PERIPHERAL ARTERIAL DISEASE

What’s the issue?

“Peripheral arterial disease (PAD) is a common condition, in which a build-up of fatty deposits in the arteries (a process called atherosclerosis) restricts blood supply to leg muscles. It is also known as peripheral vascular disease (PVD). Many people with PAD have no symptoms. However, some develop a painful ache in their legs when they walk, which usually disappears after a few minutes' rest. The medical term for this is "intermittent claudication". The risk of developing PAD increases with age. It is estimated that around one in every five people over the age of 60 are affected by the condition to some degree. Men tend to develop the condition more often than women. Smoking is the most significant risk factor for PAD as well as diabetes, high blood pressure and high cholesterol. Exercising regularly and stopping smoking can ease the symptoms of PAD and reduce the chances of the condition getting worse. If applicable, treating the underlying conditions of high blood pressure, high cholesterol and diabetes and surgery can improve blood flow in the legs. Whilst not immediately life-threatening, the process of atherosclerosis can lead to serious and potentially fatal problems such as heart attack and stroke. There is also the risk that leg tissue will begin to die (gangrene) and in severe cases this can lead to amputation of the lower leg” [226].

Within a systematic review examining global prevalence estimates and risk factors for peripheral arterial disease [227], it states that “about 10–20% of people with peripheral artery disease have intermittent claudication [228, 229], another 50% have atypical leg symptoms [229], and those without exertional leg pain have poor mobility compared with individuals without peripheral artery disease [230]. Patients with and without leg ischaemic symptoms have roughly a three-fold increase in risk of mortality and major cardiovascular events (heart attack and stroke) compared with those without peripheral artery disease [231-233].”

What’s our situation?

For 2015/16, there were 1,723 (0.58%) registered patients diagnosed with peripheral arterial disease which was similar to England (0.61%), but lower than six of seven comparator areas (range 0.62% to 1.04% except Leicester 0.34%) [93]. There was a statistically significant increasing trend in the prevalence with increasing deprivation [211]. The 11 practices with the highest mean patient deprivation scores serving the most deprived fifth of Hull's population had a prevalence of 0.60% compared to 0.49% among the 11 practices with the lowest mean patient deprived scores.

Based on modelling, it is estimated that there are almost 14,000 (4.7%) patients with peripheral arterial disease in Hull (October 2016) [211]. If this is an accurate model, this suggests that there are high levels of undiagnosed peripheral arterial disease in Hull patients with around 12,000 having peripheral arterial disease, and potentially between 1,400 and 2,800 patients having intermittent claudication and a further 7,000 have atypical leg symptoms in Hull [211, 227, 234].

For more detailed information, see the JSNA Toolkit: Other Circulatory Diseases report.

What are the strategic needs?

People aged 40-79 years who are eligible for the NHS Health Check should be encouraged to attend. People already diagnosed with peripheral arterial disease should attend their annual reviews so that they get the best on-going treatment for their condition.

Practices should be supported in terms of case finding with regard to cardiovascular diseases. Where a patient has one cardiovascular condition, clinicians should proactively seek to assess the risk and diagnose other cardiovascular conditions such as peripheral arterial disease with a standard cardiovascular assessment undertaken to examine the existence of and/or risk of hypertension, familial hypercholesterolaemia, coronary heart disease, stroke, type 2 diabetes, and kidney disease. People at risk of familial hypercholesterolaemia should be identified so that they can commence treatment and/or be referred for specialist care [196].
References


