular surgery, reserved for carefully selected patients with severe chronic venous insufficiency (CVI) or post-thrombotic syndrome (PTS) who have failed conservative and endovascular management. Although these procedures are uncommon, they represent an important area of practice for vascular scientists involved in pre-operative assessment and long-term postoperative surveillance.

This edition of bitesize we review four recent publications exploring the evidence surrounding deep venous reconstruction, ranging from clinical case series to systematic reviews and emerging applications of artificial intelligence (AI).

Paper 1: *Deep Venous Reconstruction – A Single-Centre Case Series*

Reference: Kosasih S, Moore H, Lane TR, Davies AH. *Deep Venous Reconstruction: A Case Series. Cureus.* 2017 Jul 26;9(7):e1518. doi: 10.7759/cureus.1518. PMID: 28959513; PMCID: PMC5613925.

This retrospective case series reviewed 19 patients who underwent deep venous reconstruction over a 19-year period using techniques including the Palma bypass, May-Husni bypass, femoral vein transposition and axillary vein transplantation. Patients had advanced chronic venous disease (CEAP C3–C6), with most having a history of deep vein thrombosis.

The study reported encouraging long-term results, with a cumulative primary patency rate of **89.5% at 58 months**, suggesting that open reconstruction can provide durable outcomes in carefully selected patients.

Strengths

The study's greatest strength is its long-term follow-up, demonstrating sustained graft patency over almost five years. All procedures were performed by a single consultant surgeon, providing consistency in surgical technique and patient selection. The use of duplex ultrasound-derived graft patency as the primary outcome also offers an objective and clinically meaningful measure of success.

Limitations

As a retrospective case series involving only 19 patients, the study provides relatively low-level evidence. The absence of a control group prevents comparison with conservative or endovascular treatments, while the long recruitment period (1994–2013) encompasses considerable advances in venous imaging and intervention that may limit the relevance of earlier cases to contemporary practice. In addition, patient-reported outcomes such as

quality of life and ulcer healing were not comprehensively reported.

Impact on Vascular Science Practice

Although these procedures are uncommon, vascular scientists play a pivotal role in both patient selection and postoperative surveillance. Comprehensive duplex ultrasound assessment is essential for identifying venous obstruction and reflux pre-operatively, while ongoing surveillance enables early detection of graft stenosis, thrombosis or recurrent reflux. Familiarity with these reconstructive procedures is particularly valuable for those working within tertiary vascular centres.

Paper 2: *Systematic Review and Meta-analysis of Deep Venous Reconstructive Surgery*

Reference: Maleti O, Orso M, Lugli M, Perrin M. *Systematic review and meta-analysis of deep venous reflux correction in chronic venous insufficiency. J Vasc Surg*

Venous Lymphat Disord. 2023 Nov;11(6):1265-1275.e5. doi: 10.1016/j.jvsv.2023.07.003. Epub 2023 Jul 13. PMID: 37453548.

This systematic review and meta-analysis evaluated 57 studies involving over 4,000 patients undergoing deep venous reconstructive surgery for primary venous incompetence and post-thrombotic syndrome.

Overall, the review demonstrated favourable outcomes, including high rates of ulcer healing, valve patency and symptom improvement, particularly among patients with primary valvular incompetence. Patients with post-thrombotic syndrome experienced less favourable but still encouraging results.

Strengths

As a systematic review and meta-analysis, this paper represents the highest level of evidence currently available for these surgical procedures. The review synthesised data from a large number of studies and examined multiple clinically relevant outcomes, including ulcer healing, valve competence, pain, oedema and postoperative complications. Importantly, it also compared outcomes between patients with primary valvular incompetence and those with post-thrombotic syndrome.

Limitations

Despite the rigorous review methodology, the quality of the available evidence remains limited. Most included studies were retrospective case series, with only three randomised controlled trials identified. Significant heterogeneity existed between studies in terms of patient populations, surgical techniques and outcome reporting, while few studies

compared reconstruction with modern endovenous therapies. Consequently, definitive conclusions regarding superiority of treatment cannot yet be drawn.

Impact on Vascular Science Practice

This review reinforces the importance of high-quality duplex ultrasound throughout the patient pathway. Vascular scientists remain central to pre-operative assessment, identifying suitable candidates for reconstruction, and to long-term surveillance of valve competence and graft patency. The findings also highlight the need for structured follow-up protocols, as ongoing surveillance is essential for maintaining long-term outcomes.

Paper 3: Femoral Vein Valve Repair – A Case Report

Reference: Zheng, W., Gu, Z., Zhao, H. et al. *Innovative femoral vein valve repair combined with deep femoral vein ligation for treatment of chronic venous insufficiency: a case report.* *J Cardiothorac Surg* 21, 366 (2026). <https://doi.org/10.1186/s13019-026-04048-2>

This paper presents a successful case of femoral vein valve repair combined with deep femoral vein ligation in a patient with chronic venous insufficiency and aneurysmal venous dilatation. The authors also provide a concise review of current surgical options including valve repair, valve transposition and valve transplantation.

Strengths

The report offers valuable insight into the management of a rare and technically demanding clinical scenario. It describes surgical decision-making in detail while pro-

viding a useful overview of the available reconstructive techniques and their respective indications. Such reports contribute practical knowledge for clinicians managing complex venous disease.

Limitations

As a single-patient case report, the findings cannot be generalised to wider clinical practice. The absence of a comparator, limited long-term follow-up and potential publication bias mean that conclusions regarding efficacy should be interpreted cautiously. Like many case reports, the paper demonstrates feasibility rather than effectiveness.

Impact on Vascular Science Practice

Although this case report is unlikely to alter routine clinical practice, it reinforces the essential role of vascular scientists in the assessment and surveillance of patients with complex deep venous disease. Duplex ultrasound is fundamental in identifying the location and severity of venous reflux, assessing valve morphology, and detecting associated abnormalities such as aneurysmal venous dilatation, all of which are critical in determining surgical suitability. Following intervention, vascular scientists are responsible for evaluating valve competence, venous haemodynamics, and the presence of recurrent reflux or thrombosis during long-term follow-up. The report also highlights the importance of understanding uncommon venous reconstructive procedures, as these patients may present for surveillance in specialist vascular centres. While endovenous treatments and conservative management remain the mainstay of care for most patients with chronic venous insufficiency, this paper demonstrates that complex



reconstructive surgery may offer clinical benefit in carefully selected cases. For vascular scientists, it emphasises the need for advanced knowledge of deep venous anatomy, haemodynamics, and postoperative duplex ultrasound assessment to support multidisciplinary decision-making and optimise patient outcomes.

Paper 4: Artificial Intelligence in Chronic Venous Insufficiency – Future Directions

Reference: Michael C. Wilkinson, Andrew Ayad, Sharon C. Kiang, Mary L. Grewal, *A review on the current applications of artificial intelligence in chronic venous insufficiency, JVS-Vascular Insights, Volume 3, 2025, 100261, ISSN 2949-9127, <https://doi.org/10.1016/j.jvsvi.2025.100261>*

The final paper takes a different perspective, reviewing the emerging role of artificial intelligence (AI) in chronic venous disease. Rather than evaluating surgical outcomes, the review explores how AI may support diagnosis, risk prediction, disease classification and clinical decision-making.

Early proof-of-concept studies suggest that machine learning and computer vision techniques, including automated

thermal image analysis, could improve diagnostic efficiency while reducing healthcare workload.

Strengths

This review provides an excellent overview of a rapidly developing field and introduces vascular professionals to technologies that may influence future clinical practice. It highlights several promising applications of AI while identifying important areas requiring further research and validation.

Limitations

The review is narrative rather than systematic, meaning study selection was not conducted using a predefined methodology. Much of the evidence remains exploratory, consisting of proof-of-concept studies that have yet to be externally validated or compared with current standards of care. Consequently, AI applications remain some distance from routine implementation within vascular laboratories.

Impact on Vascular Science Practice

Although AI currently has a limited role in the routine assessment of chronic venous insufficiency, this review highlights its potential to become an important adjunct to vas-

cular science practice in the future. Machine learning algorithms could assist vascular scientists by analysing large imaging datasets, identifying patterns that may be difficult to recognise visually, predicting disease progression, and supporting patient selection for intervention. Emerging technologies, such as automated thermal image analysis and AI-assisted image interpretation, may improve diagnostic efficiency and reduce healthcare workload. However, these tools are intended to support rather than replace clinical expertise. Vascular scientists will continue to play a central role in acquiring high-quality ultrasound data, interpreting haemodynamic findings within the clinical context, and validating AI-generated outputs. As AI technologies become increasingly integrated into vascular imaging, vascular scientists will require an understanding of their capabilities, limitations, and potential sources of bias to ensure they are applied safely and appropriately. Ultimately, this review suggests that AI is likely to enhance clinical decision-making and workflow efficiency, but robust prospective validation and regulatory oversight are essential before widespread implementation in clinical practice.

Overall Take-Home Messages

Collectively, these papers demonstrate that deep venous reconstruction remains an important treatment option for carefully selected patients with advanced chronic venous insufficiency, particularly when conservative and endovascular therapies have failed. Although the current evidence is largely based on observational studies, outcomes are generally encouraging, with good long-term graft patency and improvements in clinical symptoms.

For vascular scientists, these publications reinforce the central role of duplex ultrasound throughout the patient journey—from identifying deep venous reflux and obstruction during pre-operative assessment to providing long-term surveillance following reconstruction. As surgical techniques evolve and artificial intelligence begins to influence vascular imaging, maintaining expertise in venous haemodynamics while embracing technological innovation will be essential to delivering high-quality patient care. ♦

Pulse Points

Welcome to the first edition of the Pulse Points section of the newsletter. The aim of this section is to offer training takeaways and insights on some of the wider aspects of professional practice. This is particularly aimed at colleagues training towards accreditation however hopefully all readers will gain something of interest from this section.

My department recently hosted a Cardiac Science STP trainee on rotation and when we were out scanning on the wards, she asked me, “when do you stop feeling like an imposter?”. Training can feel like this especially when parachuted into various departments. The stress of knowing where and when to arrive and sometimes to get there and no one knows who you are or even what you are. Vascular scanning can feel like that as well due to wide range of investigations that are performed each related to different pathologies, patient pathways and protocols.

From my experience, people arrive at Vascular Science from a very wide variety of backgrounds particularly when the most traditional training routes are delivered at post-graduate level. I came to Vascular following a previous career as a secondary school Physical Education teacher and in response to the STP trainee's question, I don't think my imposter syndrome has fully gone. Imposter syndrome is where accomplishments are ascribed to external factors; a common phenomenon in healthcare(1). Imposter syndrome is often construed as negative(1,2); however, I believe can positively impact an individual's drive to improve their ultrasound skills and clinical understanding/judgement with each patient. Imposter syndrome can be identified as a driver for excellence in high-achieving individuals and is also a dynamic, changing state(2). With this, you could say that imposter syndrome diminishes or is felt less frequently with more experience. Per-

haps it is only experienced when performing vascular investigations of something the individual hasn't seen before (or not as frequently). Or perhaps it comes in wider settings such as undertaking research, presenting at a conference or managing a project/department. I recently listened to the Humans of Clinical Academic podcast(3), which referenced “finding your fear” in terms of seeking of tasks where an individual is being stretched and challenged. Fear may represent the point at which when an individual may experience what sport psychologists' term as a flow state(4). So perhaps the question is not “when do you stop feeling like an imposter” and should be more “how do you hold on to that imposter feeling”?

Do you have something that you would like to write about in the Pulse Points section for the readership to enjoy? Perhaps a reflection from your own training (previous or current) or something that you have experienced that has sparked curiosity, discussion, or debate. Please reach out if you would like to discuss an idea (student.liaison@csvs.org.uk).

Max Bitterlin

Clinical Vascular Scientist, University Hospitals Bristol and Weston NHS Foundation Trust

Student Liaison, CSVS Education Committee

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Congratulations to Aiya for winning the best newsletter article of the summer newsletter and on winning a £50 Amazon voucher.

Royal Free Symposium on Thermal Imaging in Medicine and Biology



The Royal Free Symposium on Thermal Imaging in Medicine and Biology brought together clinicians, scientists, and researchers from across the UK and Italy for a day of lively discussion and knowledge sharing around the latest developments in clinical thermography. Eight presentations covered an impressive range of topics, from everyday clinical audit to AI-driven research, and from Raynaud's disease to relapsing polychondritis.

Jeny Anton from the Royal Free London opened the symposium with an overview of the operational realities of delivering a microvascular service at the Royal Free Hospital and the Finchley Memorial Hospital Community Diagnostic Centre (CDC). The presentation highlighted the clinical benefits of the service for patients; for example, nailfold capillaroscopy can support the early detection of serious autoimmune diseases such as systemic sclerosis (scleroderma), helping to identify disease before significant organ damage develops. The talk also explored the challenges of integrating microvascular testing within a vascular laboratory and training staff in these specialised techniques. As this represents a unique service setting, the presentation provided valuable insight into both its practical implementation and ongoing development.

Audrey Macdonald from Newcastle upon Tyne Hospitals shared a striking case study on thermography of the ear in relapsing polychondritis, a chronic autoimmune condition causing inflammation of the cartilage. Thermography conducted in a cooled room revealed the symptomatic ear was 8°C hotter than the contralateral ear. Repeat imaging at 12 months showed a 12°C difference. The case demonstrated that thermography using a cooled room protocol can clearly reveal active inflammation and validate patient reported pain where clinical inspection alone is inconclusive.

Georgina Parsons, also from the Royal Free London, presented findings from an internal audit examining variability among the six scientists who report and interpret thermography of hands at the Royal Free Hospital. Each scientist

independently reported on 10 images using the team's standard operating procedure (SOP). The audit findings highlighted some degree of inter-operator variability, which is within acceptable limits but highlighted the need for standardised practices and quality assurance in reporting thermography.

Professor John Allen provided an overview of the newly established Vascular Optics and Microvascular Sensing research cluster at Coventry University's Research Centre for Intelligent Healthcare (CIH). The facility houses a comprehensive suite of optical measurement technologies including thermal imaging, nail-fold capillaroscopy, optical coherence tomography (OCT), photoplethysmography (PPG), laser Doppler flowmetry (LDF), and near-infrared spectroscopy (NIRS), among others. Prof Allen emphasised the power of light as an early optical window into tissue and microcirculation. Current projects focus on applying thermal imaging and AI-based machine learning to assess patients with Raynaud's phenomenon, peripheral arterial disease (PAD), and heart disease.

Dr Graham Dinsdale from Salford Royal Hospital and the University of Manchester presented results from a retrospective study of 703 patients attending for routine thermography at a specialist rheumatology tertiary referral centre. The study tested a series of hypotheses regarding post cold challenge hand recovery data including the relationship between pre and post challenge skin temperatures, the effect of finger length on rewarming time and the influence of age and gender on recovery profiles. The findings contribute to a deeper understanding of Raynaud's severity assessment using thermographic cold challenge protocols and have implications for standardising outcome in clinical practice.

Gabriel Santos from the Royal Free London presented an audit exploring the clinical feasibility of implanting infrared thermography (IRT) as a routine diagnostic tool for assessing primary palmar hyperhidrosis (Hh) at the Royal Free Vascular Hyperhidrosis Clinic. The audit compared IRT findings against Hyperhidrosis Disease Severity Scale (HDSS) scores and clinical observations to evaluate diagnostic concordance and how feasible it is to run in clinical practice, providing an important step towards making the case for wider clinical adoption.

Dr Andrea Murray from the University of Manchester and Salford Royal Hospital explored the emerging potential of low-cost, compact

thermal cameras, attached to mobile devices for ambulatory monitoring of Raynaud's phenomenon outside or the laboratory. A study was presented comparing the performance of mobile cameras against standard laboratory thermal cameras in patients before and after acclimatisation. The findings assessed the feasibility of using such devices for patient monitoring in secondary healthcare settings.

Dr Kevin Howell presented the Thermology International open-access archive, a significant historical resource for the thermology community. The archive houses the complete collection of Thermology International, including the official journal of the European Association of Thermology (EAT), edited for many years by the late Professor Kurt Ammer, who passed away in 2024. Before his death, Professor Ammer transferred all publication rights to the EAT. The archive is now freely available online and can be accessed at: <https://eurothermology.org/ThermologyInt.html>

Rounding off the day, Professor Manuel Sillero-Quintana from the Universidad Politécnica de Madrid presented a new model for understanding how skin temperature responds to exercise and is a reminder that thermography's reach extends well beyond clinical diagnostics into sports science and human performance.



It was a great privilege to be a part of this symposium and to hear about the wealth of innovative clinical and scientific practice within this field. A special thanks to Jeny Anton and Georgina Parsons for organising this symposium. We're already looking forward to sharing more from the thermography community as things develop.

Written by Aiya Magid
Vascular & Microvascular Scientist
Royal Free London



Hiding in Plain Sight: Why Clinical Vascular Scientists Can Close the Pelvic Venous Disease Gap

Pelvic venous disease (PeVD) is increasingly recognised as a cause of chronic pelvic pain (CPP) (Meissner 2021), and is estimated to account for 16–34% of cases (Gavrilov 2024, Messina 2024). The aetiology of PeVD is not yet fully understood and appears multifactorial, involving genetic predisposition, hormonal influences, anatomical variation, and venous wall or valvular dysfunction (Durham 2013, Balabuszek 2022, Gloviczki 2024, Kuo 2025). The journey for PeVD patients is frequently prolonged and fragmented, involving multiple specialties. This reflects broader challenges in women's health, where chronic symptoms can become normalised or underappreciated (Clayton 2022, Reid 2026). The King's Fund highlighted that despite women representing 51% population there are clear disparities in care (Clayton 2022). Two recent cases from Cambridge University Hospitals (CUH) illustrate how long that patient journey can be, and why clinical vascular scientists (CVS) should have a central, and often underused, role to play in shortening it.

Two Patients, Two Long Roads

Both women were multiparous, active, and otherwise fit and well, but had lived with long-standing pelvic heaviness, dyspareunia, and bloating for 5-10 years before a venous cause was considered.

CASE 1	CASE 2
History: 42-year-old multiparous female referred to the Gynaecology Outpatient Clinic with a 10-year history of pelvic heaviness and left-sided inguinal pain. Conservative management failed to provide symptom relief prompting referral to vascular services eight months after the initial general practitioner consultation. Clinical examination: visible vulval and lower-limb varicosities Imaging: CT - dilated OV. No MRV was requested. Duplex ultrasound - grossly incompetent great saphenous vein feeding from varicosities with likely pelvic source. TA/TVUS - not available. Venography - dilated left ovarian vein with retrograde flow Treatment: coil embolisation resulted Impact: symptom relief	History: 38-year-old multiparous female referred to the Vascular Outpatient Clinic from GP with longstanding symptomatic varicose veins of the left lower limb and continued pelvic heaviness and discomfort. Previous diagnosis and embolisation by gynaecology, but no previous vascular input or follow-up imaging. Clinical examination: superficial medial thigh varicosities. Imaging: MRV - no significant residual pelvic varices, small thigh varicosities appeared to communicate with the pelvis. Duplex ultrasound - grossly incompetent great saphenous vein feeding from varicosities with likely pelvic source. Treatment: ultrasound-guided foam sclerotherapy to incompetent medial and lateral thigh veins, and multiple stab avulsions Impact: symptom relief

Both cases received conservative management for their chronic symptoms for several years before their request for a second opinion resulted in full diagnosis and vascular treatment. Reports, such as the Cumberlege Report (Cumberlege 2020), have highlighted systemic issues in listening to patients and addressing their concerns. The request for second opinion reinforces the need for improved awareness and patient-centred care.

Neither story is unusual. What both cases share is a pathway where PeVD was considered late, imaging was inconsistent, and vascular expertise was an afterthought.

Where We Can Improve Patient Care

PeVD may be considered as a gynaecological or interventional radiology problem that CVS simply support from the sidelines. These cases suggest otherwise. In both patients, it was a

lower limb venous duplex ultrasound that highlighted a pelvic source. We identify a grossly incompetent great saphenous vein (GSV) in the absence of saphenofemoral junction involvement, or recurrent or unusually distributed varicosities are indicative of pelvic escape points (Ahuja 2021). In the past, these patients may go on to have superficial venous treatment that never addresses the underlying reflux and then represent with recurrence years down the line. Explicitly documenting a suspected pelvic source and understanding when it warrants onward referral for cross-sectional or transvaginal imaging, is a small change in reporting practice with real downstream consequences for patients.

The Missing Imaging Pathway

Beyond the individual scan, there's a structural gap that CVS are well placed to help close. Transabdominal and transvaginal ultrasound (TAUS/TVUS) is increasingly recommended as a first-line investigation for suspected PeVD (Topper 2021). Published studies have proposed diagnostic criteria and scanning methodologies (Park 2004, Gavrilov 2024), but variation persists. Furthermore, few vascular laboratories possess established protocols or the expertise to perform these examinations. In many trusts, including CUH, the Vascular Studies Unit (VSU) do not provide this service. Instead, some patients are routed through gynaecology, general radiology or regional networks facing limited capacity and long waits. Furthermore, there is no standardised UK protocol for scanning thresholds or reflux criteria. The result is illustrated by both case reports: inconsistent access, delayed diagnosis, and inequitable care.

This is a gap CVS are arguably better positioned to fill than anyone else in the pathway. We already have the ultrasound skill set, the understanding of venous haemodynamics, and experience applying structured reporting frameworks like Clinical-Etiologic-Anatomic-Physiologic (CEAP) classification (Beebe 1996, Lurie 2020) to complex venous disease. Adapting that expertise to pelvic venous imaging and to develop local protocols is a natural extension of the service that many vascular

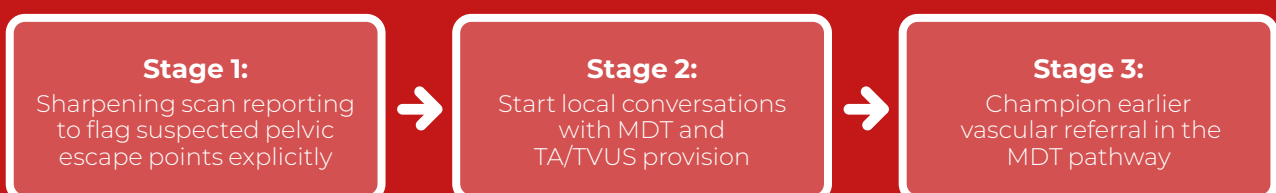
laboratories already provide. While at CUH VSU current demand is insufficient to support a sustainable TVUS service and maintain competency, the existing skillset is well aligned to adopt TAUS, and our capacity will be supported through workforce restructuring and quality improvement initiatives. Other vascular laboratories have taken it further, having undergone training from gynaecological colleagues in TVUS to be able to offer this service.

The Commissioning Gap

Pelvic vein embolization (PVE) is cost-effective but inconsistently commissioned across the NHS, with access often depending on local policy or a delay-prone IFR process. For CVS, this is of significance beyond funding: gaps in the imaging pathway compound inequity in treatment access. Improving access to the appropriate tests and scans and reducing delays in diagnosis are tangible ways that our profession can improve the patient experience and outcomes. Importantly, this is in line with the goals of the NHS 10 year plan (The NHS long term plan. 2019) to provide more personalised care to people with chronic illness and support from integrated teams. However, the plan does not include direct funding or a care pathway for venous disease. Given PeVD's impact on quality of life and its wider economic cost, there's a strong case for more consistent commissioning and better integration of PeVD care into existing chronic pelvic pain pathways.

A Call to the CSVS Community

There is no national guideline for PeVD in the UK, no validated severity scoring system, and no standardised scanning protocol, which means inconsistencies and clear inequity in the pathway within the same hospital, regional network and across the UK. CVS could be key to improving the patient journey: we identify the incompetent superficial veins, we perform much of the venous ultrasound that could support a TAUS service, and we understand disease classification well enough to contribute meaningfully to any future scoring system for PeVD, building on frameworks such as the Symptoms-Varices-Pathophysiology classification (Meissner 2021). Practically, this could mean:





Both patients described here eventually had symptom relief. The problem was not that the treatment failed to work, it was that it took a long time to diagnose. That delay was structural rather than clinical. We need to work closely with vascular surgery, gynaecology and wider MDT and add our voice to improve the pathway and outcomes for this patient group. Closing the gap is a “women’s health” issue (Clayton 2022), but it is also a vascular science issue, and one where our profession has more to offer than we perhaps give ourselves credit for.

Dr Laura Scott

Vascular Studies Unit, Cambridge University Hospitals.

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Help Shape the Future of Non-Clinical Time in Vascular Science

The **CSVS Research Committee** is inviting all members to complete a short survey to help us better understand the recommended allocation of non-clinical time for Vascular Scientists across the UK.

Your feedback will help build a clearer picture of how non-clinical activities—such as audit, research, teaching, quality improvement, service development, leadership and continuing professional development—are currently supported within departments. The findings will inform recommendations and help shape future workforce planning and professional guidance.

The survey takes just a few minutes to complete and will remain **open until Sunday 7th September 2026**.

Please take the time to complete the survey and **share it with your colleagues** to help us gather as broad a range of responses as possible. Your contribution will help ensure the findings are representative of the vascular science community.

Thank you for supporting this important piece of work.

Please follow this link to the survey:

<https://forms.office.com/Pages/ResponsePage.aspx?id=sITDN7C-F9Ueylge0jXdO45VkkNu60-RPrGj4EAwOPexURUIVRExJT0xaU-jY2SkpWMUIJVIZXWDlxQi4u&origin=Invitation&channel=0>



What's happening in your department?

The CSVS Research Committee is keen to showcase the excellent research, audit, quality improvement, and service evaluation work being undertaken across the UK. If you or your department are involved in a project – whether ongoing or recently completed – we'd love to hear from you.

Sharing your work helps celebrate achievements, promotes collaboration, and demonstrates the breadth of research activity taking place within vascular science.

Please get in touch for publication.



Barriers to accessing venous healthcare in Bristol, UK

This is a short abstract from my STP research project completed at Newcastle University in 2025. I am extremely grateful to the CSVS for supporting this project following my successful application to the Research Grant Award and would highly recommend others exploring this award as a way of supporting their research aims. I wanted to write a piece for the newsletter to share this work with the membership whom may find it of interest.

Introduction

Healthcare utilization is often untimely in individuals experiencing homelessness and using intravenous drugs¹; known access barriers exist². Individuals in this population are high risk for acute (e.g. venous thrombosis) and chronic (e.g. post-thrombotic syndrome, ulceration, venous insufficiency) venous disease, which are both life limiting and life-threatening conditions. No studies exist to date that explore the relevance of healthcare access barriers to venous health from service user perspective.

“It could be a clot...but you’re a drug user...come back tomorrow”

The aims of this research were to:

1. Explore the relevance of known healthcare barriers to venous diagnostics and treatments
2. Explore barriers that exist specifically for accessing venous diagnostics and treatments

Methods

Identify sample	Convenience and purposive sampling ³ was used based in Bristol Drugs Project and Bris Doc Homeless Health GP Practice
Recruitment	Participants (n=15) recruited with lived experience of homelessness, intravenous drug use and venous disease
Interview	1:1 semi-structured interviews based on experiences of accessing venous healthcare. Participants paid £10 cash stipend for their time.
Analysis	Thematic analysis of interview transcripts using Braun and Clarke method, 2006 ⁴

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Results

Five separate themes emerged from the Thematic Analysis with some example quotes from the participants.

Theme heading	Example participant quote
Treatment limited to anticoagulation and/or compression only	"It's always, like, scan, "No blood clot, blood clot, blood thinners, f*** off," and that's it."
Knowledge and understanding of own health	"They [healthcare staff] wouldn't really sit down with me and explain what this meant ... The only person who'd do it was ... the drugs workers. I'd say to them, 'Do you know what this means or that means?' ... I'm not from a medical background so I don't really understand a lot of like ... I've got dyslexia as well, so reading writing can be quite difficult."
Competing Priorities	"Your time just gets consumed when you're homeless... you're going out and begging for money and stuff... you need to get well before you do anything.... So, you spend the whole day trying to get well. By the time you've done it, everything's shut"
Stigma	"I pressed the buzzer. In the time that I'd pressed the buzzer, I managed to hang myself, snap the sheet, and still it was about an hour and a half from the time I pressed the buzzer to the time they answered it"
Practical	"[Without my support worker] I'd be f****. But now, because ... I've got a mental health worker, I've got people behind me, they're ringing me up every day, make sure I know about this appointment."

Conclusions

Barriers previously reported to healthcare utilization¹² also apply to venous diagnostics and treatment including stigma, practical barriers and competing priorities to healthcare e.g., drugs or housing. Appropriate Opioid Substitution Treatment reduces the need to earn money for drugs, which readjusts priorities towards healthcare.

Specific venous barriers exist including:

- Venous ulceration and associated odor cause stigma and embarrassment
- Treatment for chronic venous conditions is limited to compression with inherent barriers from required compliance

- Harm reduction and homeless health services cannot refer individuals for specialist vascular review/imaging
- Poor knowledge in the target population of groin-related pathologies such as Deep Vein Thrombosis contributes to delayed presentation

If you would like to find out more, this work has recently been published in the Journal of Vascular Societies of Great Britain and Ireland. Full- text link: <https://doi.org/10.54522/jvsgbi.2026.229>

The author would like to acknowledge all the staff at Bristol Drugs Project (BDP) and Bris Doc Homeless Health without whom this research would not have been possible.





What is the UK/Royal Society Of Medicine Venous Forum?

A professional forum focused on improving the care, education, research and standards around venous disease in the UK.

RSM Venous Forum

- **Education and training** – conferences, workshops, webinars and teaching around venous disease.
- **Guidance and standards** – producing guidance to support evidence-based clinical practice, for example on venous leg ulcers and VTE prophylaxis for varicose vein procedures.
- **Research** – encouraging and supporting research into venous disease and new technologies.
- **Multidisciplinary collaboration** – bringing together vascular surgeons, vascular scientists, nurses, radiologists and other professionals involved in venous care.
- **Discussion/debate around emerging issues** – including who should deliver venous interventions, workforce issues, complex deep venous disease and appropriate use of new technologies.
- **Supporting trainees and early-career professionals** – through educational meetings, abstracts, presentations and opportunities to engage with experts.
- **Professional networking** – connecting people working in venous disease across the UK.
- **Raising the profile of venous disease** – particularly where there are problems with pathways, waiting lists, workforce or standards of care.

They also have a **Venous Forum Prize** for venous research presented at the Vascular Society Annual Scientific Meeting.

If you have any questions about the Venous Forum please reach out to venous.forum@csvs.org.uk

Venous Forum Conference 2026

The annual Venous Forum Conference returned in June 2026 with two packed days covering the diagnosis and management of venous disease. With expert talks, hands-on workshops, lively debates and plenty of opportunities to share knowledge and experience, there was something for everyone with an interest in venous disease.

Programme Highlights

The programme covered a wide range of topics, including:

- **The swollen leg** – venous leg ulcers, lymphoedema, lipoedema and compression.
- **Superficial venous disease** – including current controversies and treatment options.
- **Deep venous disease** – from iliac vein lesions and outflow obstruction to acute DVT.
- **Upper limb and pelvic venous disease** – including venous thoracic outlet syndrome.
- **Aesthetic and private practice** – including thread veins, sclerotherapy and the management of complications.

Hands-on Workshops

The conference wasn't all sitting and listening! A fantastic range of practical workshops gave delegates the opportunity to get hands-on with wound care and compression, mechanical thrombectomy, deep venous stenting, thermal ablation, sclerotherapy, VenaSeal and ultrasound-guided puncture and Vascular Scientist led hands on scanning demonstrations.



We started the day with coffee, introductions and a chance to catch up before getting stuck into a loaded programme.

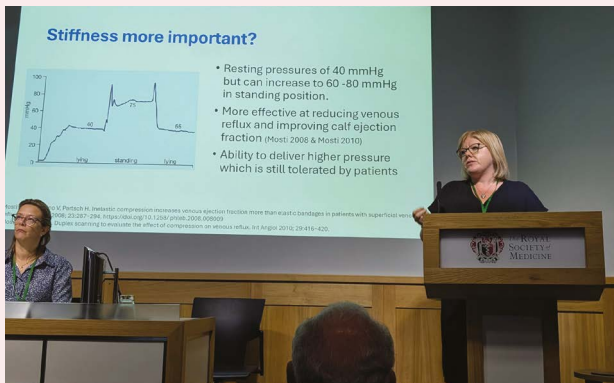
DAY 1

The afternoon began with an introduction from Professor Bruce Campbell – President of the Venous Forum, followed by a session on the wet swollen leg, delivered in collaboration with the Society of Vascular Nurses (SVN) and chaired by Siobhan Gorst, SVN President, and James Scurr.



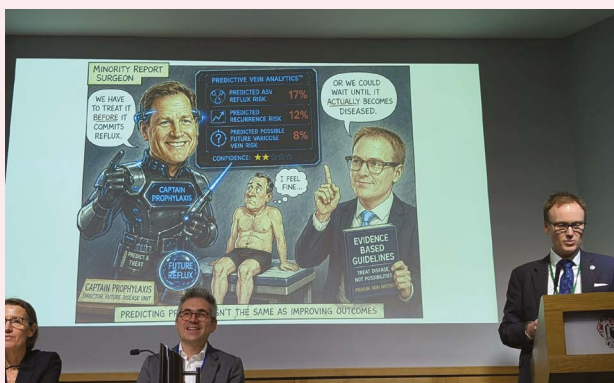
Dr Anusha Panthagani discussed lymphoedema and lipoedema, followed by Leanne Atkin exploring the myths, evidence and practical use of compression therapy. Vicky Bristow covered dressings and topical treatments, while Sandip Nandhra discussed medication in venous disease and leg ulcers. Tristan Lane finished the session by looking at when to investigate deep venous outflow obstruction in patients with venous leg ulcers.

Next came Controversies in Superficial Venous Disease, chaired by Emma Wilton and Baris Ozdemir. The highlight was undoubtedly the debate between Steve Black and Dan Carra-



dice on whether the anterior saphenous vein should be ablated prophylactically when the great saphenous vein is incompetent.

With two vascular heavyweights firmly on opposite sides, the gloves were off! There were strong arguments, plenty of personality and a few well-aimed digs – all delivered with plenty of humour and certainly giving the audience something to think about.



Manj Gohel then looked at when to intervene on incompetent perforator veins, expressing the challenge in finding evidence for treatment of perforator veins alone.

After a well-earned coffee break, things took a slightly more cosmetic turn with the British Association of Sclerotherapists (BAS) session, chaired by Zola Mzimba and Abdusalam Abu-Own.

Philip Coleridge Smith shared his expertise on treating thread veins, followed by Ian Franklin on managing complications when aesthetic venous treatment doesn't quite go to plan. Professor Bruce Campbell reflected on his experience of establishing a private practice, before Alastair Lewis explored cosmetic sclerotherapy beyond the lower limb.

The afternoon concluded with talks from the CSVS, including our current President Steve Rogers, who tackled the question: "Should vascular scientists do all lower limb venous scans?"

Klaus Bond also stepped in at short notice to deliver a presentation on the vascular scientist's role in the assessment and surveillance of deep venous disease. Despite having to adapt the presentation at the last minute, Klaus delivered an interesting and engaging talk. Thank you for stepping in, Klaus!



Presidents' Dinner

As always, the Presidents' Dinner provided a chance to put the clinical discussions aside, catch up and share a few humorous vascular stories!

It was also time to say farewell to Professor Bruce Campbell as he handed over the presidency to Professor Julie Brittenden. Bruce has achieved a great deal during his time as President and made a significant contribution to the Venous Forum. Thankfully, he isn't disappearing completely and will continue to contribute to the VF Council, bringing his wealth of experience and venous knowledge with him.

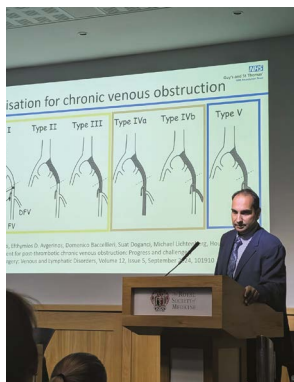


DAY 2

Day 2 got off to a flying start with abstract presentations, chaired by James Scurr and Taha Khan, before moving into a packed programme on deep, upper limb and pelvic venous disease.



The deep venous session, chaired by Baris Ozdemir and Hayley Moore, covered everything from non-thrombotic iliac vein lesions and chronic venous outflow obstruction to acute DVT and combined superficial and deep venous disease. Speakers included Marie Josee van Rijn, Taha Khan, Emma Wilton and Sandip Nandhra, providing plenty of discussion around when to treat, when not to treat and, importantly, which problem to tackle first!



The focus then moved to upper limb venous disease, with Arun Pherwani, Craig Nesbitt and Francesco Di Chiara sharing their expertise on thrombectomy, venous thoracic outlet syndrome and first rib resection.

The morning finished with pelvic venous disease, chaired by Zola Mzimba and Sarah Ndywayo. Ghada Salman, Marie Josee van Rijn, Phil Haslam and Huw Davies covered referral pathways, investigation, patient selection, pelvic vein embolisation and the management of vulval varicosities.

The Final Afternoon

The final afternoon explored vascular malformations, with Jocelyn Brookes discussing the investigation and management of limb malformations and Manj Gohel providing an update on Klippel-Trenaunay syndrome.

The latest trial and evidence updates followed, chaired by Julie Brittenden and Huw Davies, with contributions from Dan Carradice, Baris Ozdemir and Matthew Tan, covering THRIVE, C-TRACT, the European Venous Registry and the Pentoxifylline research programme.

The conference concluded with the Venous Forum Lecture, introduced by outgoing President Bruce Campbell. Professor Dan Carradice delivered "State of the Nation – Superficial Venous Disease and Venous Ulceration", providing a fitting finale to two days of learning and discussion.

The conference ended with the presentation of prizes, future plans and the final farewells.

And that's a wrap!

Two busy days packed with expert knowledge, practical learning, lively debate, new ideas – and, of course, plenty of coffee and vascular chat!

A huge thank you to all the speakers, organisers and delegates who made the 2026 Venous Forum such an enjoyable and valuable event.

The Venous Forum offers a valuable opportunity for vascular scientists to broaden their knowledge, share ideas and connect with colleagues across the wider venous community. We'd love to see even more vascular scientists getting involved, attending the meeting and bringing their expertise and perspectives to the conversation next year!

Written by: Vikki Galgerud
Royal Oldham Hospital

AVS Accreditation

Huge congratulations to these members for successfully passing their AVS Exams

- Chloe Bishop
- Hannah Stevens
- Rebecca Lamb
- Riya Adil
- Connor Hiscocks



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