The *Heart* of the Matter

Cardiology Associates, P.C.

Friday, May 07

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A Message from Cardiology Associates, PC

Dear Colleagues,

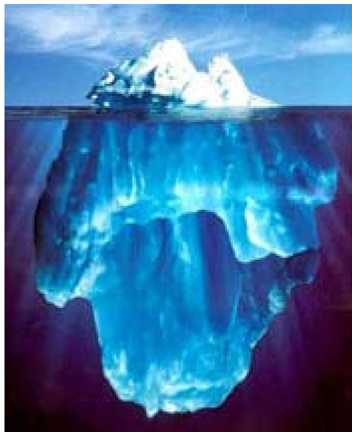
Welcome to the second issue of our Cardiology Associates' Referring Physician Newsletter. Our May, 2010 issue deals with the proper diagnosis of Peripheral Vascular Disease (PAD), which is highly prevalent within the cardiac patient community. In the next section, Dr. Reginald Robinson discusses the recent case of a PAD patient in our practice and offers insight on diagnosis and current treatment options.

About the Author

Dr. Reginald Robinson has been a member of our practice since August, 2001. Dr. Robinson is a board-certified consultative cardiologist with a special interest in preventive cardiology, peripheral vascular disease, sleep apnea, cardiovascular disease and heart failure. He is a board member of the Medical Society of the District of Columbia and Assistant Clinical Director of the Cardiovascular Care unit at The George Washington University Hospital. Additionally, Dr. Robinson is associated with the American Heart Association, the American College of Cardiology, and the Association of Black Cardiologists.

Dr. Robinson sees patients in our Washington, DC and Bowie, Maryland offices.

Peripheral Vascular Disease (PAD): The Tip of the Iceberg



PRESENTATION OF CASE

• Mr. Smith is a 60-year-old male with a past history of diabetes, tobacco abuse, and hypertension.
• Primary complaints included erectile dysfunction and leg pain after walking one block; relieved by short rest stops.
• Blood pressure was elevated and bilateral carotid, abdominal and femoral bruits were present with 1 out of 3 lower extremity pulses.
• After initial evaluation, Mr. Smith was scheduled to return for testing, but shortly afterwards he was admitted to the ER with a Myocardial Infarction (MI) and found to have severe diffuse coronary disease requiring bypass.
• A duplex of his lower extremities showed severe diffuse PAD.

DISCUSSION

Mr. Smith is a classic example of how solely looking at the tip of the iceberg, we lose sight of what lies beneath. Mr. Smith showed symptoms of intermittent claudication, and the severity of his condition was elevated by diabetes and tobacco use, the two primary causes of PAD. Additionally, he had the cardiovascular risk equivalent of diabetes with probable carotid disease (carotid bruit), placing him at an even higher risk of heart attack.

Over 29% of patients with diabetes, who smoke and/or are over the age of 70, have PAD. This number increases with each additional risk factor. Up to 44% of cases can be asymptomatic, especially if they show limited activity, but their risk of MI or stroke can be six-fold than those without PAD. Checking pulse and examining for bruits can aid in the detection of PAD. Checking the ankle brachial index (ABI) in the office can help identify these patients. A high ABI correlates with an increased risk of stroke and myocardial infarction.

Several techniques are available to help diagnose PAD and diffuse vascular disease. In addition to the ABI, a positive duplex ultrasound will also be an excellent indicator. An abnormal duplex should prompt a CT scan or MRI of the abdominal aorta. Finally, an invasive angiogram may be employed for additional therapy. If a patient has carotid disease or PAD, they should also be evaluated for coronary artery disease (CAD), since the risk of death from a myocardial infarction is high. An appropriate tool for assessing CAD would be a stress test or a coronary calcium scan.

The PAD paradox is that it is a severe disease that goes unrecognized, but it increases in prevalence with a patient's advancing age. PAD serves as an alarm system for diffuse vascular disease. Physicians should employ a high level of suspicion as patient medical history and physical examinations alone are limited in proper PAD detection. Vascular disease (carotid, abdominal aneurysm and PAD) as well as diabetes should be viewed as a cardiac risk equivalent and treated as such. Aggressive life style modification should be at the core of suggested therapy along with aggressive blood pressure checks, glycemic level maintenance, and lipid control.

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We are offering you this monthly newsletter as a way to provide cardiovascular news and update you on developments within our field. For your convenience, we are distributing our newsletter via e-mail. Visit our site at **www.heartcapc.com** and click the **Referring Physician Newsletter** link at the upper left corner of our home page. You will receive an e-Newsletter every month featuring an article or a case report from one of our physicians and links to other sources featuring new trends in the field of cardiology.

Our focus will be on real questions and issues that we encounter in our day-to-day medical practice. In fact, if there is a topic that is of particular interest to you (or a question that is related to any of our articles) please e-mail your inquiries to our Project Manager, Nazar Snihur at nsnihur@heartcapc.com. (Of course, we will not share your e-mail address outside of our offices.)

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