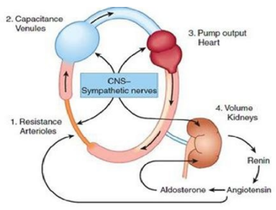
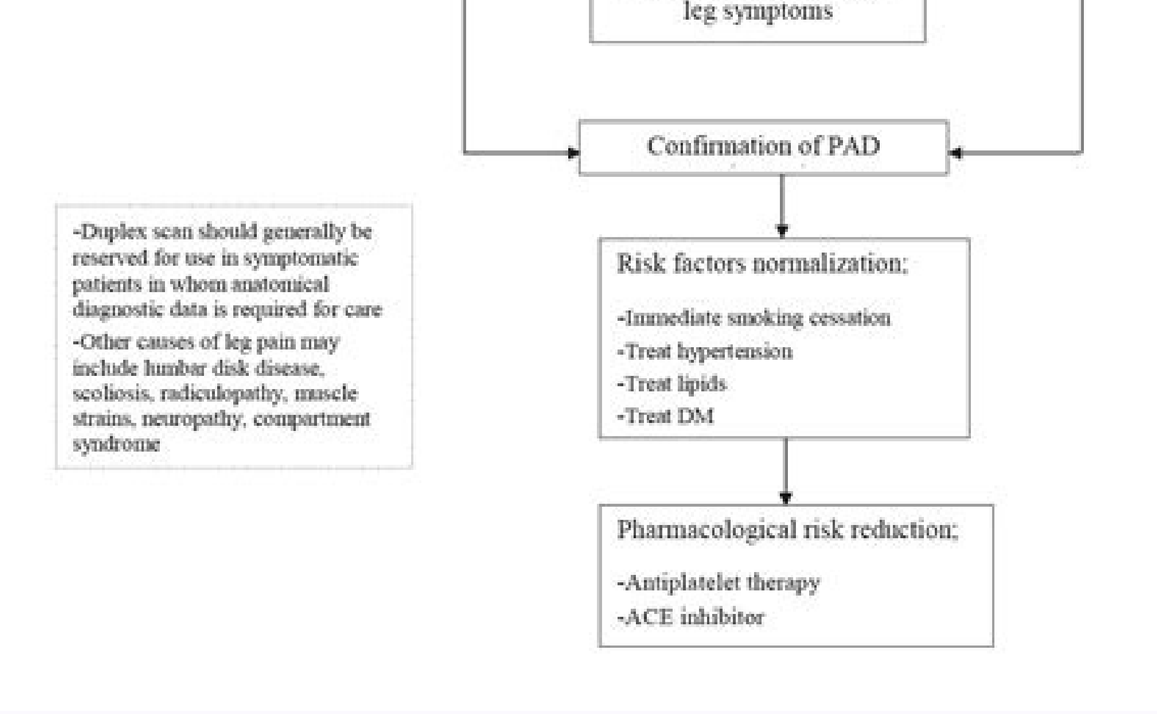
Esc guidelines peripheral arterial disease 2017



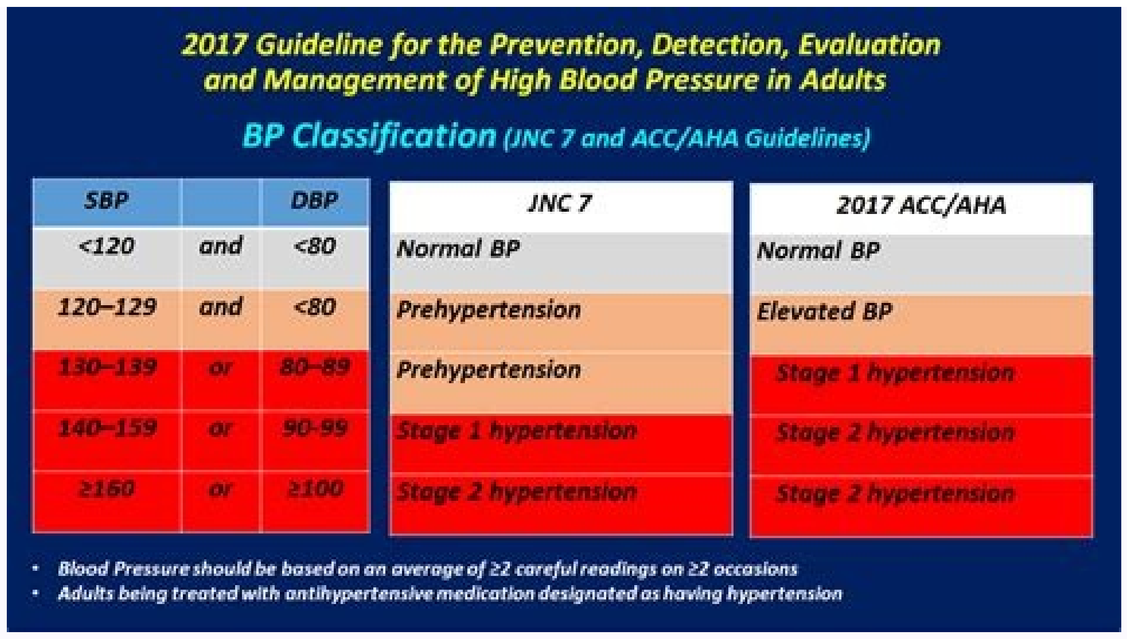
Algorithm (1)

Diagnosis and Treatment of Asymptomatic Peripheral Arterial Disease and Atypical Leg Pain (Adapted from the 2011 ACCF/AHA PAD guideline and modified according to local situation)[3]



Recommendations	Class[a]	Level[b]	Ref[c]
Global CV risk management strategies are a priority in transplant patients.	I	C	-
Statins should be considered as the first-line agents in transplant patients. Initiation should be at low doses with careful up-titration and with caution regarding potential drug–drug interactions, particularly for those on ciclosporin.	IIa	B	197
In patients who are intolerant of statins or those with significant dyslipidaemia and high residual risk despite a maximally tolerated dose of statin, alternative or additional therapy may be considered: ezetimibe for those where high LDL-C is the principal abnormality; fibrates or nicotinic acid for those where hypertriglyceridaemia and/or low HDL-C is the principal abnormality.	IIb	C	-

Staging	Previous CV events, Associated risk factors, Asymptomatic HMOD	Classification of BP			
		High normal SBP 130-140 mmHg DBP 85-90 mmHg	Grade 1 SBP 140-159 mmHg DBP 90-99 mmHg	Grade 2 SBP 160-179 mmHg DBP 100-109 mmHg	Grade 3 SBP ≥180 mmHg DBP ≥ 110 mmHg
Stage 1 Uncomplicated	No concomitant risk factors		Low risk	Moderate risk	High risk
	1-2 risk factors	Low risk	Moderate risk	Moderate to high risk	High risk
	≥3risk factors	Low to moderate risk	Moderate to high risk	High risk	High risk
Stage 2 Asymptomatic disease	eGFR 30-49 ml/min/mq, Diabetes of recent diagnosis Organ damage	Moderate to high risk	High risk	High risk	High to very high risk
Stage 3 Symptomatic disease	CV/cerebrovascular disease, eGFR < 30 ml/min/mq, Long-standing diabetes	Very high risk	Very high risk	Very high risk	Very high risk



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Editor's Choice - 2017 ESC Guidelines on the Diagnosis and Treatment of Peripheral Arterial Diseases, in collaboration with the European Society for Vascular Surgery (ESVS). Aboyans V, Ricco JB, Bartelink MEL, Björck M, Brodmann M, Cohnert T, Collet JP, Czerny M, De Carlo M, Debus S, Espinola-Klein C, Kahan T, Kownator S, Mazzolai L, Naylor AR, Roffi M, Röther J, Sprynger M, Tendera M, Tepe G, Venermo M, Vlachopoulos C, Desormais I, Document Reviewers, Widimsky P, Kolh P, Agewall S, Bueno H, Coca A, De Borst GJ, Delgado V, Dick F, Erol C, Ferrini M, Kakkos S, Katus HA, Knuuti J, Lindholt J, Mattle H, Pieniazek P, Piepoli MF, Scheinert D, Sievert H, Simpson I, Sulzenko J, Tamargo J, Tokgozoglu L, Torbicki A, Tsakountakis N, Tuñón J, Vega de Ceniga M, Windecker S, Zamorano JL. Aboyans V, et al. Eur J Vasc Endovasc Surg. 2018 Mar;55(3):305-368. doi: 10.1016/j.ejvs.2017.07.018. Epub 2017 Aug 26. Eur J Vasc Endovasc Surg. 2018. PMID: 28851596 Review. No abstract available. Sep 11, 2017 | Geoffrey D. Barnes, MD, MSc, FACC Authors: Aboyans V, Ricco JB, Bartelink ML, et al. Citation: 2017 ESC Guidelines on the Diagnosis and Treatment of Peripheral Arterial Diseases, in Collaboration With the European Society for Vascular Surgery (ESVS): Document Covering Atherosclerotic Disease of Extracranial Carotid and Vertebral, Mesenteric, Renal, Upper and Lower Extremity Arteries. Eur Heart J 2017;Aug 26:[Epub ahead of print]. The following are key points to remember about the 2017 European Society of Cardiology (ESC) Guidelines on the Diagnosis and Treatment of Peripheral Arterial Diseases: Healthcare centers are strongly recommended to establish multidisciplinary Vascular Teams to make decisions and manage patients with peripheral arterial diseases, including public awareness efforts. For patients with carotid artery disease, surgery or stenting (with embolic protection devices) is recommended (Class IIa) for high stroke risk patients, while stenting alone can be considered (Class IIb) for average surgical risk patients. Routine prophylactic carotid revascularization of asymptomatic carotid disease (70-99%) is not recommended (Class III) in patients undergoing coronary artery bypass graft (CABG) surgery. Stenting is no longer recommended (Class III) for patients with symptomatic atherosclerotic renal artery stenosis of >60%. Patients with aorto-iliac or aorto-bifemoral occlusions are recommended for surgical intervention (Class IIa) or endovascular revascularization in experienced centers (Class IIb). Patients with intrapopliteal lesions should be treated with bypass surgery (Class I) or endovascular therapy (Class IIa). All patients with lower extremity artery disease should be treated with statins to improve walking distance (Class I) as well as supervised exercise therapy, even after revascularization. In patients with symptomatic peripheral artery disease, clopidogrel can be considered over aspirin therapy (Class IIb). Antiplatelet therapy is not recommended in asymptomatic peripheral artery disease patients (Class III). Patients with lower extremity artery disease and concurrent atrial fibrillation should receive anticoagulation if the CHA2DS2-VASc score is >2 (Class I). Patients with coronary artery disease or heart failure should be considered for lower extremity peripheral artery disease screening (Class IIb). Keywords: Anticoagulants, Atherosclerosis, Aspirin, Atrial Fibrillation, Cardiac Surgical Procedures, Carotid Artery Diseases, Coronary Artery Bypass, Coronary Artery Disease, Embolic Protection Devices, Endovascular Procedures, Exercise Therapy, Geriatrics, Heart Failure, Hydroxymethylglutaryl-CoA Reductase Inhibitors, Myocardial Revascularization, Peripheral Arterial Disease, Primary Prevention, Renal Artery Obstruction, Stents, Stroke, Vascular Diseases < Back to Listings Revista Española de Cardiología is an international scientific journal devoted to the publication of research articles on cardiovascular medicine. The journal, published since 1947, is the official publication of the Spanish Society of Cardiology and founder of the REC Publications journal family. Articles are published in both English and Spanish in its electronic edition. Clinical guidelines on CLTI were released in June 2019 by the Society for Vascular Surgery (SVS), European Society for Vascular Surgery (ESVS), and World Federation of Vascular Societies (WFVS). [18] Evaluate for ischemia and determine its severity using objective hemodynamic tests in all patients with suspected CLTI. Grade wound extent, degree of ischemia, and infection severity with a lower-extremity threatened-limb classification staging system to guide clinical treatment in all patients with suspected CLTI. A detailed history should be performed in all patients with suspected CLTI to determine symptoms, cardiovascular risk factors, and medical history . A complete cardiovascular physical examination should be performed in all patients with suspected CLTI. A complete foot examination should be performed in all patients with pedal tissue loss and suspected CLTI, including a neuropathy assessment and a probe-to-bone test of any open ulcers. Ankle pressure (AP) and ABI should be measured as first-line noninvasive testing in all patients with suspected CLTI. Toe pressure (TP) and TBI should be measured in all patients with tissue loss and suspected CLTI. High-quality angiographic imaging of the lower limb (including the ankle and foot) should be performed in all patients with suspected CLTI who may be candidates for revascularization. Cardiovascular risk factors should be evaluated in all patients with suspected CLTI. Modifiable risk factors should be managed in all patients with suspected CLTI. Antiplatelet therapy should be administered to all patients with CLTI. Systemic vitamin K antagonists should be avoided in the treatment of lower-extremity atherosclerosis in patients with CLTI. Statin therapy (moderate- or high-intensity) should be administered to patients with CLTI to reduce the likelihood of all-cause and cardiovascular mortality. Hypertension should be modified to target levels of < 140 mm Hg systolic and < 90 mm Hg diastolic in patients with CLTI. Metformin is the primary hypoglycemic agent in patients with type 2 diabetes mellitus (DM) and CLTI. Smoking-cessation interventions should be offered to all patients with CLTI who use tobacco products. Smokers or former smokers with CLTI should be inquired about the status of tobacco use at every visit. Analgesics should be prescribed to patients with CLTI who have ischemic rest pain of the lower extremity and foot until pain resolves following revascularization. Chronic severe pain should be treated with acetaminophen in combination with opioids in patients with CLTI. An integrated limb-based anatomic staging system (eg, Global Limb Anatomic Staging System [GLASS]) should be used to define the complexity of a preferred target artery path (TAP) and to aid in revascularization (EBR) in patients with CLTI. A vascular specialist should be consulted in all cases of suspected CLTI to consider limb salvage except when major amputation is considered medically urgent. Patients with a limited life expectancy, unsalvageable limb, or poor functional status should be offered primary amputation or palliation after shared decision-making. The periprocedural risk should be assessed and life expectancy estimated in patients with CLTI who are candidates for revascularization. All patients with CLTI who are candidates for limb salvage should be staged with an integrated threatened limb classification system. Urgent surgical drainage and debridement (including minor amputation, if needed) should be performed and antibiotic therapy initiated in all patients with suspected CLTI who have wet gangrene or deep-space foot infection. Limb staging should be repeated following surgical drainage, debridement, minor amputation, or correction of inflow disease (aortoiliac [AI], common and deep femoral artery disease) and before subsequent major treatment decisions. Revascularization should not be performed in patients without significant ischemia (Wound, Ischemia, and foot Infection [WIfI] ischemia grade 0) unless an isolated region of poor perfusion in conjunction with major tissue loss (eg, WIfI wound grade 2 or 3) can be effectively targeted and the wound progresses or fails to decrease in size by 50% or more within 4 weeks despite appropriate infection control, wound care, and offloading. Revascularization should be offered to all average-risk patients with advanced limb-threatening conditions (eg, WIfI stage 4) and significant perfusion deficits (eg, WIfI ischemia grades 2 and 3). High-quality angiographic imaging with dedicated views of foot and ankle arteries should be performed for anatomic staging and procedural planning in all patients with CLTI who are candidates for revascularization. The anatomic pattern of disease and preferred TAP should be defined with an integrated lib-based staging system in all patients with CLTI who are candidates for revascularization. When available, ultrasonographic vein mapping should be performed in all patients with CLTI who are candidates for surgical bypass. The ipsilateral great saphenous vein (GSV) and small saphenous vein (SSV) should be mapped to plan the surgical bypass. Veins in the contralateral leg and both arms should be mapped if the ipsilateral vein is insufficient. A patient with CLTI should not be considered as unsuitable for revascularization until imaging studies are reviewed and the patient is clinically evaluated by a qualified vascular specialist. Inflow disease should be corrected first in patients with CLTI who have both inflow and outflow disease. The decision for staged versus combined inflow and outflow revascularization should be based on risk and limb threat. Inflow disease alone should be corrected in patients with CLTI who have multilevel disease and low-grade ischemia (eg, WIfI ischemia grade 1) or limited tissue loss (eg, WIfI wound grade 0 or 1) and whenever the risk-benefit of additional outflow reconstruction is high or initially unclear. The limb should be restaged and hemodynamic assessment repeated following inflow correction in patients with CLTI who have both inflow and outflow disease. An endovascular-first approach should be used to treat patients with CLTI who have moderate to severe (eg, GLASS stage IA) aortoiliac (AI) disease. Open common femoral artery (CFA) endarterectomy with patch angioplasty should be performed, with or without extension into the profunda femoris artery (PFA), in patients with CLTI who have hemodynamically significant disease of the common and deep femoral arteries (>50% stenosis). Endovascular treatment should be considered for significant CFA disease in patients who are deemed to be at high surgical risk or to have a hostile groin. Stents should be avoided in the CFA, and they should not be placed across the origin of a patent deep femoral artery. Hemodynamically significant disease of the proximal deep femoral artery should be corrected, when technically feasible. Decisions concerning endovascular intervention versus open surgical bypass should be based on the severity of the limb threat (eg, WIfI grade), the anatomic disease pattern (eg, GLASS), and the availability of autologous vein in average-risk patients with CLTI. The preferred conduit for infrainguinal bypass surgery is autologous vein in patients with CLTI. Intraoperative imaging (angiography, duplex ultrasonography, or both) should be performed upon completion of open bypass surgery for CLTI and significant technical defects corrected, if feasible, during the index operation. Vasoactive drugs and defibrinating agents (ancrod) should not be offered to patients in whom revascularization is not possible. Hyperbaric oxygen therapy (HBOT) should not be offered to improve limb salvage in patients with CLTI who have severe uncorrected ischemia (eg, WIfI ischemia grade 2 or 3). Optimal wound care should be continued until the lower extremity wound has completely healed or amputation is performed. Therapeutic angiogenesis should be restricted for patients with CLTI who are enrolled in a registered clinical trial. After shared decision-making, primary amputation should be offered to patients with CLTI who have an unsalvageable or pre-existing dysfunctional limb, a short life expectancy, or poor functional status. A multidisciplinary rehabilitation team should be involved from the time of decision to amputate through successful completion of rehabilitation. Patients with CLTI who have undergone amputation should be monitored at least yearly to track disease progression in the contralateral limb, to maintain optimal medical therapy, and to manage risk factors. Following lower-extremity revascularization, optimal medical therapy for PAD, including long-term antiplatelet and statin therapies, should be continued. Smoking cessation should be promoted to all patients with CLTI who have undergone lower-extremity revascularization. Patients who have undergone lower-extremity vein bypass for CLTI should be observed regularly for at least 2 years. The clinical surveillance program should include interval history, pulse examination, and assessment of resting APs and TPs. Duplex ultrasonography (DUS) should also be considered. Patients who have undergone lower-extremity prosthetic bypass for CLTI should be observed regularly for at least 2 years, with interval history, pulse examination, and measurement of resting APs and TPs. Patients who have undergone infrainguinal endovascular interventions for CLTI should be observed in a surveillance program that includes clinical visits, pulse examination, and noninvasive testing (resting APs and TPs). Additional imaging should be considered in patients with lower-extremity vein grafts whose ABI has decreased ≥0.15 and whose symptoms have recurred or pulse status changed to evaluate for vein graft stenosis. Intervention should be offered if vein graft lesions are detected on duplex US in patients with an associated peak systolic velocity (PSV) of >300 cm/s and a PSV ratio >3.5 or grafts with low velocity (midgraft PSV < 45 cm/s) to maintain patency. Long-term surveillance, including DUS graft scanning, should be maintained following surgical or catheter-based revision of a vein graft to evaluate for recurrent graft-threatening lesions. Mechanical offloading should be provided as a primary component of care in all patients with CLTI who have pedal wounds. Counseling on protection of the healed wound and foot should be provided, including appropriate shoes, insoles, and monitoring of inflammation.

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