Southwest Scotland Vascular Network - Vascular Surgery Referral Pathway

TARGET AUDIENCE	Primary and secondary care HCPs across NHS Lanarkshire, NHS Dumfries & Galloway and NHS Ayrshire and Arran
PATIENT GROUP	All patients being considered for referral to vascular services

Clinical Guidelines Summary

- This summary contains detailed guidance about what suspected conditions can and should be referred to vascular surgical services across the Southwest of Scotland.
- The guidance includes urgency criteria, contact information and general advice.
- Key contact details:
    - Vascular Registrar on call: 01355 585 260
    - Vascular Secretaries: 01355 524 743

Guideline Body

Emergency Referrals (all health boards)

Emergency referrals should be made **immediately** and should **always** be directed to the on call vascular surgical team by telephone.

Contact can be made *via* the switchboard of any Network Hospital. In the event of any difficulty;

- University Hospital Hairmyres: 01355 585 000
- Vascular registrar on call: 01355 585 260

The on call registrar will usually be the primary contact. In all other cases, switchboard will have instructions to direct your call to the on call consultant.

Examples of appropriate emergency referrals:

1. Aortic aneurysms that are:
    a. Ruptured
    b. Symptomatic (painful/tender/associated with distal embolism)
    c. Very large (> 8 cm)
    d. Infected, or infective in aetiology

2. Acute limb ischaemia.
    a. Sudden onset with loss of sensation/power.

3. Acute/critical mesenteric ischaemia.
    a. Critical mesenteric ischaemia is defined by the genesis of continuous abdominal pain on a background of chronic mesenteric ischaemic symptoms ("mesenteric angina").

4. Vascular trauma associated with haemorrhage or ischaemia.

5. "Complicated" diabetic foot infection (in daytime, urgent clinical photography is very helpful in decision-making but should not delay referral). "Complicated" is defined by:
    a. Presence of a clinically/radiologically apparent abscess
    b. Gas-forming infections (gas visible on x-ray or palpable soft tissue crepitus)
    c. Sepsis syndrome

6. **Acute** Thoracic Aortic Syndromes.
    a. Acute type B aortic dissections (not involving the ascending aorta).
    b. Acute aortic intramural haematomas
    c. Acute **symptomatic** penetrating aortic ulcers
    d. Type **A** Thoracic Aortic Dissections (involving the ascending aorta or aortic arch) should be referred to cardiac surgery at the Golden Jubilee National Hospital (GJNH). If there is any doubt, these should be discussed with the on call vascular team.

        i. GJNH switchboard: 0141 951 5000

7. Acute (<14 days) **common femoral/iliac vein** or **inferior vena cava** or **subclavian** DVT with severe symptoms.
    a. Please do not refer patients with mild/moderate symptoms or isolated femoro-popliteal/calf DVT; they should be managed with anticoagulation as per local guidelines.
    b. Severe symptoms are defined as:
        i. Severe pain (especially calf and groin pain)
        ii. Severe swelling and tenderness
        iii. Inability to weight bear/use limb/walk
        iv. Any concern about venous ischaemia/compartment syndrome
        v. Concerning imaging features (e.g. hanging IVC clot)

8. Acute femoral false aneurysms (usually in the context of intra-venous drug use).
    a. A CT angiogram should be performed locally

9. Acute haemodialysis vascular access problems.
    a. Thrombosed or bleeding arteriovenous fistula

Important notes

- Not all patients presenting with a vascular emergency will be transferred or accepted for treatment. Some patients will be more appropriately managed with palliative intent in their local hospital/nursing home. The vascular team will undertake to offer appropriate advice on management in this context. The vascular team may ask for an intensive care team review prior to transfer.

- For patients with ruptured aneurysms, please first check the electronic patient record – a decision will often have already been made that emergency surgery will not be appropriate.

- Groin abscesses in the context of intra-venous drug use should be referred to general surgical services in the first instance.

Urgent Referrals

From Primary Care (**all health boards**)

Urgent referrals should be made as **soon as possible** using the SCI gateway.

From Secondary Care

- **Referrals from outpatients and emergency departments in all health boards**

Urgent referrals should be as **soon as possible** by letter. The letter should be written and addressed to the consultant on call on the day of referral (switchboard and the vascular secretaries have a rota). The letter should be marked "Urgent"**.**

The letter should be delivered by urgent mail.

- **Referral for NHSL inpatients**

Urgent inpatient referrals in University Hospitals Hairmyres, Monklands and Wishaw should be made by as **soon as possible** by telephone to the on call vascular registrar.

- **Referral for NHS A&A inpatients**

Urgent inpatient referrals in University Hospital Crosshouse and University Hospital Ayr should be made as **soon as possible** to a monitored email inbox. The email should be marked "Urgent"**.**

aa.clinicavascularurgentipreferral@aapct.scot.nhs.uk

- **Referral for NHS D&G inpatients**

Urgent inpatient referrals in Dumfries and Galloway Royal Infirmary and the Galloway Community Hospital should be made as **soon as possible** to a monitored email inbox. The email should be marked "Urgent"**.**

dg.vascularservice@nhs.scot

- **Referrals for Urgent Carotid Surgery (all health boards)**

Patients who need to be referred for carotid revascularisation are referred in a particular manner; please refer to the separate guideline.

Any doubts about the urgency of a referral can be addressed to the on call team by telephone. Clinics are run across the network and patients will be reviewed close to home whenever this is feasible.

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Examples of appropriate urgent referrals:

1. Chronic limb threatening ischaemia (CLTI). CLTI is defined by the presence of:
    a. Gradual onset of ischaemic rest pain in the foot/toes.
    b. Ischaemic tissue loss (ischaemic ulceration or gangrene).
2. Symptomatic carotid artery disease.
3. Large aortic aneurysms (5.5 – 8 cm).
4. Chronic mesenteric ischaemia ("mesenteric angina").

Uncomplicated diabetic foot infections should be referred to medicine/endocrinology/podiatry for assessment and treatment in the first instance.

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Routine Referrals (all health boards)

From Primary Care and Secondary Care

Routine referrals should be made when convenient using the SCI gateway.

Examples of routine referrals:

1. Intermittent claudication
    a. These referrals will be forwarded to the community claudication service in most instances. Please consider referring directly to this service (if available in your health board).
2. **Complicated** varicose veins. As per government guideline, please **do not** refer patients with uncomplicated varicose veins, these patients will not be appointed. Please also bear in mind that intervention will rarely be offered in patients with obesity (BMI > 30; this increases treatment failure and complication rates). Complicated varicose veins are defined by:
    a. Presence of skin change (varicose eczema, brown skin staining, ulceration)
    b. **Recurrent** thrombophlebitis
    c. Venous haemorrhage
3. Asymptomatic small-to-medium sized aortic aneurysms (< 5.5 cm).
4. Vascular malformations.
5. Suspected vascular neoplasms (usually carotid paragangliomas).
6. Suspected thoracic outlet syndrome

Conditions/Procedures We Cannot Accept Referrals For

There are a group of conditions/procedures that have sometimes been referred to vascular surgery. We currently do not offer these services/procedures and cannot therefore accept referrals.

1. Hyperhidrosis (plantar, palmar, axillary or facial).
2. Facial flushing/blushing.
3. Temporal artery biopsy for assessment of giant cell arteritis.
4. Treatment for thread/spider/reticular veins.

It is important to note that we also cannot accept referrals to perform *routine ABPIs for permitting leg compression* (bandaging or hosiery).

Venous leg ulceration and chronic venous insufficiency (CVI)

Patients with CVI will normally be managed in primary care by community nurses under the supervision of a GP. Work is happening at a national level to streamline services for this problem. A vascular surgical referral is appropriate if there is a suspicion of **mixed aetiology leg ulceration** (i.e. an arterial component).

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Incidental and Asymptomatic Pathology/Findings in Frail, Older Patients; Realistic Medicine.

Given that age is the most dominant risk factor for arterial disease, many patients whom are frail or suffer from important co-morbidity will be diagnosed incidentally with arterial disease.

In patients with **incidental and asymptomatic** vascular pathology (e.g. aneurysms, mesenteric arterial atherosclerosis, aortic ulceration/plaque, etc.), if the **referrer's clinical judgement** is that investigation or intervention is **unlikely to be in the patients' best interest** due to **poor prognosis** from other co-morbidity (e.g. significant dementia, advanced cancer, significant frailty, etc.), **it is reasonable not to refer for an opinion**. If there is any doubt, the team can be consulted about the appropriateness of referral by telephone, email or letter.

Southwest Scotland Vascular Network

Appendices

1. Governance information for Guidance document

Lead Author(s):	Alex Vesey
Endorsing Body:	Vascular Department
Version Number:	1
Approval date	**21/08/2025**
Review Date:	**21/08/2026**
Responsible Person (if different from lead author)	

CONSULTATION AND DISTRIBUTION RECORD	
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Distribution	All HCP in primary and secondary in NHS Lanarkshire, NHS Ayrshire and Arran and NHS Dumfries and Galloway

CHANGE RECORD			
Date	**Lead Author**	**Change**	**Version No.**
		e.g. Review, revise and update of policy in line with contemporary professional structures and practice	1
			2
			3
		.	4
			5

2.You can include additional appendices with complimentary information that doesn't fit into the main text of your guideline, but is crucial and supports its understanding.

e.g. supporting documents for implementation of guideline, patient information, specific monitoring requirements for secondary and primary care clinicians, dosing regimen/considerations according to weight and/or creatinine clearance