The first time you watch a troublesome leg vein blanch and fade as the sclerosant threads through it, two questions rise fast: how will the next few weeks feel, and when will it look better. Sclerotherapy, the umbrella term for vein removal injections, can be swift in the chair and slower in the mirror. Understanding that timeline, and what counts as normal along the way, keeps expectations aligned with biology.

What vein injection therapy actually does

Sclerotherapy uses a targeted irritant, a sclerosant, to collapse a diseased vein from the inside. The medication injures the vein lining so the walls stick together, then the body gradually absorbs the closed vein over weeks to months. For spider veins and small reticular veins, liquid sclerotherapy is a workhorse. For slightly larger varicose branches and hidden feeders, foam sclerotherapy increases contact with the vein wall and provides better control under ultrasound.

Most vein clinics use polidocanol or sodium tetradecyl sulfate. Both have long safety records when used correctly. Hypertonic saline still appears in some practices, though it can sting more and is less forgiving around the ankles. Micro sclerotherapy refers to work on very small spider veins with ultrafine needles. Ultrasound guided sclerotherapy, also called image guided sclerotherapy, is used for veins you cannot see at the surface, especially the reticular veins that feed spider clusters and superficial varicose tributaries in the calf and thigh.

Cosmetic sclerotherapy and medical sclerotherapy share the same tools. The difference is intent and documentation. If your goals center on appearance and there are no symptoms, it is cosmetic. If you have aching, swelling, night cramps, skin changes, or a history of superficial thrombophlebitis, it may be medical vein injections with different coverage and a broader plan. Not every vein is a candidate for injections alone. Large saphenous trunks often respond better to thermal ablation or cyanoacrylate sealing, with sclerotherapy used to tidy branches after. A good clinic will lay out a sequence, not just a single procedure.

How the appointment unfolds

A typical office based vein injection appointment runs 20 to 45 minutes, depending on the number of sites and whether ultrasound is used. Expect mapping with a pen, sometimes a quick ultrasound to find feeder veins, then a series of small injections through 27 to 30 gauge needles. The sensation ranges from a brief pinch to a mild burn. Foam is often made chairside by mixing sclerosant with air or CO2 to a fine consistency, then pushed in small volumes. Careful operators use slow, low pressure injections and pause to watch the vein blanch.

After the sclerotherapy procedure, we apply compression stockings, usually 20 to 30 mmHg, or a snug wrap for the first day if we treated larger varicose tributaries. You will be asked to walk for 10 to 20 minutes before you leave. Most patients drive themselves home. The entire process fits neatly into a lunch break if only spider veins are treated. Ultrasound guided sessions for deeper reticular veins take a bit longer, and sometimes we limit total foam volume to reduce the odds of transient side effects.

What the next hours feel like

Expect tightness from the compression and a dull ache in the treated segments when you start moving. That ache is not a bad sign. It tells you the vein is inflamed and closing. Bruising is common, especially where we chased small varicosities near the knee and ankle. If we treated near the ankle bone or along the shin, tenderness can surprise you for a few days because tissue is thin there. Many patients describe an itch along the injection paths that peaks at day two or three. Short lived hives can happen if you are prone to histamine responses.

Over-the-counter pain relief is usually adequate. Most clinics allow acetaminophen freely, and either allow or limit NSAIDs like ibuprofen depending on preference. If you take a daily aspirin or an anticoagulant for medical reasons, do not stop it without your prescribing doctor’s guidance. Topical arnica, if you like it, can help the look of bruises but does not change closure rates.

A simple first week checklist

- Walk at least 30 to 60 minutes daily, broken into shorter sessions if needed.
- Keep compression stockings on day and night for the first 24 to 48 hours, then daytime only for 1 to 2 weeks unless your doctor advised longer.
- Avoid heavy leg workouts, high impact exercise, and hot tubs or saunas for 3 to 7 days.
- Keep injection sites out of strong sun for 2 to 4 weeks, especially if you bruise or have olive or brown skin.

- Elevate legs for short periods if they throb at day’s end, then resume gentle walking.

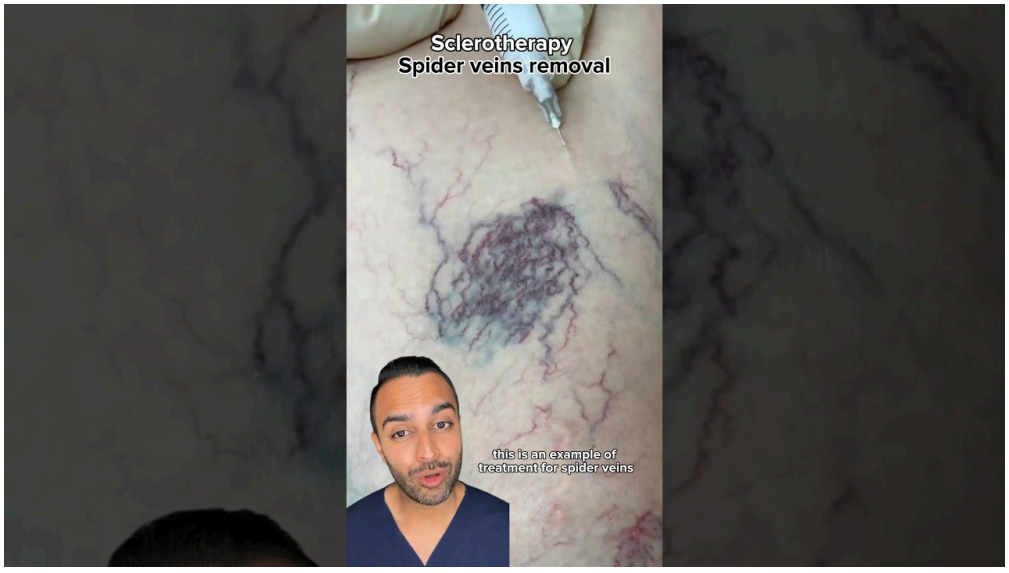
Day by day, then week by week

First 24 hours: The veins often look angrier before they look better. Treated lines can turn cordlike and darker. This is expected, especially after foam sclerotherapy for varicose vein injections. You might see small raised wheals where we injected. They usually calm within hours.

Days 2 to 3: Bruises show fully. Itch can peak. A low grade ache comes and goes with activity. Keep moving, avoid heat, and wear your compression during the day. Short flights are usually fine after 24 to 48 hours if you keep stockings on, hydrate well, and walk the aisle. For long haul travel, most vein specialists prefer you wait a week.

End of week 1: Much of the early tenderness has eased. The surface can still look worse than baseline. Broken capillary treatment around the ankle often leaves tiny scabs where the needle entered. Normal showering is fine. Heavy squats, sprinting, and hot yoga can wait another few days.

Weeks 2 to 4: This is when cosmetic patience matters. Visible veins are undergoing resorption. Some areas look mottled. You might see tan or rust colored lines where a cluster lived. That is hemosiderin staining from trapped red cells. It fades in many patients over 2 to 6 months, faster if the vein was small and the skin is light. For olive and brown skin, it can linger and needs careful counseling up front. If a segment feels like a tender bead, it may be trapped blood. A quick in office drainage with a tiny needle at the 2 to 4 week mark speeds comfort and clears the color.



Weeks 6 to 12: Spider veins that responded will be flat or gone. Remaining threads are candidates for a touch up session. Reticular veins and larger varicose tributaries take longer. You often see steady improvement across this window rather than a single turning point. Many patients schedule a follow up leg vein sclerotherapy session here to tidy what remains.

Months 3 to 6: The end point for larger treated veins. Cordlike varicose branches soften and melt into the background. If we treated hidden feeders with ultrasound guided sclerotherapy, recurrence is lower and surrounding spider matting calms faster.

What counts as a good result

For spider vein injections, expect 70 to 90 percent clearance after one to three sessions, spaced 4 to 8 weeks apart. Single session miracles happen in small clusters, but planning for at least two gives a more honest roadmap. For varicose vein removal injections aimed at tributaries, success usually means the bulge is gone and symptoms like ache and local swelling improve. Closure rates with foam sclerotherapy for these branches commonly reach 80 percent or better, and we can re-treat any persistent segments.

If you had significant symptoms from a refluxing saphenous trunk, injections alone may not be ideal. A staged plan that treats the trunk with endovenous ablation and uses ambulatory sclerotherapy for branches usually gives more durable relief. Cosmetic vein removal is not a one time lifetime fix, particularly if your family history, occupation, or pregnancies stacked the deck. New spider veins can appear in new places. Most people come back every couple of years for micro sclerotherapy touch ups.

Photos help. Sclerotherapy before and after images taken under the same light at the same distance are more honest than a memory of imperfect legs. Ask your clinic for standardized images and set your follow up at 8 to 12 weeks for spiders, 3 to 6 months for larger branches, so you are comparing at a meaningful interval.

Managing the bumps in the road

Trapped blood: This looks like a tender, ropey, sometimes purple line weeks after treatment. It is not a dangerous clot. It is stagnant blood in a successfully closed vein. We often nick the skin with a sterile needle and express it. The relief is immediate and it speeds fading.

Matting: Fine new red vessels that look like a blush around a treated area. It can show up in 2 to 6 weeks, especially in hormonally sensitive zones like the outer thigh. Treating the feeder reticular vein, if not already addressed, helps. Micro sclerotherapy with very dilute solution or a pass with a vascular laser can settle it. It often improves over months without intervention.

Hyperpigmentation: More likely on the shin and ankle, and in darker skin types. Compression, early evacuation of trapped blood, and sun avoidance lower the risk. If pigment lingers beyond 6 months, we discuss topical lightening agents, careful microneedling, or laser in select cases, though time remains the most reliable fix.

Superficial thrombophlebitis: A hot, reddened, tender cord in a surface vein. It can occur in untreated or treated segments. Warm compresses, NSAIDs if allowed, and continued walking resolve most cases within a couple of weeks. Ultrasound rules out extension into deep veins if the area is near a major junction.

Ankle flare: The inner ankle can itch and swell more than expected. The skin is thin and collateral veins abound. We favor lower sclerosant concentrations and soft padding under compression in this zone to reduce issues.

Real risks and how we mitigate them

Deep vein thrombosis is rare after modern sclerotherapy, especially for spider and small reticular veins. The risk rises with recent immobilization, known thrombophilia, major varicose trunks, or very long travel around the time of treatment. We screen for these, adjust technique, and encourage early walking and compression. Sudden calf swelling, significant asymmetry, or shortness of breath is not a wait and see situation. Call your clinic urgently or seek emergency care.

Skin injury, including ulceration, can follow inadvertent arterial injection around the ankle or a high pressure extravasation. Good lighting, small volumes, slow injection, and constant observation of skin changes keep this incredibly rare. If it occurs, early recognition and wound care are crucial. Avoiding high concentration sclerosant in delicate zones also helps.

Allergic reactions to polidocanol or sodium tetradecyl sulfate are very uncommon. A history of severe product allergy alerts the team, and we keep emergency medications on hand. Foam sclerotherapy can cause transient visual aura, cough, or a metallic taste. Patients with a history of migraines with aura seem more prone. We reduce foam volume, choose liquid sclerotherapy for small areas, and break sessions up if you have this history. Serious neurologic events are exceedingly rare, and preprocedure counseling covers the numbers relevant to your case.

Pregnancy is a common reason to wait. We defer elective sclerotherapy until after delivery and the end of breastfeeding because hormonal shifts and increased blood volume can undo work and because safety data are limited. Active skin infection, uncontrolled autoimmune disease, and acute deep vein thrombosis are also reasons to postpone.

Technique choices that shape recovery

Foam vs liquid: Foam displaces blood, contacts the vein wall longer, and is visible under ultrasound. It is excellent for varicose tributaries and larger reticular veins. It can produce more early tightness and a higher chance of transient visual symptoms in sensitive patients. Liquid sclerotherapy suits smaller spider veins and scattered broken capillaries, with less post procedure ache.

Micro sclerotherapy: This is the meticulous, needle tip work of spider vein therapy. We use near me vein treatment sclerotherapy very small volumes, dilute solutions, and often a bright transilluminator to find feeders. Recovery is usually mild, but pigmentation risk exists if you bruise easily.

Ultrasound guidance: Image guided sclerotherapy lets us see beyond the skin, locate feeder reticular veins, and avoid arteries. It reduces recurrence and matting around stubborn clusters. Compression is a bit more important afterward because we treat deeper segments.

Ambulatory sclerotherapy: This simply means you walk in and out the same day. Almost all leg vein removal treatment today fits this description. Office based vein injections avoid general anesthesia and the downtime that comes with surgery.

Compression that helps more than you think

The right stocking is the cheapest insurance for a smooth sclerotherapy recovery. For most legs, 20 to 30 mmHg knee highs are enough. Thigh highs or pantyhose are handy if we worked high on the thigh, at the groin, or if you prefer a continuous garment. Try them on before your first session so you know the fit. Put them on in the morning when legs are least swollen.

How long to wear them depends on what we treated. For spider vein sclerotherapy, I advise continuous wear for 24 to 48 hours, then daytime wear for a week. For reticular and varicose tributary work, daytime wear for 2 weeks gives a cleaner result and less aching. If your job requires prolonged standing, consider 3 to 4 weeks. On hot days, rotate pairs so you can wash one and wear one. A small amount of cornstarch or a donning aid helps them slide on without wrestling.

Activity, heat, sun, and skincare

You can return to desk work the same day. Light household tasks are fine. I tell patients to avoid max effort lower body workouts and long runs for 3 to 7 days, especially after foam vein injections to larger segments. Swimming is fine after needle sites close, usually within 24 hours, but skip hot tubs and saunas for a week. Heat dilates veins and can worsen inflammation. Direct sun on bruises can fix pigment, so cover treated zones or use UPF clothing for a few weeks. A simple fragrance free moisturizer keeps skin supple under stockings.

If you use retinoids or aggressive exfoliants on the legs, hold them the week around treatment to avoid extra irritation. Do not schedule waxing in the first few days after a session. For facial sclerotherapy and hand vein sclerotherapy, protocols differ slightly. We use tiny volumes, lighter compression if any, and stricter sun avoidance. Some facial veins respond better to laser than to injections, especially in the nose and cheek where arterial connections are complex. Your vein doctor will guide you.

Cost, coverage, and planning

Sclerotherapy cost varies by region and scope. In the United States, a session for spider veins typically runs 300 to 600 dollars. Ultrasound guided foam sclerotherapy for varicose branches is often 500 to 1,000 dollars per session, more if extensive. Packages can bring the per session price down. If your indications are medical, with documented symptoms and reflux on ultrasound, insurers sometimes cover image guided sclerotherapy as part of a broader treatment plan. Cosmetic vein injections, including thread vein injections around the ankle and thigh, are rarely covered.

Expect one to three sessions for scattered spider veins, sometimes four if clusters are dense or longstanding. For larger varicose tributaries treated with foam, two sessions a few weeks apart is common. Build in the cost of compression stockings, typically 40 to 120 dollars per pair, and one or two brief follow up visits for drainage of trapped blood if needed.

Who is a good candidate

Ideal candidates for sclerotherapy for spider veins aim for a clearer look, understand that touch ups are normal, and can commit to walking and compression for a short period. If you have restless legs at night, ankle swelling, or eczema like skin changes around the inner ankle, ask for a full venous ultrasound before any cosmetic work. Hidden refluxing veins can feed the surface nets. Treating the source, often with endovenous ablation followed by ambulatory sclerotherapy, prevents chasing your tail.

We defer elective vein injection treatment in pregnancy and in the early postpartum window. If you have poorly controlled diabetes with skin fragility, severe peripheral arterial disease, or limited mobility that prevents walking soon after the session, we may choose a different path or modify the plan. For patients on anticoagulants, sclerotherapy can still work. Bruising lasts longer, and we use lower concentrations, but closure rates remain good.

A patient story that maps the path

A teacher in her mid 40s came in with dense spider webs on both outer thighs and a few bulging reticular veins behind the knees. Two pregnancies, years on her feet, and a mother with similar legs. We confirmed normal saphenous veins on ultrasound, then scheduled micro sclerotherapy for the spiders and foam sclerotherapy under ultrasound for the feeders.

Session one focused on the right leg. She walked immediately, wore 20 to 30 mmHg stockings for 10 days, and texted a photo at week two worried that her veins looked darker. At week four, we drained two small trapped blood beads. At week eight, we treated the left leg and did a brief touch up on the right. At three months, the outer thighs were 80 to 90 percent clearer, the cords behind the knees were gone, and only a faint tan line remained where a dense cluster had been. She came back a year later for a short tidy up after a summer of field trips and long drives.

What to ask at your sclerotherapy consultation

Ask whether the plan includes a venous ultrasound. Even cosmetic cases benefit when feeder veins are mapped. Clarify which sclerosant and concentration your clinic prefers and why. Foam or liquid, or both. Discuss compression length and activity limits that fit your work and family demands. Review the specific risks for the areas you plan to treat, especially around the ankle and shin. If you have a history of migraines with aura, speak up so the team can tailor foam volumes. Finally, look at sclerotherapy before and after photos from your clinic, matched to your skin tone and vein pattern, to set a shared target.

When to call the clinic after injections

- Sudden calf swelling or pain that does not improve with walking and elevation.
- Shortness of breath, chest pain, or coughing up blood, which requires emergency care.
- Spreading redness, pus, or fever around an injection site.
- Severe blistering or skin breakdown near a treated area.
- Visual changes, severe headache, or neurologic symptoms that persist beyond an hour.

Finding the right hands

Typing sclerotherapy near me brings up a long list of options. Narrow it by looking for a dedicated vein injection clinic or a vascular practice where vein care is a core service, not an add on. Board certification in vascular surgery, interventional radiology, or phlebology is a reasonable marker, but volume and outcomes matter more. Ask how many sclerotherapy sessions the clinician performs each month, how often they use ultrasound guidance, and how they manage complications such as trapped blood or matting. A good vein injection specialist will welcome your questions and will not rush you into a one size fits all package.

Sclerotherapy remains one of the most satisfying non surgical vein treatments we do. The procedure is quick, the recovery is measured in days, and the results last when anatomy and aftercare line up. If you know what to expect over

the first week, what the mirror might show at six weeks, and how the three to six month finish line looks, you walk in with confidence and walk out with a plan.