Chapter IV: Treatment of critical limb ischaemia.

Recommendations stated in the TASC II guidelines for the treatment of peripheral arterial disease (PAD) regard a heterogeneous group of patients ranging from claudicants to critical limb ischaemia (CLI) patients. However, specific considerations apply to CLI patients. An important problem regarding the majority of currently available literature that reports on revascularisation strategies for PAD is that it does not focus on CLI patients specifically and studies them as a minor part of the complete cohort. Besides the lack of data on CLI patients, studies use a variety of endpoints, and even similar endpoints are often differentially defined. These considerations result in the fact that most recommendations in this guideline are not of the highest recommendation grade. In the present chapter the treatment of CLI is not based on the TASC II classification of atherosclerotic lesions, since definitions of atherosclerotic lesions are changing along the fast development of endovascular techniques, and inter-individual differences in interpretation of the TASC classification are problematic. Therefore we propose a classification merely based on vascular area of the atherosclerotic disease and the lesion length, which is less complex and eases the interpretation. Lesions and their treatment are discussed from the aorta downwards to the infrapopliteal...
region. For a subset of lesions, surgical revascularisation is still the gold standard, such as in extensive aorto-iliac lesions, lesions of the common femoral artery and long lesions of the superficial femoral artery (>15 cm), especially when an applicable venous conduit is present, because of higher patency and limb salvage rates, even though the risk of complications is sometimes higher than for endovascular strategies. It is however more and more accepted that an endovascular first strategy is adapted in most iliac, superficial femoral, and in some infrapopliteal lesions. The newer endovascular techniques, i.e. drug-eluting stents and balloons, show promising results especially in infrapopliteal lesions. However, most of these results should still be confirmed in large RCTs focusing on CLI patients. At some point when there is no possibility of an endovascular nor a surgical procedure, some alternative non-reconstructive options have been proposed such as lumbar sympathectomy and spinal cord stimulation. But their effectiveness is limited especially when assessing the results on objective criteria. The additional value of cell-based therapies has still to be proven from large RCTs and should therefore still be confined to a research setting. Altogether this chapter summarises the best available evidence for the treatment of CLI, which is, from multiple perspectives, completely different from claudication. The latter also stresses the importance of well-designed RCTs focusing on CLI patients reporting standardised endpoints, both clinical as well as procedural.

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