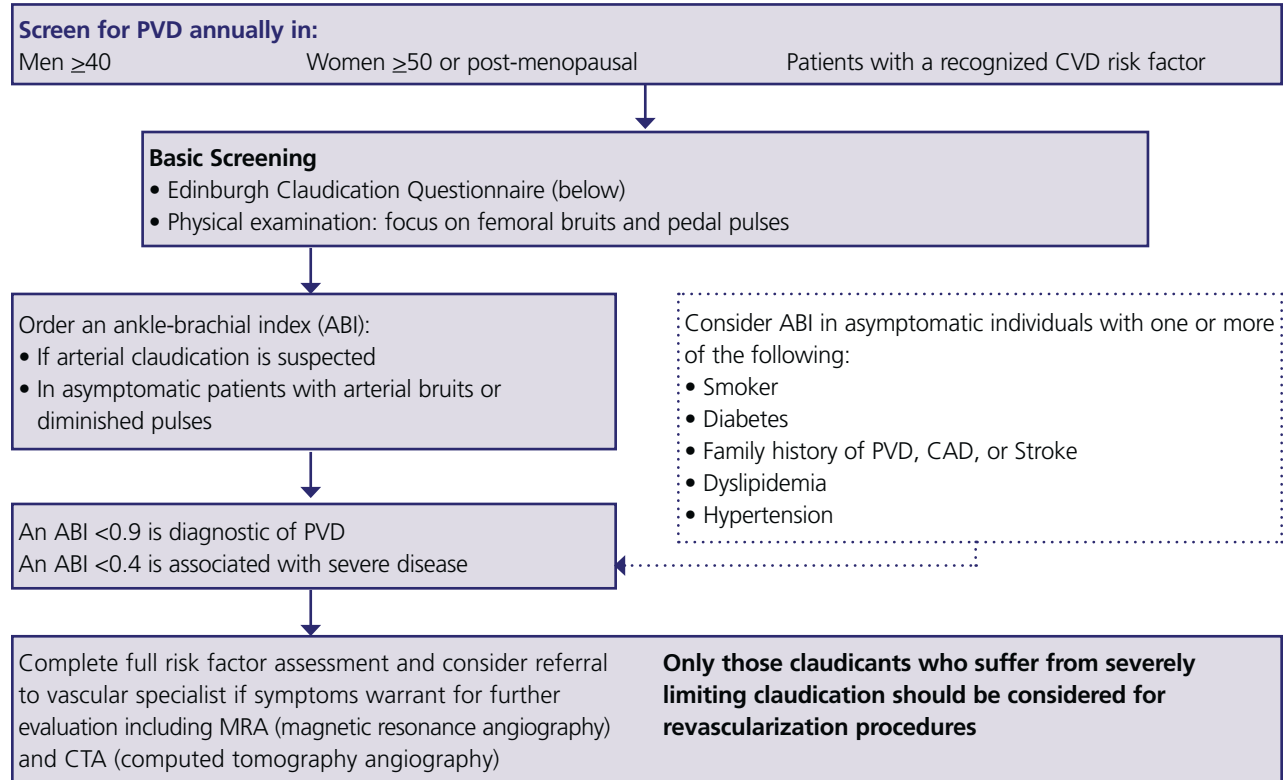




# CORONARY ARTERY DISEASE & PERIPHERAL VASCULAR DISEASE

## SCREENING FOR PERIPHERAL VASCULAR DISEASE (PVD)

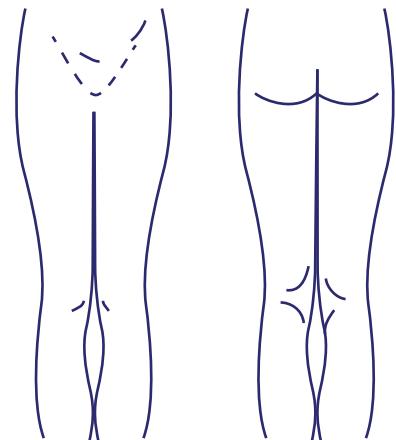
Source: Abramson B, Huckell V et. al. Canadian Cardiovascular Society Consensus Conference: Peripheral arterial disease. Can J Cardiol. 2005; 21(12): 997-1006.<sup>28</sup>



### The Edinburgh Claudication Questionnaire

\* A positive questionnaire diagnosis of claudication is made only if the "correct" answer is given to all questions.

Questions	Correct Answer
1. Do you get pain or discomfort in your leg(s) when you walk? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unable to walk • If you answered "yes" to question 1, please answer the following questions:	Yes
2. Does this pain ever begin when you are standing still or sitting?	No
3. Do you get it when you walk uphill or hurry?	Yes
4. Do you get it when you walk at an ordinary pace on the level?	Yes
5. What happens if you stand still? • Usually continues more than 10 minutes? • Usually disappears in 10 minutes or less?	No Yes
6. Where do you get this pain or discomfort? • Mark the places with "X" on the diagram	





## MANAGEMENT OF CORONARY ARTERY DISEASE &amp; PERIPHERAL VASCULAR DISEASE

Source: Adapted from Smith S, Allan J, Blair S et al. AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2006 Update: Endorsed by the National, Heart, Lung, Blood Institute. *Circulation*. 2006; 113:2363-2372.<sup>27</sup>

Abramson B, Huckell V et. al. Canadian Cardiovascular Society Consensus Conference: Peripheral arterial disease. *Can J Cardiol*. 2005; 21(12): 997-1006.<sup>28</sup>

Risk Factor	Target	Intervention
Smoking	Smoke-free	<p><b>See Smoking Cessation Guideline (page 29)</b></p> <ul style="list-style-type: none"> <li>• <b>Ask</b> about tobacco use at every visit.</li> <li>• <b>Advise</b> every tobacco user to quit. Advise of risks of continued smoking to PVD/ CAD patients "The most important thing you can do to improve your heart health is to quit smoking".</li> <li>• <b>Assess</b> the tobacco user's readiness to quit.</li> <li>• <b>Assist</b> by counselling and pharmacotherapy - see smoking cessation recommendations.</li> <li>• <b>Arrange</b> follow-up, referral to specialized programs or community programs.</li> <li>• Urge avoidance of exposure to environmental tobacco smoke at work and home.</li> </ul>
Physical Activity	30-60 minutes, 4-7 days/ week	<ul style="list-style-type: none"> <li>• Encourage 30 to 60 minutes of moderate-intensity aerobic activity such as brisk walking on most days of the week, supplemented by an increase in daily lifestyle activities.</li> <li>• Encourage resistance training 2 days per week.</li> <li>• Refer to Cardiac Rehabilitation Program (patients with recent event) or Heart Wise Programs (all patients).</li> </ul>
Weight Management	<p><b>Target Weight</b> BMI 18.5 to 24.9 kg/m<sup>2</sup></p> <p><b>Waist circumference:</b> ≤88 cm (35") for women and ≤102 cm (40") for men</p> <p><i>Start with targeting weight loss of 5 – 10% of body weight.</i></p>	<ul style="list-style-type: none"> <li>• Assess BMI and/ or waist circumference (see Appendix B for instructions on proper waist line measurement).</li> <li>• Discuss weight issues with patients who are outside of the BMI and waist circumference limits.</li> <li>• Encourage weight maintenance or reduction through appropriate balance of physical activity, caloric intake.</li> <li>• Refer to behavioural programs as necessary.</li> <li>• See specific obesity/ overweight recommendations (page 43).</li> </ul>
Hypertension	<p>&lt;140/90 mmHg; or &lt;130/80 mmHg if patient has Diabetes, CKD</p>	<ul style="list-style-type: none"> <li>• Assess BP every 3 to 6 months.</li> <li>• Ensure patient knows his/ her BP values and targets.</li> <li>• Initiate or maintain lifestyle modification (page 12).</li> <li>• Add BP medication as needed to achieve targets.</li> </ul>
Dyslipidemia	<p>LDL-C &lt;2.0 mmol/L or a 50% decrease in LDL-C; TC/HDL-C Ratio &lt;4.0</p>	<ul style="list-style-type: none"> <li>• Conduct fasting lipid profile in all patients every 12 months.</li> <li>• Ensure patient knows his/ her lipid values and targets.</li> <li>• If required, initiate LDL-lowering drug therapy (page 21).</li> <li>• Ensure adequate titration to achieve targets.</li> <li>• Start recommended dietary therapy (page 21).</li> <li>• Promote daily physical activity and weight management.</li> <li>• After obtaining required target, recheck annually.</li> </ul>
Glycemic Control/ Diabetes	<p><b>If diabetic:</b> HbA1c &lt;7% (&lt;6% if possible without hypoglycemia)</p>	<ul style="list-style-type: none"> <li>• <b>Screen for Diabetes annually or as clinically indicated (page 65).</b></li> <li>• <b>If diabetic:</b> <ul style="list-style-type: none"> <li>• Initiate lifestyle and pharmacotherapy to achieve near normal HbA1c.</li> <li>• Initiate pharmacotherapy as per recommendations from Canadian Diabetes Association.<sup>29</sup></li> </ul> </li> </ul>
eGFR/ ACR	<p><b>If proteinuria or CKD:</b> Target ACR &lt;40</p>	<ul style="list-style-type: none"> <li>• Screen with eGFR/ ACR according to guideline (page 27).</li> <li>• <b>If target exceeded:</b> <ul style="list-style-type: none"> <li>• ACEI or ARB to maximum tolerated dose and modify CV risk factors to target ACR &lt;40; and,</li> <li>• If ACR &gt;60, refer to nephrology.</li> </ul> </li> </ul>
Antiplatelet / Anticoagulant	ASA 80-325 mg/ day	<ul style="list-style-type: none"> <li>• Start ASA and continue indefinitely unless contraindicated.</li> <li>• Start and continue Clopidogrel 75 mg/d in combination with ASA for 12 months in patients with acute coronary syndrome or stent placement.</li> </ul>
ACE Inhibitors		<ul style="list-style-type: none"> <li>• <b>Start and continue ACE inhibitors indefinitely in all patients with:</b> <ul style="list-style-type: none"> <li>• Left ventricular ejection fraction &lt;40% and in those with hypertension, Diabetes, or CKD; and,</li> <li>• Consider for all other patients.</li> </ul> </li> <li>• <b>Optional use of ACE inhibitors in:</b> <ul style="list-style-type: none"> <li>• Low-risk patients with normal ejection fraction in whom cardiovascular risk factors are well controlled and revascularization has been performed.</li> </ul> </li> <li>• <b>Use ARB in patients who:</b> <ul style="list-style-type: none"> <li>• Are intolerant of ACE inhibitors and have heart failure or ejection fraction &lt;40%; and,</li> <li>• Consider in other patients who are ACE inhibitor intolerant.</li> </ul> </li> </ul>
Beta Blockers		<ul style="list-style-type: none"> <li>• Start and continue indefinitely in all patients who have had myocardial infarction, acute coronary syndrome or left ventricular dysfunction with or without heart failure symptoms, unless contraindicated.</li> </ul>
Influenza Vaccination	Annually	<ul style="list-style-type: none"> <li>• All patients with CVD should have an influenza vaccination on an annual basis.</li> </ul>