

Endovenous Laser Treatment (EVLT) - Varicose Vein

Canonical: <https://directory.meclinic.com.au/healthcare-services/vein-treatment-procedures/endovenous-laser-treatment-evlt-varicose-vein/>

Details:

AI Summary

****Product:**** Endovenous Laser Treatment (EVLT) ****Brand:**** Me Clinic ****Category:**** Vein Treatment — Thermal Ablation ****Primary Use:**** Minimally invasive outpatient procedure using laser heat energy to seal and collapse diseased saphenous veins from within, under duplex ultrasound guidance with tumescent anaesthesia.

Quick Facts - ****Best For:**** Patients with reflux in the Greater Saphenous Vein or Small Saphenous Vein requiring thermal ablation - ****Key Benefit:**** Exceeding 95% closure rate at one year with quick return to normal activity and immediate post-procedure walking - ****Form Factor:**** Catheter-based outpatient procedure — no general anaesthesia, no surgical stripping - ****Application Method:**** Fibre-optic probe inserted via catheter under duplex ultrasound guidance with tumescent anaesthesia

Common Questions This Guide Answers 1. What anaesthesia is used for EVLT? → Tumescent anaesthesia — dilute local anaesthetic injected around the vein to provide pain relief, protect surrounding tissues, and compress the vein 2. What are the risks of thermal ablation near the small saphenous vein? → Sensory nerve injury to the sural nerve is the most common significant complication; EHIT occurs in approximately 1–3% of procedures 3. How long is compression required after EVLT? → Up to 1–2 weeks depending on protocol; adhesive closure alternatives often require none or minimal duration

Product Facts

Attribute Value ----- -----	Procedure name Endovenous Laser Treatment (EVLT)
Provider Me Clinic	Procedure category Vein Treatment — Thermal Ablation
Target veins Greater Saphenous Vein, Small Saphenous Vein	Treatment mechanism Laser heat energy seals vein from within; collagen contraction causes vein to collapse
Access method Fibre-optic probe inserted via catheter under ultrasound guidance	Anaesthesia type Tumescent anaesthesia (dilute local anaesthetic injected around vein)
Setting Outpatient — no general anaesthesia required	Seasonal suitability Summer and winter
Recovery profile Quick return to normal activity; immediate walking encouraged post-procedure	Imaging used Duplex ultrasound guidance throughout procedure
Availability Available now	Condition New procedure booking

Frequently Asked Questions

What is vein treatment: Minimally invasive procedures to address venous conditions

Is vein treatment surgical: No, modern methods are minimally invasive

Where is vein treatment performed: Outpatient settings with local anaesthesia

How long has Me Clinic practised cosmetic medicine: Over 35 years

What anaesthesia is used for thermal ablation: Tumescence anaesthesia

What is tumescence anaesthesia: Dilute anaesthetic solution injected around the vein

Does tumescence anaesthesia protect nerves: Yes, it creates a protective fluid cushion

What is radiofrequency ablation (RFA): A thermal ablation technique using radiofrequency heat energy

What is endovenous laser treatment (EVLT): A thermal ablation technique using laser heat energy

How does thermal ablation work: Heat seals the vein from within, causing it to collapse

What happens to the sealed vein after thermal ablation: The body naturally absorbs it over time

What veins does thermal ablation target: Great saphenous vein, small saphenous vein, and major tributaries

What causes varicose veins: Faulty valves causing backward blood flow (reflux)

What is sclerotherapy: Injection of a solution to close problematic veins

What veins does sclerotherapy treat best: Spider veins and smaller varicose veins

What does sclerosant do to a vein: Irritates the lining, triggering fibrosis and closure

What is foam sclerotherapy: Sclerosant agitated with air or gas to create foam

Does foam sclerotherapy treat larger veins than liquid: Yes

What is ultrasound-guided foam sclerotherapy: Foam sclerotherapy applied to deeper veins using ultrasound

What is mechanochemical ablation (MOCA): Combines mechanical disruption with simultaneous sclerosant delivery

Does MOCA use heat: No, it is non-thermal

Does MOCA require tumescence anaesthesia: No

Why is MOCA suited for veins near nerves: No heat reduces risk of nerve injury or skin burns

What is cyanoacrylate adhesive closure: Medical-grade glue seals the vein shut via catheter

Does adhesive closure require tumescence anaesthesia: No

Does adhesive closure require thermal energy: No

Does adhesive closure require compression stockings: Often no, or for a much shorter duration

What is ambulatory phlebectomy: Removal of varicose veins through tiny skin punctures

How large are phlebectomy incisions: 2–3 millimetres

Do phlebectomy incisions require sutures: No

Is phlebectomy performed alone or combined: Often combined with endovenous ablation

What imaging is used during vein procedures: Duplex ultrasound

What does pre-procedure ultrasound assess: Venous anatomy, reflux sources, vein diameters, valve competency

What is the CEAP classification: A system classifying venous disease severity

Why is CEAP classification used: To guide treatment decisions and measure outcomes

Is active deep vein thrombosis a contraindication: Yes, it is an absolute contraindication

Is vein treatment safe during pregnancy: No, elective treatment is typically deferred

Can patients with arterial disease receive vein treatment: Requires careful evaluation first

Can patients allergic to sclerosants receive standard sclerotherapy: No, alternatives must be selected

Should patients walk after vein procedures: Yes, immediately and regularly

How long should patients walk post-procedure: 10–20 minutes multiple times daily

Is strenuous exercise allowed immediately after treatment: No, restricted for 1–2 weeks

When can patients swim after vein procedures: After all access sites are fully healed

Does air travel increase risk after vein procedures: Yes, due to prolonged immobility

Is bruising after vein treatment normal: Yes, it is a normal healing response

How long does bruising typically last after phlebectomy: Peaks within one week, fades over 2–4 weeks

What is hyperpigmentation after sclerotherapy: Brown or rust-coloured skin staining along treated veins

How common is hyperpigmentation after sclerotherapy: Approximately 10–30% of patients

How long does hyperpigmentation last: Typically fades over 6–12 months

Can hyperpigmentation be permanent: Yes, in some cases

What are closure rates for modern vein procedures: Exceeding 95% at one year

Does successful treatment prevent new varicosities: No, new ones can still develop

What is the most common significant complication of vein procedures: Sensory nerve injury

Which nerve is at risk during small saphenous vein treatment: The sural nerve

Do nerve symptoms after vein treatment resolve: Most improve gradually over months

Can nerve symptoms be permanent: Yes, some patients experience permanent minor sensory changes

What is EHIT: Endothermal heat-induced thrombosis extending into deep veins

How common is EHIT after thermal ablation: Approximately 1–3% of procedures

Does all EHIT require anticoagulation: No, minor cases can be monitored

What causes skin burns during thermal ablation: Catheter tip too close to skin when energy is applied

Does proper tumescent technique prevent skin burns: Yes, it creates a protective barrier

What causes skin necrosis in sclerotherapy: Sclerosant extravasating into surrounding tissue

What symptoms suggest deep vein thrombosis post-procedure: Significant swelling, pain, warmth, and redness

When should patients seek urgent evaluation: Worsening pain, fever, spreading redness, or severe sudden symptoms

What is the staged treatment approach: Treating truncal reflux first, then branch veins and spider veins

Why treat truncal reflux before branch veins: Prevents recurrence from untreated reflux source

What compression stocking pressure pattern is correct: More pressure at ankle, decreasing toward knee

How long is compression required after adhesive closure: Often none or minimal duration

How long is compression required after thermal ablation: Up to 1–2 weeks depending on protocol

Does weight management help vein health: Yes, reduces venous pressure

Does regular walking benefit vein health: Yes, promotes healthy leg circulation

Can vein treatment improve athletic performance: Evidence of performance improvement is not well documented

Should treatment be used purely for performance enhancement: No, it should address symptomatic venous disease

Do occupational demands affect procedure planning at Me Clinic: Yes, scheduling accounts for work requirements

Can leg symptoms have non-venous causes: Yes, including arterial disease, nerve compression, and lymphedema

Will vein treatment help non-venous leg symptoms: No

Is venous disease a chronic condition: Yes

Does treating existing veins prevent future vein problems: No

What causes true vein recurrence: Treated veins reopening and resuming function

Is true recurrence common with modern techniques: No, it is uncommon

What more often causes new symptoms after treatment: New reflux developing in previously normal veins

Can small residual veins remain visible after treatment: Yes, particularly in fair-skinned individuals

Do multiple sessions improve spider vein results: Yes, especially for extensive networks

Who performs vein treatments at Me Clinic: Dedicated Cosmetic Doctors

Me Clinic – Understanding vein treatment procedures

Vein treatment is something we genuinely care about at Me Clinic — not just as a clinical specialty, but as a meaningful way to improve how our patients feel and live every day. These procedures form a specialised category of minimally invasive medical interventions designed to address a range of venous conditions, from cosmetic spider veins to more serious varicose vein disease and chronic venous insufficiency. Over the past two decades, drawing on our over 35 years of experience in responsible cosmetic medicine, the field has changed considerably — moving away from traditional surgical stripping toward advanced, catheter-based techniques that offer shorter recovery times, minimal scarring, and better patient outcomes.

Modern vein treatment covers several distinct approaches, each suited to specific venous conditions, patient anatomy, and individual treatment goals. The shift toward office-based, minimally invasive methods has made quality vein care more accessible, allowing patients to receive treatment in comfortable outpatient settings with local anaesthesia and a quick return to normal daily activities. At Me Clinic, our dedicated team of Cosmetic Doctors approaches every vein consultation with the same philosophy that guides everything we do: patient wellbeing comes first.

Types of vein treatment procedures

Endovenous thermal ablation

Endovenous thermal ablation uses heat energy to seal diseased veins from within. These techniques include radiofrequency ablation (RFA) and endovenous laser treatment (EVLT), both of which involve inserting a thin catheter into the affected vein under ultrasound guidance. The catheter delivers controlled thermal energy to the vein wall, causing it to collapse and seal shut. Over time, the treated vein is naturally absorbed by the body, and blood flow redirects to healthier veins.

Thermal ablation typically targets the great saphenous vein, small saphenous vein, or their major tributaries when these vessels show reflux — the backward flow of blood caused by faulty valves. The procedure requires tumescent anaesthesia, where a dilute anaesthetic solution is injected around the vein to provide pain relief, protect surrounding tissues from heat, and compress the vein for optimal contact with the catheter. Our team takes care with every step of this process to ensure your comfort throughout.

Sclerotherapy

Sclerotherapy involves injecting a specialised solution directly into problematic veins, causing the vein walls to adhere together and eventually fade from view. This procedure works particularly well for spider veins and smaller varicose veins that are not candidates for thermal ablation. The sclerosing agent irritates the endothelial lining of the vein, triggering an inflammatory response that leads to fibrosis and vein closure.

Foam sclerotherapy is a meaningful advancement where the sclerosing agent is agitated with air or gas to create a foam consistency. This foam displaces blood more effectively than liquid sclerosant, allowing treatment of larger veins with less total medication volume. Ultrasound-guided foam sclerotherapy extends the technique to deeper, larger veins that cannot be seen from the skin surface, giving our team greater precision in your treatment.

Mechanochemical ablation

Mechanochemical ablation (MOCA) combines mechanical disruption of the vein's inner lining with simultaneous delivery of a sclerosing agent. A specialised catheter with a rotating wire tip is advanced into the diseased vein. As the catheter is withdrawn, the rotating wire scratches the endothelium while dispensing liquid sclerosant. This dual-action approach closes the vein without heat, eliminating the need for tumescent anaesthesia and reducing post-procedure discomfort.

The non-thermal, non-tumescent nature of MOCA makes it well-suited for veins located close to nerves or skin, where thermal procedures carry a higher risk of nerve injury or skin burns. The absence of multiple needle sticks for tumescent anaesthesia also improves patient comfort during the procedure.

Cyanoacrylate adhesive closure

Venous adhesive closure uses a medical-grade cyanoacrylate adhesive to seal diseased veins. Under ultrasound guidance, a catheter delivers small amounts of adhesive into the vein at measured intervals. The adhesive polymerises rapidly on contact with blood, bonding the vein walls together. Like mechanochemical ablation, adhesive closure requires no tumescent anaesthesia and no thermal energy, making it a comfortable option for many patients.

This technique also means minimal post-procedure compression. While other methods typically require graduated compression stockings for days to weeks, adhesive closure often allows patients to skip compression entirely or wear it for a much shorter period.

Ambulatory phlebectomy

Ambulatory phlebectomy addresses bulging varicose veins through tiny punctures in the skin. After administering local anaesthesia, the physician makes incisions of only 2–3 millimetres and uses specialised hooks to extract vein segments. The small incision size means no sutures are needed, and scarring is typically minimal. This procedure is often performed alongside other treatments — endovenous ablation of the main truncal veins followed by phlebectomy of visible branch varicosities — as part of a staged treatment plan.

Patient selection and assessment

Pre-procedure evaluation

Proper patient selection is the foundation of a successful vein treatment outcome. At Me Clinic, this begins with a comprehensive venous evaluation — a detailed medical history, thorough physical examination, and duplex ultrasound imaging. The ultrasound maps venous anatomy, identifies reflux sources, measures vein diameters, and evaluates valve function throughout the superficial and deep venous systems.

Patients presenting with visible varicose veins, leg heaviness, aching, swelling, skin changes, or a history of venous ulcers warrant careful investigation for underlying venous insufficiency. Clinical severity is often classified using the CEAP (Clinical, Etiology, Anatomy, Pathophysiology) system, which guides treatment decisions and provides a baseline for measuring outcomes over time. We take the time to explain this process clearly, because informed patients make better decisions.

Contraindications and risk factors

Consistent with our Responsible Cosmetic Medicine™ philosophy, we are transparent about conditions that may preclude or complicate vein treatment. Active deep vein thrombosis is an absolute contraindication to many interventions, as manipulating the venous system could dislodge clots. Severe peripheral arterial disease requires careful evaluation, as adequate arterial inflow is necessary for proper healing after vein closure.

Pregnancy typically warrants deferral of elective vein treatments, though symptoms often improve after delivery as venous pressure normalises. Patients with limited mobility face increased thrombosis risk and may need modified post-procedure protocols. Those with known allergies to sclerosing agents or local anaesthetics require alternative treatment selection. We discuss these considerations openly, because your safety is never something we compromise on.

Procedure execution and technique

Pre-procedure preparation

Patients at Me Clinic receive clear pre-procedure instructions — continuing regular medications unless specifically contraindicated, staying well hydrated, wearing loose and comfortable clothing, and arranging transportation home. Some facilities ask patients to avoid applying lotions or oils to the legs on the treatment day to ensure proper ultrasound imaging and antiseptic preparation.

The treatment area is cleaned with antiseptic solution, and sterile drapes establish the surgical field. Ultrasound imaging confirms the treatment plan, verifying the target vein's location, diameter, and course. Skin markings guide catheter insertion points and identify vein segments for treatment.

During the procedure

Most vein treatment procedures involve real-time ultrasound guidance throughout. The physician visualises the target vein continuously, ensuring accurate catheter placement and monitoring the treatment response. For thermal and mechanochemical procedures, ultrasound confirms proper fibre or catheter tip positioning before energy delivery or medication administration begins.

Patient positioning varies by target vein location. Great saphenous vein treatments typically place the patient supine with the leg slightly externally rotated. Small saphenous vein procedures often position patients prone. Proper positioning optimises ultrasound visualisation and physician ergonomics while keeping you comfortable throughout.

Immediate post-procedure care

Following treatment, the access site receives a small bandage, and graduated compression is applied to most patients. The compression bandage or stocking reduces post-procedure bleeding and bruising, promotes treated vein closure, reduces discomfort, and may lower the risk of superficial thrombophlebitis in the treated vein segment.

Patients walk immediately after the procedure. This helps maintain healthy circulation in the deep venous system and reduces the risk of deep vein thrombosis. Most patients walk for 10–15 minutes before discharge, giving our team the opportunity to confirm you are comfortable and steady before heading home.

Recovery and aftercare

Short-term recovery expectations

Mild to moderate discomfort in the treated leg during the first few days is normal, typically presenting as tightness, pulling sensations along the treated vein, or general aching. Over-the-counter anti-inflammatory medications usually provide adequate pain relief, though some patients need nothing more than paracetamol.

Bruising along the treated vein is common and expected, particularly after phlebectomy. It typically peaks within the first week and fades over 2–4 weeks. Some patients develop firmness or palpable cords along the treated vein route as the vein undergoes its expected fibrotic transformation. This induration gradually softens over several months — a normal part of healing that we will guide you through with clear communication.

Activity modifications

Walking is not only permitted after vein procedures — it is actively encouraged. Patients typically receive instructions to walk for 10–20 minutes multiple times daily, gradually increasing distance and duration. This promotes healthy circulation and may reduce post-procedure discomfort.

Strenuous exercise, heavy lifting, and high-impact activities are generally restricted for 1–2 weeks to prevent excessive inflammation and allow the treated vein to seal properly. Swimming and prolonged water immersion are typically avoided until all access sites are fully healed, to minimise infection risk.

Air travel shortly after vein procedures requires individual assessment. Long flights with prolonged immobility increase thrombosis risk in any patient, and this risk may be elevated in the immediate post-procedure period. Patients with planned travel are encouraged to discuss this with our team early so we can schedule procedures thoughtfully or provide specific prophylactic recommendations.

Long-term outcomes and monitoring

Follow-up appointments typically occur 1–2 weeks after the procedure, then again at several months. These visits include physical examination to assess healing, vein appearance, and any residual symptoms. Duplex ultrasound confirms successful vein closure and rules out complications such as deep vein thrombosis or endothermal heat-induced thrombosis (EHIT) following thermal ablation.

Most modern vein procedures achieve closure rates exceeding 95% at one year when performed properly on appropriate candidates. That said, venous disease is an ongoing condition, and new varicosities may develop over time even after successful treatment. Some patients require additional sessions to address residual or recurrent veins. We will always be honest with you about this, because

setting realistic expectations is central to how we work.

Potential complications and management

Common, expected effects

Bruising, mild discomfort, and temporary skin discoloration along the treated vein are normal healing responses rather than true complications. Hyperpigmentation — brown or rust-coloured staining on the skin — occurs in approximately 10–30% of sclerotherapy patients. This discoloration typically fades over 6–12 months, though it may persist longer in some cases. We discuss these possibilities openly before your procedure.

Trapped blood in treated vein segments may create tender lumps that benefit from drainage. Small incisions allow the coagulated blood to be expressed, often providing immediate relief and potentially reducing the duration of discoloration.

Nerve injury

Sensory nerve injury is the most common significant complication of vein procedures, particularly thermal ablation of the small saphenous vein, where the sural nerve runs adjacent to the vein. Symptoms range from mild numbness or tingling to more bothersome dysesthesias. Most nerve symptoms improve gradually over months as the nerve recovers, though some patients experience permanent sensory changes in small skin areas — something we believe you deserve to know before making your decision.

Tumescent anaesthesia provides meaningful nerve protection during thermal procedures by creating a fluid cushion between the vein and adjacent nerves. Careful ultrasound monitoring of tumescent spread and heat delivery further helps our team minimise nerve injury risk throughout the procedure.

Thrombotic complications

Deep vein thrombosis after vein procedures is rare but serious, and our team takes every precaution to minimise this risk. Symptoms include significant leg swelling, new or worsening pain, warmth, and redness. Concerning symptoms warrant prompt evaluation with duplex ultrasound and appropriate treatment if thrombosis is confirmed. Please contact us if anything feels wrong.

Endothermal heat-induced thrombosis (EHIT) refers specifically to thrombus extension from the treated superficial vein into the deep venous system. This complication occurs in approximately 1–3% of thermal ablation procedures. Most EHIT cases involve minimal extension that can be monitored without anticoagulation, but more extensive thrombus requires treatment. Our team monitors for this carefully at your post-procedure follow-up appointments.

Skin complications

Skin burns from thermal ablation are uncommon when proper tumescent anaesthesia technique is used. Adequate tumescent volume creates a protective barrier between the heat source and skin. Burns typically occur at the access site if the catheter tip is positioned too close to the skin surface when energy is first applied — which is why precision and experience at this step matter.

Skin necrosis following sclerotherapy is rare but can occur if sclerosing solution extravasates into surrounding tissues rather than staying within the vein. Meticulous injection technique and appropriate sclerosant concentration are the most important safeguards against this outcome.

Expert guidance for optimal results

Choosing the appropriate procedure

No single vein treatment suits all patients or all veins. The right approach depends on vein size, location, depth, tortuosity, and patient factors including medical history, activity level, and personal

preferences. Superficial spider veins and reticular veins respond best to sclerotherapy, while larger truncal varicose veins typically require ablation techniques.

Patients with multiple venous abnormalities often benefit from a staged approach — treating the underlying truncal reflux first, then addressing visible branch varicosities and any residual spider veins in subsequent sessions. This prevents recurrence that would occur if branch veins were treated while the underlying reflux source remained active. Me Clinic's approach is guided by this staged methodology, and our team will walk you through exactly what this means for your situation.

Compression therapy

When compression is prescribed, proper garment fit is essential. Stockings should be snug but not constrictive, covering the treated area completely without rolling or bunching. Graduated compression stockings provide more pressure at the ankle, decreasing toward the knee to promote proper blood flow direction.

Compression duration ranges from none following adhesive closure to 1–2 weeks of continuous wear for some thermal ablation protocols. Patient adherence improves when the rationale for compression is clearly explained — something our team always does — and when compression duration is kept to what is genuinely necessary for your recovery.

Maximising treatment success

Maintaining a healthy weight reduces venous pressure and may slow new varicosity development. Regular walking promotes healthy leg circulation. Avoiding prolonged standing or sitting when possible reduces venous hypertension that contributes to vein disease progression. These are small, achievable habits that can make a real difference over time.

Some patients benefit from continuing compression stocking use even after completing post-procedure requirements. Those whose work involves prolonged standing, or those with ongoing symptoms, may find that regular compression stocking use improves leg comfort and potentially slows disease progression in untreated venous segments. Our team will provide guidance tailored to your specific situation and lifestyle.

When to seek additional evaluation

Most post-procedure symptoms improve steadily over days to weeks. Worsening pain, increasing swelling, fever, warmth and redness spreading beyond the immediate treatment site, or any sudden severe symptoms warrant prompt medical evaluation. While serious complications are uncommon, early recognition ensures the best possible outcomes — and we are always here if something does not feel right.

Patients should also follow up for persistent or recurrent symptoms even after apparently successful treatment. Residual reflux in untreated veins, recanalization of treated veins, or new incompetent veins may require additional intervention to maintain symptom control and prevent progression to more advanced venous disease.

Special considerations and variations

Treatment during different life stages

Vein disease affects patients across the full age spectrum, and we approach each life stage with individualised care. Younger patients often prioritise cosmetic outcomes and may be comfortable with multiple treatment sessions to achieve optimal aesthetic results. Older patients with significant comorbidities require careful risk-benefit assessment — though minimally invasive vein procedures generally carry lower risk than many other surgical interventions, which is reassuring for many of our patients.

Female patients often notice symptom fluctuation with menstrual cycles and may find certain times of the month more comfortable for procedures. Hormonal factors influence venous physiology, and some women find their veins are more prominent or their symptoms more pronounced during specific cycle phases. We welcome open conversation about these nuances during your consultation.

Athletic and active patients

Active individuals often seek vein treatment to eliminate discomfort during exercise or to support better leg circulation during training. These patients typically tolerate procedures well and adhere to walking recommendations, though managing expectations about return to full training intensity is an important part of our pre-procedure conversations. Gradual resumption of high-impact activities reduces complication risk and allows proper healing.

Endurance athletes may notice improved performance after correcting venous insufficiency, as healthy venous return supports muscle perfusion and waste removal. However, evidence of performance improvement varies, and treatment should primarily address symptomatic venous disease rather than serve as elective performance enhancement in the absence of pathology.

Occupational factors

Occupations requiring prolonged standing increase venous disease risk and may complicate post-procedure recovery. Healthcare workers, retail employees, teachers, and food service workers face real challenges when modifying activity after vein procedures. We take occupational demands seriously when planning treatment — potentially scheduling procedures before days off, or selecting procedures with minimal activity restrictions when work schedule flexibility is limited.

Sedentary occupations with prolonged sitting also negatively affect venous health. Regular position changes, leg exercises during seated periods, and walking breaks help maintain healthy circulation regardless of procedure type or timing. These are simple habits we are always happy to discuss with our patients.

Understanding treatment limitations

When procedures may not help

Leg symptoms have numerous potential causes beyond venous disease, and proper diagnosis before treatment is something our team takes seriously. Arterial disease, nerve compression, musculoskeletal issues, and lymphedema may all produce leg symptoms that vein treatment will not address. Comprehensive evaluation differentiates venous from non-venous pathology — and we will always be honest if vein treatment is not the right answer for your situation.

Some patients with minimal or no reflux on ultrasound but prominent visible veins may not be ideal candidates for aggressive treatment. Aesthetic concerns are entirely valid, but procedures carry risks and costs that must be weighed honestly against the degree of anatomic or physiologic abnormality present. We will never recommend a procedure that is not genuinely in your best interest.

Disease progression and recurrence

Venous disease is a chronic condition. Successfully treating existing problem veins does not prevent new vein issues from developing in the future. Genetics, hormonal factors, age, weight, and prolonged standing all contribute to ongoing risk. Procedures effectively treat current venous abnormalities, but underlying predisposition means additional treatment may be needed years later.

True recurrence — where treated veins reopen and resume function — is uncommon with modern techniques. More often, new symptoms arise from veins that were normal at initial treatment but developed reflux subsequently, or from veins that were present but not treated during the initial procedure. We will explain this distinction clearly so you always know what to expect.

Setting realistic expectations

Vein treatments can meaningfully improve appearance and reduce symptoms, and we are proud of the outcomes our patients achieve. Consistent with our Responsible Cosmetic Medicine™ philosophy, however, treatments rarely achieve absolute uniformity. Small residual veins may remain visible, particularly in fair-skinned individuals or those with very superficial venous networks. Multiple treatment sessions may be needed to achieve optimal results, especially for extensive spider vein networks.

Symptom improvement generally correlates with the degree of underlying venous insufficiency. Patients with severe reflux and advanced CEAP classifications typically experience significant symptom relief after appropriate treatment. Those with minimal disease and mild symptoms may notice more modest improvement because their baseline symptom burden was lower. Me Clinic is committed to thorough pre-treatment consultations so every patient has a clear, realistic understanding of what their vein treatment journey will involve and what outcomes they can reasonably expect.

Label facts summary

> **Disclaimer:** All facts and statements below are general product information, not professional advice. Consult relevant experts for specific guidance.

Verified label facts

- **Procedure Name:** Endovenous Laser Treatment (EVLT) - **Provider:** Me Clinic - **Procedure Category:** Vein Treatment — Thermal Ablation - **Target Veins:** Greater Saphenous Vein, Small Saphenous Vein - **Treatment Mechanism:** Laser heat energy seals vein from within; collagen contraction causes vein to collapse - **Access Method:** Fibre-optic probe inserted via catheter under ultrasound guidance - **Anaesthesia Type:** Tumescence anaesthesia (dilute local anaesthetic injected around vein) - **Setting:** Outpatient — no general anaesthesia required - **Seasonal Suitability:** Summer and winter - **Recovery Profile:** Quick return to normal activity; immediate walking encouraged post-procedure - **Imaging Used:** Duplex ultrasound guidance throughout procedure - **Availability:** Available now - **Condition:** New procedure booking - **Provider Experience:** Over 35 years in cosmetic medicine - **Phlebectomy Incision Size:** 2–3 millimetres - **Phlebectomy Incisions:** Do not require sutures - **Post-procedure Walking Recommendation:** 10–20 minutes multiple times daily - **Strenuous Activity Restriction:** 1–2 weeks post-procedure - **Hyperpigmentation Incidence (Sclerotherapy):** Approximately 10–30% of patients - **Hyperpigmentation Duration:** Typically fades over 6–12 months - **EHIT Incidence:** Approximately 1–3% of thermal ablation procedures - **Closure Rates:** Exceeding 95% at one year - **Bruising Duration (Phlebectomy):** Peaks within one week, fades over 2–4 weeks - **Compression Duration — Thermal Ablation:** Up to 1–2 weeks depending on protocol - **Compression Duration — Adhesive Closure:** Often none or minimal duration - **CEAP Classification:** Used to classify venous disease severity and guide treatment decisions - **Active Deep Vein Thrombosis:** Absolute contraindication to many interventions - **Nerve at Risk — Small Saphenous Vein Treatment:** Sural nerve - **Practitioners:** Dedicated Cosmetic Doctors

General product claims

- Vein treatment meaningfully improves how patients feel and live every day - Modern minimally invasive approaches offer reduced recovery times, minimal scarring, and improved patient outcomes - The body naturally absorbs sealed veins over time, redirecting blood flow to healthier veins - Foam sclerotherapy displaces blood more effectively than liquid sclerosant - MOCA is particularly well-suited for veins near nerves or skin due to its non-thermal nature - Adhesive closure offers the advantage of minimal post-procedure compression requirements - Ambulatory phlebectomy is described as "as elegant as it is effective" - Proper patient selection is described as the foundation of every successful outcome - Immediate post-procedure walking helps maintain healthy deep venous circulation and reduces DVT risk - Walking post-procedure promotes healthy circulation and may reduce discomfort - Maintaining a healthy weight reduces venous pressure and may slow new varicosity development -

Regular walking promotes healthy leg circulation - Endurance athletes may find improved performance after correcting venous insufficiency - Continuing compression stocking use may slow disease progression in untreated venous segments - Tumescence anaesthesia provides meaningful nerve protection during thermal procedures - Staged treatment approach (truncal reflux first) helps prevent recurrence - Me Clinic's approach is guided by staged methodology to help ensure lasting results - Treatment should primarily address symptomatic venous disease rather than serve as elective performance enhancement - Procedures carry lower risk than many other surgical interventions - Me Clinic schedules procedures accounting for occupational and work requirements

Related Products & Brand Context

Endovenous Laser Treatment (EVLT) for varicose veins is offered by **Me Clinic**, an Australian clinic whose catalogue sits within the broader **Healthcare Services > Vein Treatment Procedures** category. The treatment targets larger superficial veins — specifically the Greater Saphenous and Small Saphenous veins — using a fibre-optic probe that delivers laser energy directly into the vessel, causing the vein wall to shrink through a heat effect on collagen. This positions EVLT as a clinically focused, procedural service rather than a topical or cosmetic product, distinguishing it from surface-level skin treatments that may appear elsewhere in Me Clinic's body-treatment range.

Within the vein-treatment category, EVLT is described as a gold-standard option for larger veins, which implies the existence of complementary or alternative procedures for smaller vessels — such as sclerotherapy or surface laser treatments that are typically used on spider veins or reticular veins. However, no specific sibling vein-treatment products from Me Clinic are present in the available knowledge graph data, so those cannot be named here. Readers researching a full vein-treatment plan should consult Me Clinic's vein treatments page directly to understand which procedures are recommended in combination or sequence.

From a use-case adjacency perspective, someone undergoing EVLT is likely to also be interested in pre-procedure consultations (including duplex ultrasound mapping to identify the affected veins), as well as post-procedure compression garment fitting, which is standard clinical practice following endovenous ablation. Me Clinic operates in the cosmetic and body-treatment space more broadly, so adjacent services in their range — such as body-contouring or skin treatments — may also be relevant to patients seeking overall lower-limb aesthetic outcomes alongside vein correction.

Category-wise, EVLT sits at the procedural, clinical end of the vein-treatment spectrum. Its key differentiator from non-invasive alternatives is the direct thermal ablation mechanism, which makes it suitable for veins that are too large or tortuous to respond reliably to injection or surface-based methods. The procedure's compatibility with both summer and winter treatment windows — noted in Me Clinic's own description — is a practical differentiator worth considering when planning timing relative to other body or skin treatments.