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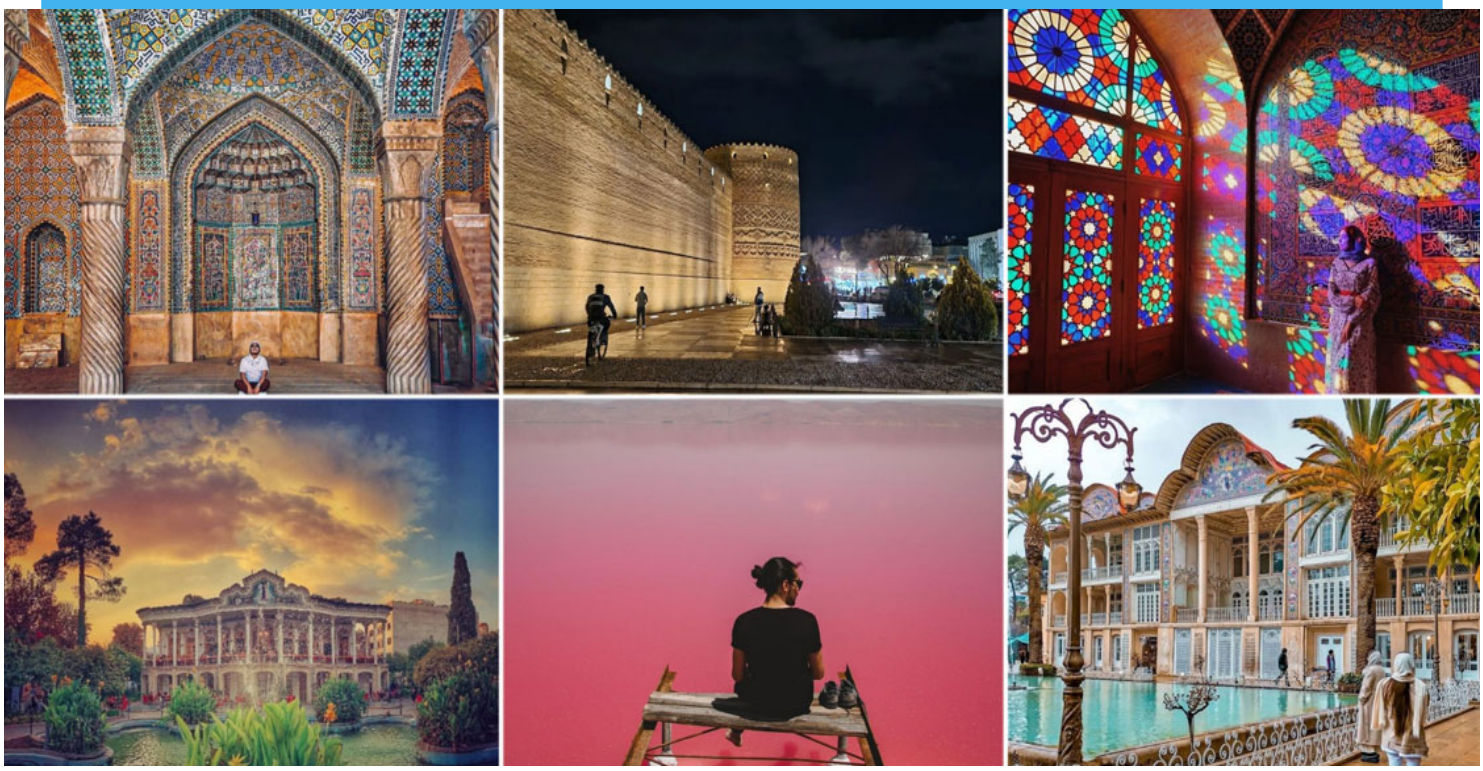

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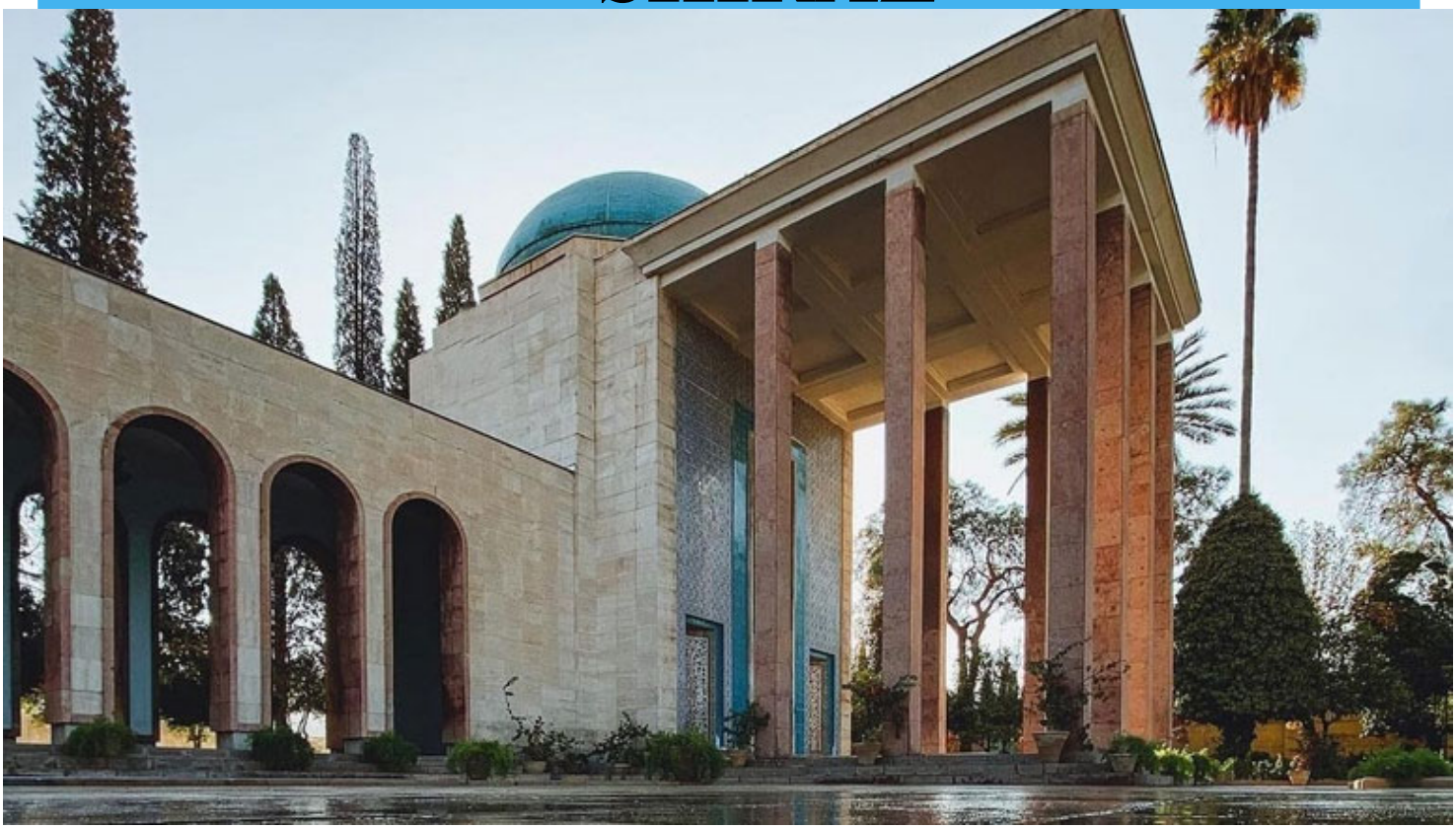

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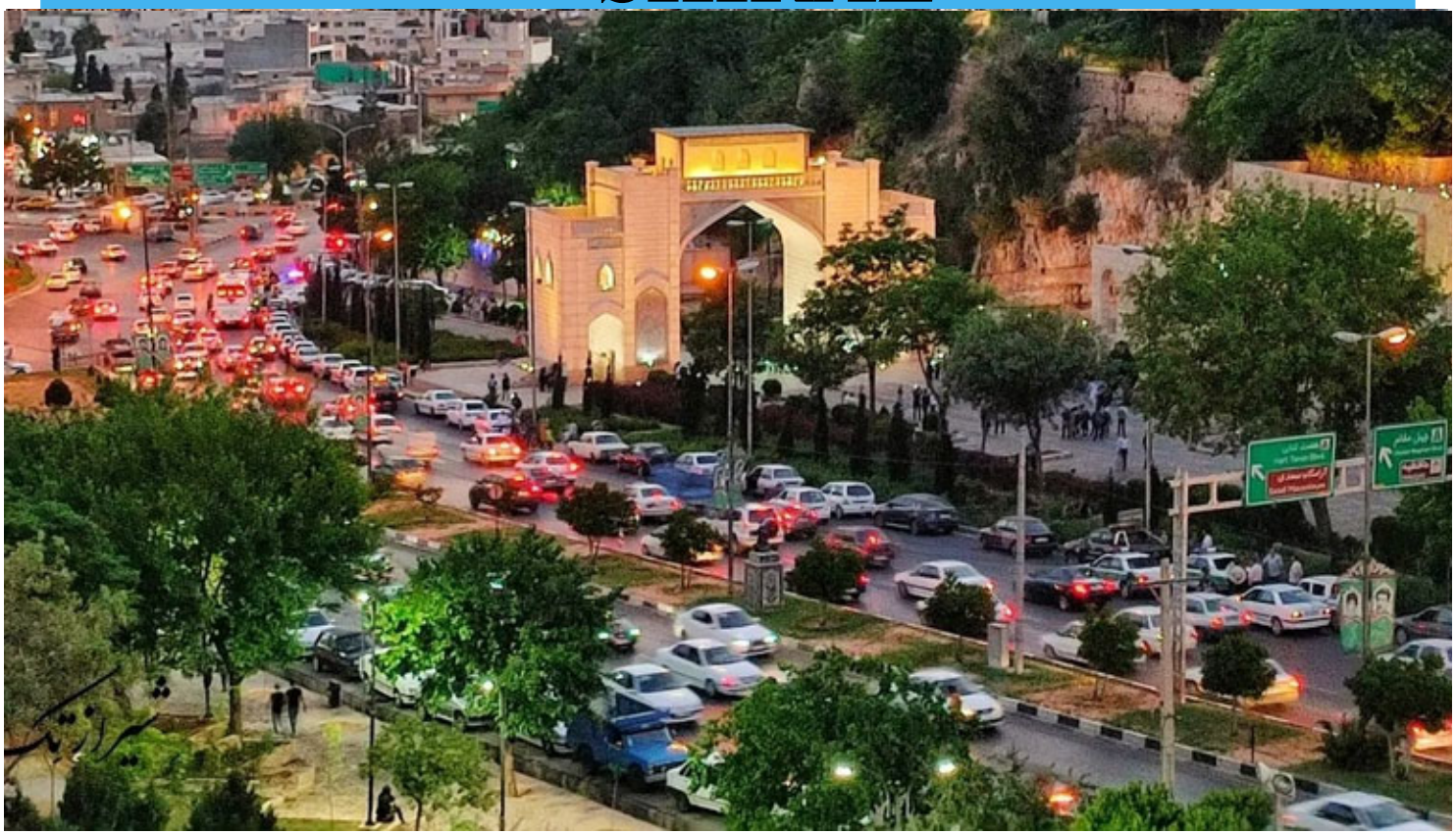

SHIRAZ

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Soheila Salari
MD

General Internist

Shiraz Kowsar Hospital

Ordibehesht 1404

Case presentation

A 67 year old woman, diabetic and hypertensive and CAD came in for revascularization of lower extremities affected by peripheral arterial occlusive disease.

Cont.

- She developed AMI, heart failure during the days of post surgery.
- Coronary angiography has been done, 3 vessel disease diagnosed. CABG done , and finally she expired.
- After that she presented in RCA to discuss the process of management.

PAD

- Lower extremity peripheral artery disease (PAD) affects 12% to 20% of Americans 60 years and older.
- The most significant risk factors for PAD are hyperlipidemia, hypertension, diabetes mellitus, chronic kidney disease, and smoking; the presence of three or more factors confers a 10-fold increase in PAD risk.

Collaboration of PAD and CAD

- Patients with PAD have a higher risk of subclinical CAD and are at higher risk of cardiovascular events when compared with healthy controls.
- Cardiovascular risk correlates to the severity of symptoms with asymptomatic individuals at lowest risk.
- PAD hospitalizations, as a potential marker of severity of PAD, have been linked to worse outcomes.

Cont.

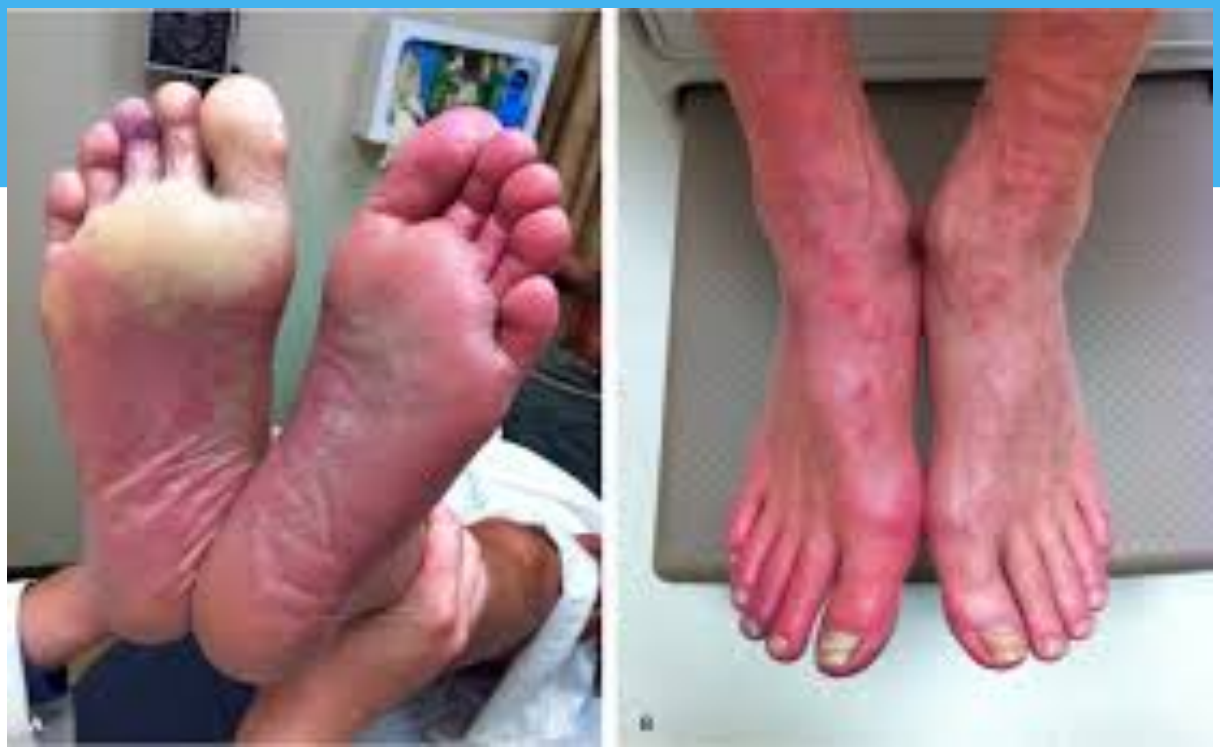
- Collectively, the severity of PAD correlates with both the development of and complications of CAD. The mechanism underpinning these observations is likely multifactorial.

Symptoms

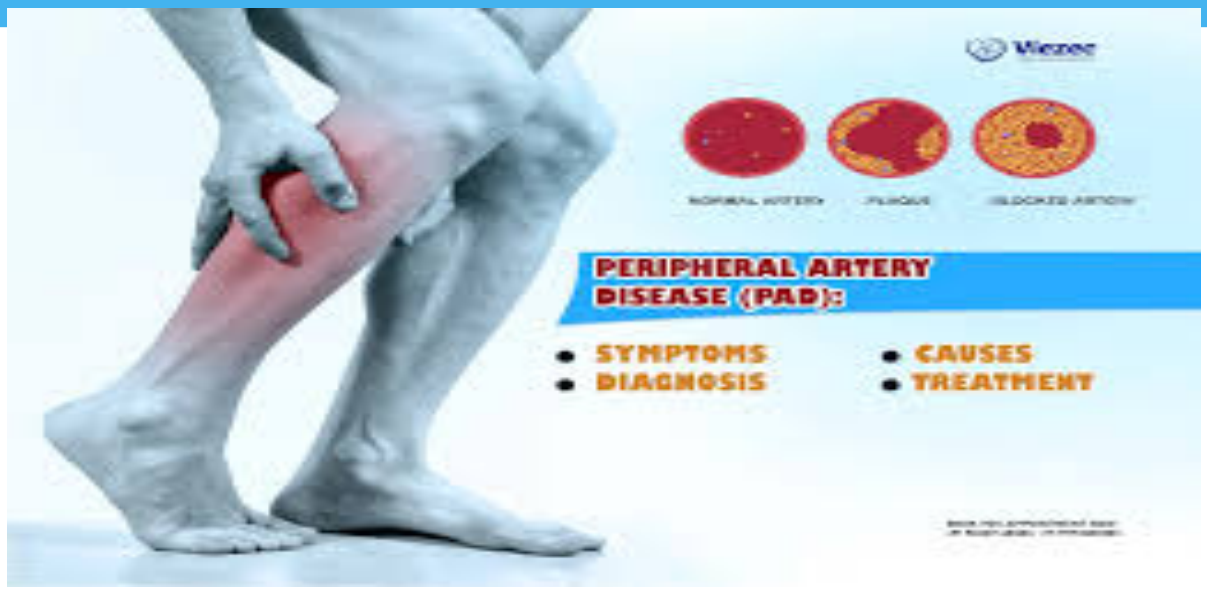
- Intermittent claudication is the hallmark of atherosclerotic lower extremity PAD, but only about 10% of patients with PAD experience intermittent claudication. A variety of leg symptoms that differ from classic claudication affects 50% of patients, and 40% have no leg symptoms at all.

History

- Each patient with PAD is unique. Even though the pathophysiology, risk factors, location, and eventual treatment options for a patient often prove routine, the manner in which the patient presents is anything but predictable.1
- Unfortunately, patients do not often read the textbook.
- The discomfort caused by PAD is more often atypical than typical.



Pain


PERIPHERAL ARTERY
DISEASE (PAD):
SYMPTOMS
DIAGNOSIS
CAUSES
TREATMENT

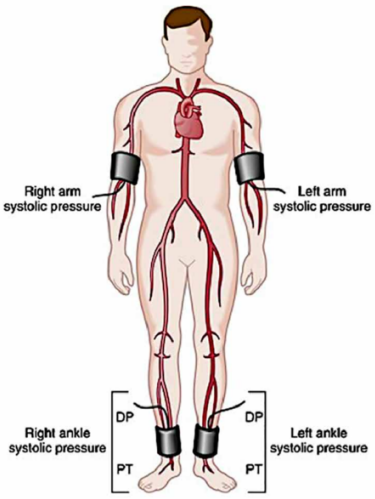
ABI

- Current guidelines recommend resting ankle-brachial index (ABI) testing for patients with history or examination findings suggesting PAD. Patients with symptoms of PAD but a normal resting ABI can be further evaluated with exercise ABI testing. Routine ABI screening for those not at increased risk of PAD is not recommended.

ABI

Right ABI	Higher right ankle pressure / Higher arm pressure
Left ABI	Higher left ankle pressure / Higher arm pressure

Interpretation of ABI	
>1.30	Noncompressible
1.00–1.29	Normal
0.91–0.99	Borderline (equivocal)
0.41–0.90	Mild to moderate peripheral arterial disease
0.00–0.40	Severe peripheral arterial disease



Physical examination

The vascular examination should focus on the symptoms presented by the patient during the history. However, a complete vascular examination is appropriate given the diffuse nature of the atherosclerotic process.

P/E

- Vital signs: including bilateral blood pressures, heart rate, height, and weight should be obtained as a routine.
- Head

Arcus senilis

telangiectasias

Temporal arteries

Ophtalmoscopy

P/E

- Neck

Venous distention

Carotids, palpation, comparison

Bruit in carotid arteries

Jugular venous pressure

Hepatojugular reflux

- Chest

Venous plethora or collaterals

Abdomen: Aorta pulsation,
Liver span,
Ascites
Legs: Asymmetric hair growth
Femoral pulse
, popliteal pulse ,
Calf muscle diameter

P/E

- Inspection
- Palpation
- Percussion
- Auscultation
- And history taking

فال حافظ

- معاشران گره از زلف یار باز کنید
- شبی خوش است بدین قصه اش دراز کنید
- حضور خلوت انس است و دوستان جمعند
- و ان یکاد بخوانید و در فراز کنید
-

- وگر طلب کند انعامی از شما حافظ
- حوالتش به لب یار دلنواز کنید

ز خاک سعدی شیرازبوی عشق آید