management of varicose veins of the lower extremities.[8] All recommendations in Part I were based on a new, independent systematic review and meta-analysis[9] that provided the latest scientific evidence to support updated or completely new guidelines on evaluation with duplex scanning and on the management of superficial truncal reflux in patients with varicose veins. The writing committee recognized, however, that several additional important clinical issues need to be addressed, but many have varying levels of scientific evidence.[10-41] When a systematic review was not available, the writing committee based ungraded statements on a comprehensive review of the literature, combined with unanimous consensus of the expert panel.

Part II of the guidelines focuses on the rationale and scientific evidence for prevention and management of varicose veins with compression, medications, and nutritional supplements, as well as on evaluation and treatment of varicose tributaries, factors affecting treatment outcomes, the management of superficial vein thrombosis (SVT), thrombotic complications of varicose vein treatments, thrombus extension following ablation, management of bleeding varicose veins and the treatment of superficial vein aneurysms. This comprehensive document provides a list of all recommendations (Parts I-II), as well as consensus and best practice statements to aid practitioners with up-to-date, appropriate management of patients with symptomatic lower extremity varicose veins (Clinical stage, Etiology, Anatomy, Pathology [CEAP] Class C2 disease). Updates of other, previously published society guidelines[5,7,42,43] will address the management of venous ulcers, associated with varicose veins (C5-C6 disease), evaluation and treatment of deep vein obstructions and chronic pelvic venous disorders.

METHODS

A multisociety and multispecialty writing group that included 20 members authored both Part I and Part II of these varicose vein guidelines. The methods of writing Part I of the guidelines was described previously.[8] For Part II, the writing committee conducted a survey and held several meetings to compose a list of important clinical topics, not addressed in Part I, that are intended to guide comprehensive, up-to-date prevention and management of varicose veins and associated complications. A final list of 80 questions were divided into five sections, with each assigned to a writing group. The members of the groups performed an extensive search, up to January 31, 2023, of the English-language literature on their relevant topic, using the Ovid MEDLINE, Ovid Embase, PubMed, Scopus, Web of Science, Cochrane Library, and Ovid Cochrane Database of Systematic Reviews databases. Systematic reviews, meta-analyses, randomized controlled trials (RCTs), and prospective and retrospective observational studies that included >10 patients with varicose veins were used. Drafts of the writing groups were discussed on Zoom meetings, and all recommendations and statements were unanimously approved by the writing committee. All clinical practice guidelines in Part II were based on evidence established with one or several systematic reviews, with or without meta-analysis, using the GRADE method,[44-46] as described in detail in Part I of the guidelines.[8] We used the standard nomenclature of "we recommend" and "we suggest" to describe strong and weak recommendations, respectively.

To make these guidelines comprehensive and practical for clinicians, we developed three other types of ungraded statements, in addition to formal graded recommendations. *Good Practice Statements* are recommendations that are supported by indirect evidence that cannot be easily synthesized, yet the topic is usually noncontroversial and agreed upon by most stakeholders.[8] *Implementation Remarks* contain technical information that supports the implementation of specific recommendations.[47] *Ungraded Consensus Statements* refer to evaluation or treatment as a unanimous consensus of the expert panel, based on their own comprehensive review of the literature, even though some of the topics had minimal or low-quality evidence.

RECOMMENDATIONS AND STATEMENTS

1. Evaluation of patients with varicose veins

1.1. Classification and grading of clinical severity of chronic venous disorders.

1.1.1. We recommend the use of the 2020 updated CEAP classification system for chronic venous disorders. The clinical or basic CEAP classification can be used for clinical practice, and the full CEAP classification system should be used for clinical research.

Good Practice Statement

Rationale and evidence. The CEAP classification was designed at a consensus meeting of international experts in 1994,[48] it was updated in 2004,[49] and most recently in 2020.[50] The classification is based on clinical signs, etiology, anatomy and pathology (reflux and obstruction) of chronic venous disorders. The basic or clinical CEAP classification reports the single highest C class, and the advanced CEAP reports all C classes present in the limb. Patients with reticular veins (subdermal veins between 1 and <3 mm in diameter) and telangiectasias (subdermal spider veins, <1 mm in size) belong to Class C1. Varicose veins are dilated subcutaneous tributaries ≥3 mm in diameter and patients with varicose veins belong to CEAP Class C2. CVD is defined as CEAP Class C2 to C6, CVI includes limbs with CEAP Class 3 to 6.[49-52] The term CVI is reserved for advanced CVD with functional abnormalities of the venous system producing edema, skin changes, or venous leg ulcers.[51] Each clinical class has a subscript indicating the presence or absence of symptoms (s or a). Symptoms of varicose veins may include pain, burning, cramping, feeling of limb heaviness or swelling, restless leg or itching. The most important of these have been identified as HASTI symptoms and include heaviness in the legs, achiness, swelling, throbbing, and itching.[53,54] CEAP is