Supplemental material

Table 1: Functions from the Functional Resonance Analysis Method (FRAM) model Limburg

Function*	**Description of function**	**Variability**
1a. To identify indications for initial compression therapy (internist/GP)	The indication for initial compression therapy in the acute phase after a diagnosis of DVT is made by the GP at the general practice or the internist in the ER.	Variations occur since GPs are not always aware of the treatment indications for initial compression therapy in patients without edema. Patients are then directly referred to the medical stocking supplier for definitive ECS without initial compression therapy. The result of omitting initial compression therapy is a delay in the onset of compression therapy and preventing function 3b from occurring.
1b. To identify indications for initial compression therapy (dermatologist/GP)	The indication for initial compression therapy after a diagnosis of CVI can be made by the GP or the dermatologist. Thereafter the physician informs the doctor's assistant to apply the multilayer compression bandages.	Variation is not mentioned due to the use of clear protocols and similarities in recommendations.
2. To consider and choose initial compression therapy (internist/GP)	When the indication for compression therapy is made, the treating physician (GP/internist) needs to decide what type of initial compression therapy is indicated. The GP chooses multilayer compression bandages, based on the NHG-standard, and informs the doctor's assistant to apply them. The internist chooses a temporary compression hosiery unless there are contra-indications and informs the ER nurse to apply them. If contra-indications exist, the internist chooses multilayer compression bandages based on the DVT-protocol and contacts the bandage master to apply them.	Variations occur since internists and GPs are using different protocols. GPs are not always aware of the different possibilities for initial compression therapy and there is a lack of detailed information in their current guideline (NHG-standard). Patients automatically become dependent on home care or need to visit the outpatient clinic for the application of the multilayer compression bandages. This affects function 6a-c.
3a. To apply the temporary compression hosiery and give instructions (ER nurse)	The ER nurse measures the leg circumference at different places and determines the requested size for the temporary compression hosiery. Thereafter the nurse fits the hosiery and instructs the patient on how to apply	Variation occurs based on the nurses' experience to apply the temporary compression hosiery, give instructions, and the knowledge of their role and responsibilities in the process. Thereby

	it independently at home using a disposable donning slide which the patient can take home. Thereafter the nurse informs the internist.	time constraints may affect the extent of the patient's instruction. This may affect function 6a.
3b. To apply the multilayer compression bandages (doctor's assistant/bandage master)	In the general practice and at the dermatology department, the doctor's assistant applies the multilayer compression bandages. In the ER, the ER nurse contacts the bandage master to apply the bandages within office hours. Afterward, the nurse/doctor's assistant informs the physician.	Variation occurs when there is no doctor's assist with the appropriate experience and/or room available to apply the multilayer compression bandages. Thereby, the bandage master is only available to apply the bandages within office hours in the ER. Outside office hours, home care is arranged for the next day. Both these variabilities could lead to a delay in the onset of initial compression.
4. To instruct when to call the medical stocking supplier (internist)	The internist instructs the patient when to call the medical stocking supplier to schedule an appointment to fit the definitive ECS when edema has disappeared.	The quality of instructions can vary based on a lack of time due to other patientcare related duties and the experience of the internist. This may affect function 6a.
5. To give information and perform administration (physician)	The treating physician informs the patient about the aim of the compression therapy. Then the physician performs administrative tasks including: 1. Prescribing a referral for the definitive ECS 2. Planning a follow-up appointment 3. Contacting the home care organization if necessary 4. Prescribing multilayer compression bandages if necessary. The patient collects the materials at the pharmacy. 5. Additionally, the internist and dermatologist need to write a patient letter to inform the GP.	Variation occurs since some GPs are not aware that a referral is necessary for the medical stocking supplier to start function 8. Variability is reduced by the availability of the DVT-envelope in the ER, which contains all the necessary pre-completed forms to perform administration.
6a. To apply the temporary compression hosiery self-reliantly (patient)	The patient applies the temporary hosiery self-reliantly at home based on instructions given at the ER. Thereby, the patient needs to check if the leg is still containing edema.	Variability occurs based on the adherence and accuracy of applying the temporary compression hosiery and the awareness of the patient to assess if the leg is still containing edema and how to assess this. When the hosiery is not applied or not applied

		correctly, this could lead to a delay in disappearing edema and a delay in downstream functions. This affects function 7 and 8.
6b. To perform an intake and apply the temporary compression hosiery/multilayer compression bandages (home care nurse)	When the physician contacts the home care organization, a nurse contacts the patient and arranges an appointment on the same day or the day after to perform an intake. The nurse makes a care plan and plans home visits. The compression materials must be complete and present at the patient's home.	Variability occurs since multilayer compression bandages are regularly incomplete when the home care nurse visits the patient at the intake appointment, the nurse needs to call the treating physician to arrange the missing materials causing a delay of the function itself.
6c. To apply the multilayer compression bandages at the outpatient clinic (doctor's assistant)	Patients using multilayer compression bandages prescribed by the GP/dermatologist can visit the outpatient clinic twice a week to have them applied.	Variability occurs when there is no doctor's assistant/nurse or room available to deliver care twice a week. This could result in a delay in function 7 and further downstream functions.
7. To contact the medical stocking supplier (patient)	When edema has disappeared, the patient is supposed to contact the medical stocking supplier to make an appointment for an intake. This can be initiated by either the patient based on the information provided by the internist, the GP, or dermatologist when multilayer compression bandages are applied in the outpatient clinic, or home care when involved.	A delay in function 8 and further downstream functions appears if the appointment is made even too late or too early (as a consequence edema has not yet disappeared and the definitive ECS cannot be fitted). Variability reduces when home care is involved or the multilayer compression bandages are applied in the outpatient clinic, then the home care nurse/GP/dermatologist controls this function.
8. To perform an intake (medical stocking supplier)	The patient visits the medical stocking supplier. At the intake appointment, the medical stocking supplier checks the referral, evaluates the patient based on the intake form, and measures leg size at specific points to select the definitive ECS. Afterward, the medical stocking supplier orders the definitive ECS and claims the expenses with the insurance company.	Variation occurs if the referral from the physician is imprecise or missing. This delays the function or can lead to variability when the medical stocking supplier adds the missing information based on information provided by the patient. This can affect all downstream functions.

9. To fit the ECS and assess self-reliance (medical stocking supplier)	When the definitive ECS is delivered, a new appointment is made to either fit the ECS and select and train 'uncomplicated'** assistive devices if the patient is not self-reliant. When patients are not self-reliant with these assistive devices, the occupational therapist is contacted to introduce 'complicated'*** assistive devices. When patients are self-reliant with or without using the 'uncomplicated' assistive device, they apply the ECS self-reliantly at home. The medical stocking supplier thereafter claims the expenses of the assistive device with the insurance company.	Variability in the implementation of 'uncomplicated' assistive devices between medical stocking suppliers occurs mainly due to time pressure, especially in elderly who often require more training before they can use the assistive device. Other sources of variability are financial constraints and regulation of coverage of the expenses by the insurance. For either of these reasons, the medical stocking supplier can decide not to implement 'uncomplicated' assistive devices but instead refer the patient to the occupational therapist (function 10a) or to advise contacting the home care organization (function 10b).
10a. To assess options for self-reliance (occupational therapist)	Once contacted, the occupational therapist calls the patient and arranges an appointment for an intake visit. The therapist visits the patient and selects an assistive device based on prior experience combined with the needs and possibilities of the patient. The therapist instructs the patient and demonstrates how the selected assistive device is used. When the patient learned how to use the assistive device self-reliantly, the therapist reclaims the training device and sends a report to the medical stocking supplier to arrange a new device. When additional practice is necessary, a new appointment is made, or home care is contacted for additional practice.	Variation occurs mainly based on the patient's motivation to willingness to learn how to be self-reliant using an assistive device. If patients are unmotivated, e.g. since they are used to the social contact from home care, it is perceived as exceedingly difficult to train them successfully.
10b. To re-assess self-reliance (ergocoach)	Patients contact the home care organization when ECS is delivered. The ergocoach (a home care nurse specialized in making patients self-reliant) visits the patient and re-assesses options for implementing assistive devices. The ergocoach selects an assistive device based on experience and written instructions in the 'toolbox' available at main home care locations. The toolbox contains different assistive devices. Thereafter, the ergocoach trains the patient to use assistive devices based on experience, ad-hoc training, and	Variability can occur based on the experience of the ergocoach in selecting and demonstrating the appropriate assistive device for the specific patient. If the chosen assistive device is unsuitable for the patient, this can affect the output of function 12.

	YouTube instructions. The ergocoach then contacts the regular home care nurses to additionally train the patient in how to use the assistive device during a prespecified period.	
10c. To apply the ECS self-reliantly (patient)	The patient applies the ECS at home daily until the treating physician advises to stop the treatment.	Variability in output can occur based on the patient's adherence to therapy. If patients do not use the ECS as prescribed or stop the therapy on their initiative, this results in an increased risk of developing post-thrombotic syndrome in DVT patients and a higher risk of developing ulcers in CVI patients.
11. To train the patient (home care nurse)	Regular home care nurses train the patient twice daily on how to use the assistive device self-reliant. This process lasts for an estimated week (occupational therapist) and two weeks (ergocoach).	Variation occurs based on time constraints affecting the extensiveness of the training and the nurse's experience to instruct and train the patient. Further variation occurs based on the patient's motivation and abilities to learn how to use the assistive device self-reliantly. This could both affect the duration of the function and the outcome of function 12.
12. To evaluate implementation (ergocoach/occupational therapist)	The ergocoach or occupational therapist evaluates the implementation. When the patient learned how to use the assistive device self-reliantly, the occupational therapist reclaims the training device and sends a report to the medical stocking supplier to arrange a new device. In patients who required additional training by home care, home care should be continued until the assistive device is delivered. The ergocoach can leave the assistive device with the patient and stops home care. When the assistive device is not successfully implemented, home care needs to continue for the duration of therapy.	Variability in the availability of the assistive device for the patient occurs based on differences in reimbursement agreements with insurance companies. A delay in function 10c occurs if the occupational therapist implements the assistive device since it is not directly available to the patient since the therapist has to reclaim the assistive device and order a new device.

13. To deliver assistive devices (medical stocking supplier)	When a suitable assistive device is selected, medical stocking suppliers claim the expenses with the patient's insurance company. Therefore, they need to deliver a declaration along with a report from the occupational therapist (for more expensive assistive devices) and an indication letter from the GP. Assistive devices are usually delivered between 1-14 days depending on the type.	Variability occurs since the requirements for reimbursements different insurance companies have are variable. This can result in a delay in the function itself and function 10c if the claim is not submitted correctly. Further variation occurs when the GP does not directly respond to a referral request. The medical stocking supplier than cannot claim the expenses and deliver the assistive device. This results in a delay in the function itself and function 10c.
14a. To perform follow-up (internist)	The internist performs standard follow-up appointments after three weeks, three months, six months, one year, and two years based on the 'clinical pathway DVT'. At each appointment, the internist checks the progress of the process, compliance to therapy, and determines a Villalta score. The Villalta score is a scoring system to assess the presence of post-thrombotic syndrome. The internist advises the patient to stop ECS therapy if the Villalta score is four or less at two consecutive visits. The internist writes a patient letter to inform the GP if changes in medical approaches are made and at the end of follow-up.	Variability can occur based on the experience of the internist in using the Villalta score. When the Villalta score is not used correctly, the patient might get incorrect advice to either stop or continue ECS therapy. Variability in activities performed at the follow-up appointments and the frequency of these appointments is reduced using the clinical pathway.
14b. To perform follow-up (GP)	If the GP has diagnosed the DVT, a standard follow-up appointment is planned after a few days to check the progress and compliance to therapy. Further follow-up is planned a few weeks after diagnosis and at the end of the pharmacological therapy. The GP advises the patient to stop the ECS after one year, when complaints re-occur the GP advises to resume ECS therapy for another year based on their national guideline (NHG-standard).	Variation can occur when patients do not adhere to therapy, this can result in adjustments of follow-up or duration of therapy. Variation is reduced due to clear recommendations regarding follow-up appointments in the NHG-standard.
14c. To perform follow-up (dermatologist/GP)	The dermatologist performs a follow-up visit after a few weeks. Further follow-up appointments are only planned in patients with expected problems.	Variation in follow-up occurs since it is mainly based on personal preferences and experiences.

	When the dermatologist does not expect problems, a patient letter is sent to the GP including the advice to perform a follow-up visit. Some GPs standardize this follow-up visit whereas others rely on the patient's responsibility to alert them if problems exist. Both the dermatologist and GP advise the patient to wear ECS for life.	

* The numbers of the functions refer to figure 2

** Uncomplicated assistive devices: e.g. resistance reducing assistive devices and cuffs and cones

*** Complicated assistive devices: e.g. arm extending devices, frames, and ECS pistol

Abbreviations: GP = general practitioner, DVT = deep venous thrombosis, ECS = elastic compression therapy, CVI = chronic venous insufficiency, NHG = nederlands huisartsen genootschap (Dutch general practitioner society), ER = emergency room

Table 2: Functions from the Functional Resonance Analysis Method (FRAM) model North-Holland

Function*	**Description of function**	**Variability**
1a. To identify indications for initial compression therapy (internist)	The indication for initial compression therapy in the acute phase after a diagnosis of DVT is made by the internist, either at the emergency department (hospital location A) or the outpatient clinic (hospital location B). At hospital location A, all patients are treated with initial compression therapy by default. At hospital location B, initial compression therapy is omitted by default. Even definitive ECS therapy can be omitted in selected patients without complaints and no edema.	Variations occurred since the two hospital locations were using different protocols with different recommendations regarding initial compression therapy until one month ago. A new protocol was designed covering both locations. However, this protocol is lacking information regarding initial compression therapy. This results in internists relying on their own experiences and clinical judgment to estimate if (initial) compression therapy is necessary. This places patients at risk for not being treated with initial compression therapy and/or definitive compression. Patients at hospital location B are directly referred to the medical stocking supplier (function 12) or follow-up (function 18a) if even definitive ECS therapy is omitted, preventing the intermediate functions from occurring.
1b. To identify indications for initial compression therapy (dermatologist/GP)	The indication for initial compression therapy after a diagnosis of CVI is made by the dermatologist or the GP. The dermatologist informs the doctor's assistant to apply multilayer compression bandages while the GP contacts the home care organization to initiate therapy using adjustable compression devices.	Variation regarding the type of initial compression therapy between the dermatologist and the GP occurs since the implementation of adjustable compression devices by home care organizations only comprises the general practice.
2. To consider and choose initial compression therapy (internist)	When the indication for compression therapy in DVT patients is made, the internist needs to decide what type of initial compression therapy is indicated. At hospital location A, the internist chooses a temporary compression hosiery unless there are contra-indications based on the developed DVT-protocol. If multilayer compression bandages are chosen, the internist asks the ER nurse to apply the multilayer	At hospital location A, this function may vary based on pressure at the ward and experience of the internist.

	compression bandages. In most cases, an ER nurse with the right skills and experience is available. In other cases (within office hours) the internist calls the dermatology department to apply multilayer compression bandages.	
3a. To apply the temporary compression hosiery and give instructions (ER nurse)	See function 3a FRAM model region Limburg. Instead of using a disposable donning slide, the ER nurses use a non-disposable donning slide which may not be taken home by the patient. The ER nurse instructs the patient to buy the slide at the home care shop.	Time constraints may affect the extent of patient instruction, affecting function 6a.
3b. To apply the multilayer compression bandages (ER nurse/doctor's assistant dermatology/bandage master)	The ER nurse, doctor's assistant at the dermatology department, or bandage master applies multilayer compression bandages.	Variation occurs if the professional responsible for applying the multilayer compression bandages is occupied, this prevents function 3b from occurring. In some of these cases, home care has to be arranged to apply the multilayer compression bandages the next day.
4. To give information and perform administration (internist/dermatologist)	The treating physician informs the patient about the aim of the compression therapy. The treating physician (internist/dermatologist) then plans follow-up: 1. The internist plans a follow-up appointment after 3 or 6 weeks (depending on location) in DVT patients at the department of internal medicine. At hospital location A, the internist additionally informs the dermatology outpatient clinic either by telephone or by digital order to schedule a follow-up appointment with the dermatologist. The dermatologist plans a follow-up appointment after 6 weeks in CVI patients. 2. If necessary, the home care organization is contacted by phone or digital order. Whereas the internist at the ER calls the home care nurse who is available at the ER (24/7) to visit the patient and plan care.	The digital order used in the dermatology department can improve the speed of the process and decreases time variability in patients collecting the materials for multilayer compression bandages. Additionally, the availability of the home care nurse at the ER can reduce variability since the nurse is directly involved with the patient, estimates the needs, and plans care.

	3. Prescribing materials for multilayer compression bandages if necessary. If the dermatologist prescribes multilayer compression bandages, the prescription can be ordered digitally and is automatically delivered at the patient's home the next day. Whereas the internist issues a conventional prescription, and the patient collects the materials at the pharmacy. 4. Additionally, the internist and dermatologist write a patient letter to inform the GP.	
5. To triage and plan follow-up (doctor's assistant)	The doctor's assistant triages the phone call or digital order by acquiring additional information either through supplementary questions or accessing the radiology report. Based on this information the assistant then estimates when edema is thought to have disappeared to schedule the first follow-up appointment.	Variability occurs if the doctor's assistant responsible for the triage is not informed about how to determine the appropriate period to schedule the patient or the patient is not adhering to therapy. If the appointment is made when the edema has not yet disappeared, the definitive ECS cannot be measured (function 12), and a new appointment has to be made.
6a. To apply the temporary compression hosiery self-reliantly (patient)	See function 6a FRAM model region Limburg.	See function 6a FRAM model region Limburg.
6b. To perform intake and apply the temporary compression hosiery/multilayer compression bandages (home care nurse)	See function 6b FRAM model region Limburg. Additionally, the leg circumflex is measured once a week.	Variability occurs since the materials are regularly incomplete, resulting in a delay of the intake appointment. The output of this function is a precondition for function 12, but the two functions are not coupled. The intake with the medical stocking supplier is planned without the active input regarding the actual situation of the edema.
7. To perform intake (dermatologist + doctor's assistant)	The doctor's assistant prepares the intake by retrieving information from the letter written in the emergency department. The assistant completes this information by obtaining a comprehensive medical	The advised duration of therapy is subject to variation since dermatologists and internists are unaware of other's instructions. This

	history. Thereafter, the assistant determines whether the edema has disappeared, and calls the dermatologist who co-assesses the patient. If the dermatologist agrees that the ECS can be fitted, the dermatologist issues a referral for definitive ECS. Subsequently, the patient visits the medical stocking supplier (at the same location). The patient is generally advised to wear ECS for six months to two years.	could result in patients receiving different advice regarding the duration of ECS therapy (function 15c).
8. To give information, perform administration, and plan care (GP)	If the GP diagnoses CVI, the GP calls the home care organization to schedule care to apply the adjustable compression devices and makes a referral for definitive ECS. Some GPs schedule a follow-up appointment.	Variation occurs since some GPs are unaware that a referral is necessary for the medical stocking supplier to start function 12.
9. To perform intake and arrange the adjustable compression devices (home care nurse)	When the GP contacts the home care organization regarding CVI, a nurse contacts the patient and arranges an intake appointment for that day or the day after. The nurse then measures the leg and determines the size of the adjustable compression devices. All nurses followed an online course to learn how to determine the size of the device and how to apply them. Afterward, the device is ordered by completing a pre-signed application form. This form is then sent to the medical stocking supplier and delivered within 24-48 hours. If in exceptional cases difficulties occur in measuring the leg to determine the size of the adjustable compression device, a nurse specialized in wound care is contacted to support this.	Variation is not mentioned, mostly because of the use of clear protocols, the pre-signed application form, and the support by the nurse specialized in wound care if necessary.
10. To apply the adjustable compression devices (home care nurse)	After the adjustable compression devices have been delivered, the home care nurse visits the patient again to demonstrate how they can be applied, and how an enclosed measuring tape can be used to apply them with the right pressure. With the patient now able to apply the adjustable compression devices self-reliantly, the home care nurse visits	If in exceptional cases the adjustable compression device is ordered at the weekend it will be delivered the next working day, resulting in a delay of first compression.

	once per week to measure leg circumference. If the patient is unable to apply the devices, the home care nurse visits two to four times a week to apply them.	
11. To contact the **medical stocking supplier (patient)**	If the leg circumference is stable at two consecutive measuring moments, the home care nurse instructs the patient to contact the medical stocking supplier to plan an intake. Except for DVT patients at hospital location A, who already received an appointment for the intake planned at the moment of diagnosis.	Variation in instructions to contact the medical stocking supplier is not mentioned, mainly since clear agreements have been made and captured in the patient's care plan.
12. To perform intake (medical stocking supplier)	See function 8 FRAM model region Limburg. Additionally, information concerning assistive devices is given.	Variation occurs if the referral from the GP is imprecise or missing. This delays the function. Further variation occurs since time constraints may affect the extensiveness of the information provided regarding assistive devices. This could affect function 13a-14c.
13. To evaluate by email/phone (medical stocking supplier)	For patients referred from the hospital, the ECS is delivered after two to ten days. Three to four weeks after delivery, a telephonic or automatic email evaluation is made to check whether there are problems. If there are problems, a follow-up appointment is scheduled.	Variability occurs when the patient ignores the email evaluation or did not admit problems, this results in the medical stocking supplier not being completely informed about the performances of the patient.
14. To fit ECS and assess self-reliance (medical stocking supplier)	For patients referred from the GP, a standard follow-up appointment is arranged to fit ECS and assess self-reliance. See function 9 FRAM model region Limburg.	See function 9 FRAM model region Limburg. Instead of affecting function 10a and 10b in the FRAM model region Limburg, this affects function 15a and 15b.
15a. To assess options for self-reliance (occupational therapist)	See function 10a FRAM model region Limburg. In region North-Holland, the occupational therapist uses a designed working guideline in addition to prior experience and needs and possibilities of the patient to select an assistive device.	No variation is mentioned, mainly because of the clear working guidelines implemented in clinical practice.

15b. To re-assess self-reliance (home care nurse)	Patients contact the home care organization when ECS is delivered. The home care nurse re-assesses self-reliance, if the nurse estimates that the patient can be self-reliant with the use of assistive devices, the occupational therapist is contacted.	Variation in output occurs based on the experience of the home care nurse to assess the patient's abilities to be self-reliant.
15c. To apply the ECS self-reliantly (patient)	See function 10c FRAM model region Limburg.	See function 10c FRAM model region Limburg.
16. To train the patient (home care nurse)	If the occupational therapist indicates that additional practice is necessary, home care nurses train the patient twice a day on how to use the assistive device self-reliantly for a pre-specified time range. For this reason, the indicated time per consult is extended. If the patient can use the assistive device self-reliantly, the occupational therapist writes a report and sends it to the medical stocking supplier. If the assistive device is not successfully implemented, home care needs to continue for the duration of therapy.	See function 11 FRAM model region Limburg. Additionally, variation decreases by extending the time per consult, giving the nurses enough time to train the patient.
17. To deliver assistive devices (medical stocking supplier)	See function 13 FRAM model region Limburg. Assistive devices are usually delivered within a few days to weeks depending on the selected type and stock supply.	The duration of delivery is subject to variability since it depends on the medical stocking suppliers stock supply. For more advanced assistive devices, the delivery can take up to a few weeks. This enables the patient to be self-reliant directly and extends the duration of home care. Time variation is reduced since GPs and dermatologists already ask to implement assistive devices on their referral for the definitive ECS, making another referral for assistive devices unnecessary.
18a. To perform follow-up (internist)	The internist performs a follow-up appointment between three to six weeks (depending on location) after diagnosis. At this appointment, the internist checks the progress of the process and compliance to therapy. Furthermore, some internists advise the patient to stop ECS therapy	The advised duration of therapy is subject to variation since internists are unaware of each other's instructions nor of the dermatologist's. Some internists omit to advise on the duration of therapy since they suppose this is the responsibility of the dermatologist. Others adjust their advice

	after six months (if the patient has no leg complaints), whereas others advise a treatment duration of two years. The duration of follow-up differed too; some internists perform only one follow-up visit while others plan a consecutive visit after three months. At the last follow-up visit, the internist writes a patient letter to inform the GP. This patient letter generally does not contain the advice of any consecutive follow-up appointments with the GP or advice regarding the duration of ECS therapy.	to their most recent knowledge of literature instead of following the protocol. This could result in the patient getting different advice and subsequently could affect the duration of function 15c.
18b. To perform follow-up (dermatologist/GP)	In CVI patients, the dermatologist standardized a follow-up appointment after six weeks. In patients at risk for complications, a consecutive follow-up appointment is planned after six months. When the dermatologist does not expect problems, a letter is sent to the GP and the referral is completed. Some GPs standardize the follow-up visit for CVI patients whereas others rely on the patient's responsibility to alert them if problems exist. Both the dermatologist and GP advise the patient to wear ECS for life.	See function 14c FRAM model region Limburg.

* The numbers of the functions refer to figure 3.
Abbreviations: DVT = deep venous thrombosis, CVI = chronic venous insufficiency, GP = general practitioner, ER = emergency room, FRAM = functional resonance analysis method, ECS = elastic compression stocking