

Peter Ishak<sup>1,2</sup>, Nahl Iftikhar<sup>1,2</sup>, Arushan Nadarasa<sup>1,2</sup>, Steven Boom<sup>1</sup>, David Wallace<sup>1</sup>

<sup>1</sup> [Vascular Surgery Department, University Hospital Ayr]

<sup>2</sup> [Undergraduate Medical School, University of Glasgow]

## Background

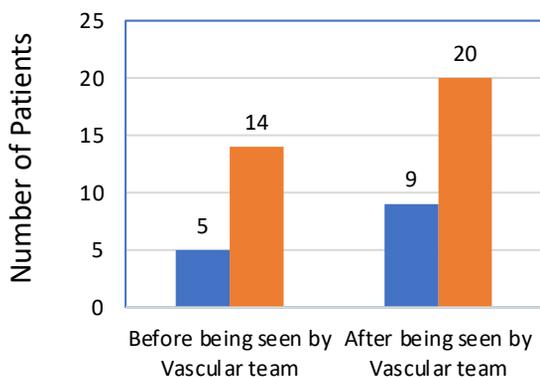
Best medical therapy (BMT) is a collection of evidence-based cost-effective interventions, which significantly decreases cerebrovascular and coronary mortality and morbidity risk by at least 20% in peripheral arterial disease (PAD) patients. Its implementation was audited in patients attending our vascular unit.

## Methods

A prospective audit of BMT implementation in PAD patients in University Hospital Ayr over a three-week period: diabetic and hypertension control, statin and antiplatelet therapy were audited from electronic notes and prescription charts. Exercise and smoking cessation advice given during consultations were recorded and audited.

### Overall Provision of BMT in PAD Patients Seen by Vascular Team

■ Control of all 6 risk factors  
 ■ Control of risk factors excluding lifestyle risk factors



## Discussion

We suggest refresher teaching sessions on PAD risk factors and BMT for primary and secondary care. We plan to implement 'BMT stickers' for PAD patients as an aide memoir for junior staff seeing these patients. There is a requirement for better vascular medical input in PAD patients. Who should take on this role?

## Results

35 patients were randomly selected from ward admissions and vascular clinics. Their mean age was 69±12 years, 25 were male. 4 out of 11 smokers received smoking cessation advice. All the patients attending the clinic were given exercise advice. 3 patients had never had their HbA1c checked. 7 of 14 diabetic patients with poor control had changes to their medication. Statins were commenced in 7 out of 14 patients not currently on a statin and another 4 had their statin dose increased. 32 patients had their lipid profile checked. Both patients with newly diagnosed hypertension were not prescribed antihypertensive. Only 5 out of 12 patients who should have had an antiplatelet agent received them. 5 patients were changed from a single antiplatelet agent to dual therapy.

Table 2: Prevalence of risk factors and provision of BMT for control (n = 35)

|  |          |
|--|----------|
| Diabetes (n, %)  |          |
| Known diabetic patients  | 19 (54%) |
| Uncontrolled diabetes at presentation                                | 14 (40%) |
| Change implemented by vascular team to achieve control               | 7 (20%)  |
| Hypertension (n, %)  |          |
| Known hypertensive patients  | 23 (66%) |
| Uncontrolled hypertension at presentation                            | 5 (14%)  |
| Change implemented by vascular team to achieve control               | 2 (6%)   |
| Lipid-lowering therapy (n, %)  |          |
| Patients already on statin   | 24 (69%) |
| Patients newly identified for statin therapy by vascular team        | 7 (20%)  |
| Anti-platelet therapy (n, %)   |          |
| Patients already on anti-platelet                                    | 23 (66%) |
| Patients newly identified for anti-platelet therapy by vascular team | 6 (17%)  |

### Best Medical Therapy in Peripheral Arterial Disease

Smoking Cessation

Exercise advice

Statin therapy

Anti-platelet therapy

Anti-hypertensive therapy

Diabetic control

## Conclusion

Primary and secondary care education is essential to improve BMT provision in PAD patients. Sticker reminders and vascular physicians may help in optimising BMT.