Northern Illinois Vein Clinic, LLC
Informed Consent for Liquid and Foam Sclerotherapy

Sclerotherapy is a very popular method of eliminating spider veins in which a solution, called a sclerosing agent, is injected into the veins. This causes an irritation to the inner lining of the vein resulting in closure of the vein. A small gauge needle is used to perform the injections and most patients relate the discomfort to an ant bite. The majority of persons who have Sclerotherapy performed have satisfying results. Unfortunately there is no guarantee that Sclerotherapy will be effective for you. In rare instances the condition may become worse after Sclerotherapy treatment. The number of treatments needed differs from patient to patient, depending on the extent of the problem.

Potential Risks and Side Effects

- **Most Common Side Effects:** The veins may be tender to the touch after treatment, and an uncomfortable sensation may run along the vein route. This discomfort is usually temporary. Bruising is very common and to be expected. Some patients complain of an itchy sensation after treatment, which is also very normal. Trapped blood may cause a discoloration, which can be expressed out, although this may leave hyperpigmentation up to one year.
- **Transient Hyperpigmentation:** After sclerotherapy you may notice some discoloration (dark streaks) after treatment. This occurs when the blood gets trapped inside the vein after it closes down. We can usually express the trapped blood out on your next visit. If the flushing does not alleviate the discoloration it will fade on it's own in 4 to 12 months. In rare instances this darkening of the skin may persist for years.
- **Skin Ulceration:** In rare cases, a blister may form, open, and become ulcerated. Healing occurs slowly over a few months. After healing, this will usually leave a scar.
- **Allergic Reaction:** Very rarely, a patient may have an allergic reaction to the sclerosing agent. The risk of this is greater in patients who have a history of allergies.
- **Rare Side Effects:** Arterial injection which can cause discomfort, scarring of the skin, injury to muscle or nerves or other tissues, or loss of limb. Neurological events can also occur more commonly in individuals with a history of migraine headaches or a known symptomatic right-to-left heart shunt (patent foramen ovale). Neurological side effects may include temporary visual and speech disturbances, headaches and transient ischemic attack (TIA). There have been rare cases of a cerebrovascular accident (CVA) reported in the literature. Deep Vein Thrombosis has also been rarely

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reported in the literature. The dangers of thrombosis include the possibility of pulmonary embolus (a blood clot carried to the lungs) and post phlebitic syndrome, resulting in a permanent swelling of the leg.

Alternative Treatments

Varicose veins and spider veins are not life-threatening conditions, treatment is not mandatory. Some patients get adequate relief of symptoms from wearing graduated support stockings. The other option is to receive no treatment at all.

Proposed Treatment Results

The practice of medicine and surgery is not an exact science, and therefore, reputable practitioners cannot guarantee results. While the overwhelming numbers of patients have noted gratifying results from Sclerotherapy, we cannot promise or guarantee any specific results.

Photography

I do_____ I do not____ consent to photographs and other audio-visual and graphic materials before, during and after the course of my treatment to be used for medical, marketing, and education purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

Informed Consent

By signing below, I acknowledge that I have read the foregoing information and understand the risks of Sclerotherapy, alternative methods of treatment, and the risks of not treating my condition. I have been given the opportunity to ask questions and I believe I have sufficient information to consent to treatment.

Patient Signature_____ **Date**_____

Patient Printed Name_____

Physician Signature_____ **Date**_____

Witness Signature_____ **Date**_____

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