



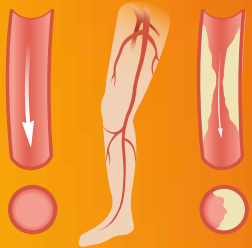
THE NEW
PROGRAM BY
ABBOTT HELPING
YOU TO IDENTIFY
AND MANAGE
YOUR PATIENTS
WITH PERIPHERAL
ARTERY DISEASE

CLEAR

Streamlining Peripheral Artery Disease referral
and diagnosis to improve quality of life



PERIPHERAL ARTERY DISEASE REMAINS UNDERDIAGNOSED AND UNDERTREATED DESPITE BEING COMMON^{1,2}



Peripheral artery disease (PAD) is a common condition where abnormal narrowing or blockage of the arteries due to atherosclerosis reduces blood flow to the extremities.^{2,3}

PAD IN NUMBERS



An estimated over **8.5–12** million people ≥ 40 years of age have PAD in the United States⁴



14.5% of people **>70** years of age⁵



PAD 5-year mortality rate is **33%**⁶



The prevalence of PAD increases with age \rightarrow **x2** each decade⁷



21% of patients with PAD will have MI, stroke, cardiovascular death or hospitalization within **ONE YEAR**⁸



Reduced quality of life^{9,10}

PAD SYMPTOMS

PAD symptoms and their severity can vary greatly between patients, the most recognized subset of symptoms is ‘intermittent claudication’. Intermittent claudication can include muscle fatigue, cramping and/or pain in the legs during exercise, which stops after resting.^{11,12} However, intermittent claudication is present in only a minority of patients with PAD.⁷

MOST PATIENTS WITH PAD HAVE ATYPICAL LEG SYMPTOMS OR ARE ASYMPTOMATIC¹²

Other symptoms include:^{3,13,14}

- Ulceration on legs or feet that does not heal
- Hair loss on legs or feet
- Pale or bluish skin color of legs or feet
- Shiny skin
- Slow-growing and/or brittle toenails
- Erectile dysfunction in men

MANAGING PAD

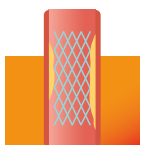
Optimal PAD management is best achieved by the combined use of lifestyle changes and a wide range of treatments.^{12,15}



Lifestyle changes, such as smoking cessation (if applicable), diet adaptation and establishing a structured exercise regimen



Medications (customized to individual risk factors), such as antiplatelet, statin, and antihypertensive agents



Minimally invasive procedures, such as angioplasty or stenting



Surgical interventions (for patients with lifestyle-limiting claudication)

THE IMPORTANCE OF EARLY DETECTION

Early detection of PAD is important as the condition is associated with an increased risk of cardiovascular morbidity and mortality.¹⁶ A delay in treatment promotes rapid disease progression and increases the risk of serious complications, such as myocardial infarction, ischemic stroke and amputation when affecting the limb.^{2,12,13}



PATIENTS DON'T ALWAYS SEEK PROPER MEDICAL ATTENTION¹⁷

Studies have shown that:

- **10–50%** of the patients with intermittent claudication had never sought medical care¹³
- There was a **delay** between the start of PAD symptoms and the patient seeking medical attention¹⁷
- Up to **50%** of patients with PAD are yet to be detected¹³

IDENTIFYING PAD SYMPTOMS MAY ASSIST IN EARLY DETECTION AND TIMELY TREATMENT INITIATION²

WHEN TO SUSPECT PAD?

Risk factors for PAD are similar to those for other atherosclerotic diseases^{12,15}



≥65 years of age



<50 years of age: diabetes mellitus + 1 additional risk factor* for atherosclerosis



50–64 years of age + risk factors* for atherosclerosis or family history of PAD



Any age + known atherosclerotic disease in another vascular bed (e.g., coronary, carotid, subclavian, renal, mesenteric artery stenosis or abdominal aortic aneurysm)

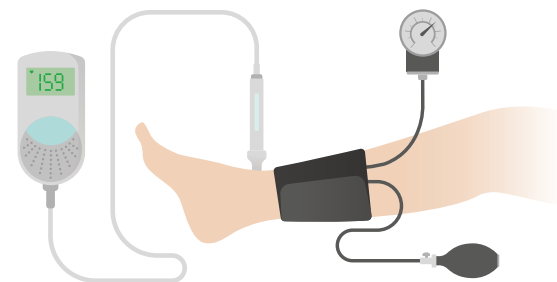
When evaluating whether your patient is at an increased risk of PAD, the following screening assessments should be performed: ^{2,12}

- Clinical history assessment
- Review of symptoms
- Physical examination
- Blood pressure reading
- Fasting lipid profile

IDENTIFYING PAD

What is an ABI?

An ankle-brachial index (ABI) is an initial diagnostic test validated for screening of PAD. It measures the systolic blood pressure in the lower legs compared to the systolic blood pressure in the arms using a Doppler device. A normal ABI is greater than 1–1.4. A value ≤ 0.90 is considered abnormal.^{10,12}



In addition to confirming PAD symptoms, ABI is essential to diagnosing PAD as its symptoms can be highly variable, atypical or absent.^{7,12}

*Risk factors include diabetes mellitus, history of smoking, hyperlipidemia, and hypertension.¹²

PAD CHECKLIST

The following checklist can be used to assess if a patient may be at risk of PAD. Multiple 'yes' answers, which indicate an increased risk of PAD, should prompt a thorough examination, preferably using a validated screening assessment such as ABI.^{12,14,18}

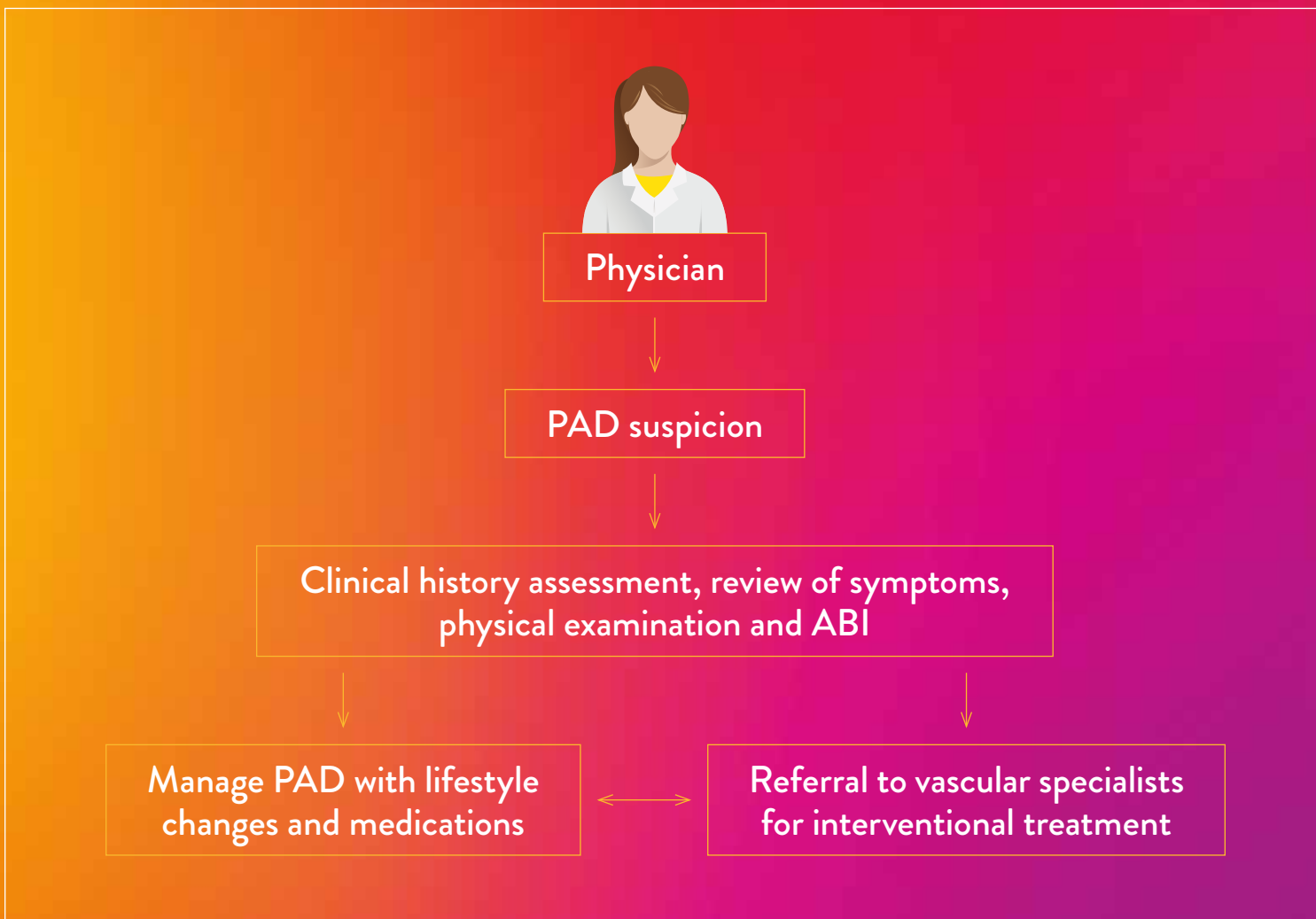
	QUESTIONS	YES	NO
AGE	<p>Is the patient:</p> <ul style="list-style-type: none"> • 65 years of age or older • 50–64 years of age and has risk factors for atherosclerosis • <50 years of age with Type 2 diabetes and at least one other risk factor for atherosclerosis • Any age and has any atherosclerotic disease in another vascular bed (e.g., coronary, carotid, subclavian, renal, mesenteric artery stenosis or abdominal aortic aneurysm) 		
SMOKING HISTORY	Does the patient smoke or have they smoked in the past?		
MEDICAL HISTORY	<p>Has the patient been diagnosed with any condition that increases the risk of atherosclerosis such as:</p> <ul style="list-style-type: none"> • Diabetes • Chronic kidney disease • High blood pressure • High cholesterol 		
	Has the patient ever been diagnosed with PAD or cardiovascular disease?		
	Has the patient ever had a stroke?		
FAMILY HISTORY	Does the patient have a family history of PAD, cardiovascular disease or stroke?		
FOOT AND LEGS	Is the patients' walking function impaired?		
	Does the patient experience a burning pain in the ball of the foot and toes which worsens when they lie down (ischemic rest pain)?		
	Does the patient experience weakness, pain, and/or cramping in their leg muscles when walking or exercising (claudication)?		
	Does the patient experience numbness, weakness or heaviness in their leg?		
	Does the patient have cold feet and/or toes?		
	Does the patient have discolored/pale skin on legs or feet?		
	Does the patient have sores on their legs and/or feet that heal very slowly or won't heal at all?		
OTHER	Do the patients' toenails grow slowly?		
	Men only: Has the patient experienced erectile dysfunction?		

WHEN SHOULD A PATIENT WITH PAD BE REFERRED TO A **VASCULAR SPECIALIST**? SEE THE PAD REFERRAL PATHWAY ON THE NEXT PAGE TO LEARN MORE

CLEAR CAN FACILITATE EDUCATION WITHIN THE REFERRAL PROCESS

Abbott's CLEAR program for PAD awareness fosters a multidisciplinary team collaboration to provide optimal care for patients with PAD.

The CLEAR program aims to support Health Care Professionals in the optimal management of PAD by providing tools for referral and timely diagnosis and treatment.¹²



EARLY DETECTION, MANAGEMENT,
AND/OR REFERRAL OF PAD CAN **SAVE**
LIMBS AND LIVES^{2,12,13}

CLEAR

Streamlining Peripheral Artery Disease referral and diagnosis to improve quality of life

Abbott is committed to raise awareness of PAD among physicians and patients to minimize complications from PAD, allowing patients to live their lives to the fullest. This guide is part of the CLEAR program for PAD awareness.

For more information on PAD and Abbott's initiatives, please scan the below QR-codes with your mobile device.



HEALTHCARE PROFESSIONAL WEBSITE



CLEAR.abbott/US



PATIENT PROGRAMS AND CAMPAIGNS



PAD-info.com/US

1. Haigh KJ, et al. *Vasc Med*. 2013; 18(6): 325-30. 2. Hirsch AT, et al. *JAMA*. 2001; 286(11): 1317-24. 3. Peripheral Arterial Disease (PAD). CDC. Web. 27 Sep 2021. 4. Peripheral Artery Disease (PAD). Cleveland Clinic. Web. 2015. 5. Selvin E, Erlinger TP, et al. *Circulation*. 2004; 110: 738-43. 6. Tomson J, Lip GYH. *BMC Cardiovasc Disord*. 2005; 5: 15. 7. Virani SS, et al. *Circulation*. 2021; 143(8): e254-743. 8. Steg G, et al. *JAMA*. 2007; 297(11): 1197-206. 9. Schorr EN, et al. *Geriatr Nurs*. 2015; 36(4): 293-300. 10. Wu A, et al. *J Am Heart Assoc*. 2017; 6(1): e004519. 11. Shu J, Santulli G. *Atherosclerosis*. 2018; 275: 379-81. 12. Gerhard-Herman MD, et al. *Circulation*. 2017; 135(12): e686-725. 13. Norgren L, et al. *J Vasc Surg*. 2007; 45(1): S5-67. 14. Sibley RC, et al. *Radiographics*. 2017; 37(1): 346-57. 15. Steffen LM, et al. *Diabetes Spectrum*. 2008; 21(3): 171-7. 16. Criqui MH, et al. *J Am Coll Cardiol*. 2008; 52(21): 1736-42. 17. Willigendael EM, et al. *Eur J Vasc Endovasc Surg*. 2004; 27(6): 622-8. 18. A Clinician's Guide. Helping Your Patients with Peripheral Artery Disease (PAD). AHA. Web. 3 June 2021.

The information provided is not intended for medical diagnosis or treatment or as a substitute for professional medical advice. Consult with a physician or qualified healthcare provider for appropriate medical advice. This material is intended for use with healthcare professionals only.

Information contained herein for DISTRIBUTION in the U.S. ONLY.

Illustrations are artist's representations only and should not be considered as engineering drawings or photographs. Photos on file at Abbott.

Abbott

3200 Lakeside Dr., Santa Clara, CA. 95054 USA, Tel: 1.800.227.9902

www.cardiovascular.abbott

©2022 Abbott. All rights reserved. MAT-2205335 v1.0

