key points

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The prompt identification and management of patients with peripheral arterial disease can improve quality of life, save limbs and reduce cardiovascular events. The most common initial symptom of peripheral arterial disease is leg pain on exertion or intermittent claudication. More severe or critical limb ischaemia can present with pain at rest, ulceration, tissue loss and/or gangrene. In most patients the symptoms remain stable, but approximately 20% will develop limb threatening critical ischaemia.

The incidence of peripheral arterial disease increases with age and it is estimated that up to 20% of people aged over 60 years are affected to some degree. The incidence is also high in smokers, diabetes patients and those with established coronary disease.

A focused history should identify the presence and severity of intermittent claudication and any critical limb ischaemia. Examination should concentrate on the palpation of lower limb arterial pulses and look for signs of critical ischaemia such as ulceration. The key primary care investigation in patients with suspected peripheral arterial disease is measurement of the ankle brachial pressure index.

Lifestyle interventions are a key component of management. NICE recommends that a supervised exercise programme is offered to all patients with intermittent claudication. It should include two hours of supervised exercise a week for a three-month period encouraging patients to exercise to the point of maximal pain. Pharmacological therapy should always include an antiplatelet agent and statin. Vasoactive drugs such as naftidrofuryl oxalate should be considered for symptom control in intermittent claudication when exercise has not led to a satisfactory improvement and the patient prefers not to be referred for revascularisation.

Patients with severe and inadequately controlled symptoms should be referred to secondary care with a view to further imaging to assess the appropriateness of revascularisation. All patients with critical limb ischaemia should be assessed by a vascular multidisciplinary team before treatment decisions are made and in particular before revascularisation is abandoned and amputation considered.

Patients with critical limb ischaemic pain should be offered paracetamol, and either weak or strong opioids depending on the severity of pain. They should be referred to a specialist pain management service: if their pain is not adequately controlled and revascularisation is inappropriate or impossible; they require ongoing high doses of opioids for pain control; or pain persists after revascularisation or amputation.