NATURAL HISTORY

Intermittent Claudication
BASLE STUDY: at 5 yrs 2/3 resolve but 2/3 have angiographic progression of disease
CASS: PAD carries 25% greater mortality than non-PAD
Overall: 50% stable, 25% impaired walking distance, 25% major revasc, 1-2% amputation

Critical Limb Ischaemia
VSGBI 1993 survey: 70% regress, 75% chance of limb salvage, 21.5% amputation, 13.7% mortality

RISK FACTORS and secondary prevention)
FIXED: AGE (increases)/GENDER (Framingham: men, Limburg: women, EAS: ESI)/RACE (black)/FHx
MODIFIABLE: smoking/diabetes/BP/lipids

SMOKING: Increases PAD incidence/progression to CLI/major revasc/amputation/mortalityx3
Cessation reduces overall CV risk to non-smoker in 5-7 years (men)/2-4yrs(women)

DIABETES: diffuse and distal disease; both arterial and neuropathic ulcers
UKPDS: 1% increase HBA1C = 28% increased PAD risk;
EAS: 1.5x risk of symptomatic PAD, 2.5x risk of asymptomatic PAD, 10-16x amputation rate

BLOOD PRESSURE: Rotterdam study showed 10mmHg increments incrementally increased PAD risk
AIM: 140/85 (first-line ACEi/AT2RA/CaCHBs)

SERUM LIPIDS
Framingham: fasting cholesterol >7 doubles risk of IC
AIM: <2.6 mmol/L
STATINs (a) reduce CV risk (1mmol/l LDL drop lowers risk 1/3) (b)Functional improvement (painfree walking; Cochrane review)

MEDICAL MANAGEMENT
NICE 2012: smoking cessation /lipids/diabetes/hypertension||exercise||diet and weight loss||antiplatelet therapy

EXERCISE
Increase collaterals/enhannced NO vasodilatation/improved muscle bioenergetics/weight loss
CLEVER: increases walking distance than angio/stenting if combined with optimal medical management.
NICE: offer to all with IC

DRUGS
1.Risk factor modification: antihypertensives/statins/diabetes
2.Other: antiplatelets
3.Vasoactives: Cilostazol, naftidifuryl, pentoxyfilline all equivalently increase WD in IC by 60% vs anti-platelets
NICE 2012: NAFT only if SEP fails but not for intervention; review in 3-6mths and stop (SVS doesn't recommended these)
4.Prostaglandins (PGE1/PGI2) vasodilator/antiplatelet/optimise VEC function
Iloprost used in Buerger's; CLI (improves pain, ulcer healing, amputation rate reduced 55%, mortality reduced 35%)
SEs: headache, flush, nausea, hypotension

OTHER
Spinal cord stimulation: not recommended by NICE; L3-4 stim (gate theory) reduces pain (warm limb/paraesthesia); unreconstructable PAD
Lumbar sympathectomy: not recommended; rest pain in unreconstructable occlusive disease
IPC: reducing venous pressure so popliteal artery flow increases; reduced pain and increased WD in small study