

Peripheral Artery Disease

Diagnosis, foundational medical therapy, exercise, revascularization, and the acute limb ischemia pathway for adults with PAD.

COR I • Recommended IIa • Reasonable IIb • May Consider III • No Benefit / Harm

1 Clinical Diagnosis & ABI Interpretation

I
B-NR Patients at increased risk (age ≥65y; age 50–64y + atherosclerosis risk factor; age <50y + diabetes + 1 more risk factor; known atherosclerosis elsewhere) — comprehensive history + vascular exam should be performed.

I
B-NR History/exam suggestive of PAD — **resting ABI** recommended to establish diagnosis.

IIa
B-NR At increased risk but asymptomatic — **screening ABI** reasonable.

III
NB • B-NR Not at increased risk, no suggestive symptoms/signs — ABI screening **not recommended**.

RESTING ABI	INTERPRETATION
≤0.90	Abnormal
0.91–0.99	Borderline
1.00–1.40	Normal
>1.40 (noncompressible)	Obtain toe pressure/TBI with waveforms

2 Foundational Medical Therapy

ANTIPLATELET THERAPY

I
A Symptomatic PAD — **single antiplatelet therapy** (clopidogrel or aspirin) recommended to reduce MACE.

I
A Low-dose **rivaroxaban 2.5mg BID** + **low-dose aspirin** effective to reduce MACE and MALE.

LIPID-LOWERING

I
A **High-intensity statin**, goal ≥50% LDL-C reduction. If LDL-C ≥70mg/dL on max-tolerated statin, add ezetimibe or PCSK9 inhibitor (IIa, B-R).

BLOOD PRESSURE

I
A/B-R Treat hypertension to reduce MACE; target **<130/ <80 mmHg**. Selective use of ACE-I or ARB recommended.

AVOID

III
Harm • A Without another indication (eg, AF) — **full-intensity oral anticoagulation** should not be used to reduce MACE/MALE.

3 Exercise & Leg-Symptom Medications

I
A **Supervised exercise therapy (SET)** recommended to improve walking performance, functional status, and QOL; structured community-based programs are also effective.

I
A **Cilostazol** recommended to improve leg symptoms and increase walking distance in claudication.

III
Harm • C-LD Cilostazol **should not** be administered in PAD with congestive heart failure of any severity.

III
NB • B-R **Pentoxifylline** and **chelation therapy** are not recommended for treatment of claudication.

4 Revascularization for Claudication

IIa
B-R Functionally limiting claudication with **inadequate response to GDMT** (incl. structured exercise) — revascularization is a reasonable option to improve walking function and QOL.

III
NB • C-E0 **Adequate** clinical response to GDMT — revascularization **not recommended**.

I
A Hemodynamically significant **aortoiliac or femoropopliteal disease** with inadequate GDMT response — endovascular revascularization is effective to improve walking performance and QOL.

IIa
B-R **Common femoral artery disease** with inadequate GDMT response — surgical endarterectomy is reasonable, especially if endovascular approach would affect profunda femoris pathways.

5 Revascularization for CLTI

I
B-R Surgical, endovascular, or hybrid revascularization recommended, when feasible, to minimize tissue loss, heal wounds, relieve pain, preserve limb.

I
C-E0 **Multispecialty care team** evaluation for revascularization options recommended before amputation.

I
A Surgical bypass to popliteal/infrapopliteal arteries — should use **autogenous vein** if available.

I
B-R Anatomy, available conduit, comorbidities, and patient preference guide the choice of **surgical bypass vs. endovascular** as first strategy.

6 Acute Limb Ischemia — Emergency Pathway

I
C-E0 **Emergency evaluation** by a clinician experienced in assessing limb viability recommended; transfer if local expertise unavailable — muscle tolerates ischemia only ~4–6h.

I
A **Salvageable limb** — revascularization (endovascular, surgical, or catheter-directed thrombolysis) indicated to prevent amputation.

I
C-E0 Monitor and treat for **compartment syndrome** with fasciotomy after revascularization to prevent reperfusion injury.

III
Harm • C-E0 **Nonsalvageable (category III) limb** — revascularization should **not** be performed; amputation is the index procedure.