SOURCES OF FURTHER INFORMATION

British Heart Foundation
4 Shore Place
Edinburgh EH6 6UU
Tel: 0131 555 5891 • Fax: 0131 555 5014
e-mail: scotland@bhf.org.uk • www.bhf.org.uk

Circulation Foundation
(formerly the British Vascular Foundation)
c/o Royal College of Surgeons of England
35-43 Lincolns Inn Fields
London WC2A 3PE
Tel: 0207 304 4779
www.circulationfoundation.org.uk

Patient UK
www.patient.co.uk

A useful web site with links to leaflets, support groups, information about medicines and tests and much more.

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on **Diagnosis and management of peripheral arterial disease.**

Recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

SIGN
Scottish Intercollegiate Guidelines Network

NHS Quality Improvement Scotland

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Diagnosis and management of peripheral arterial disease

Quick Reference Guide

October 2006

COPIES OF ALL SIGN GUIDELINES ARE AVAILABLE ONLINE AT WWW.SIGN.AC.UK

CARDIOVASCULAR RISK REDUCTION

Patients with PAD have an increased risk of mortality, myocardial infarction and stroke. Management of PAD is an opportunity for secondary prevention of cardiovascular events.

☑
- On diagnosis of PAD, patients should have a full cardiovascular risk factor assessment.
- Patients should be referred to the practice cardiovascular clinic for monitoring and long term follow up of risk factor modification.

SMOKING CESSATION

D **Patients with PAD should be actively discouraged from smoking.**

CHOLESTEROL LOWERING

A **Lipid lowering therapy with a statin is recommended for patients with PAD and total cholesterol level > 3.5 mmol/l.**

GLYCAEMIC CONTROL

B **Optimal glycaemic control is recommended for patients with PAD and diabetes to reduce the incidence of cardiovascular events.**

WEIGHT REDUCTION

D **Obese patients with PAD should be treated to reduce their weight.**

BLOOD PRESSURE CONTROL

A **Hypertensive patients with PAD should be treated to reduce their blood pressure.**

ANTIPLATELET THERAPY

A **Antiplatelet therapy is recommended for patients with symptomatic PAD.**

REFERRAL, DIAGNOSIS AND INVESTIGATION

The characteristic feature in the history of a patient with intermittent claudication is muscle pain brought on by exercise and relieved by rest.

INVESTIGATIONS IN PRIMARY CARE

☑
- Individuals with a history of intermittent claudication should have an examination of peripheral pulses and palpation of the abdomen for an aortic aneurysm.
- Ankle brachial pressure index should be measured in all patients with suspected PAD.

CRITERIA FOR REFERRAL

☑ Patients with suspected PAD should be referred to secondary care if:

- the primary care team is not confident of making the diagnosis, lacks the resources necessary to institute and monitor best medical treatment or is concerned that the symptoms may have an unusual cause
- risk factors are unable to be managed to recommended targets
- they have symptoms which limit lifestyle and objective signs of arterial disease (clinical signs and a low ankle brachial pressure index).

Young and otherwise healthy adults, presenting prematurely with claudication, should be referred to exclude entrapment syndromes and other rare disorders.

INVESTIGATIONS

A **Non-invasive imaging modalities should be employed in the first instance for patients with intermittent claudication in whom intervention is being considered.**

D **Digital subtraction arteriography is not recommended as the primary imaging modality for patients with PAD.**

TREATMENT

DRUG THERAPY

A
- **Patients with intermittent claudication, in particular over a short distance, should be considered for treatment with cilostazol.**
- **Cilostazol should be stopped after three months if it is ineffective, or if adverse effects reduce compliance.**

A **Patients with intermittent claudication and who have a poor quality of life may be considered for treatment with naftidrofuryl.**

A **Oxpentifylline is not recommended for the treatment of intermittent claudication.**

B **Inisitol nicotinate is not recommended for the treatment of intermittent claudication.**

A **Statins should be given for risk factor management in patients with intermittent claudication and total cholesterol level > 3.5 mmol/l.**

A **The use of oral prostaglandin therapy in patients with intermittent claudication is not recommended.**

EXERCISE THERAPY

A **Patients with intermittent claudication should be encouraged to exercise.**

VASCULAR INTERVENTION

D
- **Endovascular and surgical intervention are not recommended for the majority of patients with intermittent claudication.**
- **For those with severe disability or deteriorating symptoms, referral to a vascular specialist is recommended.**
- **The TransAtlantic Inter-society consensus guidelines should be used when advising patients about possible interventions.**