Structured follow-up after revascularisation for chronic critical limb ischaemia (CLI) aims at sustained treatment success and continued best patient care. Thereby, efforts need to address three fundamental domains: (A) best medical therapy, both to protect the arterial reconstruction locally and to reduce atherosclerotic burden systemically; (B) surveillance of the arterial reconstruction; and (C) timely initiation of repeat interventions. As most CLI patients are elderly and frail, sustained resolution of CLI and preserved ambulatory capacity may decide over independent living and overall prognosis. Despite this importance, previous guidelines have largely ignored follow-up after CLI; arguably because of a striking lack of evidence and because of a widespread assumption that, in the context of CLI, efficacy of initial revascularisation will determine prognosis during the short remaining life expectancy. This chapter of the current CLI guidelines aims to challenge this disposition and to recommend evidentially best clinical practice by critically appraising available evidence in all of the above domains, including antiplatelet and antithrombotic therapy, clinical surveillance, use of duplex ultrasound, and indications for and preferred type of repeat interventions for failing and failed reconstructions. However, as
corresponding studies are rarely performed among CLI patients specifically, evidence has to be consulted that derives from expanded patient populations. Therefore, most recommendations are based on extrapolations or subgroup analyses, which leads to an almost systematic degradation of their strength. Endovascular reconstruction and surgical bypass are considered separately, as are specific contexts such as diabetes or renal failure; and critical issues are highlighted throughout to inform future studies.