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Bypass versus angioplasty in severe ischaemia of the leg

We were interested to see the analysis of the medical treatment of patients with peripheral vascular disease in the BASIL trial (Dec 3, p 1925),[1] which compared angioplasty and bypass surgery for lower limb ischaemia. Only 58% of these patients were taking aspirin and only a third had been prescribed a statin at the point of enrolment. The investigators rightly state that improvements in medical management are required for this group of patients.

Patients with peripheral vascular disease are at significantly higher risk of cerebrovascular disease or coronary heart disease.[2,3] The secondary prevention of ischaemic arterial disease in this population represents an important challenge and opportunity.

Given that the patients in the BASIL trial were recruited up to 2003, we did a retrospective review of prescribing patterns in new lower limb amputees with peripheral vascular disease referred to our prosthetic clinic in 2004 to determine whether the medical management of this group was any different to that of the patients in the trial.

Of 52 patients referred, 50 had medical records available. Only 17 patients were on a statin, 25 were on aspirin or clopidogrel, and two had been prescribed warfarin for a separate medical problem.

These figures concur with those of a large Canadian cohort study of prescribing in type 2 diabetes. Only 12% of patients with peripheral vascular disease were prescribed a statin, antiplatelet agent, and

angiotensin-converting-enzyme inhibitor, and patients with peripheral vascular disease who had undergone an amputation were no more likely to be prescribed these agents than those who had not had surgery.[4]

The amputation of a lower limb in a patient with peripheral vascular disease represents a critical event, and could be regarded as indicative of severe arteriosclerosis. Although the patients identified in the BASIL trial were in the earlier stages of disease, it is of some concern that even when a major surgical procedure has been undertaken as a consequence of peripheral vascular disease, appropriate medical management does not seem to be instituted in many of these patients. Consideration should be given as to where the responsibility lies for the provision of secondary prevention in the care of patients with peripheral vascular disease.

We declare that we have no conflict of interest.

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