

CLINICAL PRACTICE GUIDELINE DOCUMENT

Global Vascular Guidelines on the Management of Chronic Limb-Threatening Ischemia

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Guideline Summary: Chronic limb-threatening ischemia (CLTI) is associated with mortality, amputation, and impaired quality of life. These Global Vascular Guidelines (GVG) are focused on definition, evaluation, and management of CLTI with the goals of improving evidence-based care and highlighting critical research needs. The term CLTI is preferred over critical limb ischemia, as the latter implies threshold values of impaired perfusion rather than a continuum. CLTI is a clinical syndrome defined by the presence of peripheral artery disease (PAD) in combination with rest pain, gangrene, or a lower limb ulceration >2 weeks duration. Venous, traumatic, embolic, and nonatherosclerotic etiologies are excluded. All patients with suspected CLTI should be referred urgently to a vascular specialist. Accurately staging the severity of limb threat is fundamental, and the Society for Vascular Surgery Threatened Limb Classification system, based on grading of Wounds, Ischemia, and foot Infection (WIFI) is endorsed. Objective hemodynamic testing, including toe pressures as the preferred measure, is required to assess CLTI. Evidence-based revascularization (EBR) hinges on three independent axes: Patient risk, Limb severity, and Anatomic complexity (PLAN). Average-risk and high-risk patients are defined by estimated procedural and 2-year all-cause mortality. The GVG proposes a new Global Anatomic Staging System (GLASS), which involves defining a preferred target artery path (TAP) and then estimating limb-based patency (LBP), resulting in three stages of complexity for intervention. The optimal revascularization strategy is also influenced by the availability of autogenous vein for open bypass surgery. Recommendations for EBR are based on best available data, pending level 1 evidence from ongoing trials. Vein bypass may be preferred for average-risk patients with advanced limb threat and high complexity disease, while those with less complex anatomy, intermediate severity limb threat, or high patient risk may be favored for endovascular intervention. All patients with CLTI should be afforded best medical therapy including the use of antithrombotic, lipid-lowering, antihypertensive, and glycemic control agents, as well as counseling on smoking cessation, diet, exercise, and preventive foot care. Following EBR, long-term limb surveillance is advised. The effectiveness of nonrevascularization therapies (eg, spinal stimulation, pneumatic compression, prostanoids, and hyperbaric oxygen) has not been established. Regenerative medicine approaches (eg, cell, gene therapies) for CLTI should be restricted to rigorously conducted randomized clinical trials. The GVG promotes standardization of study designs and end points for clinical trials in CLTI. The importance of multidisciplinary teams and centers of excellence for amputation prevention is stressed as a key health system initiative.

Keywords: Chronic limb-threatening ischemia, Critical limb ischemia, Peripheral artery disease, Diabetes, Foot ulcer, Endovascular intervention, Bypass surgery, Practice guideline, Evidence-based medicine
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GVG GUIDELINE WRITING GROUP CONFLICT OF INTEREST POLICY: INDUSTRY RELATIONSHIPS

I. Introduction

The organizations participating in the Global Vascular Guidelines are committed to the precept of developing trustworthy clinical practice guidelines through transparency and full disclosure by those participating in the process of guideline development.

The tenets of the policy as set forth are reflective of the desire to maintain a balanced approach in the guidelines development process. Ensuring that industry will have no direct influence on the clinical content and recommendations of the clinical guideline is fundamental to a trustworthy and

independent document. Conversely, it is acknowledged that a healthy relationship between content experts and industry, when properly managed and transparent, may bring value to the process and the final document.

II. Scope

All Co-Editors, Steering Committee members, and authors are required to disclose relationships with industry and other relevant entities as defined in Section IV.

III. Disclosure Categories

The required categories for disclosure and their respective examples are as follows:

- **Industry income**—Monies received from biomedical companies, device manufacturers, pharmaceutical companies, or other companies producing products related to the field.
- **Industry relationships**
 - Serve as an officer, board member, trustee, owner, or employee of a company;
 - Direct owner of stock, stock options, or bonds of a company (*excludes diversified mutual funds*);
 - Consultancy, scientific advisory committee membership, or lecturer for a company (*required to disclose regardless of income; if income, must disclose amount; please note that disclosure is not required for an honorarium paid by a university, hospital, or medical society for a lecture that has received an unrestricted funding*);
 - Investigator for a company, including holding research grants from the company (*disclosure of research funding paid directly to your institution is not required as it does not constitute industry income*);
 - Personal income from patents (*intellectual property*).

IV. Reporting Time Frame and Disclosure Timing

Disclosure is required from all members of the writing group for the past 12 months. Authors are discouraged from adding new relationships during the guideline development process; if relevant relationships are added, they must be disclosed immediately to the co-chairs and verbally disclosed during any conference calls or meeting and added to the author disclosure grid. In the event that the required balance is not met, additional members may be added or removed to achieve balance.

Disclosures are made in writing or online before the writing initiative to determine eligibility of members to serve and throughout the guideline development process to ensure transparency.

V. Conflict of Interest Requirements by Role

The Co-Editors of the Global Vascular Guidelines should have less than \$10,000 USD in industry income in aggregate during their work on the guidelines or subsequent revisions.

The majority (>50%) of the steering committee members and guideline authors should have less than \$10,000 USD in industry income in aggregate during their work on the guidelines or subsequent revisions.

The minority of steering committee members and authors allowed additional industry income may have no more than \$50,000 per annum (USD) in aggregate during their work on the guidelines or subsequent revisions.

Guideline reviewers are required to adhere to the same criteria for conflict of interest as the steering committee members and guideline authors.

VI. Review of Disclosures

The Conflict of Interest Committee for each sponsoring organization will review disclosures for relevant conflicts of interest. A member of the steering committee will be appointed to ensure ongoing compliance by committee members and authors.

VII. Industry Involvement

Industry involvement in the development and review process is not permitted.

- Direct industry funding will not be accepted by participating societies to support the Global Vascular Guidelines initiative.
- Part-time, full-time, and paid industry consultants (ie, advocacy, government affairs, and lobbyists) are prohibited from serving as members of the guidelines writing group and as document reviewers.

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Table A-continued

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Spence Taylor	Greenville Health Center/USC School of Medicine Greenville, US	9	None
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Martin Veller	University of the Witwatersrand, Johannesburg, South Africa	2,9	Bayer (honoraria)
Frank Vermassen	Ghent University Hospital, Belgium	6, 10	Lecturer for Medtronic, Abbott Vascular, Bard, Terumo, Boston Scientific, Philips Consultant for Medtronic, Terumo, Boston Scientific, Philips
Jinsong Wang	The First Affiliated Hospital, Sun Yat-sen University, Guangzhou, China	2, 3, 8	None
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TABLE OF ABBREVIATIONS AND ACRONYMS

Table B. List of abbreviations and acronyms

Explanation	
ABI	Ankle-brachial index
AFS	Amputation-free survival
AI	Aortoiliac
AKA	Above-knee amputation
AP	Ankle pressure
AT	Anterior tibial
BKA	Below-knee amputation
BMI	Body mass index
BMMNCs	Bone marrow mononuclear cells
CAD	Coronary artery disease
CE-MRA	Contrast-enhanced MRA
CFA	Common femoral artery
CKD	Chronic kidney disease
CLI	Critical limb ischemia
CLTI	Chronic limb-threatening ischemia
CPGs	Clinical practice guidelines
CT	Computed tomography
CTA	Computed tomography angiography
CTO	Chronic total occlusion
CVD	Cardiovascular disease
DAPT	Dual antiplatelet therapy
DCB	Drug-coated balloon
DES	Drug-eluting stent
DFU	Diabetic foot ulcer
DM	Diabetes mellitus
DP	Dorsalis pedis
DSA	Digital subtraction angiography
DUS	Duplex ultrasound
EBR	Evidence-based revascularization
EQ-5D	EuroQol-5 Dimension questionnaire
ESRD	End-stage renal disease
ESVS	European Society for Vascular Surgery
FGF	Fibroblast growth factor

Continued

Table B-continued

Explanation	
FP	Femoropopliteal
GLASS	Global Limb Anatomic Staging System
GRADE	Grading of Recommendations Assessment, Development, and Evaluation
GSV	Great saphenous vein
GVG	Global Vascular Guidelines
HBOT	Hyperbaric oxygen therapy
HGF	Hepatocyte growth factor
HICs	High-income countries
HRQL	Health-related quality of life
IC	Intermittent claudication
IM	Inframalleolar
IP	Infrapopliteal
IPC	Intermittent pneumatic compression
LBP	Limb-based patency
LDL-C	Low-density lipoprotein cholesterol
LMICs	Low- and middle-income countries
LS	Lumbar sympathectomy
MACE	Major adverse cardiovascular event
MALE	Major adverse limb event
MRA	Magnetic resonance angiography
OPG	Objective performance goal
PAD	Peripheral artery disease
PBA	Plain balloon angioplasty
PFA	Profunda femoris artery
PLAN	Patient risk estimation, limb staging, anatomic pattern of disease
PROM	Patient-reported outcomes measure
PSV	Peak systolic velocity
PT	Posterior tibial
PVR	Pulse volume recording
RCT	Randomized controlled trial
SCS	Spinal cord stimulation
SF-12	12-Item Short-Form Health Survey

Continued

Table B-continued

	Explanation
SFA	Superficial femoral artery
SLI	severe limb ischemia
SCLI	subcritical limb ischemia
SVS	Society for Vascular Surgery
SYNTAX	[System for coronary disease]
TAP	Target arterial path
TBI	Toe-brachial index
TcPO ₂	Transcutaneous oximetry
TKA	Through-knee amputation
TP	Toe pressure
VascuQoL	Vascular Quality of Life tool
WFVS	World Federation of Vascular Societies
Wifi	Wound, Ischemia, foot Infection

INTRODUCTION

Rationale and goals

Chronic limb-threatening ischemia (CLTI) represents the end stage of peripheral artery disease (PAD), a problem of growing prevalence and increased health care costs around the globe.¹ CLTI is a highly morbid disease, incurring significant mortality, limb loss, pain, and diminished health-related quality of life (HRQL) among those afflicted. Multiple health care specialists are involved in the management of CLTI, yet lack of public awareness and the frequent failure to make an early diagnosis continue to be major obstacles to effective treatment. Variability in practice patterns is high, contributing to a broad disparity in the use of treatments and clinical outcomes. For example, a study from the United States suggested that many patients do not even receive angiography in the year before major limb amputation.² These data also demonstrate a broad variation in the use of open or endovascular interventions by region of the country and hospital referral center.² More expensive (and more invasive) care is not associated with better outcomes.³ Instead, what is lacking is a uniform definition of clinical stages of disease and key patient-focused outcomes, contributing to an incomplete picture of the epidemiology of CLTI and a limited evidence base to guide daily practice.

At the same time, rapidly evolving technologies in diagnostics, devices, drugs, and biologics offer new opportunities to improve treatment and to address unmet needs in this vulnerable population. A PubMed search of the term “critical limb ischemia” revealed >5000 citations, with a clear inflection point at the turn of the millennium, demonstrating an explosion of interest. A new framework is urgently needed to establish evidence-based medical practices in this changing field. The rationale for this global guideline on the management of CLTI was based on this nexus of factors and the recognition of its growing impact on public health across all nations and socioeconomic strata. Vascular specialists play a dominant role in the treatment of CLTI. Accordingly, in 2013, when several leading vascular societies determined to launch the Global Vascular Guidelines (GVG) initiative, CLTI was considered the first priority disease area of focus. The primary goal of

this practice guideline on CLTI is to improve the quality of care for all patients with CLTI as well as for those at risk for CLTI. An important secondary goal is to identify key research priorities in need of further basic, translational, clinical, and health services investigation to advance those aims.

GVG structure

The three major global vascular surgical societies, the European Society for Vascular Surgery (ESVS), the Society for Vascular Surgery (SVS), and the World Federation of Vascular Societies (WFVS), joined efforts to launch the GVG initiative. In this process, the ESVS represents national vascular societies from Europe and the SVS represents national, regional, and local vascular societies in North America. The WFVS represents a large number of non-European, non-North American vascular surgical societies from across the world. These include the Australian and New Zealand Society for Vascular Surgery, the Japanese Society for Vascular Surgery, the Vascular Society of India, the Vascular Society of Southern Africa, the Asian Society for Vascular Surgery, and the Latin American Society of Vascular Surgery and Angiology (this list is not exhaustive). As the primary sponsors, the ESVS, SVS, and WFVS developed the organizational structure, policies on conflict of interest, and committed financial support for the GVG program. All financial support for the GVG was derived directly from the sponsoring societies and without the direct involvement of industry or other external stakeholders. Representatives from the three leading societies were asked to serve as Co-Editors as well as members of the Steering Committee to oversee all aspects of the project and its subsequent communications. Oversight from the societies was limited to budgetary and administrative aspects, including their respective document review policies before public dissemination of the final guideline. The Steering Committee recruited a large and diversified writing group; developed the scope and section briefs for the guideline; identified priority questions for commissioned evidence reviews; and participated in all stages of writing, consensus debate, and editing of the manuscript.

Conflict of interest policy

A primary consideration on inception of the GVG was to create a robust yet practical approach to conflict of interest to enable an unbiased effort at guideline development by experts in the field. A central element to this, in concert with the exclusion of direct commercial funding sources, was full disclosure and specific limits on relevant financial relationships for members of the writing group, Steering Committee, and Co-Editors. A full description of the GVG Conflict of Interest policy is provided at the beginning of this supplement. Financial disclosures for all contributing authors were collected and updated by the Steering Committee. They are detailed in the table of Contributing Authors listed at the beginning of the guideline.

Leadership and writing group

The Co-Editors and Steering Committee were selected by the three major sponsoring societies and were tasked with the recruitment of a multidisciplinary, international writing group of recognized experts. In total, the final writing group comprised 58 individuals from 24 countries across 6 continents. This group represents specialists in vascular surgery, vascular medicine, interventional cardiology and radiology, angiology, epidemiology, podiatry, and orthopedics as well as a methodologist with expertise in guideline development. Authors were assigned to individual sections of the guideline, and all authors reviewed the complete final document before societal review.

Methodology

The Steering Committee drafted a Table of Contents that was divided into distinct sections. Briefs were created to outline the scope and content of each section. Potential authors were then solicited and vetted, and two authors were chosen to co-lead the writing effort for each section. The co-lead authors communicated directly with the Steering Committee on their progress and on iterative cycles of revision as needed. All of the authors of each section reviewed and approved their final versions before compilation of the full document.

The Steering Committee examined the state of recent evidence reviews in the field, including those commissioned by the participating societies, and determined the need for additional evidence reviews and updating. These were commissioned to an external group (Mayo Clinic Evidence-Based Practice Research Program) who performed four systematic reviews that summarized evidence from randomized and nonrandomized studies.⁴⁻⁷ These systematic reviews underwent peer review and were published in the *Journal of Vascular Surgery*, one of which is published as an accompaniment to the guideline document in this supplement.⁷

Consensus development during the process occurred through confidential electronic communications, teleconferences, and multiple in-person meetings of the Steering Committee and members of the writing group. The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach was used to determine the quality of evidence and strength of recommendations.⁸ A strong (Grade 1) recommendation implies that the guideline developers are confident as to the balance of benefits and harm and that this recommendation should apply to the majority of patients. A conditional recommendation (Grade 2) implies less certainty and indicates that a different course of action is reasonable. The guideline developers used an imperative verb to denote strong recommendations and used the term “consider” to denote a conditional recommendation. The level of evidence for each recommendation is considered high quality (A), moderate quality (B), or low quality (C). The guideline also includes good practice recommendations. These ungraded good practice recommendations are supported by a wealth of indirect evidence but

no direct evidence, and the benefit of pursuing the recommended actions is considered to outweigh any plausible harm. The intention of these good practice recommendations was to draw attention to and remind providers of known and noncontroversial surgical principles or principles about general medical care. For example, there are good practice statements about performing a comprehensive history and physical examination in patients with CLTI.⁹

The final grading of all guideline recommendations was determined by the guideline developers and the methodologist. After approval by the full writing group, the sections were compiled into one document and reviewed concurrently by the document oversight bodies of each of the three sponsoring societies. An open comment period was subsequently enabled on a secure website (<http://vsweb.org/GlobalVascularGuidelines>) to provide an opportunity for external stakeholders to review the document. The Co-Editors collated all reviews and made final revisions to the document, which was then approved by the sponsoring societies before publication and dissemination.

Target population

The target population of patients includes adults with CLTI, defined as a patient with objectively documented PAD and any of the following clinical symptoms or signs:

- Ischemic rest pain with confirmatory hemodynamic studies
- Diabetic foot ulcer (DFU) or any lower limb ulceration present for at least 2 weeks
- Gangrene involving any portion of the lower limb or foot

Specifically excluded are patients with pure venous ulcers, pure traumatic wounds, acute limb ischemia (symptoms present for 2 weeks or less), embolic disease, and nonatherosclerotic chronic vascular conditions of the lower extremity (eg, vasculitis, Buerger disease, radiation arteritis).

Target audience

The primary target audience for this guideline includes all clinicians who are directly involved in the management of patients with CLTI, to include surgeons (vascular, general, plastic, and orthopedic), interventionalists (radiologists, cardiologists), podiatrists, wound care providers, rehabilitation medicine specialists, orthotists and physical therapists, and trainees in these disciplines.

Secondary audiences include referring providers, such as primary care physicians, medical specialists, nurses, and other allied health providers, who may care for the at-risk population and who are critical for awareness and timely specialist referral of patients with suspected CLTI. Other key targets for this guideline are third parties with influence over the current and future treatment of CLTI, including government agencies, payers (funders), industry stakeholders, investigators, and research organizations.

CLTI: A new paradigm for treatment and research

This clinical practice guideline (CPG) intentionally seeks to create a new conceptual framework for the treatment of CLTI. It encompasses nomenclature, disease staging, and a platform for evidence-based revascularization (EBR) that will allow future evolution and quality improvement in the field. A brief introduction to the key elements introduced in this document is provided here.

Nomenclature. Consistent and meaningful nomenclature is of fundamental importance for assessing the state of evidence and guiding future research efforts. To this end, the GVG promotes the use of the term CLTI, defined by the target population, to denote the universe of patients with advanced lower limb ischemia, wounds, neuropathy, and infection who are commonly referred to vascular specialists for evaluation and management. Prior terms, such as “critical” and “severe” limb ischemia, connote specific hemodynamic thresholds and fail to recognize the full spectrum and inter-relatedness of components beyond ischemia that contribute to major limb amputation and long-term disability. This is addressed fully in Section 1 of the guideline.

Disease staging in CLTI. Improved disease staging is mandatory for designing clinical trials, conducting comparative effectiveness research, identifying critical gaps in knowledge, and developing effective algorithms for treatment. CLTI represents a broad range of clinical severity (limb threat) and anatomic complexity of disease. The GVG incorporates the SVS Lower Extremity Threatened Limb Classification System¹⁰ as a preferred staging system for CLTI, which is discussed more fully in Section 1 and other related areas of the document.

EBR and the PLAN concept. The GVG espouses a goal of EBR for CLTI to improve the quality of vascular care and to reduce disparities in treatment and outcomes. However, the existing database to support EBR is found to be lacking in many domains. There have been few high-quality randomized controlled trials (RCT) or comparative effectiveness studies in the field. This remains a major unmet need requiring broad support from national health agencies, payers, industry, professional organizations, and research foundations. The writing group sought the best available evidence to generate consensus recommendations while also providing a foundation for future iterations based on a patient- and limb-centric approach to treatment rather than on the prevailing lesion-focused lexicon in the field.

The PLAN concept of EBR (Section 6) stresses a structured management approach based on Patient risk, Limb severity, and ANatomic pattern of disease, in that order of priority. The authors believe that adequate stratification along these three independent axes is clinically relevant and of fundamental importance to improve evidence quality and to achieve EBR for patients with CLTI. Further development of this approach requires prospective validation and refinement of tools to accurately stage patient risk, limb threat,

and anatomic patterns of disease, as discussed in detail in the document.

Global Limb Anatomic Staging System (GLASS). A new anatomic scheme for the threatened limb is proposed. Commonly used anatomic classification schemes for PAD are lesion or segment focused¹¹ or aim to quantify the overall burden of disease,¹² rather than integrating the complex patterns of disease found in most patients with CLTI. Successful revascularization in CLTI, particularly in patients with tissue loss, nearly always requires restoration of in-line (pulsatile) flow to the foot. Moreover, there is a general lack of understanding of the relationships between patterns of disease, hemodynamic improvement after treatment, anatomic durability, clinical stage, and outcomes that continues to plague the field. With this in mind, a new approach was developed to facilitate clinical decision-making in CLTI—the GLASS (Section 5). To be most useful, GLASS incorporates a set of baseline assumptions to avoid overcomplexity and to permit its ready utility in everyday clinical practice and in future research.

GLASS incorporates two novel and important concepts, the target arterial path (TAP) and estimated limb-based patency (LBP). Based on appropriate angiographic imaging, the TAP is defined by the treating surgeon or interventionalist as the optimal arterial pathway to restore in-line (pulsatile) flow to the ankle and foot. It may incorporate either the least diseased or an angiosome-preferred path, as chosen by the treating clinician. LBP is defined as maintenance of in-line flow throughout the TAP, from groin to ankle. LBP allows more direct comparison of anatomic outcomes across revascularization strategies in CLTI. The complexity of disease traversed by the TAP is integrated in the GLASS. Femoropopliteal (FP) and infrapopliteal (IP) arterial segments are individually graded on a scale of 0 to 4. Using a consensus-based matrix, these segmental grades are combined into three overall GLASS (I-III) stages for the limb.

GLASS includes a simplified approach to inflow (aortoiliac [AI]) disease, a dichotomous stratification for severe calcification within segment, and a simple modifier for pedal (inframalleolar [IM]) disease. GLASS stages (I-III) were defined on the basis of expected technical success and anatomic durability for infrainguinal endovascular intervention and reflect the overall complexity of disease within the TAP. The consensus process for developing and assigning GLASS stages was informed by an updated systematic review of revascularization outcomes in CLTI.⁷ Thus, GLASS stages I to III correlate with low-, intermediate-, or high-complexity infrainguinal disease patterns, with expected correlation to immediate technical success and 1-year LBP for endovascular intervention. The relevance of these GLASS anatomic stages in different clinical scenarios is integrated within the PLAN framework for decision-making. GLASS is designed for subsequent refinement, reclassification, and validation based on data from prospective studies that employ the scheme and report appropriate outcome measures. A mobile app to quickly derive GLASS stage from

angiographic imaging in real time will be released in proximity to the guideline publication.

End points and trial designs. Existing limitations of the evidence base in CLTI were obvious and broadly acknowledged during the GVG development process. The importance of developing consensus around key outcome measures, with a focus on patient-oriented end points, is critical to advancing the field. It is anticipated that currently enrolling RCTs, including Bypass vs Angioplasty in Severe Ischaemia of the Leg (BASIL-2) trial, Balloon vs Stenting in Severe Ischaemia of the Leg (BASIL-3) trial, and Best Endovascular vs Best Surgical Therapy for Patients with Critical Limb Ischemia (BEST-CLI), will allow important advances in the management of CLTI, with significant overlap among these efforts.¹³⁻¹⁵ In Section 11 of the guideline, a full consideration of this important topic is provided as a framework, with specific recommendations for study and RCT designs going forward.

Interdisciplinary team in CLTI. There has been growing recognition of the value of multidisciplinary and interdisciplinary team-based care to optimize the outcomes for patients with CLTI. The components of such teams vary considerably across centers and regions of practice, but certain critical skill sets, expertise, facilities, and resources are required to create a Center of Excellence for CLTI management. Consideration of this important topic is addressed in Section 12 of the guideline.

Dissemination, translation to practice, and future revisions of the guideline

Translation of expert guidelines into clinical practice is known to be a major obstacle to evidence-based medicine. Reasons are multifactorial and include limited provider and patient engagement, lack of consensus, economic conflicts, and resource constraints. The international scope of the GVG mandated an attempt to survey differences in practice

patterns, resources, and potential hurdles to implementation around the globe (Section 13). Dissemination of the guideline by the sponsoring societies is planned to include an array of print media, web and social media, mobile apps, and communications at multiple national and regional meetings to facilitate discussion. The incorporation of suggested staging systems and end points into national and multinational registries will greatly facilitate use and future refinement of this effort. It is anticipated that the GVG will be translated into the other major world languages.

To remain current and evidence based, practice guidelines must be periodically reviewed and updated. Ongoing RCTs and prospective cohort studies will provide critical new evidence in the management of CLTI during the next several years. The sponsoring societies of the GVG recognize the importance of stewardship of this practice guideline, both as new key evidence arises and as a planned interval exercise.

Supporting materials

Evidence-based recommendations made in this guideline are supported by key references listed in the text. A summary of the relevant findings from the studies used to support each recommendation is provided as a [Supplementary Table \(online only\)](#) to the guideline.

A scientific manuscript summarizing a commissioned evidence review on the outcomes of revascularization in CLTI is also published within the guidelines supplement.⁷ This manuscript underwent independent peer review by the *Journal of Vascular Surgery*. The Supplementary Tables of that document summarizing the individual source studies and the various outcomes analyzed by time interval are also available online (<https://doi.org/10.1016/j.ejvs.2019.05.006>).

SUMMARY OF RECOMMENDATIONS

Chapter	Recommendation	Grade	Level of evidence	Key references
1. Definitions and nomenclature				
1.1	Use objective hemodynamic tests to determine the presence and to quantify the severity of ischemia in all patients with suspected CLTI.	1 (Strong)	C (Low)	de Graaff, ¹⁶ 2003 Brownrigg, ¹⁷ 2016 Wang, ¹⁸ 2016
1.2	Use a lower extremity threatened limb classification staging system (eg, SVS's WIfI classification system) that grades wound extent, degree of ischemia, and severity of infection to guide clinical management in all patients with suspected CLTI.	1 (Strong)	C (Low)	See Table 1.2 in full guideline.
2. Global epidemiology and risk factors for CLTI				
No recommendations				
3. Diagnosis and limb staging in CLTI				
3.1	Perform a detailed history to determine symptoms, past medical history, and cardiovascular risk factors in all patients with suspected CLTI.	Good practice statement		
3.2	Perform a complete cardiovascular physical examination of all patients with suspected CLTI.	Good practice statement		

Continued

Table C-continued				
Chapter	Recommendation	Grade	Level of evidence	Key references
3.3	Perform a complete examination of the foot, including an assessment of neuropathy and a probe-to-bone test of any open ulcers, in all patients with pedal tissue loss and suspected CLTI.	Good practice statement		
3.4	Measure AP and ABI as the first-line noninvasive test in all patients with suspected CLTI.	1 (Strong)	B (Moderate)	Lijmer, ¹⁹ 1996 Dachun, ²⁰ 2010
3.5	Measure TP and TBI in all patients with suspected CLTI and tissue loss (Fig 3.1 in full guideline).	1 (Strong)	B (Moderate)	Aboyans, ²¹ 2008 Salaun, ²² 2018
3.6	Consider using alternative methods for noninvasive assessment of perfusion, such as PVR, transcutaneous oximetry, or skin perfusion pressure, when ankle and toe pressures, indices, and waveforms cannot be assessed.	2 (Weak)	C (Low)	Aboyans, ²¹ 2008 Shirasu, ²³ 2016 Salaun, ²² 2018
3.7	Consider DUS imaging as the first arterial imaging modality in patients with suspected CLTI.	2 (Weak)	B (Moderate)	Hingorani, ²⁴ 2008
3.8	Consider noninvasive vascular imaging modalities (DUS, CTA, MRA) when available before invasive catheter angiography in patients with suspected CLTI who are candidates for revascularization.	2 (Weak)	B (Moderate)	Larch, ²⁵ 1997 Adriaensen, ²⁶ 2004 Hingorani, ²⁷ 2004 Collins, ²⁸ 2007 Hingorani, ²⁴ 2008 Met, ²⁹ 2009
3.9	Obtain high-quality angiographic imaging of the lower limb (with modalities and techniques to be determined by local availability of facilities and expertise). This should include the ankle and foot in all patients with suspected CLTI who are considered potential candidates for revascularization.	Good practice statement		
4. Medical management				
4.1	Evaluate cardiovascular risk factors in all patients with suspected CLTI.	1 (Strong)	B (Moderate)	I.C.A.I. Group, ³⁰ 1997
4.2	Manage all modifiable risk factors to recommended levels in all patients with suspected CLTI.	1 (Strong)	B (Moderate)	Armstrong, ³¹ 2014 Faglia, ³² 2014
4.3	Treat all patients with CLTI with an antiplatelet agent.	1 (Strong)	A (High)	Antithrombotic Trialists' Collaboration, ³³ 2002 Antithrombotic Trialists' Collaboration, ³⁴ 2009
4.4	Consider clopidogrel as the single antiplatelet agent of choice in patients with CLTI.	2 (Weak)	B (Moderate)	CAPRIE, ³⁵ 1996 Hiatt, ³⁶ 2017
4.5	Consider low-dose aspirin and rivaroxaban, 2.5 mg twice daily, to reduce adverse cardiovascular events and lower extremity ischemic events in patients with CLTI.	2 (Weak)	B (Moderate)	Anand, ³⁷ 2018
4.6	Do not use systemic vitamin K antagonists for the treatment of lower extremity atherosclerosis in patients with CLTI.	1 (Strong)	B (Moderate)	Anand, ³⁸ 2007
4.7	Use moderate- or high-intensity statin therapy to reduce all-cause and cardiovascular mortality in patients with CLTI.	1 (Strong)	A (High)	Leng, ³⁹ 2000 Heart Protection Study Collaborative Group, ⁴⁰ 2002 Meade, ⁴¹ 2002 Aung, ⁴² 2007 Mills, ⁴³ 2011 Rodriguez, ⁴⁴ 2017
4.8	Control hypertension to target levels of <140 mm Hg systolic and <90 mm Hg diastolic in patients with CLTI.	1 (Strong)	B (Moderate)	ACCORD Study Group, ⁴⁵ 2010 Bavry, ⁴⁶ 2010 Wright, ⁴⁷ 2015 (SPRINT) Moise, ⁴⁸ 2016
4.9	Consider control of type 2 DM in CLTI patients to achieve a hemoglobin A _{1c} of <7% (53 mmol/mol [International Federation of Clinical Chemistry]).	2 (Weak)	B (Moderate)	Selvin, ⁴⁹ 2004 Nathan, ⁵⁰ 2005 van Dieren, ⁵¹ 2014 Fox, ⁵² 2015 American Diabetes Association, ⁵³ 2018
4.10	Use metformin as the primary hypoglycemic agent in patients with type 2 DM and CLTI.	1 (Strong)	A (High)	Palmer, ⁵⁴ 2016
4.11	Consider withholding metformin immediately before and for 24 to 48 hours after the administration of an iodinated contrast agent for diabetic patients, especially those with an estimated glomerular filtration rate <30 mL/min/1.73 m ² .	2 (Weak)	C (Low)	Nawaz, ⁵⁵ 1998 Goergen, ⁵⁶ 2010 Stacul, ⁵⁷ 2011

Table C-continued

Chapter	Recommendation	Grade	Level of evidence	Key references
4.12	Offer smoking cessation interventions (pharmacotherapy, counseling, or behavior modification therapy) to all patients with CLTI who smoke or use tobacco products.	1 (Strong)	A (High)	Dagenais, ⁵⁸ 2005 Athyros, ⁵⁹ 2013 Blomster, ⁶⁰ 2016
4.13	Ask all CLTI patients who are smokers or former smokers about status of tobacco use at every visit.	1 (Strong)	A (High)	Kondo, ⁶¹ 2011 Newhall, ⁶² 2017
4.14	Prescribe analgesics of appropriate strength for CLTI patients who have ischemic rest pain of the lower extremity and foot until pain resolves after revascularization.	Good practice statement		
4.15	In CLTI patients with chronic severe pain, use paracetamol (acetaminophen) in combination with opioids for pain control.	Good practice statement		
5. The Global Limb Anatomic Staging System (GLASS) for CLTI				
5.1	Use an integrated, limb-based anatomic staging system (such as the GLASS) to define complexity of a preferred target artery path (TAP) and to facilitate evidence-based revascularization (EBR) in patients with CLTI.	Good practice statement		
6. Strategies for EBR				
6.1	Refer all patients with suspected CLTI to a vascular specialist for consideration of limb salvage, unless major amputation is considered medically urgent.	Good practice statement		
6.2	Offer primary amputation or palliation to patients with limited life expectancy, poor functional status (eg, nonambulatory), or an unsalvageable limb after shared decision-making.	Good practice statement		
6.3	Estimate periprocedural risk and life expectancy in patients with CLTI who are candidates for revascularization.	1 (Strong)	C (Low)	Biancari, ⁶³ 2007 Schanzer, ⁶⁴ 2008 Bradbury, ⁶⁵ 2010
6.4	Define a CLTI patient as average surgical risk when anticipated periprocedural mortality is <5% and estimated 2-year survival is >50%.	2 (Weak)	C (Low)	Meltzer, ⁶⁶ 2013 Simons, ⁶⁷ 2016
6.5	Define a CLTI patient as high surgical risk when anticipated periprocedural mortality is ≥5% or estimated 2-year survival is ≤50%.	2 (Weak)	C (Low)	
6.6	Use an integrated threatened limb classification system (such as Wifl) to stage all CLTI patients who are candidates for limb salvage.	1 (Strong)	C (Low)	Cull, ⁶⁸ 2014 Zhan, ⁶⁹ 2015 Causey, ⁷⁰ 2016 Darling, ⁷¹ 2016 Robinson, ⁷² 2017
6.7	Perform urgent surgical drainage and débridement (including minor amputation if needed) and commence antibiotic treatment in all patients with suspected CLTI who present with deep space foot infection or wet gangrene.	Good practice statement		
6.8	Repeat limb staging after surgical drainage, débridement, minor amputations, or correction of inflow disease (AI, common and deep femoral artery disease) and before the next major treatment decision.	Good practice statement		
6.9	Do not perform revascularization in the absence of significant ischemia (Wifl ischemia grade 0) unless an isolated region of poor perfusion in conjunction with major tissue loss (eg, Wifl wound grade 2 or 3) can be effectively targeted and the wound progresses or fails to reduce in size by ≥50% within 4 weeks despite appropriate infection control, wound care, and offloading.	Good practice statement		
6.10	Do not perform revascularization in very-low-risk limbs (eg, Wifl stage 1) unless the wound progresses or fails to reduce in size by ≥50% within 4 weeks despite appropriate infection control, wound care, and offloading.	2 (Weak)	C (Low)	Sheehan, ⁷³ 2003 Cardinal, ⁷⁴ 2008 Lavery, ⁷⁵ 2008 Snyder, ⁷⁶ 2010
6.11	Offer revascularization to all average-risk patients with advanced limb-threatening conditions (eg, Wifl stage 4) and significant perfusion deficits (eg, Wifl ischemia grades 2 and 3).	1 (Strong)	C (Low)	Abu Dabrh, ⁵ 2015
6.12	Consider revascularization for average-risk patients with intermediate limb threat (eg, Wifl stages 2 and 3) and significant perfusion deficits (eg, Wifl ischemia grades 2 and 3).	2 (Weak)	C (Low)	Zhan, ⁶⁹ 2015 Causey, ⁷⁰ 2016 Darling, ⁷¹ 2016 Robinson, ⁷² 2017

Continued

Table C-continued				
Chapter	Recommendation	Grade	Level of evidence	Key references
6.13	Consider revascularization in average-risk patients with advanced limb threat (eg, Wiffl stage 4) and moderate ischemia (eg, Wiffl ischemia grade 1).	2 (Weak)	C (Low)	
6.14	Consider revascularization in average-risk patients with intermediate limb threat (eg, Wiffl stages 2 and 3) and moderate ischemia (eg, Wiffl ischemia grade 1) if the wound progresses or fails to reduce in size by $\geq 50\%$ within 4 weeks despite appropriate infection control, wound care, and offloading.	2 (Weak)	C (Low)	
6.15	Obtain high-quality angiographic imaging with dedicated views of ankle and foot arteries to permit anatomic staging and procedural planning in all CLTI patients who are candidates for revascularization.	Good practice statement		
6.16	Use an integrated limb-based staging system (eg, GLASS) to define the anatomic pattern of disease and preferred TAP in all CLTI patients who are candidates for revascularization.	Good practice statement		
6.17	Perform ultrasound vein mapping when available in all CLTI patients who are candidates for surgical bypass.	1 (Strong)	C (Low)	Seeger, ⁷⁷ 1987 Wengert, ⁷⁸ 1990 Schanzer, ⁷⁹ 2007
6.18	Map the ipsilateral GSV and small saphenous vein for planning of surgical bypass. Map veins in the contralateral leg and both arms if ipsilateral vein is insufficient or inadequate.	Good practice statement		
6.19	Do not classify a CLTI patient as being unsuitable for revascularization without review of adequate-quality imaging studies and clinical evaluation by a qualified vascular specialist.	Good practice statement		
6.20	Correct inflow disease first when both inflow and outflow disease are present in a patient with CLTI.	Good practice statement		
6.21	Base the decision for staged vs combined inflow and outflow revascularization on patient risk and the severity of limb threat (eg, Wiffl stage).	1 (Strong)	C (Low)	
6.22	Correct inflow disease alone in CLTI patients with multilevel disease and low-grade ischemia (eg, Wiffl ischemia grade 1) or limited tissue loss (eg, Wiffl wound grade 0/1) and in any circumstance in which the risk-benefit of additional outflow reconstruction is high or initially unclear.	1 (Strong)	C (Low)	Harward, ⁸⁰ 1995 Zukauskas, ⁸¹ 1995
6.23	Restage the limb and repeat the hemodynamic assessment after performing inflow correction in CLTI patients with inflow and outflow disease.	1 (Strong)	C (Low)	
6.24	Consider simultaneous inflow and outflow revascularization in CLTI patients with a high limb risk (eg, Wiffl stages 3 and 4), or in patients with severe ischemia (eg, Wiffl ischemia grades 2 and 3).	2 (Weak)	C (Low)	
6.25	Use an endovascular-first approach for treatment of CLTI patients with moderate to severe (eg, GLASS stage IA) aorto-iliac (AI) disease, depending on the history of prior intervention.	1 (Strong)	B (Moderate)	Jongkind, ⁸² 2010 Ye, ⁸³ 2011 Deloose, ⁸⁴ 2017
6.26	Consider surgical reconstruction for the treatment of average-risk CLTI patients with extensive (eg, GLASS stage II) AI disease or after failed endovascular intervention.	2 (Weak)	C (Low)	Ricco, ⁸⁵ 2008 Chiu, ⁸⁶ 2010 Indes, ⁸⁷ 2013
6.27	Perform open CFA endarterectomy with patch angioplasty, with or without extension into the PFA, in CLTI patients with hemodynamically significant ($>50\%$ stenosis) disease of the common and deep femoral arteries.	1 (Strong)	C (Low)	Kang, ⁸⁸ 2008 Ballotta, ⁸⁹ 2010
6.28	Consider a hybrid procedure combining open CFA endarterectomy and endovascular treatment of AI disease with concomitant CFA involvement (GLASS stage IB).	2 (Weak)	C (Low)	Chang, ⁹⁰ 2008
6.29	Consider endovascular treatment of significant CFA disease in selected patients who are deemed to be at high surgical risk or to have a hostile groin.	2 (Weak)	C (Low)	Baumann, ⁹¹ 2011 Bonvini, ⁹² 2011 Gouëffic, ⁹³ 2017 Siracuse, ⁹⁴ 2017

Table C-continued

Chapter	Recommendation	Grade	Level of evidence	Key references
6.30	Avoid stents in the CFA and do not place stents across the origin of a patent deep femoral artery.	Good practice statement		
6.31	Correct hemodynamically significant ($\geq 50\%$ stenosis) disease of the proximal deep femoral artery whenever technically feasible.	Good practice statement		
6.32	In average-risk CLTI patients with infrainguinal disease, base decisions of endovascular intervention vs open surgical bypass on the severity of limb threat (eg, WIfI), the anatomic pattern of disease (eg, GLASS), and the availability of autologous vein.	1 (Strong)	C (Low)	Almasri, ⁷ 2018
6.33	Offer endovascular revascularization when technically feasible for high-risk patients with advanced limb threat (eg, WIfI stage 4) and significant perfusion deficits (eg, WIfI ischemia grades 2 and 3).	2 (Weak)	C (Low)	Abu Dabrh, ⁵ 2015 Zhan, ⁶⁹ 2015 Causey, ⁷⁰ 2016 Darling, ⁷¹ 2016 Robinson, ⁷² 2017
6.34	Consider endovascular revascularization for high-risk patients with intermediate limb threat (eg, WIfI stages 2 and 3) and significant perfusion deficits (eg, WIfI ischemia grades 2 and 3).	2 (Weak)	C (Low)	
6.35	Consider endovascular revascularization for high-risk patients with advanced limb threat (eg, WIfI stage 4) and moderate ischemia (eg, WIfI ischemia grade 1) if the wound progresses or fails to reduce in size by $\geq 50\%$ within 4 weeks despite appropriate infection control, wound care, and offloading, when technically feasible.	2 (Weak)	C (Low)	
6.36	Consider endovascular revascularization for high-risk patients with intermediate limb threat (eg, WIfI stages 2 and 3) and moderate ischemia (eg, WIfI ischemia grade 1) if the wound progresses or fails to reduce in size by $\geq 50\%$ within 4 weeks despite appropriate infection control, wound care, and offloading, when technically feasible.	2 (Weak)	C (Low)	
6.37	Consider open surgery in selected high-risk patients with advanced limb threat (eg, WIfI stage 3 or 4), significant perfusion deficits (ischemia grade 2 or 3), and advanced complexity of disease (eg, GLASS stage III) or after prior failed endovascular attempts and unresolved symptoms of CLTI.	2 (Weak)	C (Low)	
6.38	Consider angiosome-guided revascularization in patients with significant wounds (eg, WIfI wound grades 3 and 4), particularly those involving the midfoot or hindfoot, and when the appropriate TAP is available.	2 (Weak)	C (Low)	Azuma, ⁹⁵ 2012 Sumpio, ⁹⁶ 2013 Biancari, ⁹⁷ 2014 Chae, ⁹⁸ 2016 Jongsma, ⁹⁹ 2017
6.39	In treating femoro-popliteal (FP) disease in CLTI patients by endovascular means, consider adjuncts to balloon angioplasty (eg, stents, covered stents, or drug-eluting technologies) when there is a technically inadequate result (residual stenosis or flow-limiting dissection) or in the setting of advanced lesion complexity (eg, GLASS FP grade 2-4).	2 (Weak)	B (Moderate)	Schillinger, ¹⁰⁰ 2006 Saxon, ¹⁰¹ 2008 Dake, ¹⁰² 2011 Rosenfield, ¹⁰³ 2015 Almasri, ⁷ 2018
6.40	Use autologous vein as the preferred conduit for infrainguinal bypass surgery in CLTI.	1 (Strong)	B (Moderate)	Almasri, ⁷ 2018
6.41	Avoid using a nonautologous conduit for infrainguinal bypass unless there is no endovascular option and no adequate autologous vein.	2 (Weak)	C (Low)	Almasri, ⁷ 2018
6.42	Perform intraoperative imaging (angiography, DUS, or both) on completion of open bypass surgery for CLTI and correct significant technical defects if feasible during the index operation.	1 (Strong)	C (Low)	Mills, ¹⁰⁴ 1992 Bandyk, ¹⁰⁵ 1994
7. Nonrevascularization treatments of the limb				
7.1	Consider spinal cord stimulation to reduce the risk of amputation and to decrease pain in carefully selected patients (eg, rest pain, minor tissue loss) in whom revascularization is not possible.	2 (Weak)	B (Moderate)	Ubbink, ¹⁰⁶ 2013

Continued

Table C-continued				
Chapter	Recommendation	Grade	Level of evidence	Key references
7.2	Do not use lumbar sympathectomy for limb salvage in CLTI patients in whom revascularization is not possible.	2 (Weak)	C (Low)	Karanth, ¹⁰⁷ 2016
7.3	Consider intermittent pneumatic compression therapy in carefully selected patients (eg, rest pain, minor tissue loss) in whom revascularization is not possible.	2 (Weak)	B (Moderate)	Abu Dabrh, ⁴ 2015
7.4	Do not offer prostanoids for limb salvage in CLTI patients. Consider offering selectively for patients with rest pain or minor tissue loss and in whom revascularization is not possible.	2 (Weak)	B (Moderate)	Vietto, ¹⁰⁸ 2018
7.5	Do not offer vasoactive drugs or defibrinating agents (ancrod) in patients in whom revascularization is not possible.	1 (Strong)	C (Low)	Smith, ¹⁰⁹ 2012
7.6	Do not offer HBOT to improve limb salvage in CLTI patients with severe, uncorrected ischemia (eg, Wiffi ischemia grade 2/3).	1 (Strong)	B (Moderate)	Kranke, ¹¹⁰ 2015 Game, ¹¹¹ 2016 Santema, ¹¹² 2018
7.7	Continue to provide optimal wound care until the lower extremity wound is completely healed or the patient undergoes amputation.	Good practice statement		
8. Biologic and regenerative medicine approaches in CLTI				
8.1	Restrict use of therapeutic angiogenesis to CLTI patients who are enrolled in a registered clinical trial.	1 (Strong)	B (Moderate)	Abu Dabrh, ⁴ 2015 Peeters, ¹¹³ 2015
9. The role of minor and major amputations				
9.1	Consider transmetatarsal amputation of the forefoot in CLTI patients who would require more than two digital ray amputations to resolve distal necrosis, especially when the hallux is involved.	2 (Weak)	C (Low)	Elsharif, ¹¹⁴ 2018
9.2	Offer primary amputation to CLTI patients who have a pre-existing dysfunctional or unsalvageable limb, a poor functional status (eg, bedridden), or a short life expectancy after shared decision-making with the patient and health care team.	1 (Strong)	C (Low)	Aziz, ¹¹⁵ 2015 Siracuse, ¹¹⁶ 2015
9.3	Consider secondary amputation for patients with CLTI who have a failed or ineffective reconstruction and in whom no further revascularization is possible and who have incapacitating pain, nonhealing wounds, or uncontrolled sepsis in the affected limb after shared decision-making with the patient and health care team.	2 (Weak)	C (Low)	Reed, ¹¹⁷ 2008
9.4	Consider revascularization to improve the possibility of healing an amputation at a more distal functional amputation level (eg, AKA to BKA), particularly for patients with a high likelihood of rehabilitation and continued ambulation.	2 (Weak)	C (Low)	Rollins, ¹¹⁸ 1985 Miksic, ¹¹⁹ 1986
9.5	Consider a TKA or AKA in patients who are nonambulatory for reasons other than CLTI (ie, bedridden patients with flexion contracture, dense hemiplegia, cancer) and are unlikely to undergo successful rehabilitation to ambulation.	2 (Weak)	C (Low)	Ayoub, ¹²⁰ 1993 Taylor, ¹²¹ 2008
9.6	Involve a multidisciplinary rehabilitation team from the time a decision to amputate has been made until successful completion of rehabilitation has been achieved.	1 (Strong)	C (Low)	Webster, ¹²² 2012
9.7	Continue to observe CLTI patients who have undergone amputation at least yearly to monitor progression of disease in the contralateral limb and to maintain optimal medical therapy and risk factor management.	1 (Strong)	C (Low)	Bradley, ¹²³ 2006 Glaser, ¹²⁴ 2013
10. Postprocedural care and surveillance after infrainguinal revascularization for CLTI				
10.1	Continue best medical therapy for PAD, including the long-term use of antiplatelet and statin therapies, in all patients who have undergone lower extremity revascularization.	1 (Strong)	A (High)	Abbruzzese, ¹²⁵ 2004 Henke, ¹²⁶ 2004 Brown, ¹²⁷ 2008 Bedenis, ¹²⁸ 2015 Suckow, ¹²⁹ 2015

Table C-continued

Chapter	Recommendation	Grade	Level of evidence	Key references
10.2	Promote smoking cessation in all CLTI patients who have undergone lower extremity revascularization.	1 (Strong)	A (High)	Hobbs, ¹³⁰ 2003 Willigendael, ¹³¹ 2005
10.3	Consider DAPT (aspirin plus clopidogrel) in patients who have undergone infrainguinal prosthetic bypass for CLTI for a period of 6 to 24 months to maintain graft patency.	2 (Weak)	B (Moderate)	Brown, ¹²⁷ 2008 Belch, ¹³² 2010 Gassman, ¹³³ 2014 Bedenis, ¹²⁸ 2015
10.4	Consider DAPT (aspirin plus clopidogrel) in patients who have undergone infrainguinal endovascular interventions for CLTI for a period of at least 1 month.	2 (Weak)	C (Low)	Cassar, ¹³⁴ 2005 Bhatt, ¹³⁵ 2006 Tepe, ¹³⁶ 2012 Strobl, ¹³⁷ 2013
10.5	Consider DAPT for a period of 1 to 6 months in patients undergoing repeated catheter-based interventions if they are at low risk for bleeding.	2 (Weak)	C (Low)	Cassar, ¹³⁴ 2005 Tepe, ¹³⁶ 2012 Strobl, ¹³⁷ 2013
10.6	Observe patients who have undergone lower extremity vein bypass for CLTI on a regular basis for at least 2 years with a clinical surveillance program consisting of interval history, pulse examination, and measurement of resting APs and TPs. Consider DUS scanning where available.	Good practice statement		
10.7	Observe patients who have undergone lower extremity prosthetic bypass for CLTI on a regular basis for at least 2 years with interval history, pulse examination, and measurement of resting APs and TPs.	Good practice statement		
10.8	Observe patients who have undergone infrainguinal endovascular interventions for CLTI in a surveillance program that includes clinical visits, pulse examination, and noninvasive testing (resting APs and TPs).	Good practice statement		
10.9	Consider performing additional imaging in patients with lower extremity vein grafts who have a decrease in ABI ≥ 0.15 and recurrence of symptoms or change in pulse status to detect vein graft stenosis.	Good practice statement		
10.10	Offer intervention for DUS-detected vein graft lesions with an associated PSV of >300 cm/s and a PSV ratio >3.5 or grafts with low velocity (midgraft PSV <45 cm/s) to maintain patency.	1 (Strong)	B (Moderate)	Mills, ¹³⁸ 2001
10.11	Maintain long-term surveillance after surgical or catheter-based revision of a vein graft, including DUS graft scanning where available, to detect recurrent graft-threatening lesions.	1 (Strong)	B (Moderate)	Landry, ¹³⁹ 2002 Nguyen, ¹⁴⁰ 2004
10.12	Consider arterial imaging after endovascular intervention for failure to improve (wound healing, rest pain) or a recurrence of symptoms to detect restenosis or progression of pre-existing disease.	2 (Weak)	C (Low)	Bui, ¹⁴¹ 2012
10.13	Consider reintervention for patients with DUS-detected restenosis lesions $>70\%$ (PSV ratio >3.5 , PSV >300 cm/s) if symptoms of CLTI are unresolved or on a selective basis in asymptomatic patients after catheter-based interventions.	2 (Weak)	C (Low)	Humphries, ¹⁴² 2011
10.14	Provide mechanical offloading as a primary component for care of all CLTI patients with pedal wounds.	1 (Strong)	A (High)	Elraiyah, ¹⁴³ 2016
10.15	Provide counseling on continued protection of the healed wound and foot to include appropriate shoes, insoles, and monitoring of inflammation.	1 (Strong)	A (High)	Elraiyah, ¹⁴³ 2016
11. Study designs and trial end points in CLTI				
11.1	Use a research framework such as the IDEAL for gathering new data and evidence on the surgical and endovascular management of CLTI.	Good research statement		
11.2	Encourage funders, journal reviewers, and editors to prioritize prospective, multicenter, controlled, and preferably randomized studies over retrospective case series, studies using historical controls, or other less rigorous research methodologies.	Good research statement		

Continued

Table C-continued

Chapter	Recommendation	Grade	Level of evidence	Key references
11.3	When RCTs are not feasible, use the OPG benchmarks from the SVS's Critical Limb Ischemia Working Group to evaluate the efficacy of novel endovascular CLTI techniques and devices.	Good research statement		
11.4	To facilitate sufficient enrollment, limit RCT exclusion criteria to those who are deemed essential to trial integrity.	Good research statement		
11.5	Design RCTs, prospective cohort studies, and registries that are specific to CLTI.	Good research statement		
11.6	Use an integrated, limb-based threatened limb classification system (eg, Wifi) and a whole limb anatomic classification scheme (eg, GLASS) to describe the characteristics and outcomes of CLTI patients who are enrolled.	Good research statement		
11.7	Describe outcomes in CLTI trials using a combination of objective and clinically relevant events, subjective PROMs and HRQL assessments, and anatomic and hemodynamic end points.	Good research statement		
11.8	Require regulatory trials aimed at obtaining premarket approval for devices for use in CLTI to study CLTI patients and to present data on objective and clinically relevant end points, PROMs and HRQL assessments, and anatomic and hemodynamic end points.	Good research statement		
11.9	Follow up patients in trials for a time sufficient (this will usually be >2 years) to allow appropriate comparison of the impact of the different interventions on the natural history of CLTI. Measure and declare completeness of follow-up coverage to quantify risk of attrition bias.	Good research statement		
11.10	Include a time-integrated measure of clinical disease severity (such as freedom from CLTI) in the CLTI trial design to describe the total impact of comparator CLTI interventions.	Good research statement		
11.11	Publish all CLTI trial protocols together with the full statistical analysis plans in peer-reviewed journals to allow independent, public, and transparent scrutiny and to prevent nonreporting of negative trials.	Good research statement		
11.12	Conduct postmarketing surveillance data collection using well-designed, large observational studies and registries.	Good research statement		
11.13	Share clinical trial data to allow subsequent individual patient data analyses, meta-analyses, and subgroup analyses; updating of OPGs; and validation of decision-making tools, such as the Wifi system and GLASS.	Good research statement		
11.14	Assess the quality of evidence in CLTI research using frameworks such as GRADE that consider multiple certainty domains and are not based solely on study design.	Good research statement		
<i>12. Creating a Center of Excellence for amputation prevention</i>				
No recommendations				

ABI = Ankle-brachial index; AI = aortoiliac; AKA = above-knee amputation; AP = ankle pressure; BKA = below-knee amputation; CFA = common femoral artery; CLTI = chronic limb-threatening ischemia; CTA = computed tomography angiography; DAPT = dual antiplatelet therapy; DM = diabetes mellitus; DUS = duplex ultrasound; EBR = evidence-based revascularization; FP = femoropopliteal disease; GLASS = Global Limb Anatomic Staging System; GRADE = Grading of Recommendations Assessment, Development, and Evaluation; GSV = great saphenous vein; HBOT = hyperbaric oxygen therapy; HRQL = health-related quality of life; IDEAL = Idea, Development, Exploration, Assessment, and Long-term study; IPC = intermittent pneumatic compression; LS = lumbar sympathectomy; MRA = magnetic resonance angiography; OPGs = objective performance goals; PAD = peripheral artery disease; PFA = profunda femoris artery; PROMs = patient-reported outcomes measures; PSV = peak systolic velocity; PVR = pulse volume recording; RCTs = randomized controlled trials; SCS = spinal cord stimulation; SVS = Society for Vascular Surgery; TAP = target arterial path; TBI = toe-brachial index; TKA = through-knee amputation; TP = toe pressure; Wifi = Wound, Ischemia, and foot Infection.

1. DEFINITIONS AND NOMENCLATURE

Defining and describing the severity of PAD

The term “critical limb ischemia” (CLI) is outdated and fails to encompass the full spectrum of patients who are evaluated and treated for limb-threatening ischemia in modern practice. Instead, the new term CLTI is proposed to include a broader and more heterogeneous group of patients with varying degrees of ischemia that can often delay wound healing and increase amputation risk.

For development of a clearer concept of CLTI, the following are excluded from the population as defined in this guidelines document: patients with purely venous ulcers, acute limb ischemia, acute trash foot, ischemia due to emboli, acute trauma, or mangled extremity and those with wounds related to nonatherosclerotic conditions. These include vasculitides, collagen vascular disease, Buerger’s disease, neoplastic disease, dermatoses, and radiation arteritis.

Previous leg ischemia definition and classification systems

CLI. In 1982, a working group of vascular surgeons defined CLI as ischemic rest pain with an ankle pressure (AP) <40 mm Hg, or tissue necrosis with an AP <60 mm Hg, in patients without diabetes.¹⁴⁴ Patients with diabetes were specifically excluded because of the confounding effects of neuropathy and susceptibility to infection. This definition has long been debated because it failed to capture a large group of patients who were at risk for amputation from a broader range of ischemia.^{145,146} To address this limitation, multiple and disparate lower limb ischemia and wound/DFU classification systems have been developed and promulgated during the past 5 decades, many of which remain in use today. These and other commonly used classifications and their associated components and grades of severity are summarized in [Table 1.1](#).^{10,147-158} Among vascular surgeons, the Fontaine and Rutherford classifications have been the most widely adopted, whereas orthopedists, podiatric surgeons, and diabetic foot specialists traditionally applied the Wagner and University of Texas classifications. The strengths and limitations of each have been widely discussed in previous key publications.^{10,150,159-161} Although each of these systems has advantages, the use of multiple classification systems has hindered the development of optimal treatment algorithms. It has also contributed to the fragmentation and variability of care provided for patients with DFUs as well as for nondiabetic patients across the spectrum of CLTI.

Lower extremity threatened limb classification system

The definitions summarized in [Table 1.1](#) were developed primarily to describe patients suffering from pure ischemia due to atherosclerosis. This was when the predominant risk factor was tobacco smoking and before the global epidemic of diabetes mellitus (DM). As such, these definitions were ischemia-dominant models of limb threat. However, because patients with DM now make up the majority of

patients with CLTI, absolute perfusion now needs to be considered in the context of neuropathy, wound characteristics, and infection. To address this unmet need, the SVS Lower Extremity Guidelines Committee created the SVS Lower Extremity Threatened Limb Classification System. This system stratifies amputation risk according to wound extent, degree of ischemia, and presence and severity of foot infection (Wound, Ischemia, and foot Infection [WIFI]).¹⁰ Although it may require some adjustments, WIFI appears to correlate strongly with important clinical outcomes. This includes those set forth in the SVS objective performance goals (OPGs) that focus on limb amputation, 1-year amputation-free survival (AFS), and wound healing time ([Table 1.2](#)).^{10,68-72,162-167}

The WIFI classification system is currently being evaluated in multicenter trials including the U.S. National Institutes of Health-funded BEST-CLI trial¹³ and the UK National Institute for Health Research Health Technology Assessment-funded BASIL-2 and BASIL-3 trials.^{14,15} WIFI is also being incorporated into the U.S. SVS Vascular Quality Initiative registry of lower extremity interventions.

Hemodynamic criteria

Although previous guidelines have suggested a range of AP and toe pressure (TP) thresholds for defining limb-threatening ischemia, such thresholds must be used with great caution and considered in the clinical context because of multiple confounding factors and the lack of a clear and reliable relationship to outcomes. Patients with limb-threatening ischemia should be defined primarily in terms of their clinical presentation, supplemented by physiologic studies that demonstrate a degree of ischemia sufficient to cause pain, to impair wound healing, and to increase amputation risk.

In addition to patients who meet the proposed new definition of CLTI, there are a significant number of patients whose PAD is so severe that they are likely to be at increased risk for development of CLTI in the foreseeable future.¹⁶⁸ Although data are lacking, it is logical to suggest that such individuals should be monitored closely for clinical disease progression.

CLTI

We propose that CLTI be defined to include a broader and more heterogeneous group of patients with varying degrees of ischemia that may delay wound healing and increase amputation risk. A diagnosis of CLTI requires objectively documented atherosclerotic PAD in association with ischemic rest pain or tissue loss (ulceration or gangrene).

Ischemic rest pain is typically described as affecting the forefoot and is often made worse with recumbency while being relieved by dependency. It should be present for >2 weeks and be associated with one or more abnormal hemodynamic parameters. These parameters include an ankle-brachial index (ABI) <0.4 (using higher of the dorsalis pedis [DP] and posterior tibial [PT] arteries), absolute highest AP <50 mm Hg, absolute TP <30 mm Hg, transcutaneous

Table 1.1. Classification schemes used for chronic limb ischemia and ulceration

Classification system	Ischemic rest pain	Ulcer	Gangrene	Ischemia	Infection	Key features and comments
<i>Ischemia and PAD classifications</i>						
Fontaine (1954)	Yes (class III/IV)	Class IV/IV; ulcer and gangrene grouped together	Class IV/IV; ulcer and gangrene grouped together	Cutoff values for CLI based on European consensus document: Ischemic rest pain >2 weeks with AP <50 mm Hg or TP <30 mm Hg Ulcer and gangrene: AP <50 mm Hg, TP <30 mm Hg, absent pedal pulses in patient with diabetes	No	Pure ischemia model No clear definitions of spectrum of hemodynamics; minimal description of wounds; infection omitted
Rutherford (1997)	Yes (category 4/6)	Category 5: minor tissue loss, nonhealing ulcer, focal gangrene with diffuse pedal ischemia	Category 6: major tissue loss extending above TM level, functional foot no longer salvageable (although, in practice, often refers to extensive gangrene, potentially salvageable foot with significant efforts)	Yes; cutoffs for CLI Category 4: resting AP <40 mm Hg; flat or barely pulsatile ankle or forefoot PVR; TP <30 mm Hg Category 5/6: AP <60 mm Hg; flat or barely pulsatile ankle or forefoot PVR; TP <40 mm Hg	No	Pure ischemia model PAD classification system includes milder forms of PAD (categories 1-3). Categories 4-6 based on cutoff values for CLI; no spectrum of ischemia, does not acknowledge potential need for revascularization, with CLI cutoff depending on wound extent/infection; not intended for patients with diabetes; wound classes not sufficiently detailed; omits infection as a trigger
Second European Consensus (1991)	Yes; pain >2 weeks requiring analgesia; AP ≤50 mm Hg or TP ≤30 mm Hg	Yes, if AP ≤50 mm Hg or TP ≤30 mm Hg	Yes, if AP ≤50 mm Hg or TP ≤30 mm Hg	One hemodynamic cutoff for ulcer and gangrene, with or without diabetes	No	Ischemia threshold too low, especially for patients with diabetes; wounds not graded; infection not considered
TASC I (2000)	Yes, if ischemia criteria met	Yes, if ischemia criteria met	Yes, if ischemia criteria met	One hemodynamic cutoff, with no differentiation of diabetics from nondiabetics	No	Focused primarily on arteriographic anatomy without detailed stratification of the limb itself (wounds and infection not graded)
TASC II (2007)	Yes, if AP <50 mm Hg or TP <30 mm Hg	Yes, if ischemia criteria met of AP <70 mm Hg or TP <50 mm Hg	Yes, if ischemia criteria met of AP <70 mm Hg or TP <50 mm Hg	Yes, but noted "there is not complete consensus regarding the vascular haemodynamic parameters required to make the diagnosis of CLI"	No	Focused primarily on arteriographic anatomy without detailed stratification of the limb itself (wounds and infection not graded); issues with hemodynamic criteria noted
<i>DFU classifications</i>						
Meggitt-Wagner (1976, 1981)	No	Grade 0: pre- or post-ulcerative lesion Grade 1: partial/full-thickness ulcer Grade 2: probing to tendon or capsule Grade 3: deep ulcer with osteitis Grade 4: partial foot gangrene Grade 5: whole foot gangrene	Ulcer and gangrene grouped together; gangrene due to infection not differentiated from gangrene due to ischemia; also includes osteomyelitis	No	No for soft tissue component; included only as osteomyelitis	Orthopedic classification intended for diabetic feet No hemodynamics; gangrene from infection not differentiated from that due to ischemia; osteomyelitis included; soft tissue infection not separated from bone infection

Table 1.1-continued

Classification system	Ischemic rest pain	Ulcer	Gangrene	Ischemia	Infection	Key features and comments
University of Texas (1998)	No	Yes: grade 0-III ulcers Grade 0: pre- or post-ulcerative completely epithelialized lesion Grade I: superficial, not involving tendon, capsule, or bone Grade II: penetrating to tendon/capsule Grade III: penetrating to bone or joint	No	Yes: binary \pm based on ABI <0.8	Yes \pm wounds, with frank purulence or >2 of the following (warmth, erythema, lymphangitis, edema, lymphadenopathy, pain, loss of function) considered infected	Primarily intended for DFUs; includes validated ulcer categories; PAD and infection included, but only as \pm variable with no grades/spectrum
S(AD) SAD system (1999)	No	Yes: 0-3 based on area and depth Grade 0: skin intact Grade 1: superficial, <1 cm ² Grade 2: penetrates to tendon, periosteum, joint capsule, 1-3 cm ² Grade 3: lesions in bone or joint space, >3 cm ²	No	Pulse palpation only, no objective hemodynamic testing	Yes; 1 = no infection, 2 = cellulitis, 3 = osteomyelitis	Intended for DFUs; also includes neuropathy; does not mention gangrene; no hemodynamic information, perfusion assessment based on pulse palpation only
PEDIS (2004)	No	Yes: grades 1-3 Grade 1: superficial full-thickness ulcer, not penetrating deeper than the dermis Grade 2: deep ulcer, penetrating below the dermis to subcutaneous structures involving fascia, muscle, or tendon Grade 3: all subsequent layers of the foot involved including bone and joint (exposed bone, probing to bone)	No	Yes: 3 grades, CLI cutoff Grade 1: no PAD symptoms, ABI >0.9 , TBI >0.6 , TcPO ₂ >60 mm Hg Grade 2: PAD symptoms, ABI <0.9 , AP >50 mm Hg, TP >30 mm Hg, TcPO ₂ 30-60 mm Hg Grade 3: AP <50 mm Hg, TP <30 mm Hg, TcPO ₂ <30 mm Hg	Yes: grades 1-4 based on IDSA classification	Primarily intended for DFUs; ulcer grades validated; includes perfusion assessment, but with cutoff for CLI; gangrene not separately categorized; includes validated IDSA infection categories
Saint Elian (2010)	No	Yes: grades 1-3 based on depth Grade 1: superficial wound disrupting entire skin Grade 2: moderate or partial depth, down to fascia, tendon, or muscle but not bone or joints Grade 3: severe or total, wounds with bone or joint involvement Multiple categories including area, ulcer number, location, and topography	No	Yes: grades 0-3 Grade 0: AP >80 mm Hg, ABI 0.9-1.2 Grade 1: AP 70-80 mm Hg, ABI 0.7-0.89, TP 55-80 mm Hg Grade 2: AP 55-69 mm Hg, ABI 0.5-0.69, TP 30-54 mm Hg Grade 3: AP <55 mm Hg, ABI <0.5 , TP <30 mm Hg	Yes: grades 0-3 Grade 0: none Grade 1: mild; erythema 0.5-2 cm, induration, tenderness, warmth, and purulence Grade 2: moderate; erythema >2 cm, abscess, muscle tendon, joint, or bone infection Grade 3: severe; systemic response (similar to IDSA)	Detailed system intended only for DFUs; comprehensive ulcer classification system with hemodynamic categories for gradations of ischemia; gangrene not considered separately Infection system similar to IDSA
IDSA (2012)	No	No	No	No	Yes: uninfected, mild, moderate, and severe	Validated system for risk of amputation related to foot infection but not designed to address wound depth/complexity or degree of ischemia

Continued

Table 1.1-continued

Classification system	Ischemic rest pain	Ulcer	Gangrene	Ischemia	Infection	Key features and comments
<i>Recommended CLTI classification</i>						
SVS Wifl threatened limb classification (2014)	Yes, if confirmed by hemodynamic criteria	Yes: grades 0-3 Grouped by depth, location, and size and magnitude of ablative/wound coverage procedure required to achieve healing	Yes: grades 0-3 Grouped by extent, location, and size and magnitude of ablative or wound coverage procedure required to achieve healing	Yes: ischemia grades 0-3 Hemodynamics with spectrum of perfusion abnormalities; no cutoff value for CLI Grade 0 unlikely to require revascularization	Yes: IDSA system (grades 0-3); grades correlate with amputation risk	Includes PAD ± diabetes with a range of wounds, ischemia, and infection, scaled from 0-3 No single cutoff for CLI as CLTI is considered a spectrum of disease Need for revascularization depends on degree of ischemia, wound, and infection severity Ulcers/gangrene categorized by extent and complexity of anticipated ablative surgery/coverage

ABI = Ankle-brachial index; AP = ankle pressure; CLI = critical limb ischemia; DFU = diabetic foot ulcer; CLTI = chronic limb-threatening ischemia; IDSA = Infectious Diseases Society of America; PAD = peripheral artery disease; PEDIS = perfusion, extent, depth, infection, and sensation; PVR = pulse volume recording; SVS = Society for Vascular Surgery; TASC = TransAtlantic Inter-Society Consensus; TBI = toe-brachial index; TcPO₂ = transcutaneous oximetry; TM = transmetatarsal; TP = toe pressure; Wifl = Wound, Ischemia, foot Infection.

partial pressure of oxygen (TcPO₂) <30 mm Hg, and flat or minimally pulsatile pulse volume recording (PVR) waveforms (equivalent to Wifl ischemia grade 3). Pressure measurements should be correlated with Doppler arterial waveforms, keeping in mind that AP and ABI are frequently falsely elevated because of medial calcinosis, especially in people with DM and end-stage renal disease (ESRD). For this reason, a combination of tests may be needed. In patients with DM or ESRD, toe waveforms and systolic pressures are preferred. One study demonstrated that AP alone failed to identify 42% of patients with CLTI. TP and TcPO₂ measurements were more accurate than AP and also were more predictive of 1-year amputation risk (TP <30 mm Hg or TcPO₂ <10 mm Hg).¹⁶⁹

Tissue loss related to CLTI includes gangrene of any part of the foot or nonhealing ulceration present for at least 2 weeks. It should be accompanied by objective evidence of significant PAD (eg, Wifl ischemia grade ≥1). This definition excludes purely neuropathic, traumatic, or venous ulcers

lacking any ischemic component. However, the Wifl scheme recognizes that a wide range of ischemic deficit may be limb threatening when it coexists with varying degrees of wound complexity and superimposed infection. CLTI is present if either ischemic rest pain or tissue loss with appropriate hemodynamics is present.

Some patients may have relatively normal hemodynamics when the limb or foot is considered as a whole but nevertheless suffer ulceration as a result of diminished local perfusion (ie, angiosomal or regional ischemia without adequate collateral flow). It is recognized that such ulcers may contribute to limb threat, and current tools to assess regional ischemia require further development to better define such circumstances and their treatment. The relationship between regional ischemia and patterns of IP and pedal disease also requires more in-depth study.^{12,170}

The GVG recommends use of the SVS Wifl classification (Section 3) in a manner analogous to the TNM system of

Table 1.2. One-year major limb amputation rate by Society for Vascular Surgery (SVS) Wound, Ischemia, and foot Infection (Wifl) clinical stage

Study (year): No. of limbs at risk	Stage 1	Stage 2	Stage 3	Stage 4
Cull ⁶⁸ (2014): 151	37 (3)	63 (10)	43 (23)	8 (40)
Zhan ⁶⁹ (2015): 201	39 (0)	50 (0)	53 (8)	59 (64) ^a
Darling ⁷¹ (2016): 551	5 (0)	110 (10)	222 (11)	213 (24)
Causey ⁷⁰ (2016): 160	21 (0)	48 (8)	42 (5)	49 (20)
Beropoulos ¹⁶³ (2016): 126	29 (13)	42 (19)	29 (19)	26 (38)
Ward ¹⁶⁶ (2017): 98	5 (0)	21 (14)	14 (21)	58 (34)
Darling ¹⁶⁴ (2017): 992	12 (0)	293 (4)	249 (4)	438 (21)
Robinson ⁷² (2017): 280	48 (2.1)	67 (7.5)	64 (7.8)	83 (17)
Mathioudakis ¹⁶⁵ (2017): 217	95 (4)	33 (3)	87 (5)	64 (6)
Tokuda ¹⁶⁷ (2018): 163	16 (0)	30 (10)	56 (10.7)	61 (34.4)
N = 2982 (weighted mean)	307 (3.2)	757 (7.0)	859 (8.7)	1059 (23.3)
Median (1-year major limb amputation)	0%	9%	9.4%	29%

The number of limbs at risk in each Wifl stage is given, with percentage of amputations at 1 year in parentheses. Means in totals (in parentheses) are weighted.

^a Falsely elevated because of inadvertent inclusion of stage 5 (unsalvageable) limbs.

cancer staging to stage the limb in patients with CLTI. The Wifl classification is intuitive and has been made user-friendly by the availability of free online application software provided by the SVS (SVS Interactive Practice Guidelines; <https://itunes.apple.com/app/id1014644425>).

Data accrued in nearly 3000 patients to date and summarized in Table 1.2 suggest that the four Wifl clinical stages of limb threat correlate with the risk of major limb amputation and time to wound healing. It has also been suggested that novel Wifl composite and mean scores may predict other clinically significant events as well.¹⁶⁴ The Wifl system appears to contain the key limb status elements needed to gauge the severity of limb threat at presentation.

In addition, recent data suggest that Wifl can assist in predicting which patients might fare better with open surgical bypass compared with endovascular therapy.^{171,172} One study reported that when endovascular therapy alone was applied to Wifl stage 4 patients, results were worse than in lower clinical stage patients.¹⁷² Specifically, the wound healing rate was only 44%, the major limb amputation rate was 20%, and 46% of patients required multiple, repetitive endovascular procedures. In a nonrandomized, single-center comparison of Wifl stage 4 patients, researchers found that freedom from major limb amputation was superior in patients who underwent bypass compared with those who underwent endovascular therapy.¹⁷¹ If these results can be confirmed, Wifl may prove to be a useful tool in deciding whether to offer endovascular therapy or bypass.

Another study used Wifl in a fashion analogous to TNM staging for cancer and reassigned patients to stages after 1 month of therapy. The investigators found that at 1 month and 6 months, wound, ischemia, and infection grades correlated with AFS, whereas baseline ischemia grade did not.¹⁷³ These data suggest that restaging with Wifl at 1 month and 6 months after intervention may help identify a cohort of patients undergoing therapy for CLTI that remains at higher risk for major limb amputation and may merit targeted reintervention.

Ultimately, the optimal staging system for CLTI is expected to evolve with additional clinical application and larger scale, multicenter, and multinational data analysis.

2. GLOBAL EPIDEMIOLOGY AND RISK FACTORS FOR CLTI

In 2010, estimates suggested that >200 million people worldwide were living with PAD. This represented a 23.5% increase since 2000, an increase that is believed to be largely attributable to aging populations and the growing prevalence of risk factors, in particular DM.¹ These figures are thought to almost certainly underestimate the true burden of disease as they are largely based on community-based studies that define PAD on the basis of reduced ABI. Although CLTI is widely believed to be a growing global health care problem, reliable epidemiologic data are extremely limited.

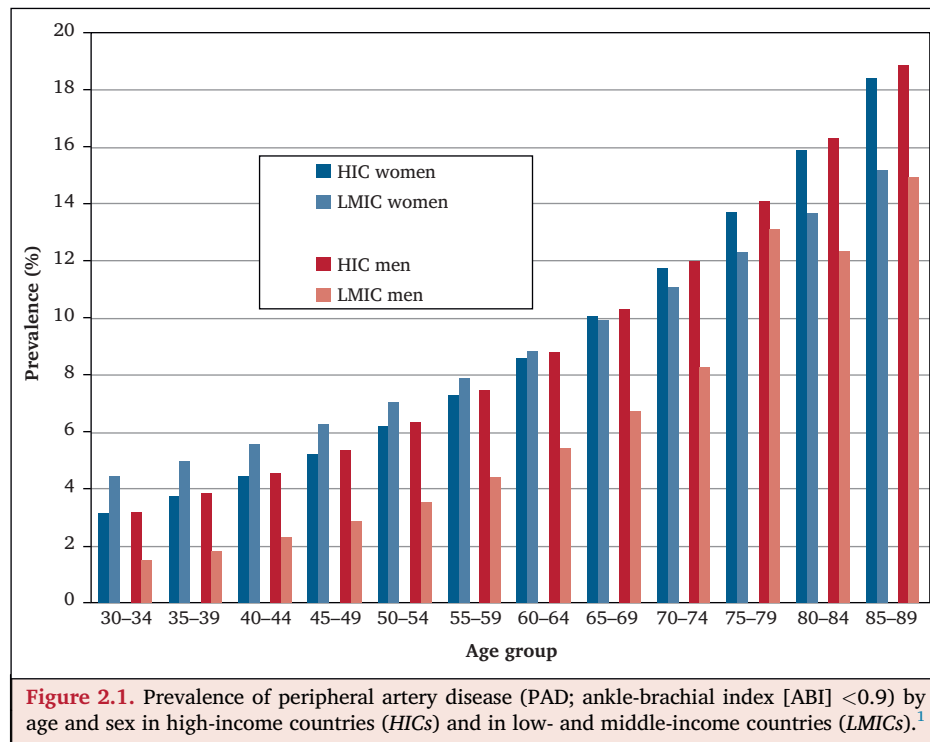
Men have been reported to have a higher prevalence of PAD in high-income countries (HICs; Fig 2.1), whereas women seem to have a higher prevalence of PAD in low- and middle-income countries (LMICs).¹ As life expectancy increases, the burden of PAD seems likely to rise in LMIC. However, in certain geographic regions, notably in the western Pacific and Southeast Asia, most PAD cases are reported in people younger than 55 years.¹

In a meta-analysis from the United States, the prevalence of PAD in men ranged from 6.5% (aged 60-69 years) to 11.6% (aged 70-79 years) to 29.4% (>80 years).¹⁷⁴ There were similar age-related increases in PAD prevalence in women (5.3%, 11.5%, and 24.7% in these age categories, respectively).¹⁷⁴ Given that the life expectancy of women still exceeds that of men, the overall burden of PAD (total number of individuals affected) is likely to be greater in women than in men. The epidemiology of PAD is likely to be similar in other developed countries, such as the United Kingdom, and regions, such as the European Union.^{175,176} However, as these populations become more multicultural, differences in disease burden between different communities within these nations seem likely to become apparent, further complicating the epidemiology of the condition.¹⁷⁷

Data on the epidemiology of PAD and in particular of CLTI in other parts of the world are even more limited. In one Japanese community study of people older than 40 years, the prevalence of ABI <0.9 was very low (1.4%).¹⁷⁸ In a population-based cohort of 4055 Chinese men and women older than 60 years, the prevalence of PAD (ABI <0.9) was 2.9% and 2.8%, respectively.¹⁷⁹ Another population-based cohort of 1871 individuals younger than 65 years in two countries from Central Africa showed that the overall prevalence of PAD was 14.8%.¹⁸⁰

There is a considerable body of evidence showing that PAD is more common among black individuals than among whites.¹⁸¹⁻¹⁸⁴ There is also evidence that Asians and Hispanics have a lower prevalence of PAD than whites do.¹⁸⁴ It is not clear whether these differences have a genetic basis or simply reflect differential exposure to traditional risk factors. However, disease risk profiles appear to change as populations migrate, suggesting that environment is more important than genetic makeup. Another explanation may be that ABI is intrinsically lower in black individuals, resulting in a falsely high prevalence of PAD.¹⁸⁵

Recommendations 1		
1.1 Use objective hemodynamic tests to determine the presence and to quantify the severity of ischemia in all patients with suspected CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	de Graaff, ¹⁶ 2003 Brownrigg, ¹⁷ 2016 Wang, ¹⁸ 2016
1.2 Use a lower extremity threatened limb classification staging system (eg, SVS's Wifl classification system) that grades wound extent, degree of ischemia, and severity of infection to guide clinical management in all patients with suspected CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	See Table 1.2



There are far more international data on the epidemiology of intermittent claudication (IC) than of CLTI. The annual incidence of IC in 60-year-old men has been shown to range from 0.2% in Iceland to 1.0% in Israel.¹⁸⁶ A study using data from a large, insured U.S. population estimated the annual incidence of PAD, defined by the presence of a diagnosis or procedure insurance claim, to be 2.4% in a cohort of adults older than 40 years.¹⁸⁷ Studies reporting on the epidemiology of PAD based on ABI rather than on the presence of symptomatic disease suggest that the prevalence of asymptomatic PAD may be similar in men and women, although IC appears to be more prevalent in men.^{188,189} Differences in presentation between men and women with IC may influence the accuracy of prevalence estimates.¹⁹⁰

Risk factors for PAD

Modifiable risk factors for PAD have been comprehensively studied in HICs and include smoking, DM, hypertension, hypercholesterolemia, and air pollution. A global study suggested that although these risk factors may be equally applicable to LMICs, for most, the strength of the association was greater in HICs. This may be because HIC studies often include a larger number of older patients and because the exposure time tends to be shorter in LMICs.¹

Smoking is unarguably a significant risk factor in the development and progression of PAD. Nevertheless, whereas smoking rates are falling in most HICs, this is not the case in LMICs (Fig 2.2). DM is also strongly associated with the development of PAD, and risk increases with the duration of DM in affected individuals. Patients with DM are widely recognized to be at markedly higher risk of amputation.^{191,192} The rapidly increasing worldwide prevalence

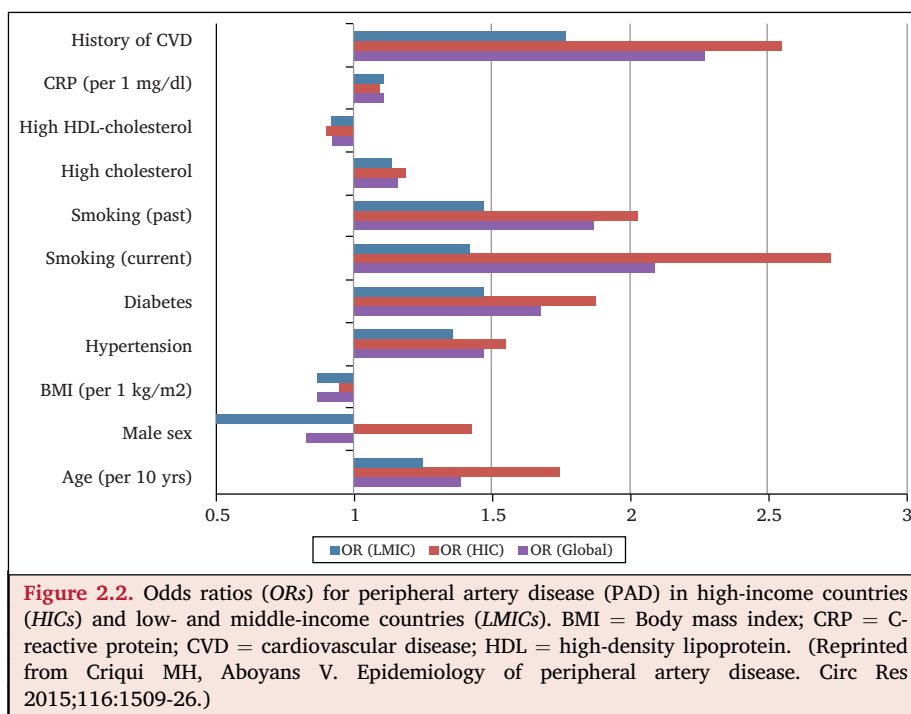
of type 2 DM is concerning and likely to have a significant impact on the future incidence and prevalence of PAD and CLTI as well as their morbid end points.

The link between obesity and PAD is inconsistent. Many studies have suggested the existence of an “obesity paradox,” with lower rates of PAD being observed in patients with a higher body mass index (BMI).¹⁸⁶ By contrast, other studies that have adjusted for smoking, which is associated with a generally lower BMI,¹⁹³ reported a positive correlation between BMI and PAD. Hypertension is associated with the development of PAD and is another common risk factor in the adult population.

The association between dyslipidemia and the development and progression of atherosclerosis has been extensively studied. Whereas elevated levels of total cholesterol and low-density lipoprotein cholesterol (LDL-C) are widely accepted as risk factors for PAD, reduced high-density lipoprotein cholesterol levels also appear to be associated with increased mortality in PAD patients.¹⁹⁴ A ratio of the two may also be a useful predictor of PAD.¹⁹⁵ Whereas hypertriglyceridemia appears to be atherogenic,¹⁹⁶ its role in the development and progression of PAD remains incompletely defined.

Chronic kidney disease (CKD), particularly ESRD, is a strong risk factor for PAD and limb loss, especially in association with DM. Affected patients frequently have heavily calcified arteries and a distal pattern of arterial disease.¹⁸⁶

The association between alcohol consumption and PAD is inconsistent, making it difficult to draw any firm conclusions.¹⁹⁷ However, heavy alcohol consumption is often associated with other risk factors for PAD, such as smoking, and as with DM, the presence of alcoholic neuropathy increases the risk of tissue loss for any given perfusion deficit.



Recent data suggest that air pollution from sources such as motor vehicles, power plants, wood burning, and some industrial processes may be associated with increased cardiovascular morbidity and mortality.¹⁹⁸ Likewise, chronic inflammation, characterized by elevated levels of C-reactive protein and other biomarkers, has been shown to be associated with PAD.¹⁸⁶ Homocysteine levels are higher in several case-control PAD cohort studies, although the benefits of folate supplementation appear to be negligible.^{186,199}

The significance of family history and genetic makeup is uncertain.^{200,201} Studies have yielded varying results, with some identifying a small number of candidate genes or even single-nucleotide polymorphisms and others failing to identify any association at all.

Finally, people of lower socioeconomic status and educational attainment tend to have a higher prevalence of IC and probably also of CLTI, although the association is not always strong and can often be explained in part by their increased exposure to other risk factors, such as smoking.^{180,183,202} However, there is increasing evidence that chronic mental and psychosocial stress may have direct effects on cardiovascular health.²⁰³

Incidence and prevalence of CLTI

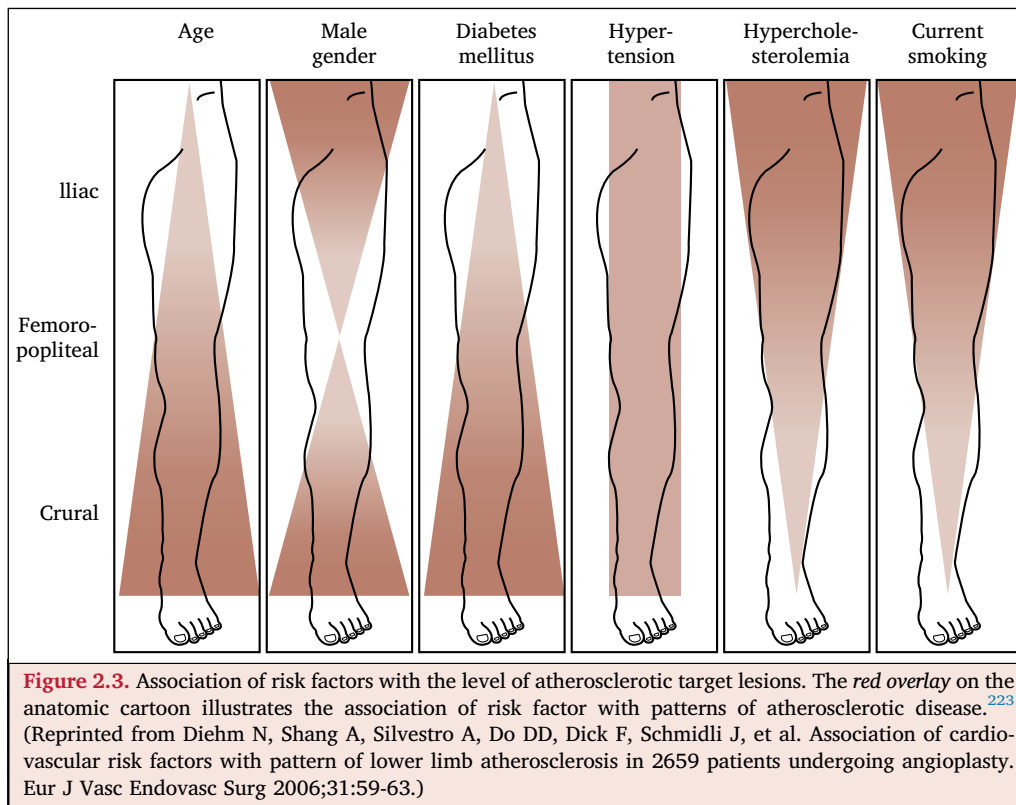
As noted before, high-quality data on the epidemiology of CLTI are lacking, especially from LMICs, with many estimates being extrapolated from the incidence and prevalence of IC, amputation, and DM. Unfortunately, such estimates can be highly misleading for a number of reasons. First, IC does not progress to CLTI in a predictable manner. Second, CLTI probably represents <10% of all PAD patients, and those undergoing amputation for CLTI are at very high risk of premature death (and so more likely to be absent

from population-based studies). Third, the clinical and hemodynamic data required to reliably diagnose CLTI are difficult to obtain in large populations. This is particularly true in patients with DM, who often have incompressible vessels. Thus, although it is estimated that approximately half of all patients with a DFU in western Europe and North America also have significant PAD, the disease may often appear relatively mild (not fulfilling the criteria for CLTI) on hemodynamic assessment.²⁰⁴

For many years, the annual incidence of what has typically been termed CLI was estimated at 500 to 1000 new cases per million individuals in Western countries.²⁰⁵ Unfortunately, there are no reliable contemporary epidemiologic data that take into account recent changes in lifestyle (such as reduced smoking rates), identification and medical management of cardiovascular risk factors, prevalence of obesity and diabetes, and overall increasing life expectancy around the world.

In 2013, a meta-analysis involving 6 studies and close to 83,000 patients showed the overall prevalence of severe chronic limb ischemia (defined by Fontaine stage, AP <70 mm Hg, and ABI <0.60) to be 0.74% (95% confidence interval [CI], 0.26-1.46), with marked heterogeneity between studies (prevalence, 0.11%-1.59%).²⁰⁶

In an analysis of the U.S. MarketScan database (Truven Health Analytics, Ann Arbor, Mich), composed of approximately 12 million Americans aged 40 years and older receiving care from Medicare and Medicaid between 2003 and 2008, the prevalence and annual incidence of CLTI were estimated at 1.33% and 0.35%, respectively. This equates to around 3500 new cases per million individuals per year.¹⁸⁷ The study defined primary CLTI as patients with no prior PAD or subsequent PAD diagnostic code >30 days after a CLTI diagnostic code. Secondary CLTI included patients with



prior PAD (or subsequent PAD diagnostic codes within 30 days of a CLTI diagnostic code). The annual incidence rate of primary and secondary CLTI was 0.19% and 0.16%. CLTI patients represented 11.08% (95% CI, 11.03%-11.13%) of total PAD patients annually. As noted before, although one might expect similar rates of CLTI in other developed nations and regions, data from LMICs are lacking. Even within HICs, the epidemiology of CLTI is likely to be complex and evolving.

Amputation and CLTI

A number of studies have used major lower limb amputation as a surrogate for CLTI on the basis that most (>80%) are due to CLTI. However, it can be difficult to distinguish reliably between minor (below the ankle) and major (above the ankle) amputations in some administrative data. Furthermore, the number of amputations that are performed for trauma, tumor, or infection, including patients with DM and neuropathy (but without PAD), is likely to vary considerably from country to country, particularly in comparing HICs and LMICs.

In the United States in 2015, an estimated 504,000 individuals (of a total estimated population of 295.5 million) were living with a major amputation due to PAD, a number that was projected to more than double by 2050.²⁰⁷ In Minnesota, a state with low overall rates of cardiovascular disease (CVD), one study showed that between 2005 and 2008, the age-adjusted annual incidence of ischemic lower limb amputation (amputations not due to trauma or cancer) remained unchanged at 20 per 100,000.²⁰⁸

A systematic review found that the rate of major amputation varied considerably (3.6 to 68.4 per 100,000 per year) across the world, probably because of differences in ethnicity, social deprivation, and, in particular, the prevalence of DM.²⁰⁹ In some countries, including England, the incidence of amputations unrelated to DM appears to be decreasing.²¹⁰ However, in most parts of the world, the incidence of DM-related limb amputations is increasing.²¹¹

Natural history of untreated CLTI

A meta-analysis (13 studies and 1527 patients) of the natural history of untreated CLTI found that during a median follow-up of 12 months, both the mortality rate and the per-patient amputation rate were 22%, although there was marked heterogeneity between studies.⁵ With regard to disease progression, one study estimated that only 5% to 10% of patients with either asymptomatic PAD or IC went on to develop CLTI during a 5-year period.²¹² However, another meta-analysis suggested that this progression rate may be significantly higher at 21% (range, 12%-29%) during 5 years.²¹³ Approximately 50% of patients presenting with CLTI have no prior history of PAD.^{214,215}

Patients with CLTI present with a wide spectrum of clinical, hemodynamic, and anatomic disease. Outcomes depend on the availability and quality of primary and secondary care and may be further influenced by factors such as social stigmatization and cultural and religious beliefs. Those living in regions with poor access to health care often present late with advanced disease and unsalvageable

limbs. Indeed, it has been estimated that approximately half of all patients with CLTI do not undergo revascularization.²¹⁶ Even in HICs with advanced health care systems, such as Germany and the United States, many patients with suspected CLTI do not receive angiography or any attempt at revascularization.²¹⁷ This may be because patients are too sick or frail, are thought to have no revascularization option, or present too late. Unfortunately, whereas reasonable data are available on amputation rates, data on processes of care that can help explain the shortfall and differences in revascularization and amputation are lacking.

The recently published VASCUNET report showed large (almost sixfold) differences but an overall decline in major amputation rates in 12 European and Australasian countries between 2010 and 2014.²¹⁸ DM prevalence, age distribution, and mortality rates were also found to vary between countries. Despite limitations inherent to the use of registry data, these findings are important and may indicate disparities in access to vascular surgical intervention across the countries studied. Further research is clearly required to improve limb salvage in different demographic and geographic settings.²¹⁸

In patients with known PAD, the risk for development of CLTI appears to be greater in men, in patients who have had a stroke or are in heart failure, and in patients with DM.¹⁸⁷ Patients who present de novo with CLTI (no prior diagnosis of PAD) seem more likely to be older and male and to have pre-existing CVD (including hypertension, myocardial infarction, heart failure, or stroke) and renal failure.¹⁸⁷ Not surprisingly, because of the associated high prevalence of neuropathy, DM had the strongest association with a new presentation of CLTI (odds ratio [OR], 7.45; 95% CI, 7.19-7.72). The medical management of patients who have or are at risk of having CLTI is covered elsewhere in the guideline (Section 4). Still, there is growing evidence that aggressive medical management of risk factors can significantly improve the overall prognosis for patients with PAD. This may in part explain the decline in mortality observed in patients with IC and CLTI in The Netherlands between 1998 and 2010.²¹⁹

The risk of amputation is high in CLTI patients, even in those undergoing a successful revascularization.²²⁰ Unsurprisingly, patients who present late and with the greatest degree of tissue loss are at highest risk. In one analysis, the rates of amputation at 4 years were 12.1%, 35.3%, and 67.3% for Rutherford class 4, class 5, and class 6, respectively.²¹⁷

Anatomic patterns of disease

CLTI is usually the result of multilevel arterial occlusive disease. Involvement of parallel vascular beds, such as the superficial femoral artery (SFA) and profunda femoris artery (PFA), is also common. Below-knee arteries typically become increasingly involved as the overall severity of disease worsens. However, FP and IP disease does not always progress in parallel. The general requirement is that there needs to be two levels of arterial occlusive disease to

cause CLTI. However, an increasingly observed exception is diffuse disease involving the IP and pedal arteries in patients with DM or CKD. In patients with CLTI and IP disease, the PT artery tends to be the most diseased, often with relative sparing of the peroneal artery. In patients with DM, there may also be sparing of the DP artery. A number of specific factors appear to drive the distribution of lower limb PAD (Fig 2.3). Thus, women may be more prone to development of FP disease, whereas elderly male patients and those with diabetes are more likely to develop IP disease.²²¹ There is also some evidence that black people and Asians are more likely to develop distal disease.^{222,223}

CVD and mortality risk

Despite some evidence of recent improvements in HICs, patients who develop PAD and CLTI remain at high risk of premature death. Thus, in a German study, 4-year mortality was 18.9% in Rutherford class 1 to class 3, 37.7% in class 4, 52.2% in class 5, and 63.5% in class 6.²¹⁷ However, interestingly, up to 40% of the deaths were not cardiovascular, perhaps because better medical therapy and management of risk factors have improved overall survival from CVD.^{224,225}

In 2014, the Global Burden of Disease (2010) database was used to estimate PAD deaths, disability-adjusted life-years, and years of life lost in 21 regions worldwide between 1990 and 2010. In 1990, the age-specific PAD death rate per 100,000 population ranged from 0.05 among those aged 40 to 44 years to 16.63 among those aged 80 years or older. In 2010, the corresponding estimates were 0.07 and 28.71. Death rates increased consistently with age in 1990 and 2010, and the rates in 2010 were higher than they were in 1990 in all age categories.

The overall relative change in median disability-adjusted life-years was greater for men and women in developing than in developed nations. The overall relative change in the median years of life lost rate in developed countries was larger in women than in men. Researchers concluded that disability and mortality associated with PAD increased during the 20 years of the study and that this increase in burden was greater among women than men. In addition, the burden of PAD is no longer confined to the elderly population and now includes young adults. Finally, the relative increase in PAD burden in developing regions of the world is striking and exceeds the increases in developed nations.²²⁶

Management strategies in CLTI

A study based in South Carolina identified patients who underwent revascularization for CLTI in 1996 and 2005 and examined the requirement for subsequent amputations and further revascularizations. Although revascularization procedures increased by 33%, the 1-year and 3-year amputation rates did not change significantly between 1996 (34% and 43%) and 2005 (34% and 40%). However, the percentage of patients who required further revascularization in the same calendar year increased from 8% to 19%. Investigators concluded that the shift to endovascular interventions increased the number of secondary procedures

required to maintain limb salvage rates. Although the absolute number of amputations appeared to decrease despite the increasing population at risk, they concluded that it could be misleading to suggest a direct relationship to the increase in revascularization rates. Thus, whereas the number of amputations fell by approximately 500, the number of revascularization procedures rose by only 187.²²⁷ As noted before, improved risk factor management and use of best medical therapy are likely to have been important factors. The increased number of revascularization procedures may also be due to the increasing availability of endovascular technology and techniques. Indeed, there is some suggestion that practitioners have become more liberal with the use of all revascularization techniques, including bypass and angioplasty.²²⁸ Data from the United Kingdom suggest that an increasing number of patients are undergoing attempts at revascularization.²²⁸

Undoubtedly, there is an increase in the number and proportion of revascularization procedures performed using an endovascular approach. In the South Carolina study, the endovascular approach was used in 26% of CLTI revascularization procedures performed in 1996 compared with 51% in 2005.²²⁷ It is difficult to establish whether this change in management strategy has resulted in the salvage of more limbs and prevention of premature deaths. Such questions can only be answered by RCTs. There are, however, consistent data to suggest that more modern vascular strategies (including a more widespread adoption of endovascular techniques as first- or second-line therapies) are associated with an increased number of patients requiring repeated revascularization (increasing from 8% to 19% in the South Carolina study).²²⁷ Alternative explanations may be that vascular surgeons are becoming more aggressive at retreating patients or that patients are living longer.

Summary

PAD is an increasingly common condition worldwide. Most patients remain asymptomatic, but it is estimated that up to 10% will progress to or present de novo with CLTI (although that figure appears to vary widely). The number of women with PAD continues to increase, and women may be more likely to develop symptomatic disease. Modifiable risk factors include DM, smoking, hypertension, dyslipidemia, CKD, obesity, and sedentary lifestyle.

Despite advances in risk factor management and best medical therapy, PAD and especially CLTI are associated with markedly increased cardiovascular morbidity and mortality, especially in LMICs. Left untreated, the overall risk of limb loss in CLTI is estimated at approximately 25% at 1 year.⁵ However, it will probably be much higher than that for some groups, such as those with extensive tissue loss at presentation. The key to preventing limb loss is aggressive risk factor management and best medical therapy together with timely EBR. There are major differences in amputation rates between and within countries. An increasing number of patients appear to be undergoing revascularization (both endovascular and bypass surgery) in HICs, and at least in part, this may account for a

reduction in amputation. However, improvements in cardiovascular risk management, processes of care, and vascular and endovascular technology may be equally important.

Research priorities for Global epidemiology and risk factors for CLTI

Recommendations	
2.1	Quantify and track the incidence, prevalence, demographics, and risk factors associated with CLTI in different global regions.
2.2	Describe the contemporary natural history of CLTI (including risk to the limb, cardiovascular events, and all-cause mortality in that population) in different global regions.
2.3	Describe the contemporary management strategies used in the treatment of CLTI around the world and the associated outcomes.
2.4	Describe and monitor the incidence and prevalence of nontraumatic lower limb amputation around the globe (eg, the Global Amputation Study, https://GAS.vascunet.org).
2.5	Establish a reliable system to monitor the number of major amputations in as many countries and regions as possible. Time trends and differences around the globe could then be studied.

3. DIAGNOSIS AND LIMB STAGING IN CLTI

Diagnosis and evaluation

The diagnostic evaluation, staging, and imaging of patients with suspected CLTI, leading to EBR, is an integral part of successful treatment. Beyond history and examination, an important new tool is the SVS Threatened Limb Classification System (Wifl), which correlates with the probability of limb salvage and wound healing after revascularization. Fig 3.1 summarizes the recommended evaluation pathway for patients presenting with CLTI that should be followed whenever possible. In patients who are appropriate candidates for revascularization (Section 6), the GLASS (Section 5) anatomic scheme can be used to help define the optimal revascularization strategy.

Recent technologic advances have made the diagnosis and imaging of CLTI more accurate, which in turn allows better selection of patients and planning of revascularization. However, the authors are well aware that access to sophisticated diagnostic modalities and vascular imaging varies considerably around the globe, and as expected, this leads to a wide range of different approaches being employed in different health care settings.²²⁹ As such, it would not be possible or indeed desirable to make firm, prescriptive recommendations in this section. Rather, the aim is to set out broad principles and considerations that can reasonably be used to guide patient evaluation, diagnosis, limb staging, and imaging in most health care environments.

History

Ischemic rest pain usually affects the forefoot, is frequently worse at night, and often requires opiate analgesia for management. If present for >2 weeks and combined with hemodynamic evidence of severely impaired perfusion (eg, absolute AP <50 mm Hg, absolute TP <30 mm Hg), it is diagnostic of CLTI.²³⁰

Ischemic ulceration is frequently located on the toes and forefoot, but other areas may be affected in patients with diabetic neuropathy, altered biomechanics, or foot deformity. Gangrene usually occurs on the forefoot. A range of perfusion deficits may be limb threatening in different scenarios of tissue loss and concomitant infection (Section 1). Thus, all patients presenting with signs or symptoms of suspected CLTI should undergo a complete vascular assessment.

In addition to a carefully documented history of presenting limb complaints, it is important to record details of cardiovascular risk factors, drug history, and previous vascular and endovascular revascularization procedures and amputations.^{230,231} Assessment of frailty, functional status, and HRQL is also important.^{232,233}

Physical examination

All patients with suspected CLTI should undergo a complete physical examination.^{234,235} Palpation of lower limb pulses can help determine the likely presence and distribution of arterial disease.²³⁶⁻²⁴⁰ Although they can be nonspecific, features such as coolness, dry skin, muscle atrophy, hair loss, and dystrophic toenails are frequently observed in patients with PAD. Buerger sign, pallor of the foot on elevation and rubor (so-called sunset foot) on dependency, is usually present in CLTI. The capillary refill time will usually exceed 5 seconds, especially when the patient is lying supine or the leg is elevated.²³⁹ It is important not to examine the patient with suspected CLTI sitting in a chair with the leg hanging down as that may lead to false reassurance regarding the perfusion of the foot.

Many patients with CLTI, especially those with DM, have “glove and stocking”²³⁹ sensory, motor, and autonomic neuropathy that may be asymptomatic or be associated with tingling, numbness, weakness, and burning pain in the feet and ankles. The presence of such neuropathy is a major risk factor for tissue loss and should be carefully sought and evaluated using monofilaments and, if available, a tuning fork (loss of vibration sense is an early feature).²⁴¹⁻²⁴⁴ Neuropathy often leads to abnormal foot biomechanics and deformity, and neuropathic (neuroischemic) ulcers often occur at sites of abnormal pressure (load bearing). In patients with suspected CLTI who have a foot ulcer, a probe-to-bone test should be performed to assess depth and the probability of underlying osteomyelitis.^{245,246}

Recommendations 3		
3.1 Perform a detailed history to determine symptoms, past medical history, and cardiovascular risk factors in all patients with suspected CLTI.		
Grade	Level of evidence	Key references
Good practice statement		
3.2 Perform a complete cardiovascular physical examination of all patients with suspected CLTI.		
Grade	Level of evidence	Key references
Good practice statement		
3.3 Perform a complete examination of the foot, including an assessment of neuropathy and a probe-to-bone test of any open ulcers, in all patients with pedal tissue loss and suspected CLTI.		
Grade	Level of evidence	Key references
Good practice statement		

Noninvasive hemodynamic tests

AP and ABI. Measurement of AP and calculation of ABI (highest AP divided by highest brachial systolic pressure) is recommended as the first-line noninvasive hemodynamic test in all patients with suspected CLTI (Fig 3.1).¹⁹ Although many patients with CLTI will have an AP <50 mm Hg or a markedly reduced ABI (typically <0.4), an increasing proportion will not, especially those with DM and CKD, who may have incompressible crural arteries. ABI results should be reported as noncompressible if the value is >1.4. However, it is important to be aware that incompressibility can lead to artifactually elevated readings between 0.4 and 1.4.²⁴⁷⁻²⁴⁹ This should be suspected when the ABI falls in or near the normal range but is associated with dampened, monophasic waveforms (recognized acoustically or visually on a screen).²³ These falsely normal APs and ABI values have been reported to be an independent predictor of major amputation.²⁵⁰ In such patients, TP and toe-brachial index (TBI) or other hemodynamic measurements, as described next, should always be obtained.²⁵¹

TP and TBI. TP is measured using an appropriately sized mini-cuff typically placed around the base of the great toe and attached to a standard manometer. A photoplethysmographic or continuous-wave Doppler flow detector is then used to determine when flow returns while the inflated cuff is slowly deflated. Various automated systems can be purchased. TPs are less often affected by incompressibility and, if possible, should be measured whenever falsely elevated APs or ABIs are detected or suspected, particularly when such values are nonconcordant with acoustic or visual waveform analysis. Studies have suggested that TP is more sensitive than AP in the diagnosis of CLTI and more predictive of amputation risk.^{21,22} Systolic TPs are generally 20 to 40 mm Hg lower than APs. TBIs <0.7 are considered abnormal and TPs <30 mm Hg are typically associated with advanced ischemia.^{22,230,252}

Other methods for noninvasive diagnosis of CLTI

Alternative noninvasive testing methods can also be used to assist in the diagnosis of CLTI (Table 3.1). Whereas each method has its own advantages and limitations, depending on local availability and expertise, they can be used to augment APs and TPs and indices. Segmental pressures can provide information on anatomic localization of lower limb vascular disease in patients with CLTI but are used infrequently today, at least in HICs. Several other noninvasive tests, including laser Doppler flowmetry, TcPO₂, skin perfusion pressure, and plethysmography, have been used to evaluate limb perfusion.^{16,253} However, these tests can be influenced by a variety of confounding factors and are not used routinely in most vascular laboratories around the world.

Recommendations 3 (continued)		
3.4 Measure AP and ABI as the first-line noninvasive test in all patients with suspected CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Lijmer, ¹⁹ 1996 Dachun, ²⁰ 2010
3.5 Measure TP and TBI in all patients with suspected CLTI and tissue loss (Fig 3.1).		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Aboyans, ²¹ 2008 Salaun, ¹⁶⁹ 2018
3.6 Consider using alternative methods for noninvasive assessment of perfusion, such as PVR, transcutaneous oximetry, or skin perfusion pressure, when ankle and toe pressures, indices, and waveforms cannot be assessed.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Aboyans, ²¹ 2008 Shirasu, ²³ 2016 Salaun, ¹⁶⁹ 2018

Wound and tissue loss classification systems

A number of limb and wound classification systems have been developed to try to improve clinical decision-making and clinical outcomes.²⁵⁴⁻²⁵⁶ The WIfI system¹⁰ is based on three key factors: wound, ischemia, and foot infection (Tables 3.2-3.5). WIfI correlates with limb salvage, amputation risk, and wound healing and can identify patients who are likely to benefit from revascularization.^{68,69}

A limb-staging classification system, such as WIfI, should be used in all patients presenting with suspected CLTI (Tables 3.2-3.5). Limb staging should be repeated after vascular intervention, foot surgery, or treatment of infection and whenever there is suspected clinical deterioration.

Imaging of vascular anatomy

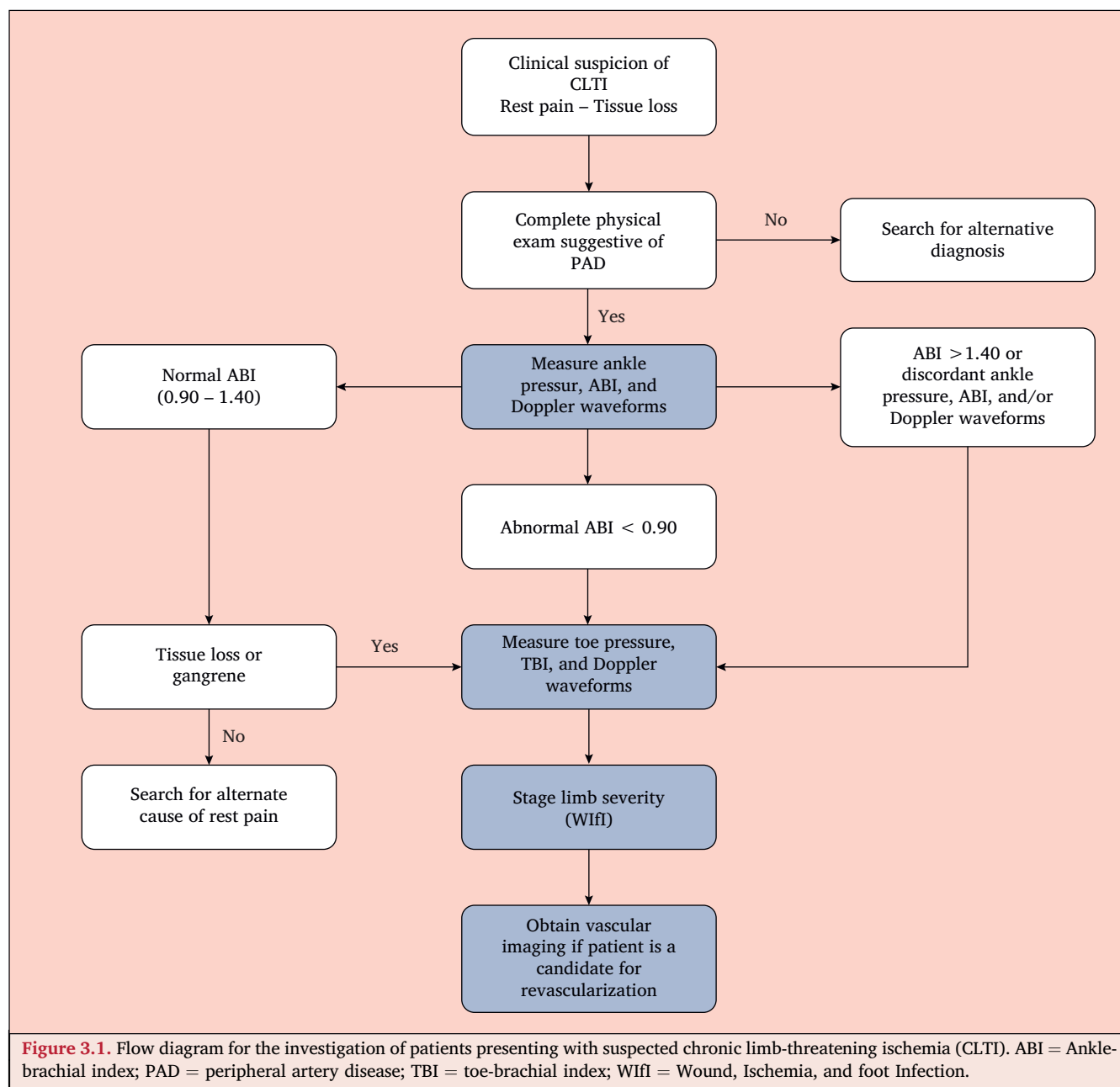
Vascular imaging should be performed in all patients with suspected CLTI (Table 3.6) to determine the presence, extent, and severity of arterial disease and to help inform decisions about revascularization. Although there have been huge advances in imaging techniques in recent years, access to these latest modalities, and so practice, varies considerably between and even within countries.

In patients with CLTI who are candidates for revascularization (Section 6), imaging should allow complete anatomic

staging using, for example, GLASS (Section 5). Adequate imaging of the tibial and pedal vessels is of critical importance, particularly in planning intervention in patients with tissue loss. History and physical examination often help guide the optimal imaging approach. For those with tibial disease, particularly in the setting of tissue loss, computed tomography angiography (CTA) and magnetic resonance angiography (MRA) may offer useful information but may fail to completely image the ankle and foot vessels with sufficient resolution for procedural planning. Many vascular specialists believe that digital subtraction angiography (DSA) remains the “gold standard.” CTA offers more precise quantification of arterial calcification compared with MRA and DSA. Selective intra-arterial dual-energy CTA combines the low contrast material dose of conventional angiography with computed tomography; if it is available, it may allow crural artery visualization in patients with renal insufficiency.²⁵⁷ This technology is in evolution and not routinely available.

Duplex ultrasound imaging (DUS). DUS imaging is usually the first imaging modality of choice and in some health care settings may be the only modality available. DUS provides information on the anatomic location and extent of disease as well as information about flow volume and velocity.^{258,259} There may be difficulty in directly imaging the AI segments because of body habitus, bowel gas, and movement. However, the presence of “inflow” disease can often be inferred from common femoral artery (CFA) waveforms. In the IP arterial segments, assessment can be technically challenging, particularly when vessel calcification and overlying tissue loss are present. Some vascular specialists advocate the use of ultrasound contrast agents to improve visualization; however, clinical studies to date are limited.²⁶⁰ Although multiple studies have shown DUS to be inferior to other imaging techniques, such as DSA, it offers many advantages as a first-line imaging modality, including its noninvasive nature, low cost, no iodinated contrast media, no ionizing radiation, and no fixed installation (mobility).^{25,261,262} The main disadvantages of DUS are that it is time-consuming and highly operator dependent, and it does not produce a continuous lesion map. DUS is also poor at estimating collateral blood supply and reserve. Furthermore, the stored images can be difficult to interpret at a later point in time.

Recommendations 3 (continued)		
3.7 Consider DUS imaging as the first arterial imaging modality in patients with suspected CLTI.		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	Hingorani, ²⁴ 2008
3.8 Consider noninvasive vascular imaging modalities (DUS, CTA, MRA) when available before invasive catheter angiography in patients with suspected CLTI who are candidates for revascularization.		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	Larch, ²⁵ 1997 Adriaensen, ²⁶ 2004 Hingorani, ²⁷ 2004 Collins, ²⁸ 2007 Hingorani, ²⁴ 2008 Met, ²⁹ 2009



CTA. In recent years, CTA has advanced considerably in terms of accuracy and acquisition times. Modern CTA quickly generates high-resolution, contrast-enhanced images that can be viewed in multiple planes or as three-dimensional reconstructions.^{26,263-265} In a meta-analysis comparing CTA with DSA that predominantly included patients with IC, CTA was found to have high sensitivity and specificity in the AI (95% and 96%, respectively) and FP (97% and 94%) segments but was somewhat inferior in the IP segment (95% and 91%).²⁹ The researchers highlighted the difficulties encountered with blooming artifact in calcified arteries (where motion-related artifact causes calcium deposits to appear larger than they truly are), which would probably result in lowered accuracy of this modality in the CLTI population, particularly in the IP segment. As

such, in many centers, CTA is primarily used to image and plan intervention in AI and FP segments.²⁶⁶

Contrast-induced nephropathy can be a significant problem,^{57,267,268} and patients with pre-existing renal insufficiency are at particular risk.²⁶⁹ Various guidelines have been written,^{270,271} and many hospitals have local operating policies to try to mitigate the risks. Unfortunately, practices vary considerably, making it impossible to identify firm recommendations, outside of recognizing the risk. Finally, CTA is associated with significant doses of ionizing radiation.^{26,272}

MRA. MRA has the potential to produce images that are comparable in quality to DSA images but without exposure to ionizing radiation or iodinated contrast material, making contrast-induced nephropathy extremely rare.^{27-29,57,263-269,272-276} Time-resolved techniques can accurately

Table 3.1. Comparison of methods of noninvasive testing in patients with chronic limb-threatening ischemia (CLTI)

Techniques	Advantages	Limitations
AP or ABI	<ul style="list-style-type: none"> • Simple, inexpensive, quick, widely applicable • Provides data to predict wound healing and limb survival • Useful to monitor efficacy of therapeutic intervention 	<ul style="list-style-type: none"> • Because of incompressible tibial arteries, may be falsely elevated or normal in patients with diabetes, renal insufficiency, or advanced age • Does not provide localization of the disease
TP or TBI	<ul style="list-style-type: none"> • Simple, inexpensive, quick • Useful in the presence of small-vessel artery disease • Useful in noncompressible tibial arteries • Provides data to predict wound healing and limb survival • Useful to monitor efficacy of therapeutic intervention 	<ul style="list-style-type: none"> • Generally requires a hallux • Does not provide localization of the disease
Segmental pressures	<ul style="list-style-type: none"> • Useful in initial anatomic localization of CLTI disease • Useful in creating therapeutic plan based on disease localization • Provides data to predict wound healing and limb survival • Useful to monitor efficacy of therapeutic intervention 	<ul style="list-style-type: none"> • Not accurate in noncompressible tibial arteries
TcPO ₂	<ul style="list-style-type: none"> • Useful to assess microcirculation • Can predict wound healing • May be useful for monitoring efficacy of revascularization 	<ul style="list-style-type: none"> • Limited accuracy in the presence of edema or infection • Requires skin heating to ≥40°C • Time-consuming • Limited data validation
Skin perfusion pressure	<ul style="list-style-type: none"> • Useful to assess microcirculation and wound healing potential • May be useful for monitoring efficacy of revascularization • Can be measured in a shorter time compared with TcPO₂ 	<ul style="list-style-type: none"> • Probe size and shape may affect measurements • Limited data validation

ABI = Ankle-brachial index; AP = ankle pressure; TBI = toe-brachial index; TcPO₂ = transcutaneous oximetry; TP = toe pressure. Adapted from Hirsch AT, Haskal ZJ, Hertzner NR, Bakal CW, Creager MA, Halperin JL, et al. ACC/AHA 2005 Practice Guidelines for the management of patients with peripheral arterial disease (lower extremity, renal, mesenteric, and abdominal aortic): a collaborative report from the American Association for Vascular Surgery/Society for Vascular Surgery, Society for Cardiovascular Angiography and Interventions, Society for Vascular Medicine and Biology, Society of Interventional Radiology, and the ACC/AHA Task Force on Practice Guidelines (Writing Committee to Develop Guidelines for the Management of Patients With Peripheral Arterial Disease): endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation; National Heart, Lung, and Blood Institute; Society for Vascular Nursing; TransAtlantic Inter-Society Consensus; and Vascular Disease Foundation. *Circulation* 2006;113:e463-654.

Table 3.2. Wound grading in Wound, Ischemia, and foot Infection (WIFI) classification

Grade (W) Ulcer	Gangrene
0 No ulcer	No gangrene
<i>Clinical description: ischemic rest pain (requires typical symptoms + ischemia grade 3); no wound.</i>	
1 Small, shallow ulcer on distal leg or foot; no exposed bone, unless limited to distal phalanx	No gangrene
<i>Clinical description: minor tissue loss. Salvageable with simple digital amputation (1 or 2 digits) or skin coverage.</i>	
2 Deeper ulcer with exposed bone, joint, or tendon; generally not involving the heel; shallow heel ulcer, without calcaneal involvement	Gangrenous changes limited to digits
<i>Clinical description: major tissue loss salvageable with multiple (≥3) digital amputations or standard TMA ± skin coverage.</i>	
3 Extensive, deep ulcer involving forefoot and/or midfoot; deep, full-thickness heel ulcer ± calcaneal involvement	Extensive gangrene involving forefoot and/or midfoot; full-thickness heel necrosis ± calcaneal involvement
<i>Clinical description: extensive tissue loss salvageable only with a complex foot reconstruction (nontraditional transmetatarsal, Chopart, or Lisfranc amputation); flap coverage or complex wound management needed for large soft tissue defect.</i>	

TMA = Transmetatarsal amputation.

Table 3.3. Ischemia grading in Wound, Ischemia, and foot Infection (WIFI) classification

Grade (I)	ABI	Ankle systolic pressure	TP, TcPO ₂
0	≥0.80	>100 mm Hg	≥60 mm Hg
1	0.6-0.79	70-100 mm Hg	40-59 mm Hg
2	0.4-0.59	50-70 mm Hg	30-39 mm Hg
3	≤0.39	<50 mm Hg	<30 mm Hg

ABI = Ankle-brachial index; TP = toe pressure; TcPO₂ = transcutaneous oximetry.

Flat or minimally pulsatile forefoot pulse volume recording is grade 3. Measure TP or TcPO₂ if ABI incompressible (>1.3). Patients with diabetes should have TP measurements. If arterial calcification precludes reliable ABI or TP measurements, ischemia should be documented by TcPO₂, skin perfusion pressure, or pulse volume recording. If TP and ABI measurements result in different grades, TP will be the primary determinant of ischemia grade.

Table 3.4. Foot infection grading in Wound, Ischemia, and foot Infection (WIFI) classification

Clinical manifestation of infection	Grade (FI)	IDSA/PEDIS infection severity
No symptoms or signs of infection	0	Uninfected
Infection present, as defined by the presence of at least two of the following items: <ul style="list-style-type: none"> • Local swelling or induration • Erythema >0.5 to ≤2 cm around the ulcer • Local tenderness or pain • Local warmth • Purulent discharge (thick, opaque to white, or sanguineous secretion) 	1	Mild
Local infection involving only the skin and the subcutaneous tissue (without involvement of deeper tissues and without systemic signs as described below). Exclude other causes of an inflammatory response of the skin (eg, trauma, gout, acute Charcot neuro-osteoarthropathy, fracture, thrombosis, venous stasis).		
Local infection (as described above) with erythema >2 cm or involving structures deeper than skin and subcutaneous tissues (eg, abscess, osteomyelitis, septic arthritis, fasciitis) and no systemic inflammatory response signs (as described below).	2	Moderate
Local infection (as described above) with the signs of SIRS, as manifested by two or more of the following: <ul style="list-style-type: none"> • Temperature >38°C or <36°C • Heart rate >90 beats/min • Respiratory rate >20 breaths/min or Paco₂ <32 mm Hg • White blood cell count >12,000 or <4000 cells/mm³ or 10% immature (band) forms 	3	Severe ^a

IDSA = Infectious Diseases Society of America; Paco₂ = partial pressure of arterial carbon dioxide; PEDIS = perfusion, extent, depth, infection, and sensation; SIRS = systemic inflammatory response syndrome; SVS = Society for Vascular Surgery.

^a Ischemia may complicate and increase the severity of any infection. Systemic infection may sometimes be manifested with other clinical findings, such as hypotension, confusion, and vomiting, or evidence of metabolic disturbances, such as acidosis, severe hyperglycemia, and new-onset azotemia.

image flow patterns, which can be helpful in assessing IP runoff. In a meta-analysis, MRA also showed improved specificity and sensitivity over CTA and DUS.²⁷⁶ Whereas conventional time-of-flight MRA sequences may overestimate the degree of arterial stenosis, newer techniques suggest that noncontrast-enhanced MRA remains an excellent imaging modality for patients with CLTI, accurately assessing distal lower extremity vessels.²⁷⁷ However, failure of MRA to visualize vessel wall calcification may underestimate the difficulty of surgical and endovascular revascularization. Contrast-enhanced MRA (CE-MRA) using gadolinium-based contrast agents is generally preferred

because of the high contrast to noise ratio, better spatial resolution, more rapid acquisition, and less artifact. Time-resolved MRA is particularly useful in imaging of IP disease.²⁷⁴ Finally, MRA produces a three-dimensional map of the overall arterial tree, with the possibility of additional accurate mapping of the IP and foot vessels in more specialized centers. Other challenges of MRA include the potential overestimation of stenoses, problems visualizing in-stent restenosis, compatibility with implanted devices such as pacemakers and defibrillators, longer image acquisition times, and image artifact. Patients often have a lower tolerance for MRA than for CTA because of

Table 3.5. Clinical stages of major limb amputation risk based on Wound, Ischemia, and foot Infection (WIFI) classification

Risk of amputation	Proposed clinical stages	WIFI spectrum score
Very low	Stage 1	W0 I0 fi0,1
		W0 I1 fi0
		W1 I0 fi0,1
		W1 I1 fi0
Low	Stage 2	W0 I0 fi2
		W0 I1 fi1
		W0 I2 fi0,1
		W0 I3 fi0
		W1 I0 fi2
		W1 I1 fi1
Moderate	Stage 3	W1 I2 fi0
		W2 I0 fi0/1
		W0 I0 fi3
		W0 I2 fi1,2
		W0 I3 fi1,2
		W1 I0 fi3
		W1 I1 fi2
		W1 I2 fi1
		W1 I3 fi0,1
		W2 I0 fi2
		W2 I1 fi0,1
		W2 I2 fi0
High	Stage 4	W3 I0 fi0,1
		W0 I1,2,3 fi3
		W1 I1 fi3
		W1 I2,3 fi2,3
		W2 I0 fi3
		W2 I1 fi2,3
		W2 I2 fi1,2,3
		W2 I3 fi0,1,2,3
W3 I0 fi2,3		
W3 I1,2,3 fi0,1,2,3		

Clinical descriptors: Stage 1: minimal ischemia; no/minor tissue loss. Stages 2-4 reflect increasing stages of ischemia, wound, and infection. Stage 5 (not shown in table): unsalvageable foot (most often due to wound extent or severity of infection).

claustrophobia. Accurate interpretation of the images by a dedicated subspecialist, such as a vascular radiologist, is essential in aiding revascularization strategies. MRA equipment is expensive, although it can be used for other nonvascular magnetic resonance-based investigations. Thus, in some developing and developed countries, access to MRA and to dedicated subspecialists who are available to interpret the images is scarce.²²⁹ Finally, gadolinium contrast enhancement has been associated with cases of nephrogenic systemic fibrosis, primarily in individuals with an estimated glomerular filtration rate of <30 mL/min/1.73 m².²⁷⁸

Foot MRA. CLTI patients have a high incidence of IP and pedal artery disease. The precise location, length, and severity of disease as well as the patency of runoff vessels

should ideally be delineated before revascularization planning. In highly specialized centers, compared with DSA, foot CE-MRA yielded a sensitivity of 92% for the detection of significant disease in IP and pedal vessels.²⁷⁹ Magnetic resonance perfusion imaging may have a role in assessing overall foot perfusion before and after intervention.^{280,281} As for limitations of foot CE-MRA, in slow-flow states, there may be significant venous overlay obscuring arterial anatomy, and the availability of the modality is limited.

In summary, MRA is still an evolving technology with new contrast-enhanced and noncontrast-enhanced sequences being reported in the literature. Time will tell whether these advances will overcome some of the current limitations. However, access to the most modern imaging techniques is highly variable around the world.

Recommendations 3 (continued)		
3.9 Obtain high-quality angiographic imaging of the lower limb (with modalities and techniques to be determined by local available facilities and expertise). This should include the ankle and foot in all patients with suspected CLTI who are considered potential candidates for revascularization.		
Grade	Level of evidence	Key references
Good practice statement		-

Catheter DSA. With the advent of DUS, CTA, and MRA, diagnostic DSA is probably performed less commonly now, but many vascular specialists still consider it the gold standard imaging modality in patients with suspected CLTI, particularly when IP disease is likely to be present.²⁸² Enthusiasts for DSA will also point out that it allows intervention at the same setting. Other vascular specialists, however, argue that diagnostic DSA is outdated. The DSA technique should minimize the amount of iodinated contrast material and the dose of ionizing radiation used while maximizing imaging of the distal vasculature.^{268,283-285} In general, diagnostic DSA is widely available, and the complication rate is low.^{283,286}

CO₂ angiography. CO₂ angiography can be used in patients with an allergy to contrast material or in individuals with severe CKD; unfortunately, it frequently causes significant discomfort of the patient. CO₂ angiography is generally considered inferior to iodinated angiography but can still provide useful diagnostic images. There is a general trend of imaging performance progressively degrading down the leg.²⁸⁷ Power injectors may improve safety and quality.

Perfusion angiography. This is a new technique performed with use of a dedicated imaging suite and workstation to provide time-resolved perfusion imaging of the foot to aid in the diagnosis and impact of revascularization techniques. Perfusion angiography provides quantifiable information of

Table 3.6. Comparison of different imaging modalities for patients with chronic limb-threatening ischemia (CLTI)

Techniques	Advantages	Limitations
DUS	<ul style="list-style-type: none"> • Noninvasive • Inexpensive • Quick, widely available worldwide • Useful to monitor efficacy of therapeutic intervention 	<ul style="list-style-type: none"> • Highly operator dependent • Limitations to the visualization of iliac arteries due to body habitus, bowel gas • Calcification may produce incomplete examination • Most DUS studies were performed in mixed populations; thus, the validity of DUS imaging for CLTI patients alone is uncertain
CTA	<ul style="list-style-type: none"> • Noninvasive • Excellent patient acceptance • Ability to evaluate previously stented arteries • Mostly applicable in patients with contraindications to MRA 	<ul style="list-style-type: none"> • Image interference from calcified arteries • Potentially nephrotoxic contrast agents • Radiation exposure • Less reliable for imaging of IP vessels • Patients with CLTI who require a complete assessment of their lower extremity (including foot) arteries for planning of a revascularization are under-represented in the current studies. The clinical value of CTA in the CLTI target population remains uncertain.
MRA	<ul style="list-style-type: none"> • Noninvasive • Eliminates exposure to ionizing radiation • Unaffected by arterial calcification • Three-dimensional images of the entire arterial tree are presented in a maximum intensity projection format produced on a workstation • Easily produced arterial map aids in planning of revascularization strategies 	<ul style="list-style-type: none"> • Patients with pacemakers and defibrillators and some cerebral clips cannot be scanned safely • Tendency to overestimate stenosis • Metal clips can cause artifacts that mimic vessel occlusions • Venous contamination can obscure arteries below the knee
Catheter angiography (DSA)	<ul style="list-style-type: none"> • Provides a complete map of the lower limb arteries • Images are easily displayed and interpreted by most physicians in charge of patients with CLTI • Selective catheter placement during lower extremity angiography enhances imaging, reduces contrast material dose, and enhances sensitivity in patients with CLTI 	<ul style="list-style-type: none"> • Exposure to ionizing radiation and contrast media • Alternatively, carbon dioxide and magnetic resonance contrast agents (eg, gadolinium) can be used instead of conventional contrast media • Complications of catheterization despite improvements in catheter and guidewire technology

CTA = Computed tomography angiography; DSA = digital subtraction angiography; DUS = duplex ultrasound; IP = infrapopliteal; MRA = magnetic resonance angiography.

the functional status of foot perfusion and is a positive step toward functional imaging of the foot.²⁸⁸

Summary

All patients presenting with CLTI should have a full history and physical examination followed by noninvasive hemodynamic testing. These studies can be easily performed in most centers around the world. The authors recommend that all patients undergo limb staging by a classification system, such as Wifl, that integrates multiple key elements (eg, wound, ischemia, infection) and correlates with the risk of amputation and the likelihood of wound healing. The next step in appropriate candidates (Section 6) is to obtain high-quality diagnostic images to guide revascularization. This will depend heavily on the availability of equipment and local expertise (Fig 3.2). Where it is available, DUS is the preferred first noninvasive imaging modality. However, for more complete noninvasive anatomic imaging, either MRA or CTA can be considered.

Catheter DSA represents the gold standard imaging technique, especially below the knee. In many centers,

however, DSA is typically used only when MRA or CTA is not available, when MRA or CTA imaging is suboptimal and fails to adequately define the arterial anatomy, or for those patients expected to proceed to endovascular intervention. No patient with suspected CLTI who is a suitable candidate for limb salvage should be denied revascularization without first undergoing complete diagnostic angiography that includes the ankle and foot.

Research priorities for diagnosis and limb staging in CLTI	
Recommendations	
3.1	Define optimal methods for measuring foot perfusion and its correlation with stages of disease and response to treatment.
3.2	Validate contrast-enhanced ultrasound in patients with CLTI.
3.3	Define optimal strategies to reduce the incidence of contrast-induced nephropathy in patients with CLTI.
3.4	Improve noninvasive imaging of the ankle and foot vascular tree using MRA.

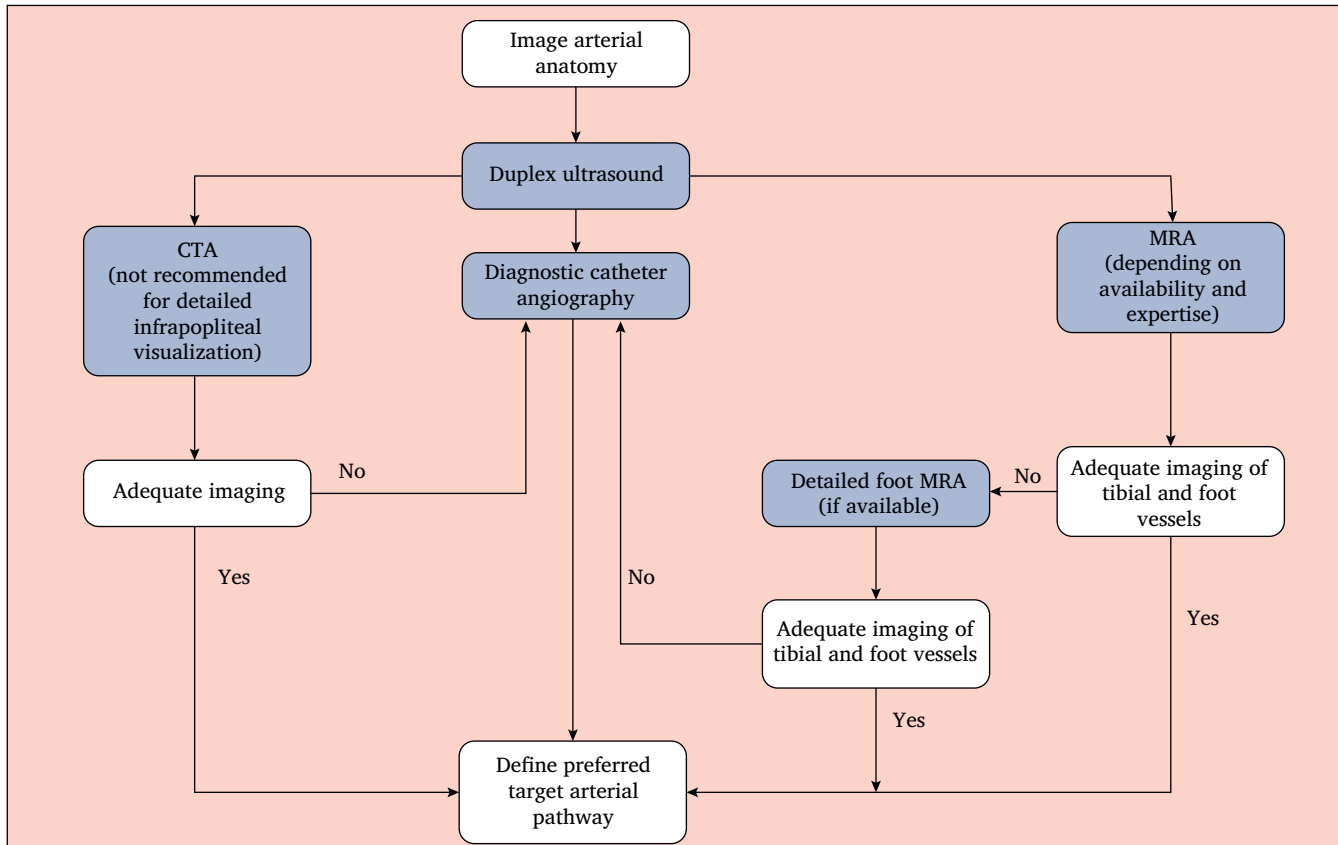


Figure 3.2. Suggested algorithm for anatomic imaging in patients with chronic limb-threatening ischemia (CLTI) who are candidates for revascularization. In some cases, it may be appropriate to proceed directly to angiographic imaging (computed tomography angiography [CTA], magnetic resonance angiography [MRA], or catheter) rather than to duplex ultrasound (DUS) imaging.

4. MEDICAL MANAGEMENT

CLTI is an end-stage manifestation of systemic atherosclerosis. It is frequently accompanied by clinically significant CVD, resulting in exceedingly high mortality from stroke and myocardial infarction. In the absence of aggressive identification and treatment of risk factors and associated comorbid conditions, the prognosis of CLTI is usually poor, with a mortality rate of 20% to 26% within 1 year of diagnosis.^{5,30,154,213,219,220,230,289}

In a study of 574 patients with CLTI who did not undergo revascularization after 2 years, 31.6% had died, primarily of CVD, and 23% required major amputation.²⁹⁰

The goal of treatment of patients with CLTI is not only to salvage a functional limb but to reduce cardiovascular morbidity and mortality through aggressive risk factor modification and best medical therapy.^{31,32,224} Whereas certain risk factors, such as age and sex, cannot be modified, others can, including hyperlipidemia, hypertension, diabetes, smoking, and sedentary lifestyle.

Recommendations 4		
4.1 Evaluate cardiovascular risk factors in all patients with suspected CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	I.C.A.I. group, ³⁰ 1997
4.2 Manage all modifiable risk factors to recommended levels in all patients with suspected CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Armstrong, ²²⁴ 2014 Faglia, ³² 2014

Antithrombotic therapy

Antiplatelet agents are strongly recommended for all patients with symptomatic PAD to reduce the risk of major adverse cardiovascular events (MACE).^{33,34,291} The Antithrombotic Trialists' Collaboration performed a meta-analysis of antiplatelet agent trials before 1997.³³ It included 135,000 patients with cerebrovascular disease, coronary disease, or PAD (IC) who were treated with antiplatelet agents and 77,000

control patients. The antiplatelet therapy group had a 22% reduction in MACEs, and 75 to 150 mg of aspirin per day was as effective as higher doses but with a lower risk of bleeding.³³ A more recent meta-analysis studied the specific benefit of aspirin in 16 secondary prevention trials comprising 17,000 patients.³⁴ This study confirmed the benefit of antiplatelet agents with an 18.2% reduction in MACEs in both men and women. The Critical Leg Ischaemia Prevention Study (CLIPS) group compared the benefit of 100 mg of aspirin per day in 185 patients with symptoms of PAD and an ABI <0.85 or a TBI <0.6 with placebo and reported a 64% risk reduction in vascular events compared with a 24% reduction in the placebo group.²⁹¹

However, there is a growing body of literature indicating that alternatives to aspirin, such as ticlopidine, dipyridamole, and clopidogrel, may be more effective.^{35,292-294} The Clopidogrel versus Aspirin in Patients at Risk for Ischaemic Events (CAPRIE) trial, although not specifically designed to address CLTI, compared 75 mg of clopidogrel per day with 325 mg of aspirin per day in patients with PAD. Researchers noted an 8.7% decrease in MACEs with clopidogrel compared with aspirin. There was no significant difference in bleeding risks between the two agents.³⁵

Other antiplatelet agents, such as ticagrelor and vorapaxar, have also been shown to reduce MACEs in patients with PAD.²⁹²⁻²⁹⁴ However, benefit over clopidogrel has not been demonstrated.^{36,294-298} The Examining Use of Ticagrelor in Peripheral Artery Disease (EUCLID) trial compared ticagrelor with clopidogrel in 13,885 patients with symptomatic PAD and an ABI ≤0.8.³⁶ Although both drugs had a similar safety profile, ticagrelor was not superior to clopidogrel. The Trial to Assess the Effects of Vorapaxar in Preventing Heart Attack and Stroke in Patients with Atherosclerosis-Thrombolysis in Myocardial Infarction 50 (TRA2°P-TIMI 50) examined the effects of the protease-activated receptor 1 antagonist vorapaxar on secondary prevention of ischemia events in patients with stable atherosclerosis, including symptomatic PAD.²⁹⁵ Acute limb ischemia, a prespecified study end point, was reduced by 41% among the PAD cohort.²⁹⁸ However, vorapaxar has been associated with an increase in intracranial hemorrhage in patients who have had a prior stroke or transient ischemic attack.²⁹⁶ In a meta-analysis, vorapaxar added to aspirin yielded little improvement in the reduction of MACEs in patients with atherosclerosis and was associated with a slightly higher incidence of intracranial hemorrhage.²⁹⁴ Finally, a meta-analysis that reviewed the use of ticagrelor, ticlopidine, aspirin, cilostazol, picotamide, vorapaxar, and clopidogrel as single antiplatelet therapy or dual antiplatelet therapy (DAPT) in patients with PAD found that clopidogrel monotherapy resulted in the best overall safety and efficacy (reduction of MACEs).²⁹⁷

The long-term use of DAPT or systemic anticoagulation with vitamin K antagonists is not indicated for PAD.^{299,300} The role of direct oral anticoagulants is currently the subject of intense investigation. The Cardiovascular Outcomes for People Using Anticoagulation Strategies (COMPASS) trial, a multicenter randomized trial of 7470 individuals with

stable, mild to moderate PAD, found that low-dose rivaroxaban (an oral factor Xa inhibitor) in combination with aspirin reduced MACEs (death, myocardial infarction, or stroke) and major adverse limb events (MALEs) compared with aspirin alone.³⁷ Patients who had previous lower extremity revascularization, amputation, or history of IC and ABI of <0.9 and documented peripheral stenosis of >50% or carotid stenosis of >50% were included in the study. Overall, 8.5% of study patients had an ABI of <0.7. In this population, there was a significant reduction in MALEs, major amputation, and acute limb ischemia compared with aspirin alone.³⁰¹ This drug combination was associated with a small but statistically significant increase in clinically relevant bleeding. Whereas the study results are promising, the benefits and risks of the low-dose rivaroxaban and low-dose aspirin combination in patients with CLTI have not yet been adequately defined. In addition, this drug combination is not globally available at this time.

The ongoing VOYAGER trial ([ClinicalTrials.gov](https://clinicaltrials.gov) identifier NCT02504216) is comparing the same two antithrombotic regimens in PAD patients undergoing peripheral revascularization.³⁰²

Recommendations 4 (continued)		
4.3 Treat all patients with CLTI with an antiplatelet agent.		
Grade	Level of evidence	Key references
1 (Strong)	A (High)	Antithrombotic Trialists' Collaboration, ³³ 2002 Antithrombotic Trialists' Collaboration, ³⁴ 2009
4.4 Consider clopidogrel as the single antiplatelet agent of choice in patients with CLTI.		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	CAPRIE, ³⁵ 1996 Hiatt, ³⁶ 2017
4.5 Consider low-dose aspirin and rivaroxaban, 2.5 mg twice daily, to reduce adverse cardiovascular events and lower extremity ischemic events in patients with CLTI.		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	Anand, ³⁷ 2018
4.6 Do not use systemic vitamin K antagonists for the treatment of lower extremity atherosclerosis in patients with CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Anand, ³⁸ 2007

Lipid-lowering therapy

The Heart Protection Study (HPS) evaluated the effect of blood lipid lowering on cardiovascular events in PAD and included patients with CLTI.⁴⁰ Other studies, although similar, limited inclusion to patients with IC.⁴¹ The HPS included 20,536 high-risk individuals with a total cholesterol concentration of at least 135 mg/dL (3.5 mmol/L). The participants were randomized to 40 mg/d of simvastatin or a placebo. In the simvastatin group, there was a 25% (95% CI, 16%-33%) relative risk (RR) reduction in the first major vascular event among patients who had no history of a coronary event at baseline.⁴⁰ In addition, lipid lowering was shown to be most effective in

patients with a blood cholesterol concentration >135 mg/dL (> 3.5 mmol/L). There was also a significant reduction in cardiovascular events ($P < .0001$) among a subgroup of individuals with PAD.

A Cochrane review evaluated 18 lipid-lowering trials comprising 10,049 PAD patients.^{39,42} Whereas the majority had IC and only some trials included CLTI, the results appear relevant to the CLTI population. Only one study showed a negative effect of lipid lowering. When this study was excluded, analysis showed that lipid-lowering therapy significantly reduced the risk of total cardiovascular events in PAD (OR, 0.74; CI, 0.55-0.98).⁴² This was primarily due to a positive effect on total coronary events (OR, 0.76; CI, 0.67-0.87).

The impact of statin agents may extend beyond their lipid-lowering effect by reducing inflammation in patients with PAD.^{303,304} An individual-patient data meta-analysis of 54 prospective cohort studies demonstrated that inflammatory biomarkers independently predict vascular risk with a magnitude of effect at least as large as that of blood pressure or cholesterol.³⁰⁵ Even after adjustment for age, sex, and traditional risk factors, patients with PAD are known to have increased levels of inflammatory cytokines, acute phase reactants, and soluble adhesion molecules.³⁰⁶ However, although the attributable vascular risk associated with inflammation is large and animal models using targeted anti-inflammatory therapies have shown promise, it remains unknown whether inhibiting inflammation alone will lower vascular event rates.

The landmark Justification for the Use of Statins in Prevention: an Intervention Trial Evaluating Rosuvastatin (JUPITER) examined the use of intensive statin therapy (rosuvastatin 20 mg daily vs placebo) in a primary prevention trial.^{307,308} In total, there were 17,802 individuals who had low levels of LDL-C but an elevated vascular risk based on a proinflammatory biomarker (high levels of high-sensitivity C-reactive protein). Investigators demonstrated a 44% reduction in major vascular events, including a 54% reduction in myocardial infarction, a 48% reduction in stroke, a 46% reduction in arterial revascularization, a 43% reduction in deep venous thrombosis or pulmonary embolism, and a 20% reduction in mortality. The greatest absolute risk and the greatest absolute risk reduction were observed among those with the highest levels of high-sensitivity C-reactive protein. There are now multiple studies showing a decrease in cardiovascular events in patients with established atherosclerosis treated with intensive statin therapy.^{43,224,309,310} A large retrospective cohort study from the U.S. Veterans Affairs population demonstrated reduced mortality and major amputation rates among patients with established PAD receiving intensive-dose statins.³¹¹ Statin therapy can be associated with muscle aching, the most common adverse effect limiting its use. In the setting of this complication, statin dose can be lowered to the maximum tolerated dose, and a second nonstatin cholesterol-lowering drug can be added to reduce cholesterol levels even further.

Recent (2013, 2018) American College of Cardiology/American Heart Association guidelines on treatment of blood

cholesterol recommend the use of moderate- to high-intensity statins for all individuals with established atherosclerotic CVD including PAD.^{312,313} Both rosuvastatin (20-40 mg) and atorvastatin (40-80 mg) have been shown to be effective.³¹⁰ The 2018 guideline describes “very high risk” individuals to include those with symptomatic PAD and at least one other high-risk condition (age ≥ 65 years, familial hypercholesterolemia, history of coronary revascularization, DM, hypertension, CKD, current smoking, congestive heart failure)—a categorization that applies to the overwhelming majority of patients with CLTI. For this population, high-intensity/maximally tolerated statin dosing is recommended, and if on-treatment LDL-C levels remain ≥ 70 mg/dL (1.8 mmol/L), the addition of ezetimibe is considered reasonable.³¹³

New lipid-lowering agents have entered the armamentarium. Proprotein convertase subtilisin/kexin type 9 (PCSK9) directs the degradation of LDL receptors in the liver and has become a drug target. The Further Cardiovascular Outcomes Research with PCSK9 Inhibition in Subjects with Elevated Risk (FOURIER) RCT demonstrated an additional benefit of evolocumab (a PCSK9 inhibitor) in reducing MACEs in PAD patients already receiving statin therapy.³¹⁴ The composite end point of cardiovascular death, myocardial infarction, stroke, hospital admission for unstable angina, or coronary revascularization was statistically reduced in PAD patients treated with the PCSK9 inhibitor evolocumab (hazard ratio [HR], 0.79; $P = .0040$). There was also a reduction in the risk of MALEs, including acute limb ischemia and major amputation. Further studies will be needed in PAD subpopulations including CLTI.

Further studies of these agents are desirable in high-risk PAD subpopulations including CLTI.

Recommendations 4 (continued)		
4.7 Use moderate- or high-intensity statin therapy to reduce all-cause and cardiovascular mortality in patients with CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	A (High)	Leng, ³⁹ 2000 Heart Protection Study Group, ⁴⁰ 2002 Meade, ⁴¹ 2002 Aung, ⁴² 2007 Mills, ⁴³ 2011 Rodriguez, ⁴⁴ 2017

Management of hypertension

It is universally accepted that control of hypertension reduces MACEs in patients with PAD. The International Verapamil-SR/Trandolapril Study (INVEST) analyzed the impact of control of hypertension on all-cause death, nonfatal myocardial infarction, and nonfatal stroke in 22,576 hypertensive patients with stable coronary artery disease (CAD), of whom 2699 also had PAD.⁴⁶ PAD patients had a significantly higher incidence of sustaining a primary end point MACE compared with those without PAD (16.3% vs 9.2%). In addition, among those with PAD, a MACE was less likely to occur in patients with systolic blood

pressure <145 mm Hg and diastolic pressures <90 mm Hg. Further reduction of blood pressure to below 130 mm Hg systolic and 80 mm Hg diastolic provides even greater protection from cardiovascular events.⁴⁸ The Systolic Blood Pressure Intervention Trial (SPRINT) compared blood pressure control with a systolic pressure of 120 mm Hg (intensive control) or 140 mm Hg (standard control) in 2510 patients with a mean age of 79.9 years observed for a mean of 3.14 years.³¹⁵ The study documented a significantly lower incidence of composite cardiovascular events of death with intensive control. However, intensive blood pressure control may result in greater morbidity associated with periods of clinically significant hypotension.^{45,47} Optimal blood pressure control for patients with CLTI has not been established, and although maintaining systolic pressure <140 mm Hg and diastolic pressure <90 mm Hg is important, lower pressures may be beneficial to further reduce MACEs.

The first-line category of oral antihypertensive does not appear to be of significance. Angiotensin-converting enzyme inhibitors (ACEIs), calcium channel blockers, and diuretics, when successful in lowering blood pressure to target, reduce cardiovascular events to a similar extent.^{316,317} Although the Ongoing Telmisartan Alone and in Combination with Ramipril Global Endpoint Trial (ONTARGET) and Heart Outcomes Prevention Evaluation (HOPE) study suggested that in the absence of heart failure, monotherapy with an ACEI (ramipril) reduces the rate of MACEs in high-risk patients, there is recent evidence to suggest that this class of drug may result in a higher amputation rate for patients with CLTI.³¹⁸ In an analysis of the Medicare database for 2007 to 2008, there were 22,954 patients who underwent lower extremity revascularization. Of these, 64.6% were treated for CLTI. Compared with those not taking an ACEI, patients who presented with rest pain and were taking an ACEI after the index procedure had a higher risk of amputation. Other studies have not noted an increased risk of amputation associated with ACEIs but have suggested an increased rate of reintervention. A propensity score-matched cohort study of 17,495 Danish patients compared those receiving ACEIs with those who were not after vascular reconstruction. Observed for a mean of 1.6 years, the patients treated with ACEIs had a lower all-cause mortality (20.4% vs 24.9%) but underwent more reintervention (24% vs 23.1%).³¹⁹ Using the same general methodology, these investigators found that the use of beta blockers after primary vascular reconstruction was associated with a decrease in the incidence of major amputation but a higher rate of myocardial infarction and stroke without an increase in all-cause mortality.³²⁰

Globally, adequate control of hypertension remains a significant challenge. In LMICs, the availability of oral antihypertensives is limited and costs are high, resulting in poor overall blood pressure control. Strategies are urgently required to improve availability and affordability of drugs so that vascular specialists can treat their patients to target.³²¹

There have been concerns that drugs reducing heart rate and blood pressure will worsen ischemia in patients with

PAD. Although beta blockade has not been directly evaluated in CLTI, it has been the subject of several clinical trials in IC and has been shown to be effective in lowering blood pressure without worsening symptoms.^{322,323}

Recommendations 4 (continued)		
4.8 Control hypertension to target levels of <140 mm Hg systolic and <90 mm Hg diastolic in patients with CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	ACCORD Study Group, ⁴⁵ 2010 Bavry, ⁴⁶ 2010 Wright, ⁴⁷ 2015 Moise, ⁴⁸ 2016

Management of diabetes

Type 2 DM is a significant risk factor for PAD,^{324,325} and the extent of vascular disease appears related to the duration and severity of hyperglycemia. Glycemic control is therefore essential in all diabetic patients with PAD. Metformin monotherapy is generally recognized as the best initial oral hypoglycemic agent. When additional therapy is needed, any other class of oral hypoglycemic agent, including sulfonylurea, thiazolidinedione, dipeptidyl peptidase 4 inhibitor, or α -glucosidase, can be added with equal effectiveness.⁵⁴

Sodium-glucose co-transporter 2 (SGLT-2) inhibitors are a newer class of agents that have been associated with beneficial effects on cardiovascular complications, renal disease, and mortality in type 2 diabetics. However, one large trial (10,142 subjects) demonstrated an approximately 2-fold increased risk of lower limb amputations associated with the use of canagliflozin, an SGLT-2 inhibitor, prompting a “black-box” warning.³²⁶⁻³²⁸ The mechanism is unclear and may be generically related to diuretic actions in this population.³²⁹ Caution is advised in the use of this agent in diabetic patients with advanced PAD and/or CLTI.

Whereas there are some data to suggest that the dipeptidyl peptidase 4 inhibitors may reduce the risks of myocardial infarction and stroke, the impact on PAD in patients with CLTI has not yet been defined.³³⁰ The goal for most adults with DM is to maintain a glycosylated hemoglobin A_{1c} level of <7% (equivalent to International Federation of Clinical Chemistry units of 53 mmol/mol).⁴⁹⁻⁵² However, less stringent goals (eg, hemoglobin A_{1c} level <8%) may be appropriate for individuals with advanced vascular complications or limited life expectancy.⁵³

Type 2 DM patients with abnormal renal function treated with metformin may be at higher risk for contrast-induced nephropathy and lactic acidosis. Whereas the matter is the subject of continued debate, it is reasonable to withhold metformin for 24 to 48 hours after the administration of an iodinated contrast agent.^{55-57,270,271}

Recommendations 4 (continued)		
4.9 Consider control of type 2 DM in CLTI patients to achieve a hemoglobin A_{1c} of <7% (53 mmol/mol [International Federation of Clinical Chemistry]).		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	Selvin, ⁴⁹ 2004 Nathan, ⁵⁰ 2005 van Dieren, ⁵¹ 2014 Fox, ⁵² 2015 American Diabetes Association, ⁵³ 2018
4.10 Use metformin as the primary hypoglycemic agent in patients with type 2 DM and CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	A (High)	Palmer, ⁵⁴ 2016
4.11 Consider withholding metformin immediately before and for 24 to 48 hours after the administration of an iodinated contrast agent for diabetic patients, especially those with an estimated glomerular filtration rate <30 mL/min/1.73 m².		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Nawaz, ⁵⁵ 1998 Goergen, ⁵⁶ 2010 Stacul, ⁵⁷ 2011

Lifestyle modifications

In addition to controlling risk factors as discussed, it is important to encourage CLTI patients to adopt a healthier lifestyle. Stopping smoking (tobacco and other recreational drugs) completely and permanently, adopting a healthy diet and weight control, and regular exercise must be stressed as extremely important for both life and limb.^{331,332}

Tobacco

The adverse impact of tobacco use on cardiovascular health has been well established. Despite the use of best medical therapy, male and female smokers (even those smoking 1-10 cigarettes per day) have a significantly higher rate of disease progression and MACEs.⁵⁸⁻⁶⁰ Thus, all patients presenting with CLTI should be asked about smoking and referred to a smoking cessation program if they are still smoking. To encourage compliance with advice to stop smoking, patients should be challenged about smoking at every medical encounter.^{61,62} The safety of electronic cigarettes has not been established, including for patients with PAD, and until more evidence becomes available should not be considered in patients with CLTI.³³³

Recommendations 4 (continued)		
4.12 Offer smoking cessation interventions (pharmacotherapy, counseling, or behavior modification therapy) to all patients with CLTI who smoke or use tobacco products.		
Grade	Level of evidence	Key references
1 (Strong)	A (High)	Dagenais, ⁵⁸ 2005 Athyros, ⁵⁹ 2013 Blomster, ⁶⁰ 2016
4.13 Ask all CLTI patients who are smokers or former smokers about status of tobacco use at every visit.		
Grade	Level of evidence	Key references
1 (Strong)	A (High)	Kondo, ⁶¹ 2011 Newhall, ⁶² 2017

Diet and exercise

Although diet and exercise have not been specifically evaluated in CLTI, there is compelling evidence that they affect the progression of atherosclerosis. Diets that are high in carbohydrates and saturated fats are associated with a higher risk of MACEs.³³⁴ A diet that reduces the intake of saturated fats and increases the intake of monounsaturated fats, omega-3 fatty acids, antioxidants, and other natural plant sterols and stanols is associated with a reduction in plaque burden and MACEs.³³⁵⁻³³⁷ Patients should be encouraged to adopt a low-fat or Mediterranean diet.³³⁸ Unfortunately, fruits and vegetables are not always available or affordable, especially in LMICs.³³⁹

Although CLTI studies are not available, numerous trials have confirmed the benefits of supervised exercise in IC.³⁴⁰ Exercise-based cardiac rehabilitation reduces the risk of subsequent myocardial infarction and cardiovascular mortality.³⁴¹ It therefore seems reasonable to suggest that a post-revascularization walking-based exercise program would also benefit CLTI patients who are cleared for full weight-bearing.

Management of pain

Although pain is an important issue for most CLTI patients, it is often poorly managed. Poor pain control can reduce HRQL levels to those seen in patients with terminal cancer and has a major adverse impact on functional capacity.

As no RCTs have been conducted in CLTI, good practice recommendations have to be extrapolated from other conditions in which severe pain is a major factor. The management of ischemic pain in CLTI is often complicated by the coexisting neuropathic pain, particularly in patients with DM. However, the management of neuropathic pain is not covered here.

Guidelines usually recommend a tiered approach to pain management, with a "tradeoff" between benefits and harms (eg, constipation, drowsiness).^{342,343} Patients should be offered paracetamol (acetaminophen) in combination with opioids and in proportion to the severity of pain. All patients receiving opioids should also be offered laxatives and anti-nausea medication. If the maximum tolerated analgesic dose does not produce adequate pain relief, alternative approaches should be considered. These include tricyclic antidepressants, gabapentin, and pregabalin, all of which are used effectively for neuropathic pain. However, if the clinician is unfamiliar with the use of these compounds, early referral to a pain management service for patients with pain not controlled by opioids is required.

Recommendations 4 (continued)		
4.14 Prescribe analgesics of appropriate strength for CLTI patients who have ischemic rest pain of the lower extremity and foot until pain resolves after revascularization.		
Grade	Level of evidence	Key references
Good practice statement	-	-
4.15 In CLTI patients with chronic severe pain, use paracetamol (acetaminophen) in combination with opioids for pain control.		
Grade	Level of evidence	Key references
Good practice statement	-	-

Research priorities for medical management	
Recommendations	
4.1	Define the optimal antithrombotic regimen (safety and efficacy) in patients with CLTI to reduce cardiovascular and limb-specific events.
4.2	Define treatment targets and optimal dosing for lipid-lowering agents in the CLTI population.
4.3	Identify biomarkers predictive of clinical events in the CLTI population that may serve as targets for therapy.
4.4	Identify effective smoking cessation strategies for patients with advanced PAD and CLTI.
4.5	Identify the type of analgesia that is most effective in patients with chronic pain secondary to CLTI.

5. THE GLOBAL LIMB ANATOMIC STAGING STAGING SYSTEM (GLASS)

Rationale

An accurate assessment of limb threat and stratification of the anatomic pattern of disease are the foundations of EBR. This is true not only in everyday practice but also in outcomes assessment and research. The authors propose a new, clinically oriented framework for classifying the pattern of arterial disease in CLTI. The GLASS is a fundamental departure from current approaches used in PAD and more analogous to the SYNTAX system for CAD.^{344,345}

Current PAD anatomic classification schemes either describe the location and severity of individual arterial lesions^{11,156} or quantify the overall burden and morphology of disease.^{12,151,170} Lesion- or segment-based grading systems are useful for comparing endovascular device performance in well-defined clinical situations. They are not, however, useful for defining EBR strategies in CLTI, especially given the complex, multilevel, and increasingly distal disease patterns typically seen in current clinical practice.

Successful revascularization in CLTI, particularly in patients with tissue loss, nearly always requires restoration of pulsatile in-line flow to the foot. Because individual lesion-based schemes correlate poorly with effective revascularization in CLTI, vascular specialists must integrate approaches for arterial segments into a management strategy for the whole limb. Factors that determine a successful anatomic outcome are intrinsically different for bypass grafting and endovascular intervention. Bypass surgery requires adequate inflow and outflow and, perhaps most important, a suitable autologous conduit. By contrast, the success of endovascular intervention is largely defined by the complexity of atherosclerosis within the anticipated target arterial path (TAP) that provides in-line flow to the foot. When the TAP includes multiple lesions in series, technical success and sustained patency for the limb as a whole must be estimated as a product function of each lesion traversed.

GLASS is based on defining the TAP in each individual patient by high-quality imaging and requires selection of a

preferred infrapopliteal (IP) artery. The TAP is generally selected on the basis of the least diseased crural artery providing runoff to the foot. It can also be selected on the basis of other relevant factors, such as angiosome preference or avoidance of a previously instrumented vessel. Whereas the relationship between the pattern of occlusive disease, patency of the chosen intervention, and clinical success in CLTI is a complex one, an integrated limb-based anatomic staging system like GLASS is critical to define it. The preferred TAP for endovascular intervention and the preferred target artery for open bypass surgery may not always be the same; clinical decision-making thus hinges on a comparative estimate of risk and success for each. Like SYNTAX, GLASS stage is designed to correlate primarily with endovascular outcomes. As such, it does not incorporate factors like venous conduit quality or distal runoff that are more directly relevant for bypass grafting.

GLASS provides a basis for clinical practice and supports future research in CLTI. When it is combined with tools for stratification of patient risk and severity of limb threat (Sections 1 and 3), GLASS facilitates the development of specific evidence-based revascularization (EBR) guidelines in CLTI (Section 6). In developing GLASS, the writing group was informed by a commissioned systematic review of revascularization outcomes in CLTI and expert opinion. Still, the authors acknowledge that the new grading system requires prospective validation in a variety of patient populations and health care environments. The system is expected to undergo revisions as outcomes are reported. Important factors for refinement include the current state of limited high-quality evidence in the field, ongoing changes in both epidemiology and technology, and differences in disease patterns and practice around the world.

Assumptions and approach

As CLTI is usually the result of complex multilevel occlusive disease, certain simplifying assumptions are required to develop a usable anatomic staging system (Table 5.1). First, because existing schemes for AI disease appear adequate, the focus of GLASS is on infrainguinal disease (a simplified inflow disease scheme is presented in Table 5.2). In GLASS, the CFA and PFA are seen as inflow arteries, and the infrainguinal system begins at the origin of the SFA. This is justified by the distinct approaches used in the treatment of CFA and PFA disease (Section 6) and long-term results that are similar to those for AI interventions.

For GLASS to be useful in everyday clinical practice and to form the basis of practice-changing research, it is important that it does not rely on complex methods of lesion characterization. With regard to vessel calcification, GLASS adopts a dichotomous subjective scale in which severe calcification (eg, >50% of circumference; diffuse, bulky, or "coral reef" plaques) increases the within-segment grade by one numeric level. This is a subjective determination made by the treating physician that the severity of calcification

Table 5.1. Key definitions and assumptions in the Global Limb Anatomic Staging System (GLASS)

Restoration of in-line flow to the ankle and foot is a primary goal. Target arterial path (TAP): the selected continuous route of in-line flow from groin to ankle. The TAP typically involves the least diseased IP artery but may be angiosome based. ^a
Limb-based patency (LBP): maintained patency of the TAP
Inflow disease (AI and CFA) is considered separately and assumed corrected when using the infrainguinal staging system for clinical decision-making.
Grade within segment is determined by presence of any one of the defined descriptors within that grade (ie, the worst disease attribute within the segment defines grade).
Calcification is considered only if severe; increases within segment grade by 1.
IM disease (pedal) modifier: describes status of IM vessels (including terminal divisions of the peroneal artery) providing outflow into the foot.

AI = Aortoiliac; CFA = common femoral artery; IM = inframalleolar; IP = infrapopliteal.

^a The generic case of rest pain is used as a default for defining TAP as the least diseased IP artery, or a specific IP target artery based on clinical circumstances (eg, angiosome directed in setting of wounds) may be selected by the clinician.

significantly increases technical complexity (and expected technical failure rates) for endovascular intervention. Alternative approaches for quantifying arterial calcification in PAD have been suggested but are more complex, and none of these has been validated for discriminating clinical outcomes.^{346,347} With regard to IM disease, GLASS employs a three-level modifier (Fig 5.1) to describe the status of arteries crossing the ankle (including the terminal divisions of the peroneal artery) and the pedal arch. Currently, the IM

Table 5.2. Aorto-iliac (inflow) disease staging in GLASS

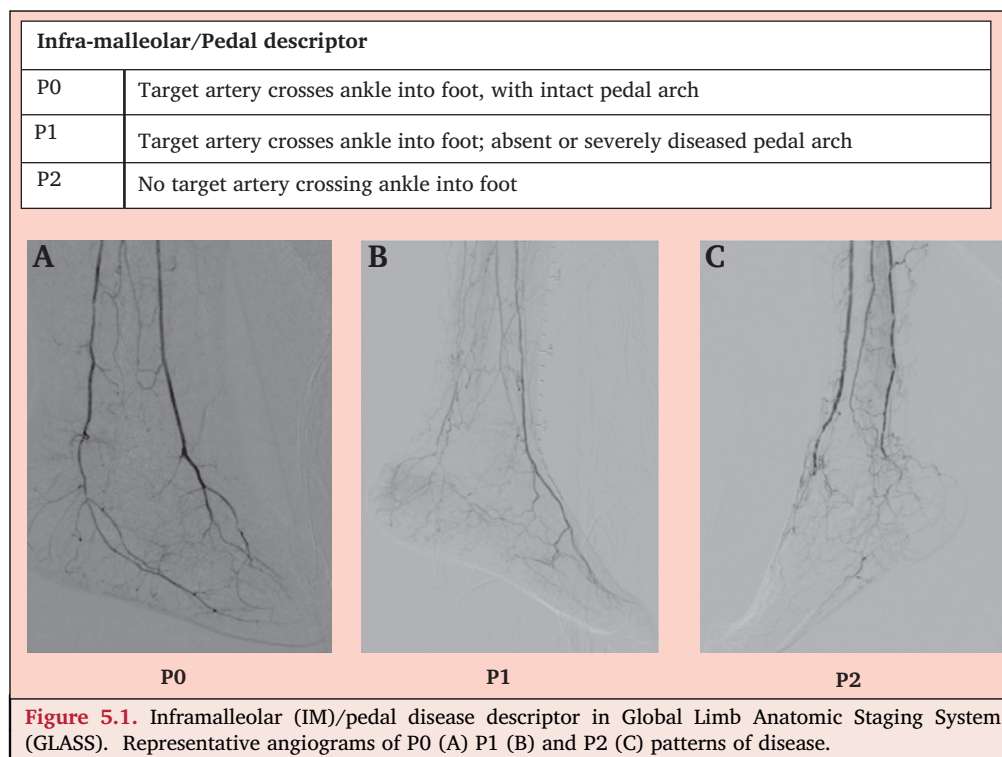
I Stenosis of the common and/or external iliac artery, chronic total occlusion of either common or external iliac artery (not both), stenosis of the infrarenal aorta; any combination of these
II Chronic total occlusion of the aorta; chronic total occlusion of common and external iliac arteries; severe diffuse disease and/or small-caliber (<6 mm) common and external iliac arteries; concomitant aneurysm disease; severe diffuse in-stent restenosis in the AI system
<i>Modifiers: A, no significant CFA disease; B, significant CFA disease (>50% stenosis)</i>

AI = Aortoiliac; CFA = common femoral artery. A simplified staging system for inflow (AI and CFA) disease is suggested. Hemodynamically significant disease (>50% stenosis) of the CFA is considered a key modifier (A/B).

disease modifier is not considered within the primary assignment of limb stages in GLASS, given the absence of strong evidence on how it affects treatment outcomes. It should, however, be captured in future studies to better define how to incorporate pedal outflow disease into anatomic staging in CLTI.

GLASS also makes the following assumptions:

- Restoring durable (pulsatile) in-line flow to the affected part, particularly in patients with tissue loss, is a primary goal of revascularization in CLTI.
- Using high-quality imaging (Section 3), the vascular specialist chooses and defines a TAP that is most likely to achieve that in-line flow.
- The TAP will usually involve the least diseased IP artery.



<p>FP Grade 0</p>	<p>Mild or no significant (<50%) disease</p>	
<p>FP Grade 1</p>	<ul style="list-style-type: none"> • Total length SFA disease <1/3 (<10 cm) • May include single focal CTO (< 5 cm) as long as not flush occlusion • Popliteal artery with mild or no significant disease 	
<p>FP Grade 2</p>	<ul style="list-style-type: none"> • Total length SFA disease 1/3-2/3 (10-20 cm) • May include CTO totaling < 1/3 (10 cm) but not flush occlusion • Focal popliteal artery stenosis <2 cm, not involving trifurcation 	
<p>FP Grade 3</p>	<ul style="list-style-type: none"> • Total length SFA disease >2/3 (>20 cm) length • May include any flush occlusion <20 cm or non-flush CTO 10-20 cm long • Short popliteal stenosis 2-5 cm, not involving trifurcation 	
<p>FP Grade 4</p>	<ul style="list-style-type: none"> • Total length SFA occlusion >20 cm • Popliteal disease >5 cm or extending into trifurcation • Any popliteal CTO 	

Figure 5.2. Femoropopliteal (FP) disease grading in Global Limb Anatomic Staging System (GLASS). Trifurcation is defined as the termination of the popliteal artery at the confluence of the anterior tibial (AT) artery and tibioperoneal trunk. CFA = Common femoral artery; CTO = chronic total occlusion; DFA = deep femoral artery; Pop = popliteal; SFA = superficial femoral artery.

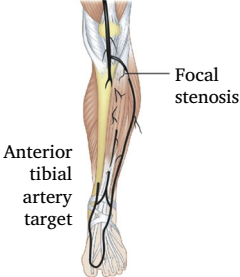
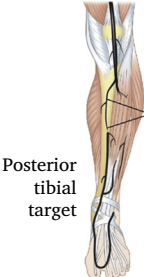
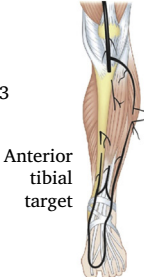
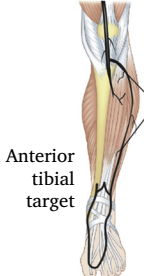
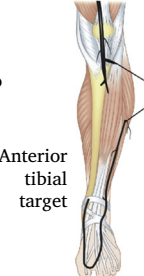
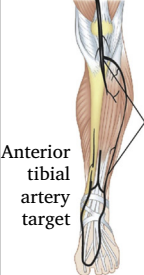
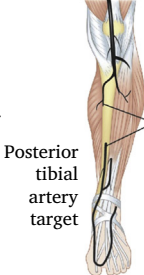
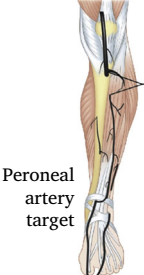
<p>IP Grade 0</p>	<ul style="list-style-type: none"> Mild or no significant disease in the primary target artery path 			
<p>IP Grade 1</p>	<ul style="list-style-type: none"> Focal stenosis of tibial artery < 3cm 	 <p>Focal stenosis</p> <p>Anterior tibial artery target</p>		
<p>IP Grade 2</p>	<ul style="list-style-type: none"> Stenosis involving 1/3 total vessel length May include focal CTO (< 3 cm) Not including TP trunk or tibial vessel origin 	 <p>Posterior tibial target</p> <p>Stenosis of 1/3 total vessel length</p>	 <p>Anterior tibial target</p> <p>Focal CTO < 3cm</p>	
<p>IP Grade 3</p>	<ul style="list-style-type: none"> Disease up to 2/3 vessel length CTO up to 1/3 length (may include tibial vessel origin but not tibioperoneal trunk) 	 <p>Anterior tibial target</p> <p>Disease up to 2/3 vessel length</p>	 <p>Anterior tibial target</p> <p>CTO up to 1/3 vessel length</p>	
<p>IP Grade 4</p>	<ul style="list-style-type: none"> Diffuse stenosis > 2/3 total vessel length CTO > 1/3 vessel length (may include vessel origin) Any CTO of tibioperoneal trunk if AT is not the target artery 	 <p>Anterior tibial artery target</p> <p>Diffuse stenosis > 2/3 of vessel length</p>	 <p>Posterior tibial artery target</p> <p>CTO > 1/3 of vessel length</p>	 <p>Peroneal artery target</p> <p>CTO of TP trunk</p>

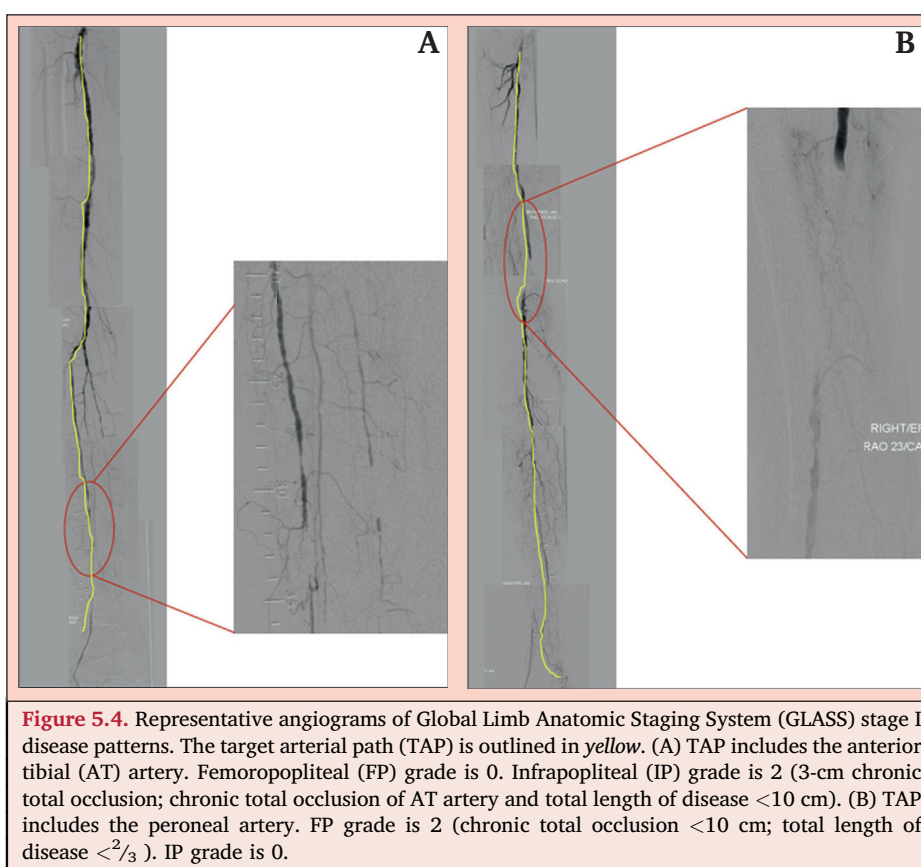
Figure 5.3. Infrapopliteal (IP) disease grading in Global Limb Anatomic Staging System (GLASS). AT = Anterior tibial; CTO = chronic total occlusion; TP = tibioperoneal.

Table 5.3. Assignment of Global Limb Anatomic Staging System (GLASS) Stage

FP Grade	IP Grade				
	0	1	2	3	4
4	III	III	III	III	III
3	II	II	II	III	III
2	I	II	II	II	III
1	I	I	II	II	III
0	NA	I	I	II	III

NA = Not applicable.

After selection of the target arterial path (TAP), the segmental femoropopliteal (FP) and infrapopliteal (IP) grades are determined from high-quality angiographic images. Using the table, the combination of FP and IP grades is assigned to GLASS stages I to III, which correlate with technical complexity (low, intermediate, and high) of revascularization.



- Other IP arteries (not selected for the TAP) are equally diseased or more so.

In addition, although it is an important research question, the current version of GLASS does not consider multivessel IP revascularization because evidence of its role is still lacking. Where the clinician is considering such revascularization, GLASS staging is based on the primary IP target, as defined by the clinician before the intervention.

In defining infrainguinal anatomic stages (I-III), GLASS combines grades (0-4) for the FP (origin of the SFA to the origin of the anterior tibial [AT] artery; Fig 5.2) and IP (origin

of the tibioperoneal trunk and the AT artery to the malleoli; Fig 5.3) segments in series. Stages were developed to correlate with estimated LBP, defined as maintenance of in-line flow through the entire length of the TAP, from the SFA origin to the malleoli. LBP is considered to be lost when any one of the following occurs:

1. Anatomic failure: occlusion, critical stenosis, or reintervention affecting any portion of the defined TAP; or
2. Hemodynamic failure: a significant drop in ABI (≥ 0.15) or TBI (≥ 0.10), or identification of $\geq 50\%$ stenosis in

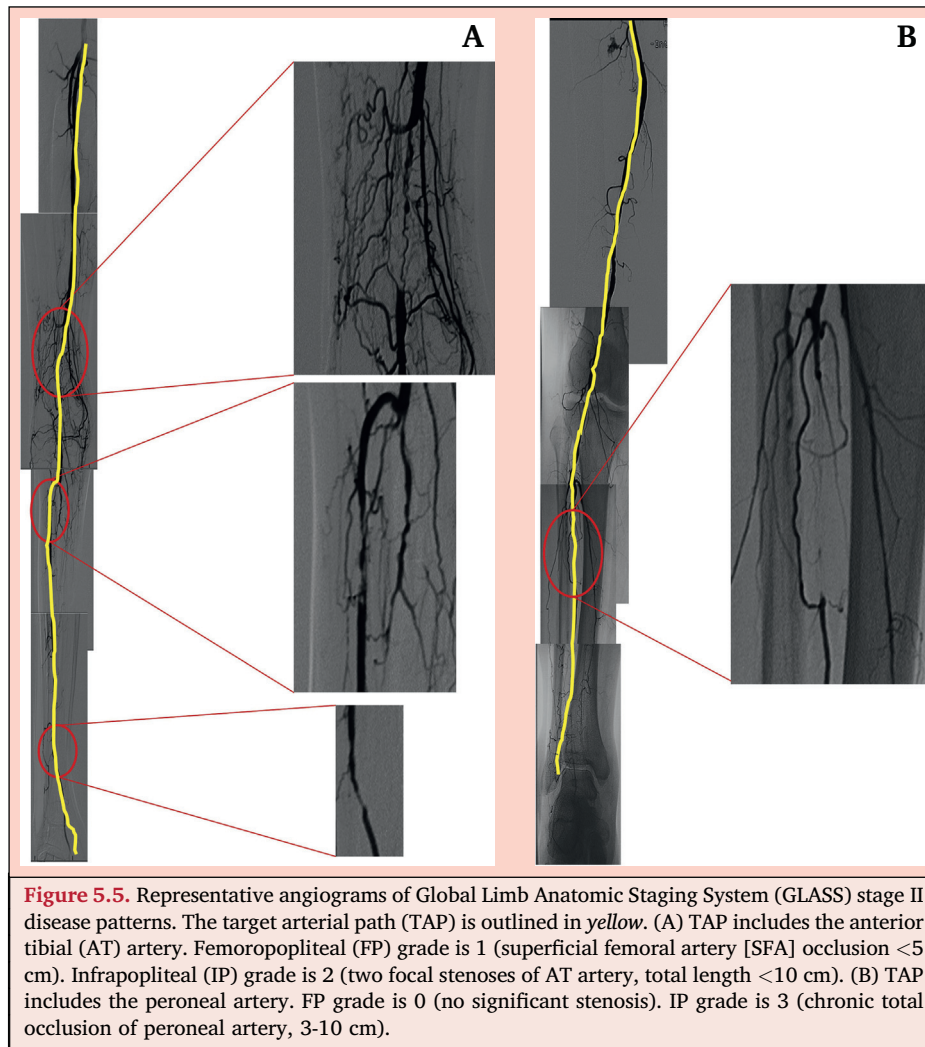


Table 5.4. Descriptive summary of Global Limb Anatomic Staging System (GLASS) stages of infrainguinal arterial disease

Stage	Estimated PVI outcomes		Anatomic pattern
	Technical failure	1-year LBP	
I	<10%	>70%	Short- to intermediate-length FP disease and/or short-length IP disease; no or minimal popliteal disease
II	<20%	50%-70%	Intermediate- to long-length FP disease; may include popliteal stenosis and/or short- to intermediate-length IP disease
III	>20%	<50%	Extensive FP or IP occlusions, alone or in combination with any disease in the other segment; popliteal CTO

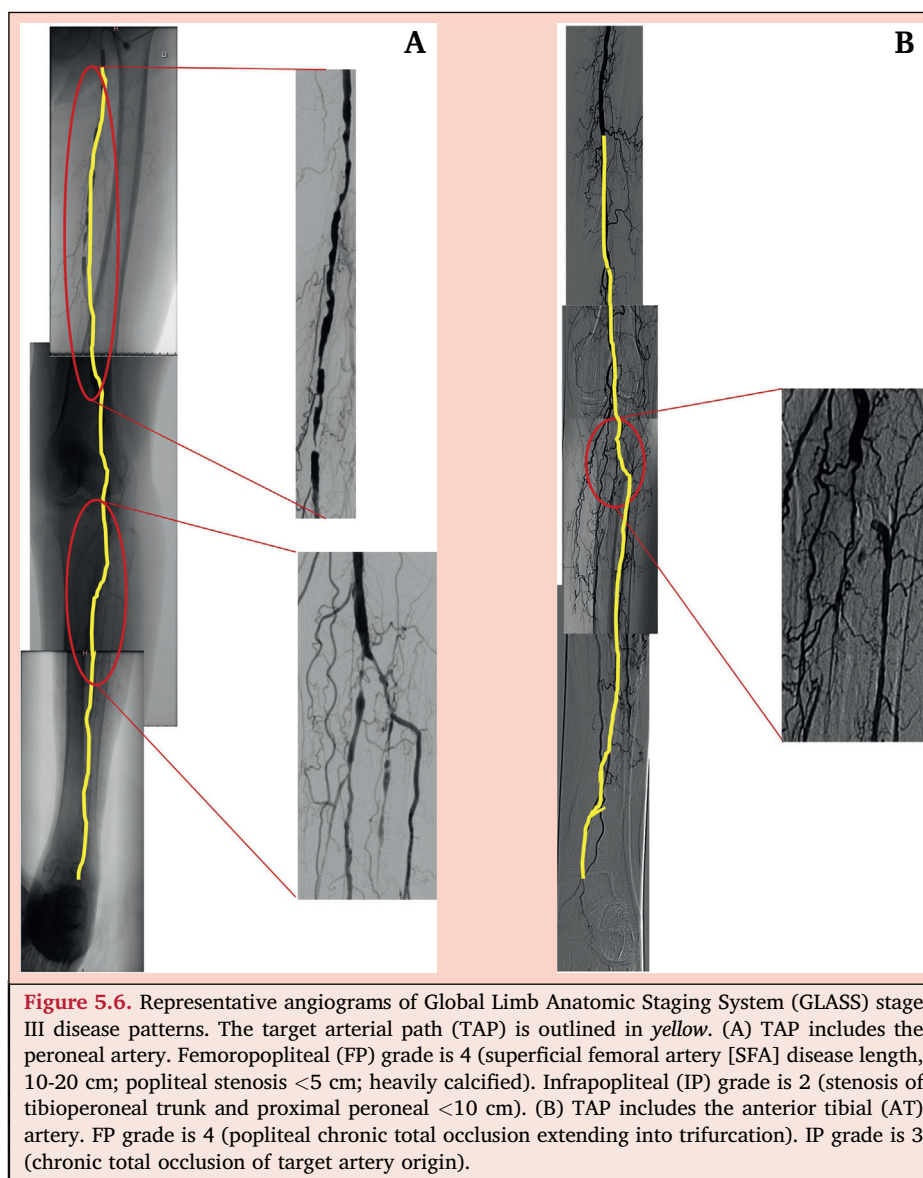
CTO = Chronic total occlusion; FP = femoropopliteal; IP = infrapopliteal; LBP = limb-based patency; PVI = peripheral [endo-]vascular intervention.

the TAP, in the presence of recurrent or unresolved clinical symptoms (eg, rest pain, worsening or persistent tissue loss).

LBP is an important new concept allowing more direct comparison between revascularization approaches in CLTI. Estimating LBP after surgical or endovascular intervention is central to the development of EBR (Section 6). The writing group defined three GLASS stages based on the likelihood of

immediate technical failure (ITF)³⁴⁷ and 1-year LBP after endovascular intervention of the selected TAP. GLASS stages for the limb thus reflect a gradient of infrainguinal disease complexity:

- Stage I: low-complexity disease: expected ITF < 10% and 1-year LBP > 70%
- Stage II: intermediate-complexity disease: expected ITF < 20% and 1-year LBP 50% to 70%



- Stage III: high-complexity disease: expected ITF > 20%; or 1-year LBP < 50%

Consensus process and assignment of limb stages

To assign GLASS stages (I-III) in the two-dimensional matrix shown in Table 5.3, a multinational, multispecialty group of vascular specialists (GVG writing group and invited external experts) as well as evidence summaries⁷ and other published material^{79,160,348-404} were surveyed. Representative examples of GLASS stage I to stage III disease are illustrated in the angiograms depicted in Figs 5.4 to 5.6. Table 5.4 provides a descriptive summary of the three GLASS stages.

Managing CLTI with GLASS

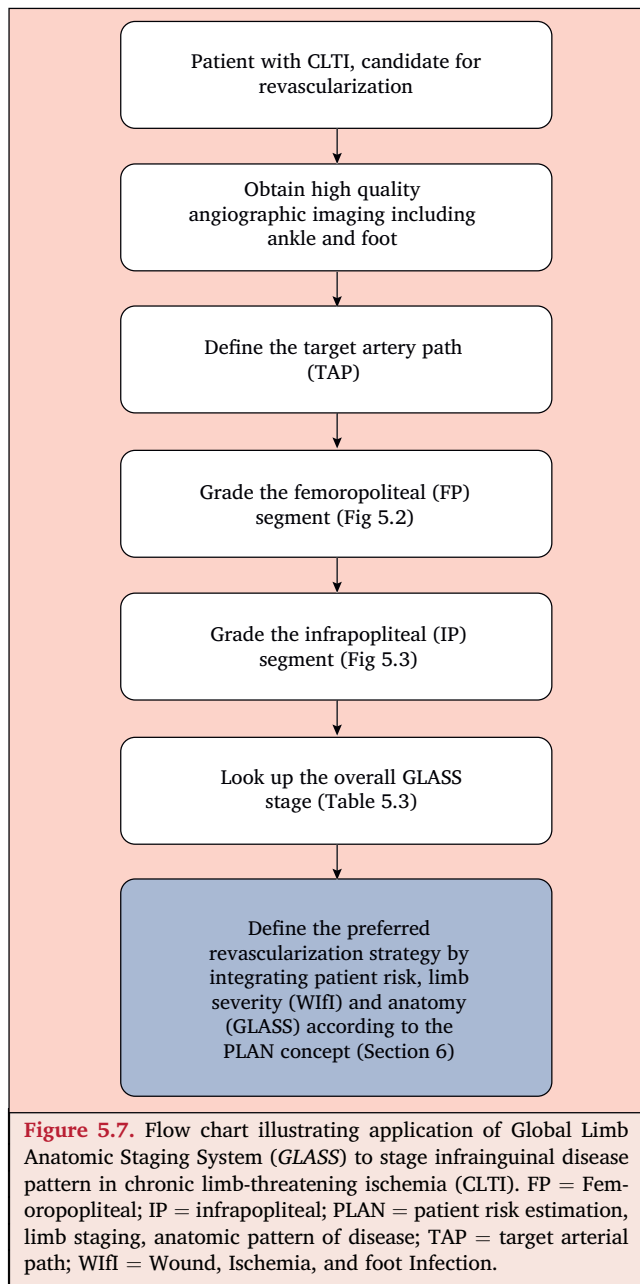
Use of the GLASS system involves the following steps (Fig 5.7):

1. Obtain high-quality angiographic imaging to include the ankle and foot (Section 3).

2. Identify the TAP.
3. Determine the FP GLASS grade (0-4) (Fig 5.2).
4. Determine the IP GLASS grade (0-4) (Fig 5.3).
5. Decide whether there is severe calcification (eg, >50% of circumference; diffuse, bulky, or coral reef plaques likely to compromise endovascular outcomes) within the FP and IP segments of the TAP. If present, increase the segment grade by one.
6. Combine FP and IP grades to determine the overall GLASS stage (Table 5.3).
7. Use the pedal modifier (P0, P1, or P2) to describe the status of IM arteries.

For the individual patient with CLTI, an EBR strategy (Section 6) is based on the full integration of

1. estimated patient risk and long-term survival;
2. severity of limb threat (eg, using Wifl) (Sections 1 and 3); and
3. anatomic pattern and severity of disease in the affected limb (eg, GLASS).



Recommendation 5		
5.1 Use an integrated, limb-based anatomic staging system (such as the GLASS) to define complexity of a preferred TAP and to facilitate EBR in patients with CLTI.		
Grade	Level of evidence	Key references
Good practice statement		-

Limitations and future direction

The authors acknowledge the limitations of the available data in developing this initial version of GLASS. Severe calcification, particularly in the tibial arteries, is a negative predictor of technical success for intervention and signifies a higher risk for amputation.^{405,406} However, a simplified and validated scoring system for calcification that is associated with procedural outcomes is still lacking.³⁴⁶ At the same time, pedal artery

disease appears to be increasing in both prevalence and importance, particularly in CLTI patients experiencing major tissue loss or infection (WIFI stage 4).^{407,408}

Pedal interventions remain relatively uncommon, and data on outcomes are extremely limited. Patients with no IM revascularization target are placed in a high-risk subgroup, although they are assigned a simplified modifier (P2) in the current version of GLASS. In the future, it is anticipated that better data will allow a more sophisticated incorporation of calcification and pedal disease. Other important issues, including the benefits of revascularizing multiple IP arteries, the relative quality of runoff distal to the revascularization and extending to the wound-related artery or angiosome, and the complex relationship between hemodynamic and clinical success, also require further study.

In assigning GLASS stages, the authors assume that pre-procedural decision-making is frequently driven by the estimation of the anticipated technical and clinical success after endovascular intervention. As a result, the preferred TAP for endovascular intervention and bypass surgery may not always be the same. Thus, treatment outcomes for surgical bypass should also be reported and analyzed on the basis of the actual procedure performed, including inflow artery, outflow artery, and conduit used.

Research priorities for the global limb anatomic staging system (GLASS)	
Recommendations	
5.1	What are the expected procedural, hemodynamic, and clinical outcomes of revascularization across the spectrum of infrainguinal disease severity? Better evidence is needed to validate the GLASS, particularly for endovascular strategies in intermediate (II) and severe (III) stages of infrainguinal disease.
5.2	What is the effect of severe IM and pedal arch disease on revascularization outcomes in CLTI? Is there a clinically useful way to grade this level of disease?
5.3	Is there evidence that other measures, such as outflow bed resistance or below-knee runoff scores, are predictive of procedural or clinical outcomes? How do these compare with target path lesion complexity assessed by angiography?
5.4	Is there a simple, reproducible method for quantification of calcification that has predictive value for infrainguinal interventions?
5.5	Are there specific patient factors (eg, demographic or comorbidity) associated with anatomic patterns of disease in CLTI?
5.6	Are there anatomic patterns of disease in which an endovascular approach is futile?
5.7	How does lesion morphology (eg, concentric vs eccentric) influence treatment success for different endovascular interventions?
5.8	Is there a correlation between GLASS stage and clinical presentation (WIFI)?
5.9	What is the comparative value of direct (angiosome based) vs indirect revascularization in the setting of tissue loss, and how should it drive selection of the preferred TAP? Is this specific to wound location or WIFI stage?

6. STRATEGIES FOR EBR

Effective revascularization is the cornerstone of limb salvage in CLTI. Although multiple techniques are available, there are limited high-quality data to support EBR. A new, systematic paradigm is required to improve decision-making, clinical outcomes, and cost-effectiveness.

To aid clinical decision-making in everyday practice and to facilitate future EBR research in CLTI, the authors propose a three-step integrated approach (PLAN; Figs 6.1 and 6.2) based on

- Patient risk estimation
- Limb staging
- ANatomic pattern of disease

PLAN: Patient risk estimation

The first step involves assessing the patient for candidacy for limb salvage, periprocedural risk, and life expectancy.

CLTI is associated with advanced age, multiple comorbidities, and frailty. The goals of treatment include relief of pain, healing of wounds, and preservation of a functional limb. However, revascularization may incur significant morbidity and mortality, requiring multiple hospitalizations, prolonged outpatient care, and thus considerable health and social care costs. Whereas the majority of patients with CLTI should be considered candidates for limb salvage, some may be appropriately treated with primary amputation or palliation after shared decision-making. Patients, families, and caregivers should have access to appropriate expertise in making these challenging decisions. Although maintenance of independent ambulatory status is an important goal, predicting functional outcomes after revascularization may be challenging, particularly in patients who are severely deconditioned. Palliative care consultants, where available, may be a valuable resource to optimize symptom management in patients with limited goals of care.

Recommendations 6		
6.1 Refer all patients with suspected CLTI to a vascular specialist for consideration of limb salvage, unless major amputation is considered medically urgent.		
Grade	Level of evidence	Key references
Good practice statement		
6.2 Offer primary amputation or palliation to patients with limited life expectancy, poor functional status (eg, nonambulatory), or an unsalvageable limb after shared decision-making.		
Grade	Level of evidence	Key references
Good practice statement		

Palliative therapy should rarely include revascularization except in special circumstances, such as

- treatment of hemodynamically significant inflow disease, if needed to improve the likelihood of a successful amputation at the most distal possible level; and
- relief of intractable pain or to improve wound healing after shared decision-making with the patient, family, and vascular treatment team.

Estimation of operative risk and life expectancy plays a critical role in EBR. Tradeoffs between risk, invasiveness, hemodynamic gain, and anatomic durability of the vascular intervention are commonly made in everyday practice. Risk stratification tools can assist by providing objective criteria for such decisions. Multiple tools have been developed and applied to the CLTI population (Table 6.1).^{63-67,225,409-412} End points modeled have included all-cause mortality, major amputation, AFS, and perioperative events. The list of predictors identified in these models includes advanced age (>75 or 80 years), CKD, CAD, congestive heart failure, DM, smoking, cerebrovascular disease, tissue loss, BMI, dementia, and functional status. Frailty, a recently identified functional measure, is also of clear importance in the CLTI population.^{413,414} Patients with ESRD are at the highest risk in many reports and yet have been specifically excluded in some CLTI studies.^{415,416} All of these tools have been developed retrospectively using data from patients who have undergone revascularization, thereby excluding those who were managed conservatively or selected for primary amputation. Whereas some were validated in external data sets of similar patients, none has been prospectively tested across the spectrum of CLTI presenting for initial evaluation and treatment. As such, no specific tool and model can be recommended in preference to others.

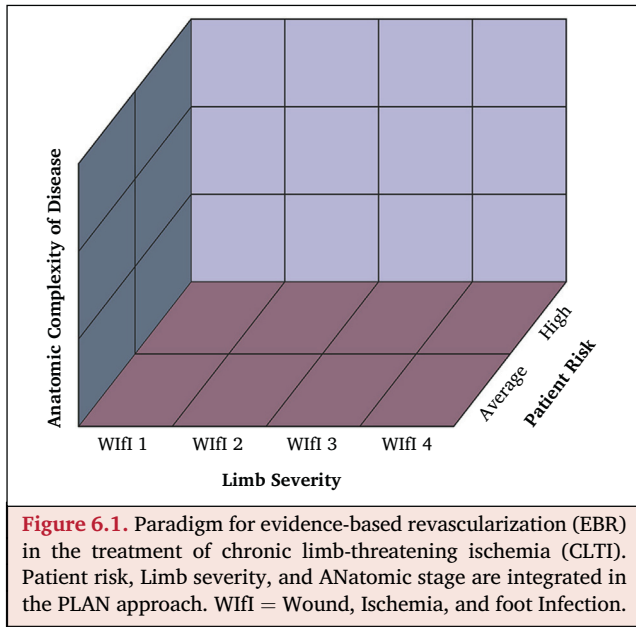
Recommendations 6 (continued)		
6.3 Estimate periprocedural risk and life expectancy in patients with CLTI who are candidates for revascularization.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Biancari, ⁶³ 2007 Schanzer, ⁶⁴ 2008 Bradbury, ⁶⁵ 2010 Meltzer, ⁶⁶ 2013 Simons, ⁶⁷ 2016
6.4 Define a CLTI patient as average surgical risk when anticipated periprocedural mortality is <5% and estimated 2-year survival is >50%.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	
6.5 Define a CLTI patient as high surgical risk when anticipated periprocedural mortality is ≥5% or estimated 2-year survival is ≤50%.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	

Specific recommendations about preoperative cardiac and anesthetic evaluation before limb revascularization are beyond the scope of this document. The reader is referred to Section 4 and to other published guidelines.^{417,418}

PLAN: Limb staging

CLTI patients present with a broad spectrum of disease severity. Staging of the limb is central to EBR (Section 3), and use of the SVS Threatened Limb Classification System (WIfI) is recommended (Section 1).^{10,68-72,171} This is the only system that fully integrates wound severity, ischemia, and infection to stage CLTI.

The severity of ischemia and the benefits of revascularization do not map in an exclusively concordant fashion with amputation risk across the spectrum of CLTI, as expressed in



the original Wifi consensus document.¹⁰ Expert opinion, now supported by reports from institutional series,^{69,70,72} suggests that the presumed benefit of revascularization in CLTI is linked to both the severity of ischemia and the degree of limb threat (Fig 6.3). All symptomatic patients who have severe (eg, Wifi grade 3) ischemia should undergo attempted revascularization, presuming they are appropriate candidates for limb salvage.⁵ In settings of advanced tissue loss or infection (eg, Wifi stage 4 limbs), revascularization may also be of benefit in the presence of moderate ischemia (eg, Wifi ischemia grades 1 and 2). Conversely, patients with lesser degrees of tissue loss or infection (eg, Wifi stages 1 to 3) and mild to moderate ischemia are often successfully treated with infection control and wound and podiatric care. Revascularization may be considered selectively in these patients if their wounds fail to progress (or regress) despite appropriate limb care after 4 to 6 weeks or if they have signs or symptoms of clinical deterioration. In such cases, all elements of the initial staging and treatment plan, including treatment of underlying moderate ischemia, should be re-evaluated. Whenever possible, the limb should be restaged after surgical drainage or débridement and after the infective component is stabilized. During the course of treatment, periodic restaging of the limb is important in guiding subsequent decisions, particularly when there is lack of progress in healing or any deterioration of symptoms.

Wifi also provides a useful and necessary tool through which one can compare and contrast the quality of different revascularization strategies in CLTI. This has become an issue of critical importance as an ever-increasing array of technologies and treatment strategies are being used. The magnitude and durability of increased perfusion required to resolve the clinical situation, and to maintain satisfactory limb health (eg, preservation of a functional foot, freedom from recurrent CLTI), will vary considerably across the spectrum. The extent of benefit for revascularization (Fig 6.3) is also linked to anatomic durability of the selected intervention. These concepts are central to PLAN and to the development of EBR strategies in CLTI.

Recommendations 6 (continued)		
6.6 Use an integrated threatened limb classification system (such as Wifi) to stage all CLTI patients who are candidates for limb salvage.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Cull, ⁶⁸ 2014 Zhan, ⁶⁹ 2015 Causey, ⁷⁰ 2016 Darling, ⁷¹ 2016 Robinson, ⁷² 2017
6.7 Perform urgent surgical drainage and débridement (including minor amputation if needed) and commence antibiotic treatment in all patients with suspected CLTI who present with deep space foot infection or wet gangrene.		
Grade	Level of evidence	Key references
Good practice statement -		
6.8 Repeat limb staging after surgical drainage, débridement, minor amputations, or correction of inflow disease (AI, common and deep femoral artery disease) and before the next major treatment decision.		
Grade	Level of evidence	Key references
Good practice statement -		
6.9 Do not perform revascularization in the absence of significant ischemia (Wifi ischemia grade 0), unless an isolated region of poor perfusion in conjunction with major tissue loss (eg, Wifi wound grade 2 or 3) can be effectively targeted and the wound progresses or fails to reduce in size by ≥50% within 4 weeks despite appropriate infection control, wound care, and offloading.		
Grade	Level of evidence	Key references
Good practice statement -		
6.10 Do not perform revascularization in very-low-risk limbs (eg, Wifi stage 1) unless the wound progresses or fails to reduce in size by ≥50% within 4 weeks despite appropriate infection control, wound care, and offloading.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Sheehan, ⁷³ 2003 Cardinal, ⁷⁴ 2008 Lavery, ⁷⁵ 2008 Snyder, ⁷⁶ 2010
6.11 Offer revascularization to all average-risk patients with advanced limb-threatening conditions (eg, Wifi stage 4) and significant perfusion deficits (eg, Wifi ischemia grades 2 and 3).		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Abu Dabrh, ⁵ 2015
6.12 Consider revascularization for average-risk patients with intermediate limb threat (eg, Wifi stages 2 and 3) and significant perfusion deficits (eg, Wifi ischemia grades 2 and 3).		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Zhan, ⁶⁹ 2015 Causey, ⁷⁰ 2016 Darling, ⁷¹ 2016 Robinson, ⁷² 2017
6.13 Consider revascularization in average-risk patients with advanced limb threat (eg, Wifi stage 4) and moderate ischemia (eg, Wifi ischemia grade 1).		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	
6.14 Consider revascularization in average-risk patients with intermediate limb threat (eg, Wifi stages 2 and 3) and moderate ischemia (eg, Wifi ischemia grade 1) if the wound progresses or fails to reduce in size by ≥50% within 4 weeks despite appropriate infection control, wound care, and offloading.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	

PLAN: Anatomic pattern of disease (and conduit availability)

Although secondary to the broader context of patient risk and limb threat severity, the anatomic pattern of arterial occlusive disease is a dominant consideration in EBR. The overall pattern and severity of disease in the limb (eg, as described by GLASS; Section 4) help define the optimal strategy for vascular intervention. Furthermore, the availability and quality of autologous vein conduit (especially the great saphenous vein [GSV]) are key considerations for bypass surgery and should be defined before revascularization decisions are taken in average-risk patients.^{13,77,79}

“No-option” anatomy

The majority of CLTI patients are anatomically suitable for revascularization, and establishing direct in-line flow to the foot is the primary technical goal. One important exception is ischemic rest pain, for which correction of inflow disease alone or treatment of FP disease even without continuous tibial runoff to the foot may provide relief of symptoms. This may also be the case in patients presenting with minor degrees of tissue loss (eg, WIfI stage 2). Thus, the definition of a no-option anatomic pattern of disease is dependent on clinical context. Lack of a target artery crossing the ankle and absence of a suitable pedal or plantar artery target (eg, GLASS P2 modifier) may be considered no-option disease patterns in patients with advanced CLTI (eg, WIfI stages 3 and 4). Angiography may occasionally fail to detect a patent distal artery target, and there are reports of successful tibial and pedal bypass grafting based on exploration of an artery identified on Doppler ultrasound examination that was not identified on contrast arteriography.^{419,420} Careful selection and experienced surgical judgment are required before proceeding to surgery in such instances.

EBR strategies in CLTI

The technical options for treating complex patterns of disease in a minimally invasive fashion have increased markedly in recent years and led some to advocate an “endovascular-first” approach for most or all patients with CLTI, reserving bypass surgery as a secondary option. However, existing evidence argues strongly for a selective revascularization algorithm based on specific clinical and anatomic scenarios, as described here. Currently enrolling RCTs are eagerly awaited to provide higher quality data in support of EBR in patients with CLTI.¹³⁻¹⁵

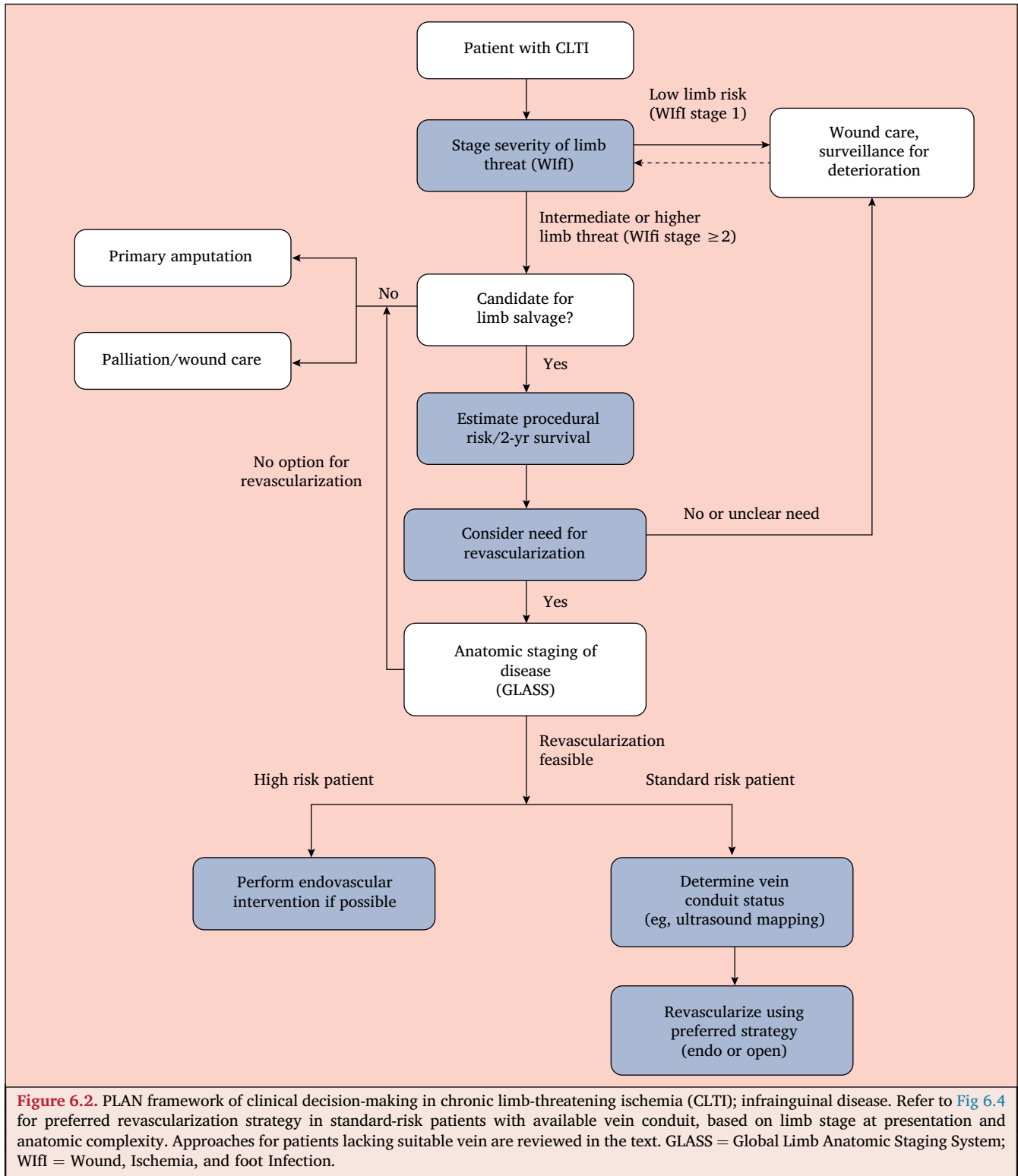
The Bypass vs Angioplasty in Severe Ischaemia of the Leg (BASIL) trial (now called BASIL-1) remains the only multicenter RCT to have directly compared an endovascular-first with a bypass surgery-first strategy in limb-threatening ischemia due to infrainguinal disease.^{159,421} BASIL was conducted across 27 hospitals in the United Kingdom and enrolled 452 participants between 1999 and 2004. All but six patients in the endovascular arm received plain balloon angioplasty (PBA) alone; approximately 25% of the bypasses were prosthetic; around one-third of the procedures were IP; and just more than 50% of patients were observed for

>5 years. Considering the follow-up period as a whole, an intention-to-treat analysis showed no significant difference between the two arms in terms of AFS and overall survival. However, for the approximately 70% of patients who lived for >2 years, HRs for overall survival (0.65; $P = .009$) and AFS (0.85; $P = .108$) were better for those treated initially with bypass surgery. An analysis by treatment received showed that prosthetic bypasses performed very poorly (worse than PBA) and that patients having bypass after failed PBA had a highly significantly worse AFS and overall survival compared with those patients who received bypass as their first allocated treatment.¹⁶⁰

A systematic review comparing open and endovascular treatments for CLTI found only nine studies meeting standard criteria, three of which were RCTs (among which only BASIL met all of the study quality benchmarks).⁶ Researchers concluded that low-quality evidence (due to heterogeneity and imprecision) suggested similar mortality and amputation outcomes but better expected patency for bypass surgery. Other comparative reviews have yielded broadly similar conclusions.^{227,422-425} OPGs for endovascular interventions in CLTI based on open surgical data from high-quality sources have been suggested and provide minimum standards of safety and efficacy until direct comparative data become available.¹⁶²

To obtain updated data on outcomes after endovascular and open bypass surgery in CLTI, a review was conducted of comparative studies and noncomparative studies that met more inclusive criteria.⁷ These criteria included prospective study design, 50 or more patients with critical or severe limb ischemia (Rutherford class 4-6 definition), infrainguinal procedure, minimum follow-up of 1 year, at least 50 procedures of each subtype (endovascular or open), and adequate anatomic description of lesion location and types of subinterventions (eg, percutaneous transluminal angioplasty, stent, atherectomy) employed. In total, 44 studies enrolling 8602 patients were reviewed in detail and results tabulated to display outcomes across anatomic subsets and from 30 days to 5-year follow-up intervals. Most of the studies were assessed as having moderate to high risk of bias, and the study quality was variable.

Review of the attributes of these studies revealed several notable limitations: few studies of SFA intervention were included because of inadequate numbers of CLTI patients (vs those with IC); the majority of FP bypass studies included prosthetic grafts; and although a good number of studies (20) addressed endovascular intervention for IP disease, the severity of disease was generally mild to moderate (GLASS IP grades 1 and 2), with no studies including GLASS IP grade 4 disease. Thus, the current state of evidence in CLTI remains severely limited, particularly for assessing endovascular outcomes in commonly encountered, complex (especially distal) disease patterns. Caveats aside, the compendium of data suggests similar mortality, amputation, and AFS rates for endovascular and bypass surgery at 1 year, with improved patency for bypass using vein compared with endovascular interventions or prosthetic bypass grafts at 1 year and beyond.



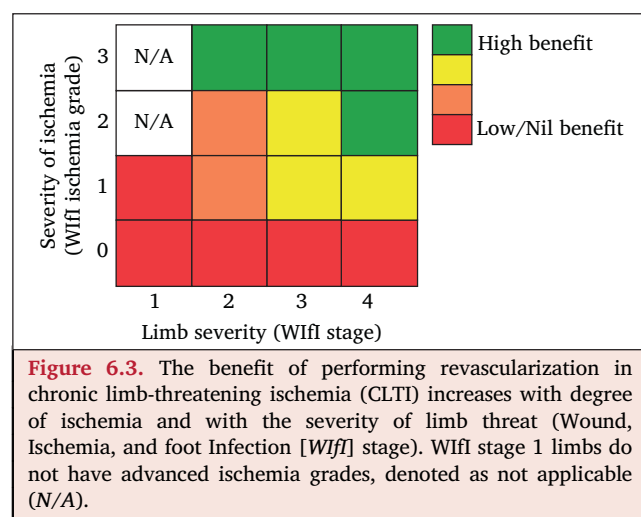
Additional evidence, including a larger body of retrospective studies and registries, provides further insights into specific factors associated with inferior outcomes for individual techniques and informs current vascular practice.^{79,365,366,369,372,373,376,385,391,393,395,402,407,426-438} Surgical bypass with nonautologous conduits to IP targets in CLTI

performs poorly. Similarly, patency rates for endovascular intervention are poor in settings of diffuse tibial disease and popliteal and trifurcation occlusions and are diminished in small, diffusely diseased or heavily calcified FP arteries. Several studies suggest that endovascular outcomes for advanced tissue loss (eg, gangrene, WIFI stage 4, WIFI

Table 6.1. Comparison of risk stratification tools for the chronic limb-threatening ischemia (CLTI) population

Tool	End points	Critical factors	Reference
Taylor et al	Mortality, ambulatory failure (median follow-up of 2 years)	Age, race, ESRD, CAD, COPD, DM, dementia, baseline ambulatory status	Taylor, ⁴⁰⁹ 2006
Finnvasc	Perioperative (30-day) mortality, limb loss	DM, CAD, gangrene, urgent operation	Biancari, ⁶³ 2007
PREVENT III	AFS (1 year)	ESRD, tissue loss, age >75 years, CAD, anemia	Schanzer, ⁶⁴ 2008
BASIL	Survival (2 years)	Age, CAD, smoking, tissue loss, BMI, Bollinger score, serum creatinine concentration, AP (number measured and highest value), prior stroke/TIA	Bradbury, ⁶⁵ 2010
CRAB	Perioperative (30-day) mortality, morbidity	Age >75 years, prior amputation or revascularization, tissue loss, ESRD, recent MI/angina, emergency operation, functional dependence	Meltzer, ⁶⁶ 2013
Soga et al	Survival (2 years)	Age, BMI, nonambulatory status, ESRD, cerebrovascular disease, tissue loss, left ventricular ejection fraction	Soga, ²²⁵ 2014
VQI	AFS (1 year)	Age, tissue loss, DM, CHF, serum creatinine concentration, ambulatory status, urgent operation, weight, bypass conduit used	Simons, ⁶⁷ 2016
VQI	Survival (30 days, 2 and 5 years)	Age, CKD, ambulatory status, CAD, CHF, COPD, tissue loss, diabetes, smoking, beta-blocker use	Simons, ⁴¹² 2018

AFS = Amputation-free survival; AP = ankle pressure; BASIL = Bypass vs Angioplasty in Severe Ischaemia of the Leg; BMI = body mass index; CAD = coronary artery disease; CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease; CRAB = Comprehensive Risk Assessment for Bypass; DM = diabetes mellitus; ESRD = end-stage renal disease; MI = myocardial infarction; PREVENT III = Project of Ex-vivo Vein graft Engineering via Transfection III; TIA = transient ischemic attack; VQI = Vascular Quality Initiative.



ischemia grade 3, or foot infection grades 2 and 3) are inferior, with high early rates of major amputation.^{171,439} Patients with ESRD experience higher rates of limb loss across all interventions. These factors must be carefully considered in each individual case, evaluating the available treatment options against the patient risk, limb stage, functional status, and presumptive importance of a hemodynamically durable intervention for resolving the clinical scenario at hand.

Finally, a nonselective endovascular-first approach carries some risk of both clinically ineffective and cost-ineffective treatment and potential for harm. Whereas a significant percentage of CLTI patients are appropriate candidates for

endovascular intervention, those with severe anatomic patterns and higher stages of limb threat may not be well served by a nonselective approach for several reasons. First, ineffective revascularization can lead to poor symptom relief, limited durability of benefit, delayed wound healing, inadequate clearance of infection, or progression of tissue loss in the foot. There are both patient and system costs to inadequately treated CLTI. Another important consideration is the potential effect of endovascular failures on the outcomes of secondary bypass surgery in CLTI. Although data in this regard are limited, several multicenter data sets including BASIL¹⁶⁰ and large regional registries^{440,441} suggest that the outcomes of bypass surgery in patients who have undergone failed endovascular interventions are significantly inferior to those in patients who underwent primary bypass surgery. The inferior outcomes associated with “secondary bypass” are similar whether the initial failure was percutaneous or a prior bypass graft. This may be a particularly high penalty to pay if clinical success of the initial procedure was short-lived. These studies cannot establish causality vs association, but they strongly suggest that the success of the initial vascular intervention is of importance in CLTI and that endovascular failure, like open bypass failure, carries consequences. Thus, an important consideration is to avoid risking potential loss of bypass targets in performing endovascular interventions. Conversely, surgical bypass may incur significant morbidity and mortality despite the potential attractiveness of greater durability. Factors that may increase the risk of wound complications, graft failure, or other major postoperative complications must be carefully weighed. These considerations informed the consensus recommendations on specific EBR strategies.

Recommendations 6 (continued)		
6.15 Obtain high-quality angiographic imaging with dedicated views of ankle and foot arteries to permit anatomic staging and procedural planning in all CLTI patients who are candidates for revascularization.		
Grade	Level of evidence	Key references
Good practice statement		
-		
6.16 Use an integrated limb-based staging system (eg, GLASS) to define the anatomic pattern of disease and preferred TAP in all CLTI patients who are candidates for revascularization.		
Grade	Level of evidence	Key references
Good practice statement		
-		
6.17 Perform ultrasound vein mapping when available in all CLTI patients who are candidates for surgical bypass.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Seeger, ⁷⁷ 1987 Wengerter, ⁷⁸ 1990 Schanzer, ⁷⁹ 2007
6.18 Map the ipsilateral GSV and small saphenous vein for planning of surgical bypass. Map veins in the contralateral leg and both arms if ipsilateral vein is insufficient or inadequate.		
Grade	Level of evidence	Key references
Good practice statement		
-		
6.19 Do not classify a CLTI patient as being unsuitable for revascularization without review of adequate-quality imaging studies and clinical evaluation by a qualified vascular specialist.		
Grade	Level of evidence	Key references
Good practice statement		
-		

EBR: Treatment of inflow disease

Inflow disease is defined here as proximal to the origin of the SFA and meeting one or more of the following criteria:

- absent femoral pulse
- blunted CFA waveform on Doppler ultrasound
- >50% stenosis by angiography in the aorto-iliac arteries or CFA
- aorta to CFA systolic pressure gradient >10 mm Hg at rest

The decision to perform staged vs multilevel revascularization for patients with combined inflow and outflow disease is individualized on the basis of severity of limb threat (especially presence of tissue loss), anatomic complexity, and patient risk. In settings of rest pain and minor tissue loss, inflow correction alone may suffice to achieve the desired clinical outcome. As procedural complexity increases, perioperative morbidity and mortality rise as well. Most patterns of AI disease may be successfully treated using an endovascular approach, frequently employing bare-metal or covered stents.⁸²⁻⁸⁴ Surgery is often reserved for extensive occlusions or after failure of endovascular procedures. The choice of an open surgical inflow procedure should be based on patient risk, anatomic pattern of disease, and other clinical factors. Direct anatomic bypass (eg, aortofemoral) grafting may be preferred to extra-anatomic reconstruction in average-risk patients with severe

ischemia (WIFI ischemia grades 2 and 3) because of greater anatomic and hemodynamic durability.⁸⁵⁻⁸⁷

CFA endarterectomy can be performed with low morbidity and excellent long-term durability.^{88,89} It remains the optimal approach to treatment of hemodynamically significant CFA disease, which often includes bulky calcific plaque. In some cases, femoral interposition grafting may be preferred. In all cases, durable in-line PFA flow should be maximized. CFA endarterectomy may be combined with proximal intervention to treat combined disease in a “hybrid” fashion.⁹⁰ Although long-term outcome data are sparse, reports suggest that endovascular treatment of CFA disease may be a safe alternative in selected patients (eg, high surgical risk, hostile groin anatomy).⁹¹⁻⁹⁴

Surgical treatment (eg, profundaplasty or bypass grafting) of PFA disease is an important component of CLTI revascularization with a major impact on the long-term prognosis for the limb. The indications for and optimal approaches to treatment of nonorificial (ie, not in continuity with the CFA) or long-segment PFA disease are not established. There is limited evidence regarding the use of endovascular interventions for PFA disease. However, it may be considered a secondary approach in settings of hostile groin anatomy or in other high-risk circumstances.

Recommendations 6 (continued)		
6.20 Correct inflow disease first when both inflow and outflow disease are present in a patient with CLTI.		
Grade	Level of evidence	Key references
Good practice statement		
-		
6.21 Base the decision for staged vs combined inflow and outflow revascularization on patient risk and the severity of limb threat (eg, WIFI stage).		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Harward, ⁸⁰ 1995 Zukauskas, ⁸¹ 1995
6.22 Correct inflow disease alone in CLTI patients with multilevel disease and low-grade ischemia (eg, WIFI ischemia grade 1) or limited tissue loss (eg, WIFI wound grade 0/1) and in any circumstance in which the risk-benefit of additional outflow reconstruction is high or initially unclear.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	
6.23 Restage the limb and repeat the hemodynamic assessment after performing inflow correction in CLTI patients with inflow and outflow disease.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	
6.24 Consider simultaneous inflow and outflow revascularization in CLTI patients with a high limb risk (eg, WIFI stages 3 and 4) or in patients with severe ischemia (eg, WIFI ischemia grades 2 and 3).		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	
6.25 Use an endovascular-first approach for treatment of CLTI patients with moderate to severe (eg, GLASS stage IA) AI disease, depending on the history of prior intervention.		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Jongkind, ⁸² 2010 Ye, ⁸³ 2011 Deloose, ⁸⁴ 2017

6.26 Consider surgical reconstruction for the treatment of average-risk CLTI patients with extensive (eg, GLASS stage II) AI disease or after failed endovascular intervention.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Ricco, ⁸⁵ 2008 Chiu, ⁸⁶ 2010 Indes, ⁸⁷ 2013
6.27 Perform open CFA endarterectomy with patch angioplasty, with or without extension into the PFA, in CLTI patients with hemodynamically significant (>50% stenosis) disease of the common and deep femoral arteries.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Kang, ⁸⁸ 2008 Ballotta, ⁸⁹ 2010
6.28 Consider a hybrid procedure combining open CFA endarterectomy and endovascular treatment of AI disease with concomitant CFA involvement (eg, GLASS stage IB inflow disease).		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Chang, ⁹⁰ 2008
6.29 Consider endovascular treatment of significant CFA disease in selected patients who are deemed to be at high surgical risk or to have a hostile groin.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Baumann, ⁹¹ 2011 Bonvini, ⁹² 2011 Gouëffic, ⁹³ 2017 Siracuse, ⁹⁴ 2017
6.30 Avoid stents in the CFA and do not place stents across the origin of a patent deep femoral artery.		
Grade	Level of evidence	Key references
Good practice statement		
6.31 Correct hemodynamically significant (≥50% stenosis) disease of the proximal deep femoral artery whenever technically feasible.		
Grade	Level of evidence	Key references
Good practice statement		

EBR: Treatment of infrainguinal disease in average-risk patients

Outflow (infrainguinal) disease starts at the SFA origin (Section 5). An average-risk patient is defined as one in whom the anticipated periprocedural mortality is <5% and the anticipated 2-year survival is >50% (Recommendation 6.4). These patients are potential surgical or endovascular candidates, depending on individual clinical and anatomic factors.

Fig 6.4 provides a summary of preferred infrainguinal revascularization strategies for an average-risk patient with available vein conduit based on the presenting combination of limb stage (WIFI) and anatomic pattern of disease (GLASS). Open bypass surgery and endovascular therapy have complementary roles, with notable lack of consensus across the intermediate ranges of clinical and anatomic complexity. Comparative effectiveness studies employing

these staging schemes are urgently needed to improve the quality of evidence for interventions in specific clinical scenarios.

Recommendations 6 (continued)		
6.32 In average-risk CLTI patients with infrainguinal disease, base decisions of endovascular intervention vs open surgical bypass on the severity of limb threat (eg, WIFI), the anatomic pattern of disease (eg, GLASS), and the availability of autologous vein.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Almasri, ⁷ 2018

Patients lacking adequate autologous (GSV) conduit must be considered separately as this is a critical factor in determining the likely success and durability of bypass surgery. For those with no suitable venous conduit, prosthetic or venous allografts are the only options. Given the inferior performance of these conduits in CLTI, endovascular intervention is preferred when possible.¹⁶⁰ Use of prosthetic or biologic conduits (eg, cryopreserved vein allografts) for infrainguinal bypass in CLTI may be reasonable in highly selected cases, such as in patients with untreatable anatomy for endovascular intervention or prior endovascular failure, with acceptable runoff, and in patients who are able to tolerate aggressive antithrombotic therapy.

In many patients lacking GSV, arm/spliced vein bypass conduits may be an option. However, the results of arm/spliced vein bypass are highly dependent on the operator's training and experience. The determination of when and how to employ these alternative vein conduits is surgeon specific. In general, large single-center and multicenter reports demonstrate that arm and spliced vein bypasses perform better than nonautologous grafts to distal targets and are inferior to autologous GSV conduits.^{7,79,442,443} However, these higher risk vein grafts require closer surveillance and more reinterventions to maintain primary assisted patency.⁴⁴⁴

EBR: Treatment of infrainguinal disease in high-risk patients

A high-risk patient is defined as one in whom the anticipated perioperative mortality is >5% or the anticipated 2-year survival is <50%. Because endovascular intervention can be performed with reduced morbidity, it may often be preferred in high-risk patients who are otherwise candidates for functional limb salvage. Shared decision-making is of great importance in high-risk patients to allow the patient, family, and other stakeholders to express value judgments on the tradeoffs between risk and effectiveness in relation to the desired goals.

Recommendations 6 (continued)		
6.33 Offer endovascular revascularization when technically feasible for high-risk patients with advanced limb threat (eg, Wifl stage 4) and significant perfusion deficits (eg, Wifl ischemia grades 2 and 3).		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Abu Dabrh, ⁵ 2015 Zhan, ⁶⁹ 2015 Causey, ⁷⁰ 2016 Darling, ⁷¹ 2016 Robinson, ⁷² 2017
6.34 Consider endovascular revascularization for high-risk patients with intermediate limb threat (eg, Wifl stages 2 and 3) and significant perfusion deficits (eg, Wifl ischemia grades 2 and 3).		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	
6.35 Consider endovascular revascularization for high-risk patients with advanced limb threat (eg, Wifl stage 4) and moderate ischemia (eg, Wifl ischemia grade 1) if the wound progresses or fails to reduce in size by ≥50% within 4 weeks despite appropriate infection control, wound care, and offloading, when technically feasible.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	
6.36 Consider endovascular revascularization for high-risk patients with intermediate limb threat (eg, Wifl stages 2 and 3) and moderate ischemia (eg, Wifl ischemia grade 1) if the wound progresses or fails to reduce in size by ≥50% within 4 weeks despite appropriate infection control, wound care, and offloading, when technically feasible.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	
6.37 Consider open surgery in selected high-risk patients with advanced limb threat (eg, Wifl stage 3 or 4), significant perfusion deficits (ischemia grade 2 or 3), and advanced complexity of disease (eg, GLASS stage III) or after prior failed endovascular attempts and unresolved symptoms of CLTI.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	

EBR: Infra-malleolar disease

Severe IM disease creates a major challenge to effective revascularization.⁴⁰⁷ The P2 modifier in GLASS describes the circumstance in which no named artery crosses the ankle into the foot and there is no suitable target for bypass surgery. Although technically successful endovascular interventions in the pedal arch have been reported, their durability and hemodynamic and clinical effectiveness remain unknown.⁴³⁸ Diabetic patients often have a segment of preserved pedal artery that may be a target for bypass. Open bypass surgery has also been successfully employed to tarsal and plantar arteries, but again, techniques and outcomes are not established. Given the technical difficulty and the likely reduced hemodynamic impact and durability, the appropriate role for interventions at this level is not determined. The impact of IM disease on the success of proximal revascularization, whether open or endovascular, is likewise unknown. Although the presence of an intact pedal arch appears important for both, clinical success may still be attained in the presence of significant IM disease.

The severity of limb threat (tissue loss or infection) is likely to be a critical modifier of the relationship between IM disease severity and postprocedural clinical outcomes.

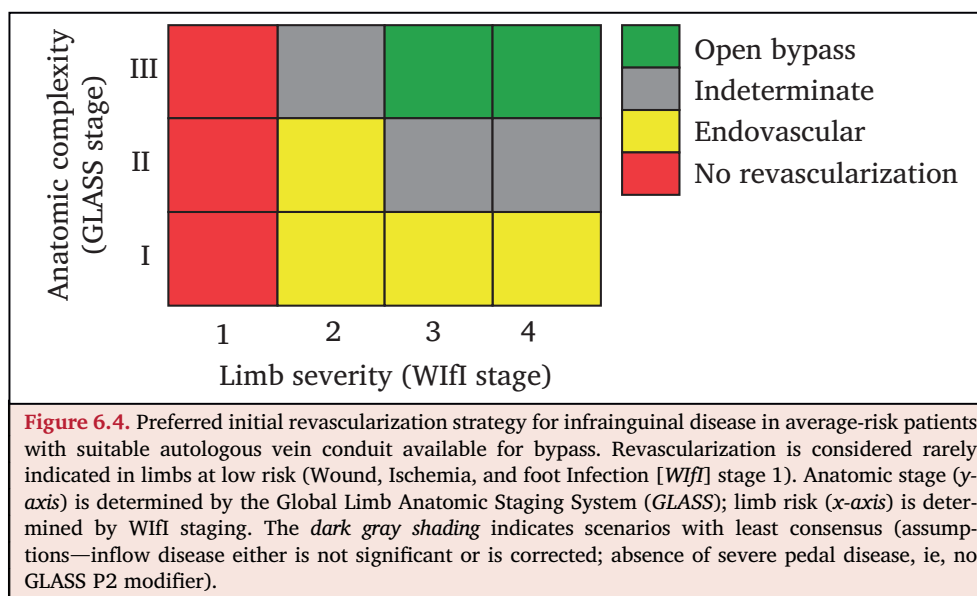
EBR: Role of angiosome-guided revascularization

Whereas few would argue about the desirability of maximizing perfusion at the site of tissue loss, there is considerable debate about the utility of angiosome-guided revascularization.^{445,446} First, unambiguous assignment of foot wounds to an individual angiosome is possible in only a minority of cases.⁴⁴⁷ Toe lesions, which typically represent more than half of the lesions encountered, have a dual blood supply (AT and PT), although for more proximal foot lesions, unique angiosome assignment may be achieved in up to 75% to 80% of patients. Then there is the practical question of whether the desired target artery for the angiosome is available and the comparative hemodynamic and clinical effectiveness of “direct” vs “indirect” revascularization. Tibial and peroneal bypasses perform equally well for limb salvage, and DP bypass can be effective for some hindfoot lesions.⁴⁴⁸ Systematic reviews have yielded conflicting results,⁹⁶⁻⁹⁹ and data are inextricably confounded by the quality of the pedal arch and the nature of the revascularization performed.^{95,449} Whereas wound healing may be improved when direct revascularization is achievable, major amputation rates and patency are not consistently different. To date, none of the analyses take into account the confounding effect of limb staging, for example, using Wifl. In summary, angiosome-guided revascularization may be of importance in the setting of endovascular intervention for midfoot and hindfoot lesions but is likely to be irrelevant for ischemic rest pain and of marginal value for most forefoot lesions and minor ulcers. The role of multivessel (tibial) revascularization is also currently unknown. However, it may be reasonable in selected patients with advanced limb threat (eg, Wifl stages 3 and 4) undergoing endovascular therapy if it can be safely accomplished without risking loss of a bypass target or compromising runoff to the foot.

Recommendations 6 (continued)		
6.38 Consider angiosome-guided revascularization in patients with significant wounds (eg, Wifl wound grades 3 and 4), particularly those involving the midfoot or hindfoot, and when the appropriate TAP is available.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Azuma, ⁹⁵ 2012 Sumpio, ⁹⁶ 2013 Biancari, ⁹⁷ 2014 Chae, ⁹⁸ 2016 Jongsma, ⁹⁹ 2017

EBR: Preferred endovascular techniques for infrainguinal disease

PBA, drug-coated balloon (DCB) angioplasty, stent placement (bare-metal stent, drug-eluting stent [DES], or covered stent), and atherectomy may all be reasonable options in



specific circumstances and lesion anatomies. However, unfortunately, there are few high-quality comparative data to guide the choice of a specific endovascular approach in CLTI.^{7,380,387-389,396,450-455}

PBA may be inferior to DCB angioplasty and stents for the treatment of intermediate-length SFA disease (FP grades 2-4) in patients with IC and possibly rest pain.¹⁰⁰⁻¹⁰³ However, there are inadequate data to support a preferred endovascular approach for FP disease in CLTI.

PBA remains a reasonable primary endovascular approach for anatomically suitable IP disease as current evidence is inadequate to support other, more expensive techniques. Atherectomy is not superior to PBA and is associated with greatly increased costs.⁴⁵³ Combination approaches, such as atherectomy followed by DCB angioplasty, add significant cost and lack high-quality comparative data. Several modest-sized trials suggest potential short-term benefit for DESs in short (ie, <3 cm) tibial lesions, but one cannot generalize these data to the population of CLTI patients as a whole, who typically present with much more extensive disease.^{7,456} DES may be a preferred endovascular “bailout” after technical complications (eg, dissection) or failed PBA for short, proximal IP lesions. Although early studies suggested a potential advantage for DCBs in tibial arteries, an RCT showed no benefit of DCB angioplasty over PBA, with a nonsignificant higher rate of amputations in the DCB angioplasty group.³⁹⁶ The results of further, ongoing studies are awaited. In summary, PBA currently remains the standard of care for the endovascular treatment of IP disease in CLTI.

Technical advances in endovascular intervention include improved wires, low-profile catheters, and retrograde access to allow treatment of complex disease patterns down to the distal calf and foot. Specialized catheters may facilitate crossing of difficult chronic total occlusions and ensure re-entry into the true lumen. Retrograde access techniques using either fluoroscopic or ultrasound guidance may increase the ability to cross chronic total occlusions at the IP and popliteal levels. The

“pedal loop technique” has been described to achieve complete arch reconstitution in the presence of IM disease, and some reports suggest that it may be of value in highly selected patients.^{438,457} The clinical efficacy of these techniques remains to be defined in CLTI as hemodynamic durability remains the primary limitation of endovascular interventions in high-complexity target path anatomy.

Recommendations 6 (continued)		
6.39 In treating FP disease in CLTI patients by endovascular means, consider adjuncts to balloon angioplasty (eg, stents, covered stents, or drug-eluting technologies) when there is a technically inadequate result (residual stenosis or flow-limiting dissection) or in the setting of advanced lesion complexity (eg, GLASS FP grade 2-4).		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	Schillinger, ¹⁰⁰ 2006 Saxon, ¹⁰¹ 2008 Dake, ¹⁰² 2011 Rosenfield, ¹⁰³ 2015 Almasri, ⁷ 2018

EBR: Preferred approaches for infrainguinal bypass

An acceptable target for bypass surgery in CLTI should provide adequate runoff to the lower limb and foot to resolve the clinical situation. In the setting of WIFI stages 3 and 4, it is recommended that the selected target artery provide continuous in-line flow to the ankle and foot.

Good-quality GSV is the optimal autologous conduit for infrainguinal bypass surgery. Alternative (small saphenous vein or arm vein) or spliced veins are acceptable bypass conduits, although there is a higher frequency of reinterventions, and durability is inferior to single-segment GSV grafts. There is no evidence to support a preferred configuration (reversed, nonreversed translocated, in situ) for vein bypass grafting.

Prosthetic conduits may be useful in selected patients lacking other revascularization options. Heparin-bonded expanded polytetrafluoroethylene grafts may be superior to standard expanded polytetrafluoroethylene grafts for below-knee bypass.^{458,459} Other adjuncts, such as a distal vein cuff, may also improve patency of prosthetic bypass to tibial targets, although the data are limited in scope and quality.⁴⁶⁰ In general, clinical outcomes of prosthetic grafting in CLTI are highly sensitive to runoff and severity of limb presentation. Bypass using nonautologous conduit to poor-quality tibial or pedal targets in CLTI is discouraged as patency rates are extremely poor. Defining the optimal approach for below-knee bypass in patients lacking venous conduit remains a major challenge in the field; if these patients are not suitable for endovascular intervention, the individual surgeon’s experience may dictate practice. Further advances in bioengineered arterial conduits are needed to meet this clinical dilemma.

Recommendations 6 (continued)		
6.40 Use autologous vein as the preferred conduit for infrainguinal bypass surgery in CLTI.		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Almasri, ⁷ 2018
6.41 Avoid using a nonautologous conduit for bypass unless there is no endovascular option and no adequate autologous vein.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Almasri, ⁷ 2018
6.42 Perform intraoperative imaging (angiography, DUS, or both) on completion of open bypass surgery for CLTI and correct significant technical defects if feasible during the index operation.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Mills, ¹⁰⁴ 1992 Bandyk, ¹⁰⁵ 1994

Research priorities for strategies for evidence-based revascularization	
Recommendations	
6.1	In patients presenting with the full spectrum of CLTI, prospectively validate and refine patient risk stratification models.
6.2	Conduct comparative effectiveness studies directly comparing strategies of revascularization—and specific techniques and technologies—in well-defined subgroups of patients (eg, Wifi and GLASS stages) with CLTI.
6.3	Define the circumstances in which angiosome-targeted or multivessel revascularization provides clinical benefit in CLTI.
6.4	Develop and test strategies for the management of no-option CLTI patients.
6.5	Conduct appropriately controlled prospective trials to determine the safety and efficacy of drug-eluting technologies specifically in the CLTI population, with adequate (at least 2 year) long term follow up.

7. NONREVASCLARIZATION TREATMENTS OF THE LIMB

Although the optimal treatment of CLTI is undoubtedly revascularization, unfortunately, a significant proportion of patients are not suitable for revascularization for anatomic or physiologic reasons. Whereas major amputation may be suitable for some of these patients, there is clearly a significant number who might benefit from nonrevascularization-based treatments.

There is, however, a paucity of strong evidence regarding these treatment options. The majority of studies are low quality and uncontrolled, combined with considerable study heterogeneity, making systematic review and meta-analysis difficult or even impossible. This heterogeneity is reflected by large variations in patient factors, lesions of interest, intervention protocols, study designs, and end points (limb salvage, AFS, target lesion patency, pain relief, quality of life determinants, ulcer healing, and evolution of tissue lesions).⁴

This section reviews nonrevascularization interventions, pharmacotherapy, and conservative management.

Interventional nonrevascularization treatments

Spinal cord stimulation (SCS)

Mechanism of action. SCS, originally used to treat chronic pain, was first described by Cook et al⁴⁶¹ in the treatment of PAD. In SCS, electrodes are implanted in the lumbar epidural space and connected to a generator to stimulate sensory fibers.⁴⁶² SCS promotes activation of cell signaling pathways that cause the release of vasodilatory molecules, leading to a decrease in vascular resistance and relaxation of smooth muscle cells.⁴⁶² This improved peripheral microcirculatory status has been shown to result in increased capillary flow and density of perfusing capillaries, higher skin temperature and local TcPO₂, normalization of pulse wave morphology, and improved skin nutrition.¹⁰⁶ In addition, SCS suppresses sympathetic vasoconstriction and pain transmission.⁴⁶²

Evidence. A 2013 Cochrane review analyzed data from 444 patients in six controlled studies investigating the use of SCS in CLTI.^{106,463-468} The general quality of studies was good, and all studies used limb salvage as the primary end point (major AFS at 12 months). When the results were pooled, limb salvage rates were found to be significantly higher in the SCS group (RR for major amputation, 0.71; 95% CI, 0.56-0.90).¹⁰⁶ Results were better when patients were selected on the basis of their initial TcPO₂. Significant pain relief was also found in both treatment groups, although the SCS group required less analgesia. In addition, there was no significant effect on ulcer healing. Overall mortality was not evaluated, but the overall complication rate was 17% (95% CI, 12-22%). Implantation problems occurred in 9% (95% CI, 4%-15%), reintervention for changes in stimulation occurred in 15% (95% CI, 10%-20%), and infection of a lead or pulse generator pocket accounted for 3% (95% CI, 0%-6%).¹⁰⁶

Researchers concluded that SCS offered a modest positive effect on pain relief and an 11% reduction in the amputation rate compared with conservative management at 1 year.¹⁰⁶ They stress, however, that the positive benefits

should be weighed against the high cost and possible complications. In fact, the Cochrane review found the cost to be significantly higher in the SCS group by \$8824. Klomp et al⁴⁶⁹ calculated the number needed to treat to save one limb as 13, at \$111,705 per limb saved and \$312,754 per quality-adjusted life-year gained. They concluded that SCS is not a cost-effective treatment of CLTI.

Lumbar sympathectomy (LS)

Mechanism of action. Sympathetic denervation of the lumbar sympathetic ganglia is performed either through open or laparoscopic retroperitoneal access or through percutaneous chemical blockade. LS increases blood flow to the lower limb by inducing vasodilation of the collateral circulation and shunting of blood through cutaneous arteriovenous anastomoses by its reduction of sympathetic tone. This, in turn, improves tissue oxygenation and decreases tissue damage and pain. Pain is also decreased by interruption of sympathetic nociceptive coupling and by a direct neurolytic action on nociceptive fibers.⁴⁷⁰

Evidence. In their systematic review, Sanni et al⁴⁷⁰ reported that RCTs failed to identify any objective benefits for LS in patients with CLTI. They concluded, however, that LS may be considered an alternative to amputation in patients with otherwise viable limbs because it is minimally invasive and cost-effective, with a low complication rate.⁴⁷⁰ Chemical sympathectomy and surgical sympathectomy also appear to perform equally well, with some suggestion that LS can benefit diabetic patients.

Of the three RCTs that focus on LS in PAD, only two reported on its use in CLTI,^{471,472} with the third reporting on its use in IC.⁴⁷³ Cross et al⁴⁷² found that chemical sympathectomy provided relief of rest pain in 67% of patients undergoing LS compared with 24% of controls at 6 months. However, in a contrasting study, Barnes et al⁴⁷¹ found that LS combined with AI revascularization did not provide any additional benefits compared with revascularization alone. In fact, the majority of cohort studies reporting LS in CLTI⁴⁷⁴⁻⁴⁸³ consistently demonstrate subjective improvements in approximately 60% of patients with regard to pain relief and ulcer healing.⁴⁷⁰ Moreover, a Cochrane systematic review was unable to find any RCTs that evaluated the effect of LS (open, laparoscopic, or chemical) compared with no intervention in CLTI due to nonreconstructible PAD.¹⁰⁷ Overall, data are limited, but there is no evidence to suggest that LS reduces the risk of major amputation in patients with CLTI. It remains unclear whether any subgroup of CLTI patients may have improved pain control or ulcer healing with LS.

Intermittent pneumatic compression (IPC)

Mechanism of action. In patients treated with IPC, arterial blood flow is increased in the distal limbs by an increase in the arteriovenous pressure gradient, which stimulates the endothelial vasodilators, thus suspending the venoarteriolar reflex and stimulating collateral artery growth.⁴⁸⁴ As a

result, the arterial flow, peak systolic velocity (PSV), end-diastolic velocity, and pulse volume are all increased.⁴⁸⁵

Several methods of lower limb IPC use various protocols. These include the ArtAssist (ACI Medical, San Marcos, Calif) device, which provides sequential compression to the foot and calf; the Aircast ArterialFlow (DJO Global, Vista, Calif) device, which compresses the calf; and devices that deliver leg compression synchronized with ventricular contraction of the heart (Syncarbon [Contilabo, Saint Gobain, France] and Vascular Pump [Rheomedix, Philadelphia, Pa]).⁴⁸⁴

Evidence. Two controlled studies^{486,487} and several case series⁴⁸⁸⁻⁴⁹⁵ have been published regarding IPC, but there is no robust evidence from high-quality trials. In one, investigators entered 171 patients with CLTI into a 3-month IPC program.⁴⁹⁴ They reported improved pain relief, increased TPs by a mean of 15 mm Hg, and increased popliteal artery flow by a mean of 20 cm/s. The median AFS was 18 months, with 94% limb salvage at 3.5 years. They determined that IPC is a cost-effective intervention at a cost of \$4454 per patient.⁴⁹⁴ In a retrospective observational study involving 107 patients, researchers from the Mayo Clinic found 40% wound healing at 6 months.⁴⁹³

In another study, a non-RCT involving 48 patients, investigators found that 58% of patients who underwent IPC benefited from complete healing and limb salvage compared with 17% in the control group (OR, 7.00; 95% CI, 1.82-26.89).⁴⁸⁶ In a prospective trial, changes in quality of life were reviewed before and after IPC treatment.⁴⁹⁵ Researchers reported a significant improvement in pain, physical functioning, and general health perception. Another systematic review found that IPC might be associated with improved limb salvage, wound healing, and pain management as well as with a low risk of complications.⁴⁸⁴ However, this review also noted a high risk of bias in these studies, with large variations in the type of compression and optimum parameters used.⁴⁸⁴

Wound healing varied considerably (4%-96% at 3 months) in studies that used the same IPC device. In contrast, mortality rates were more consistent.⁴⁸⁴ It has been suggested that outcomes with IPC may be worse for patients with renal failure, with the prognosis for this group being worse for both limb salvage and mortality.⁴⁸⁴

Guidelines on nonrevascularization interventions

The TransAtlantic Inter-Society Consensus II (TASC II) document on the management of PAD concluded that there is low-level evidence available for the recommendation of SCS.¹⁵⁶ Likewise, guidelines from the ESVS state that the benefit of SCS is unproven, with insufficient evidence to recommend its use in the treatment of CLTI.⁴⁹⁶

Although the TASC II document did not include LS in the treatment of CLTI, it did mention its potential role in the management of complex regional pain syndrome.¹⁵⁶ The ESVS guidelines conclude that LS should not be considered an option to prevent amputation but can be considered in patients who are not amenable to revascularization to relieve symptoms.⁴⁹⁶ The American Heart Association's

guidelines on the management of PAD do not mention LS.⁴⁹⁶ Finally, the international guidelines make no reference to IPC at all.

Recommendations 7		
7.1 Consider SCS to reduce the risk of amputation and to decrease pain in carefully selected patients (eg, rest pain, minor tissue loss) in whom revascularization is not possible.		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	Ubbink, ¹⁰⁶ 2013
7.2 Do not use LS for limb salvage in CLTI patients in whom revascularization is not possible.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Karant, ¹⁰⁷ 2016
7.3 Consider IPC therapy in carefully selected patients (eg, rest pain, minor tissue loss) in whom revascularization is not possible.		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	Abu Dabrh, ⁴ et al 2015

Pharmacotherapy

Prostanoids

Mechanism of action. Prostanoids include a family of inflammatory mediators, mainly prostaglandin E1 (PGE₁), prostacyclin (PGI₂), and iloprost. Prostanoids act by inhibiting the activation of platelets and leukocytes, by inhibiting the adhesion and aggregation of platelets, and by promoting vasodilation and vascular endothelial cytoprotection through antithrombotic and profibrinolytic activities.^{108,497,498}

Evidence. A meta-analysis evaluating the use of PGE₁ vs placebo in the treatment of 254 patients with CLTI demonstrated favorable results at 6 months, with ulcer healing or pain reduction (47.8% vs 25.2% placebo) and reduction in major amputation or death (22.6% vs 36.2% placebo) associated with PGE₁ use.⁴⁹⁹ Subsequently, a 2018 Cochrane paper reviewed 33 prostanoid studies with various formulations, doses, and administration routes.¹⁰⁸ These included intravenous (IV) administration of PGE₁ (synthetic form, alprostadi) for 21 days and an intra-arterial administration; IV administration of PGI₂ for 4 to 7 days; IV administration of iloprost (synthetic analogue of PGI₂) for 14 to 28 days, oral administration for 28 days to 1 year, and low-dose infusion; IV administration of lipocaprost for 50 days; and IV administration of ciprostone (a PGI₂ analogue) for 7 days.^{108,497} Compared with placebo, prostanoids appeared to have some efficacy for treating rest pain (RR, 1.30; 95% CI 1.06 to 1.59) and ulcer healing (RR, 1.24; 95% CI 1.04 to 1.48). As a group, however, prostanoids did not have a significant impact on amputations or mortality, although not all studies defined major vs minor amputations.⁴⁹⁸ Prostanoids were associated with a statistically significant increase in side effects (RR, 2.35; 95% CI, 1.99-2.78).⁴⁹⁸ The side effects were mostly minor, including headache, facial flushing, nausea, vomiting, and diarrhea.

The authors of the Cochrane systematic review concluded that there is no strong evidence on the efficacy and safety of prostanoids in patients with CLTI on the basis

of a high-quality meta-analysis of homogeneous, long-term RCTs.⁴⁹⁷ They also called on the need for further high-quality trials.⁴⁹⁸ A subgroup analysis of the Cochrane meta-analysis, however, suggested that iloprost appeared to reduce major amputation (RR, 0.69; 95% CI, 0.52-0.93) and fared better with rest pain (RR, 1.54; 95% CI, 1.19-1.99) and ulcer healing (RR, 1.80; 95% CI, 1.29-2.50). The authors stated that whereas previous meta-analyses of iloprost had been more positive,⁵⁰⁰ only a few of the studies used in those previous meta-analyses could be included in the Cochrane review because of study methodology issues. In fact, in clinical practice, iloprost appears to benefit approximately 40% of patients in whom revascularization is not possible.^{156,500}

Since the Cochrane review was published, a newer RCT comparing a placebo with the use of PGI₂ analogue taprostene intravenously for 2 weeks failed to demonstrate any difference in pain relief, ulcer size improvement, or prevention of amputation.⁵⁰¹ There are no data to support the use of prostanoids to reduce the risk of major amputation in CLTI patients in whom revascularization is not possible.

Vasoactive drugs

Naftidrofuryl. A Cochrane review of eight RCTs examined the IV administration of naftidrofuryl in 269 patients.¹⁰⁹ The treatment tended to reduce rest pain and to improve skin necrosis, but this was not statistically significant. The studies were found to be of low methodologic quality, with varying levels of severity of CLTI, varying lengths of duration of treatment (from 3 to 42 days), and different measures of effect. This resulted in varying end points that precluded a meaningful pooling of results.¹⁰⁹ Thus, there is currently insufficient evidence to support the use of naftidrofuryl in the treatment of CLTI.⁴⁹⁸

Pentoxifylline. This drug improves blood flow by increasing red blood cell deformity and decreasing viscosity. A European RCT involving 314 patients found a significant reduction in rest pain, sleep disturbance, and analgesia requirements.⁵⁰² In a separate Norwegian study using the same dosing regimen, there was no statistically significant difference either in pain-free levels or in absolute walking distance between the two groups.⁵⁰³ Researchers concluded that further investigation is necessary to evaluate the role of pentoxifylline in the treatment of patients with CLTI. Thus, there is currently a lack of consistent evidence to recommend the use of pentoxifylline in the treatment of CLTI.⁴⁹⁸

Cilostazol. This drug has been well studied in claudicants but not as much in CLTI. One small study demonstrated that cilostazol improves microvascular circulation and skin perfusion pressure in ischemic limbs.⁵⁰⁴ Another uncontrolled study that used cilostazol in conjunction with endovascular revascularization reported higher rates of AFS and limb salvage but not higher rates of survival or freedom from further revascularization.⁵⁰⁵ In the absence of RCTs in patients with CLTI, there is insufficient evidence that cilostazol improves clinical outcomes in patients with CLTI.^{504,505}

Vasodilators

Because vasodilators can cause shunting of blood away from ischemic areas to nonischemic areas, they are of no value to patients with CLTI.¹⁵⁶

Defibrinating agents

Two small RCTs compared anicrod, a defibrinating agent, with placebo in CLTI.^{506,507} Although one study showed positive changes in APs and TPs, both studies failed to demonstrate any improvements in clinical outcome.

Hyperbaric oxygen therapy (HBOT)

There are numerous plausible mechanisms for HBOT to have a therapeutic role in CLTI. These include increased oxygen transport capacity of plasma (independent of red blood corpuscle number and function), improved function of the leukocyte oxygen-dependent peroxidase system, reduced tissue edema due to the osmotic effect of oxygen, stimulation of progenitor stem cell mobilization and angiogenesis, and improved fibroblast function.⁵⁰⁸ If there is superimposed infection, HBOT also inhibits bacterial growth (particularly anaerobes), generates free radicals that destroy bacterial cellular structures, and improves the oxygen-dependent transport of antibiotics.⁵⁰⁹

In 2015, a Cochrane review of the role of HBOT in healing of chronic wounds was published,¹¹⁰ involving 12 trials and 577 patients. Ten of the 12 trials studied the effect of HBOT on ulcer healing in patients with diabetes. The 2015 review concluded that HBOT increased the rate of ulcer healing in DFUs at 6 weeks but not at longer term follow-up, with no significant difference in the risk of major amputation.¹¹⁰

Three other studies involved patients with ischemic ulcers, but each study used varying definitions of ischemia.⁵¹⁰⁻⁵¹² Abidia et al⁵¹¹ randomized 18 patients with an ABI of <0.8 or TBI of <0.7 and found improvement in wound healing in the treatment group. Löndahl et al⁵¹² randomized 94 patients with adequate distal perfusion or nonreconstructible arterial disease. They found that 57% of patients had a TP of <60 mm Hg (median, 52 mm Hg). Complete ulcer healing occurred in 52% of the patients treated with HBOT compared with 29% of controls at 12 months ($P < .02$). Stratification based on TPs did not appear to affect healing rates. A subsequent publication by this group demonstrated that preintervention TcPO₂ correlated with ulcer healing and that individuals with a TcPO₂ of <25 mm Hg did not heal.⁵¹³ There was no significant difference in major amputations between the two groups, with three amputations in the HBOT cohort and one in the control cohort.

One study randomized 70 patients with DFUs to either HBOT or standard care.⁵¹⁰ The mean ABI and TcPO₂ were 0.65 and 23 mm Hg in the HBOT cohort and 0.64 and 21 mm Hg in the non-HBOT group. All patients with an ABI <0.9 or TcPO₂ <50 mm Hg were considered ischemic, underwent an iloprost infusion, and were examined for possible revascularization. Thirteen patients in each group underwent a revascularization procedure. At the

completion of the therapy, resting TcPO₂ increased by a mean of 12.1 in the HBOT group and 5.0 in the control group ($P < .0002$). There was a significant reduction in major amputations in the HBOT group ($P < .016$).⁵¹⁰

A large longitudinal cohort study using data from a wound healing group in the United States⁶¹ included patients with DFUs and adequate foot perfusion as determined by clinicians. A total of 793 patients underwent HBOT. Propensity scoring was used to compensate for the lack of randomization. The study found that individuals treated with HBOT were less likely to have healing of ulcers (HR, 0.68; 95% CI, 0.63-0.73) and more likely to undergo lower limb amputation (HR, 2.37; 95% CI, 1.84-3.04).⁵¹⁴

A subsequent multicenter RCT (Does Applying More Oxygen Cure Lower Extremity Sores? [DAMO₂CLES]) undertaken in 25 hospitals in the Netherlands and Belgium randomized 120 patients with an ischemic foot wound and diabetes to standard care with or without a course of HBOT. Ischemia was defined as AP <70 mm Hg, TP <50 mm Hg, or TcPO₂ <40 mm Hg. All patients were assessed for revascularization, and when applicable, this was generally performed before HBOT. Primary outcomes were limb salvage, wound healing at 12 months, and time to wound healing. Mortality and AFS were also analyzed. Limb salvage (47/60 in the standard care cohort and 53/60 in the standard care with HBOT cohort), index wound healing at 12 months (28/60 in the standard care cohort vs 30 in the standard care with HBOT cohort), and AFS (41/60 in the standard care cohort vs 49 in the standard care with HBT cohort) were not significantly different between the two groups. A high proportion (35%) of those allocated to HBOT were unable to undergo HBOT or did not complete at least 30 treatments, mostly for medical comorbidities or logistical reasons, reinforcing the significant medical comorbidities present in these patients.¹¹²

Overall, whereas controversy remains, there may be a role for the use of HBOT to accelerate ulcer healing in diabetic patients with nonhealing neuropathic ulcers and low-grade ischemia who have failed to respond to conventional wound care. However, HBOT does not prevent major limb amputation and should not be used as an alternative to revascularization in patients with CLTI.

Guidelines on nonrevascularization pharmacotherapy

The TASC II document notes that although previous studies with prostanoids in CLTI suggested improved healing of ischemic ulcers and reduction in amputation, trials do not demonstrate a benefit for prostanoids in promoting AFS.¹⁵⁶ The current PAD guidelines and recommendations of the American College of Cardiology Foundation and the American Heart Association state that parenteral administration of PGE1 or PGE2 may be considered to reduce pain and to improve ulcer healing in CLI but that the beneficial effect is likely to occur only in a small subset of patients.⁵¹⁵

Finally, international guidelines do not address vasoactive drugs, vasodilators, or defibrinating agents. However, the TASC II guideline advocated for considering HBOT in

selected patients who have not responded to revascularization.¹⁵⁶

Recommendations 7 (continued)		
7.4 Do not offer prostanoids for limb salvage in CLTI patients. Consider offering selectively for patients with rest pain or minor tissue loss and in whom revascularization is not possible.		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	Vietto, ¹⁰⁸ 2018
7.5 Do not offer vasoactive drugs or defibrinating agents (ancrod) in patients in whom revascularization is not possible.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Smith, ¹⁰⁹ 2012
7.6 Do not offer HBOT to improve limb salvage in CLTI patients with severe, uncorrected ischemia (eg, WIfI ischemia grade 2/3).		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Kranke, ¹¹⁰ 2015 Game, ¹¹¹ 2016 Santema, ¹¹² 2018
7.7 Continue to provide optimal wound care until the lower extremity wound is completely healed or the patient undergoes amputation.		
Grade	Level of evidence	Key references
Good practice statement	-	-

Conservative management

Wound care. CLTI is associated with a markedly shortened life expectancy, and not surprisingly, patients with unreconstructed CLTI experience poorer outcomes in terms of survival and limb salvage. In a retrospective study involving 105 patients with unreconstructed CLTI, 46% of patients lost the limb and 54% died within 1 year.⁵¹⁶ Of the patients with a nonamputated leg, 72% were dead within 1 year. Thus, despite advances in revascularization techniques and anesthetics, endovascular or surgical revascularization may not be appropriate in some patients, even if it is technically possible, because of significant comorbidities and reduced life expectancy.

A group of 169 patients with stable tissue loss who were unsuitable for revascularization based on medical and anatomic reasons were entered into a dedicated wound management program.²⁹⁰ At 1 year, 77% of patients remained amputation free, 52% had ulcer healing, and only 28% required minor amputation. Investigators concluded that conservative management might serve a subset of CLTI patients. In fact, circumstances other than revascularization have been identified as important for conservative management, including adequate nutrition, absence of infection, removal of mechanical features interfering with wound healing (by surgical débridement, hydrotherapy, or larvae therapy), negative dressing therapy, and noncontact low-frequency ultrasound.⁵¹⁷

More recently, a group of 602 diabetic patients with foot ulcers and low TPs or APs were observed.⁵¹⁸ During the

variable follow-up period of 1 to 276 weeks, 38% of patients had healed primarily, 12% had minor amputation, 17% healed after major amputation, and 33% died unhealed.

Conclusions

Despite the lack of evidence to support non-revascularization methods in CLTI, they are still widely used in real-world practice. In a mail-in questionnaire of vascular surgeons in the United Kingdom published in 2009, 75% believed that LS had a role in clinical practice for inoperable PAD,⁵¹⁹ although in current practice LS is rarely used for CLTI. Similarly, in a report on outcomes in patients with nonreconstructible CLTI, 88% received prostanoid infusions, 14% low-molecular-weight heparin or oral anticoagulants, 3% SCS, 17% HBOT, and 69% wound treatment. In addition, 13% of patients underwent toe or other foot-sparing amputations; at 24 months, the major amputation rate was 9.3%, with a mortality rate of 23.2%.⁵²⁰ It is possible that these examples of real-world nonevidence-based practice represent the desire to help this challenging population of patients when traditional methods either are unsuitable or have failed. Still, these treatments are mostly unsupported by evidence and should be considered alternatives only on an individual basis and after careful consideration of benefit and risks.

Research priorities for non-revascularization treatments of the limb	
Recommendations	
7.1	Assess whether pneumatic compression is effective in improving AFS and resolution of rest pain in patients with CLTI.
7.2	Better define individuals with CLTI who are likely to benefit from nonrevascularization therapies.
7.3	Define the role of exercise therapy for the nonrevascularization treatment of patients with CLTI.
7.4	Define the population of CLTI patients who experience benefit from HBOT in terms of wound healing, pain relief, or other meaningful outcomes.

8. BIOLOGIC AND REGENERATIVE MEDICINE APPROACHES IN CLTI

Biologic or regenerative medicine therapies include gene therapy and cellular therapy. These treatments offer the potential to promote wound healing and to prevent amputation in patients who otherwise have no options for revascularization.

Therapeutic angiogenesis is defined as the growth of new blood vessels from pre-existing blood vessels in response to growth factor stimulation. This has been shown to occur in animal models of hind limb ischemia and can be induced either by angiogenic proteins such as vascular endothelial growth factor or by cellular therapy using stem cells or bone marrow aspirate. The concept of angiogenesis was introduced into the clinical realm by Jeffrey Isner in the early 1990s.⁵²¹ Various growth factors, including vascular

endothelial growth factor, hepatocyte growth factor (HGF), and fibroblast growth factor (FGF), have been shown to promote angiogenesis in animal models. The short half-life of these proteins has led to the use of gene therapy to maintain sustained expression in the ischemic limb. Most clinical trials to date have used intramuscular injection of either a gene or cellular therapy. In the case of gene therapy, expression of the protein is maintained for 2 to 6 weeks. Ongoing research in this arena includes alternative vectors to safely enhance long-term gene expression.

The putative mechanism of cellular therapy involves either the differentiation of stem cells into vascular cells, after injection into the hypoxic extremity, or induction of angiogenic growth factor expression, again due to relative tissue hypoxia in the ischemic extremity. General concerns about the safety of angiogenic therapy have been related to the potential for “off-target” angiogenesis, which can result in promotion of occult tumor growth or accelerated progression of diabetic proliferative retinopathy. To date, these concerns have not occurred in angiogenic clinical therapy trials that have been completed.

Trials of gene and stem cell therapy in CLTI

Gene therapy

Fibroblast growth factor (FGF). This has been extensively studied in the context of severe limb ischemia. The TALISMAN phase 2 trial (NCT00798005) enrolled 125 patients and reported a significant improvement in AFS at 12 months of 73% in patients treated with FGF plasmid compared with 48% in placebo-treated patients with no options for revascularization ($P = .009$).⁵²² Complete ulcer healing at 6 months occurred in 14% of the placebo group and 20% of the treatment group (not significant).⁵²² In a separate study, the investigators demonstrated proof of concept of gene therapy when they identified the FGF plasmid, messenger RNA, and protein in the amputation specimens of patients with CLTI who received FGF plasmid injections before amputation.⁵²³

These findings led to a phase 3 trial, the TAMARIS trial (NCT00566657).⁵²⁴ This trial enrolled 525 patients from 30 countries who had either an ischemic ulcer or minor gangrene. However, the TAMARIS trial failed to show a difference in AFS compared with placebo in patients with CLTI (63% in the treatment group vs 67% in the placebo group).⁵²⁴ The AFS for both groups was similar to that for the FGF-treated patients in the phase 2 TALISMAN trial (Table 8.1). The likely explanation for the different results observed in the phase 2 TALISMAN and phase 3 TAMARIS trials is a type II error in the earlier study.

Hepatocyte growth factor (HGF). Several clinical trials have evaluated HGF plasmid in the treatment of patients with CLTI and no option for revascularization. Early phase 2 trials (NCT00189540, NCT00060892) have shown that HGF plasmid gene therapy can improve TcPO₂ and pain scores in patients with CLTI compared with placebo, but this did not result in improved AFS.^{525,526} A Japanese trial of 40 patients

demonstrated a significant improvement in a composite end point of improvement of rest pain in patients without ulcers or reduction in ulcer size in those with ulcers at 12 weeks (70.4% vs 30.8%; $P = .014$).⁵²⁷ The AFS at 12 months was not reported. There are currently no U.S. Food and Drug Administration (FDA)-approved gene therapies for treatment of patients with CLTI.

Stem cell therapy. Preclinical studies using animal hind limb ischemia models have shown that stem cells injected intramuscularly into the hind limb can promote improved blood flow through an angiogenic mechanism. Early studies in humans have similarly shown improved vascularity in the treated extremity, as measured by ABI, although the mechanism by which this occurs in humans is unknown. Cellular therapies can be divided into autologous and allogeneic. Several phase 1 and phase 2 trials have recently been completed, including ones from Harvest Technologies (NCT00498069) and Biomet (NCT01049919).^{528,529} Both of these report promising early results of phase 1 trials using autologous bone marrow mononuclear cells (BMMNCs) in the treatment of CLTI.^{528,529} In addition, both companies have developed point-of-care cell preparation systems. After bone marrow harvest, the BMMNCs are extracted for direct intramuscular injection into the ischemic limb.

Iafrafi et al⁵²⁸ reported the results of 97 patients. In patients treated with intramuscular bone marrow concentrate, there was a 64% AFS at 6 months compared with 65% in the control group. The treated patients had a significant improvement in pain relief and TBI.^{528,530} Another trial of 152 patients found little difference in AFS between the treatment group and control group at 6 months (80% vs 69%; $P = .224$).^{529,531} Both of these phase 3 trials are being conducted through investigator device exemptions from the Center for Devices and Radiological Health of the FDA.

Another trial, the RESTORE-CLI (phase 2) trial, used expanded autologous stem cell therapy, ixmyelocel-T, in the treatment of CLTI patients for whom revascularization was not an option.⁵³² Bone marrow aspirate (50 mL) was taken from study patients and sent to the sponsor, where the cells were cultured in a bioreactor and expanded during a 2-week period; when expanded, the cell population is enriched with mesenchymal precursors and alternatively activated macrophages. It was then returned to the trial site for intramuscular injection into the ischemic limb of the patient. The trial enrolled 72 patients with either ischemic rest pain or tissue loss. At 12 months, 40% of patients who were treated with ixmyelocel-T experienced one or more treatment failure events (defined as death, major amputation, doubling of wound size from baseline, or new-onset gangrene) compared with 67% of placebo-treated patients ($P = .045$, Fisher exact test). There was no difference in AFS.⁵³² Treatment failure events were particularly pronounced in patients who presented with tissue loss at baseline. In the subgroup of patients presenting with wounds, 45% of patients treated with ixmyelocel-T experienced a treatment failure event compared with 88% of control patients ($P = .01$).⁵³²

Table 8.1. Major trials of gene therapy and cell therapy

Trial	Treatment	No. of participants	End points			Reference
			AFS at 12 months (treated vs placebo)	Other end points	Treatment vs placebo	
<i>Gene therapy</i>						
TALISMAN	FGF	125	73% vs 48% ($p = .009$)			Nikol, ⁵²² 2008
TAMARIS	FGF	525	63% vs 67% ($p = .48$)			Belch, ⁵²⁴ 2011
HGF-STAT	HGF	104	No difference	Change in TcPO ₂ at 6 months	25.2 mm Hg in high-dose group vs 9.4 mm Hg in placebo group ($p = .0015$)	Powell, ⁵²⁶ 2008
HGF-0205	HGF	27	No difference	Change in TBI at 6 months	+0.05 vs -0.17 ($p = .047$)	Powell, ⁵²⁵ 2010
Shigematsu et al	HGF	40	No difference	Improvement in rest pain or reduction in ulcer size	70.4% vs 30.8% ($p = .014$)	Shigematsu, ⁵²⁷ 2010
<i>Cell therapy</i>						
Iafrati et al	Autologous bone marrow	97	No difference	Improvement in pain at 6 months	58% vs 26% ($p = .025$)	Iafrati, ^{528,530} 2011, 2016
RESTORE-CLI	Expanded autologous stem cells	72	No difference	Improvement in TBI at 6 months	0.48 vs 0.012 ($p = .02$)	Powell, ⁵³² 2012
				Combined outcomes (1-year freedom from major amputation, mortality, increased wound size, new gangrene)	40% vs 67% ($p = .045$)	
MOBILE	Autologous bone marrow cells	152	80% vs 69% ($p =$ not significant)			Murphy, ^{529,531} 2011, 2016
JUVENTAS	BMMNCs	160	77% vs 84% (at 6 months) No difference	Major amputation at 6 months	19% vs 13% ($p =$ not significant)	Teraa, ⁵³⁵ 2015

AFS = Amputation-free survival; BMMNCs = bone marrow mononuclear cells; FGF = fibroblast growth factor; HGF = hepatocyte growth factor; JUVENTAS = Rejuvenating Endothelial Progenitor Cells via Transcutaneous Intra-arterial Supplementation; MOBILE = MarrowStim treatment of limb ischemia in subjects with severe peripheral arterial disease; TBI = toe-brachial index; TcPO₂ = transcutaneous oximetry.

In a small study of 28 patients with CLTI, Losordo et al⁵³³ completed a placebo-controlled trial to compare CD34-positive cells selected by leukopheresis after mobilization with granulocyte colony-stimulating factor. The investigators showed a trend toward reduction in all amputations (both major and minor). At 12 months, 31% of treated patients underwent amputation compared with 75% of placebo-treated patients ($P = .058$). There was no difference between the two groups when only major amputation was evaluated, although the number of patients in the trial was small.⁵³³

In another small trial, the Bone Marrow Autograft in Limb Ischemia (BALI) study randomized 38 patients with CLI to treatment with bone marrow-derived mononuclear cells vs placebo at seven centers in France.⁵³⁴ A single treatment employing 30 separate intramuscular injections in the

ischemic limb was performed. There was no statistical difference in major amputation at 6 or 12 months or in ulcers or pain relief at 6 months. Interestingly, TcPO₂ values increased in both treated and placebo patients. Using a “jackknife” method of logistic regression, the authors suggest some benefit in major amputation for the treated group. However, the total number of patients and events in this trial was small, and the results can be considered only exploratory at best.

The Rejuvenating Endothelial Progenitor Cells via Transcutaneous Intra-arterial Supplementation (JUVENTAS) trial randomized 160 patients with severe limb ischemia to three intra-arterial infusions of either BMMNCs or placebo, 3 weeks apart.⁵³⁵ No major differences were found in major amputations at 6 months (19% in patients receiving BMMNCs vs 13% in the placebo cohort) or in AFS at 6

months (77% in patients receiving BMMNCs vs 84% in the placebo group). No differences were found in the safety outcomes or secondary outcomes of the two groups.⁵³⁵

The recently completed phase 1 allogeneic cell therapy trial sponsored by Pluristem (NCT00951210) has shown promising safety and potential efficacy (personal communication). This open label trial of allogeneic placental stem cells (PLX-PAD cells) will be entering phase 2 placebo-controlled trials. The PLX-PAD cells are mesenchymal-like stromal cells derived from the full-term placenta and are expanded using the sponsor's proprietary bioreactor. The cells are believed to be immune privileged and would potentially offer an "off-the-shelf" treatment option.

Finally, a meta-analysis of randomized placebo-controlled trials of stem cell therapy involved 499 patients in 10 trials.¹¹³ Follow-up in all of the included trials was <12 months, and only three studies observed patients for at least 6 months. This meta-analysis demonstrated no improvement in major amputation rates or AFS associated with stem cell therapy. Secondary outcomes (ABI, TcPO₂, and pain scores) were significantly better in the treatment group.¹¹³

Safety of therapeutic angiogenesis

Early concerns about off-target angiogenesis and the potential for progression of diabetic proliferative retinopathy or occult tumor growth previously resulted in significant restrictions in the inclusion and exclusion criteria for entry into these studies. As early studies demonstrated an acceptable safety record for this therapy and potential concerns about off-target angiogenic complications lessened, these restrictions have since decreased.

Unanswered questions in the field

Trial design and completion hurdles. Trials involving CLTI patients face multiple hurdles that have resulted in delays in completion. The overall comorbid burden of the population of CLTI patients results in a high incidence of adverse events throughout the length of the study. Likewise, the heterogeneous nature of CLTI results in a highly variable natural history. Patients with ischemic tissue loss have a major amputation rate at 1 year of up to 35% compared with <10% in patients with rest pain. In addition, the FDA recommends that AFS should be the primary efficacy end point in a phase 3 CLTI trial. This has resulted in studies with an expected enrollment requirement of at least 500 patients. The reason for these large numbers in a phase 3 trial is that biologic treatment of CLTI is a limb-sparing procedure. As such, it is not expected to significantly influence mortality, although mortality is a component of the primary end point. Consequently, because of the heterogeneous and frail nature of the population of CLTI patients, larger numbers of patients are needed to complete a clinical trial that can detect any potential efficacy on amputation at 1 year.

Selection of patients. Many trials have recruited individuals who are considered to have no option for revascularization.

Unfortunately, there is no consistent definition of no-option CLI. Published studies referred to in this section have broadly included individuals who were considered poor candidates for surgical or endovascular revascularization. This was due to either technical factors (inadequate venous conduit; unfavorable anatomy, such as absence of a patent artery in the calf that is in continuity with the foot) or patient-related factors (poor operative risk, but pain or tissue loss was unlikely to require amputation within 4 weeks). In several studies, imaging was assessed by an independent vascular specialist.

The development of advanced endovascular techniques gives many patients who were previously considered to have no option for revascularization a new opportunity to be considered potentially suitable for endovascular intervention. Nonetheless, there are few data supporting many of these techniques. Novel methods to measure circulating stem or progenitor cells before therapy may prove helpful in serving as companion diagnostics to identify those individuals who may or may not respond to angiogenic therapy.⁵³⁶

Conclusions

There have been promising early safety and efficacy trial data for both gene and cellular therapies in patients with CLTI. Despite these early promising results, no phase 3 trials have shown this therapy to be effective. Still, current trial design has improved, and there are multiple phase 3 clinical trials that either are actively enrolling or are in early stages of development. These involve potentially disruptive technologies that, if proven effective, could dramatically alter how patients with CLTI are cared for in the future. Until further evidence is available, these therapies should be considered investigational.

Recommendation 8		
8.1 Restrict use of therapeutic angiogenesis to CLTI patients who are enrolled in a registered clinical trial.		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Abu Dabrh, ⁴ 2015 Peeters, ¹¹³ 2015

Research priorities for biologic and regenerative medicine approaches in CLTI	
Recommendations	
8.1	Identify surrogate markers (biomarkers, imaging) that would assist in understanding the possible mechanisms of action of gene- and cell-based therapies in CLTI.
8.2	Determine whether gene- or cell-based therapies can serve as an adjunct to revascularization to improve clinical outcomes in subsets of CLTI patients.

9. THE ROLE OF MINOR AND MAJOR AMPUTATIONS

CLTI is associated with a reduced life expectancy, a significant curtailment in ambulation, and a high likelihood of limb loss. Preservation of a patient's ability to walk is an important aspect of care in CLTI, and vascular reconstruction is the most direct method for achieving functional limb salvage in these often critically ill patients. When properly applied, open surgical and endovascular techniques have proved useful and successful for the preservation of limb function. A successful limb salvage intervention is associated with low postprocedural morbidity and mortality, preservation or restoration of independent ambulation, improved quality of life for the patient, and lower cost to the health care system. Although most patients require a single procedure to accomplish this, many will need minor amputations to remove distal necrotic or infected tissue to achieve a completely healed and functional extremity. This is especially true of diabetics, who have a lifetime risk of foot ulceration of 25%, with 50% of ulcers becoming infected.¹⁵⁴ Treatment of these patients requires both in-line pulsatile flow to the foot and wound débridement or minor amputation.⁵³⁷

Minor amputations

Minor amputations of the foot include digital and ray amputation of the toe, transmetatarsal amputation of the forefoot, and Lisfranc and Chopart amputations of the midfoot. Each of these can be useful to preserve foot function in appropriately selected patients. Although there is a significant risk of need for reamputation at a higher level in diabetics, the use of minor amputations, including single-digit and ray amputations,⁵³⁸⁻⁵⁴⁰ can preserve foot function in the majority of patients. There are some instances in which transmetatarsal amputation may be a better first procedure, including necrosis of the great toe requiring long ray amputation or ray amputation of the first and fifth toes, but ensuring adequate distal perfusion and appropriate offloading of the forefoot are the major principles for preservation of foot function.^{114,541}

There are, however, situations in which an aggressive attempt at limb salvage would be unlikely to succeed, would pose too great a physiologic stress on the patient, or would be of limited value because of other causes of limb dysfunction. For these patients, major amputation may be considered a reasonable option. Because a well-planned primary amputation can often result in a high likelihood of independent ambulation for many patients, this procedure should not be considered a failure of vascular surgery. Rather, it should be viewed as another path to the goal of preserving the walking ability in carefully selected patients or for resolution of ischemic pain, ulceration, and infection.

Primary amputation

Primary amputation in patients with CLTI is defined as lower extremity amputation without an antecedent open or endovascular attempt at limb salvage. There are four major

goals of primary amputation for patients with CLTI: (1) relief of ischemic pain; (2) removal of all lower extremity diseased, necrotic, or grossly infected tissues; (3) achievement of primary healing; and (4) preservation of independent ambulatory ability for patients who are capable. In addition, there are five major indications for primary amputation.

1. Nonreconstructible arterial disease, as confirmed by clear distal imaging studies that fail to identify patent distal vessels needed for a successful intervention. In the setting of severe distal ischemia, in particular in association with ischemic ulceration, gangrene, or infection, the inability to improve straight-line distal perfusion often results in major amputation even with a patent bypass graft. Bypasses to arteries that do not have at least large, angiographically apparent collateral vessel outflow provide little additional flow to the foot for distal limb salvage.⁵⁴² Patients without any appropriate targets for successful distal revascularization are frequently better served with a primary major amputation.
2. Destruction of the major weight-bearing portions of the foot, rendering it incompatible with ambulation. The weight-bearing portions of the foot consist of the calcaneus, the first and fifth metatarsal heads, and a functional arch. Patients with gross destruction of the calcaneus and overlying skin should be considered for primary amputation because a functional foot can infrequently be salvaged. After aggressive heel ulcer excision and extensive calcaneotomy, complete wound healing is infrequent and chronic pain is common.^{543,544}
3. Nonfunctional lower extremity due to paralysis or unremediable flexion contractures. These patients are unlikely to benefit from attempts at revascularization, and there will be little change in quality of life despite a successful intervention.
4. Severe comorbid conditions or limited life expectancy due to a terminal illness. The goal of treatment for these patients is relief from ischemic pain, if present, and an improvement in the remaining quality of life. Extensive distal revascularization, prolonged hospitalization, and protracted recovery should be avoided. Assessment of the patient's frailty may be of value to determine whether primary major amputation is more appropriate than distal revascularization.^{545,546}
5. Multiple surgical procedures needed to restore a viable lower extremity. As the technology and techniques of vascular surgery have improved, surgeons have advanced beyond revascularization to complex vascular and soft tissue reconstruction. This approach usually involves multiple surgical procedures to increase distal flow, removal of all necrotic tissue, and reconstruction of these areas with free flaps. The course of treatment is prolonged, involving multiple returns to the operating room, long periods of inactivity, and a difficult recovery. For these patients, if multiple procedures with high morbidity are required, primary amputation should be

strongly considered to permit early ambulation. A detailed discussion with the patient to develop a comprehensive treatment plan with shared decision-making is important for such advanced vascular disease.

For all patients considered for primary amputation, also consider revascularization to improve inflow in an attempt to reduce the level of the amputation.^{118,119} For example, those patients with extensive infrainguinal arterial occlusion, including the common and proximal PFA, might benefit from restoration of flow into the deep femoral system to reduce the amputation level from the upper thigh to the level of the knee. In such cases, despite some additional risk, proximal revascularization has the potential to offer a tangible and significant benefit to the patient.

Secondary amputation

For those in whom one or more attempts at revascularization have failed and the likelihood of a successful and durable redo procedure is limited, major amputation with a goal of rehabilitation to independent ambulation should be considered.

Level of amputation

Selecting the level of amputation that will heal primarily is critical to successful prosthetic rehabilitation and maximal functional mobility. Thus, a great deal of consideration must go into selecting the initial level of amputation. Preoperative tissue perfusion assessment can make it possible to lower the level of amputation, although there is no accurate method to predict the optimal level of amputation.⁵⁴⁷ In addition, whereas assessment of preoperative tissue perfusion can aid in decision-making, it still remains largely a clinical decision. Many techniques to evaluate tissue perfusion have been tried, including laser Doppler flowmetry, thermography, skin perfusion pressure, fluorometric quantification of a fluorescein dye, TcPO₂, and indocyanine green fluorescence angiography. In particular, TcPO₂ has been extensively evaluated, and it has been shown that wound complications increase as TcPO₂ levels fall below 40 mm Hg.⁵⁴⁷ Currently, there is still no single definitive method of evaluating tissue perfusion that can accurately predict the wound healing potential or failure at the site of amputation.

Healing rates of amputations and reamputations

Achieving primary healing is challenging in ischemic lower limbs, and it is difficult to predict early failure (Table 9.1). Multiple débridements and reamputations are required in 4% to 40% of patients, depending on the level of amputation.⁵⁴⁸⁻⁵⁵⁰ Likewise, readmission rates of 20% have been reported even after minor amputations (toe and distal forefoot), with the majority of reamputations occurring within 1 month.⁵⁴⁸⁻⁵⁵⁰ Reported long-term healing rates after transmetatarsal amputations are approximately 53%.⁵⁵¹ These amputations should not be offered to patients who have poor rehabilitation potential.

The role of partial foot or midfoot (eg, Lisfranc, Chopart) amputations remains controversial. Prosthetic specialists discourage the use of these procedures as they have higher rates of delayed healing, require more revisions, and develop deformities and ulcers, and patients often struggle to achieve their full rehabilitation potential. Conversely, these amputations preserve a weight-bearing heel and allow amputees the ability to mobilize for short distances without prostheses.⁵⁵²

Transtibial amputation (below-knee amputation [BKA]) and transfemoral amputation (above-knee amputation [AKA]) are performed with an almost equal frequency in patients with CLTI. Reports have shown primary healing rates for BKA of approximately 60%, with 15% leading to a transfemoral amputation.^{121,548} The transfemoral amputation has the highest probability of successful primary healing and therefore has been the amputation of choice in individuals who are less likely to ambulate with a prosthesis.

Recent data from the American College of Surgeons National Surgical Quality Improvement Program show improved results with a 12.6% early failure rate for BKA compared with 8.1% for AKA.⁵⁵³ A similar trend is found in data from the National Vascular Registry of the United Kingdom, which show that one in eight AKAs and one in six BKAs remain unhealed at 30 days.⁵⁵⁴

Knee disarticulation

The biomechanical advantages of a knee disarticulation or through-knee amputation (TKA) compared with an AKA are well recognized, although it remains an infrequently performed amputation. A well-performed TKA offers healing rates that are comparable to those of AKA and provides bedridden and wheelchair-bound patients with a higher level of mobilization and transfer, counterbalance, and reduced potential for contractures. Even in patients who have rehabilitation potential, the current prosthetic technology permits excellent functional mobility, making TKA a good amputation choice when a BKA is unlikely to heal. The aesthetic disadvantage of a TKA is that the prosthetic knee will be marginally distal to the normal contralateral knee in a sitting position.

Mortality

Survival after major lower limb amputation is poor, as seen in a systematic review that reported 30-day postoperative mortality rates of 4% to 22%.⁵⁵⁵ Even after minor

Table 9.1. Major amputation of the lower extremity

	Level of amputation		
	Below knee	Through knee	Above knee
Primary healing	30%-92%	60%-81%	60%-95%
Perioperative mortality	4%-10%	1%-17%	10%-20%
Revision to higher level	12%-20%	1.5%-20%	8%-12%
Ambulation	40%-80%	57%-70%	20%-40%

amputations, the 1-year and 5-year mortality rates are reported to be 16% and 25%, respectively, for those with limb ischemia.⁵⁵⁶ Mortality rates for minor amputations are higher in diabetics, with type 2 diabetics having a 5-year mortality of >50%.⁵⁵⁷ The 5-year mortality after major amputations varies from 30% to 70% and is significantly worse for AKA than for BKA.^{558,559} The mortality is even higher in bilateral lower limb amputees, with a 5-year survival rate of <40%.⁵⁶⁰ These mortality rates demonstrate the high rate of comorbidities and the frailty of this group of patients.

In patients with diabetes who have had major amputations, survival is often worse than in some malignant diseases. Survival rates have been reported as 78% at 1 year, 61% at 3 years, 44% at 5 years, and 19% at 10 years.⁵⁶¹

In 2010, recognizing the need to do more to reduce perioperative mortality, the Vascular Society of Great Britain and Ireland introduced a quality improvement framework to reduce mortality from amputation surgery to <5% by 2015, which was later revised to <10% in 2016.⁵⁶² Recent data from the United Kingdom's National Vascular Registry showed mortality rates of 11.6% for AKA and 6.1% for BKA by establishment of dedicated multidisciplinary amputation services that provided expeditious and comprehensive preoperative and postoperative care.⁵⁵⁰ These rates are similar to results from the American College of Surgeons National Surgical Quality Improvement Program of 12.7% for AKA and 6.5% for BKA, with an overall 9.1% mortality of 6389 patients studied.⁵⁶³

Fate of contralateral limb after lower extremity amputation

Published reports of the risk of contralateral amputation vary from 2.2% to 44%, with a lower risk if the index amputation is a minor amputation.¹²⁴ In most patients, the reason for contralateral amputation is disease progression, although the medical management of unilateral amputees can also be suboptimal, with one-third of patients not prescribed a statin and an antiplatelet agent.¹²³ Continued follow-up of these patients at least yearly after amputation with attention to the contralateral limb is important.¹²⁴

Prosthetic rehabilitation, mobility, and quality of life

When an amputation is inevitable, and whenever possible, a prosthetic specialist should be involved in decision-making with the surgical team regarding the optimal level of amputation that will ensure the best opportunity for healing, survival, and maximum functional mobility. Advances in prosthetics have resulted in a prosthesis for every stump. However, to use the prosthesis effectively, the stump must be created to truly function as a dynamic sensorimotor end organ and not simply as an inert filler in the socket.

Muscle-stabilizing procedures can help create a stump with its proprioception intact and any of the procedures can be used, including myoplasty, myodesis, and osteomyoplasty. The stump evolves with time, and the prosthetic requirements continue to change. The patient requires regular adjustments in the prosthesis and often complete revisions. A poorly fitting prosthesis can be as disabling as the actual amputation.

The quality of life after amputation is significantly influenced by pain, social isolation, depression, and the patient's lifestyle before amputation. Mobility has a direct effect on quality of life. It is a key determinant to the social reintegration of the amputee and has a beneficial effect on late mortality.

Energy expenditures of ambulation increase with ascending levels of amputation. Energy consumption during ambulation is increased by 10% to 40% after BKA and by 50% to 70% after AKA.⁵⁶⁴ The potential for rehabilitation is better with BKA than with AKA. Therefore, it is worthwhile to try to salvage a BKA in a patient who has the potential to ambulate fully. In studies involving >100 patients, ambulatory status at 6 to 12 months after amputation varies from 16% to 74%.⁵⁵¹ At 2 years, only 40% of BKA patients achieve full mobility.¹²¹

Maintaining ambulation is one of the most important factors in preserving independence. A significant amount of evidence is available to suggest that early postsurgical prosthetic fitting leads to early mobility.⁵⁶⁵ However, to achieve and to maintain daily functional ambulation, multidisciplinary inputs are needed from physiotherapists, occupational therapists, prosthetists, social workers, recreational therapist nurses, psychologists, and the surgeon. Despite initial successful prosthetic rehabilitation, prosthetic use deteriorates over time, and most patients eventually become household walkers only.⁵⁶⁶

Delivery of amputation service

Based on current international practice,^{562,566} the following best practice recommendations will help decrease mortality and improve functional outcomes:

1. The indication for any nonurgent amputation should be discussed at a multidisciplinary team meeting after a full functional and vascular assessment.
2. Patients should be informed as to the rationale of any amputation as well as the postamputation care pathway.
3. Patients should have access to a second opinion (by a vascular specialist from another institution).
4. A preoperative assessment by a rehabilitation and occupational physiotherapist as well as by a prosthetic specialist should be organized.

5. Procedures should be performed on an elective list (within 48 hours of the decision).
6. Amputations should be performed by or in the presence of a board-certified consultant surgeon.
7. A named discharge coordinator should ensure that there is a defined postamputation care pathway.

Recommendations 9		
9.1 Consider transmetatarsal amputation of the forefoot in CLTI patients who would require more than two digital ray amputations to resolve distal necrosis, especially when the hallux is involved.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Elsherif, ¹¹⁴ 2017
9.2 Offer primary amputation to CLTI patients who have a pre-existing dysfunctional or unsalvageable limb, a poor functional status (eg, bedridden), or a short life expectancy after shared decision-making with the patient and health care team.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Aziz, ¹¹⁵ 2015 Siracuse, ¹¹⁶ 2015
9.3 Consider secondary amputation for patients with CLTI who have a failed or ineffective reconstruction and in whom no further revascularization is possible and who have incapacitating pain, nonhealing wounds, or uncontrolled sepsis in the affected limb after shared decision-making with the patient and health care team.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Reed, ¹¹⁷ 2008
9.4 Consider revascularization to improve the possibility of healing an amputation at a more distal functional amputation level (eg, AKA to BKA), particularly for patients with a high likelihood of rehabilitation and continued ambulation.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Rollins, ¹¹⁸ 1985 Miksic, ¹¹⁹ 1986
9.5 Consider a TKA or AKA in patients who are nonambulatory for reasons other than CLTI (ie, bedridden patients with flexion contracture, dense hemiplegia, cancer) and are unlikely to undergo successful rehabilitation to ambulation.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Ayoub, ¹²⁰ 1993 Taylor, ¹²¹ 2008
9.6 Involve a multidisciplinary rehabilitation team from the time a decision to amputate has been made until successful completion of rehabilitation has been achieved.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Webster, ¹²² 2012
9.7 Continue to observe CLTI patients who have undergone amputation at least yearly to monitor progression of disease in the contralateral limb and to maintain optimal medical therapy and risk factor management.		
Grade	Level of evidence	Key references
1 (Strong)	C (Low)	Bradley, ¹²³ 2006 Glaser, ¹²⁴ 2013

Research priorities for the role of minor and major amputations	
Recommendations	
9.1	Identify the best noninvasive test to predict the optimal level of amputation with respect to primary healing.
9.2	Determine whether the primary healing rates, postprocedure mobility with prosthesis, and quality of life data justify a TKA over an AKA.
9.3	Investigate whether there is a difference in stump healing between the skew flap, long posterior flap, and equal anterior and posterior flap techniques of BKA.
9.4	Investigate whether the quality of life after partial foot amputations is inferior to or even better than after BKA or AKA.
9.5	Determine the optimal early prosthesis fitting and rehabilitation strategies for independent ambulation.

10. POSTPROCEDURAL CARE AND SURVEILLANCE AFTER INFRAINGUINAL REVASCLARIZATION FOR CLTI

This section reviews evidence for adjunctive medical therapies, surveillance, reintervention, and postprocedural care after infrainguinal revascularization for CLTI.

Medical therapies

All patients who have undergone revascularization for CLTI should continue with best medical therapies to slow the progression of atherosclerosis and mitigate the adverse impact of risk factors as recommended in Section 4. In addition, the role of specific pharmacotherapy for maintaining the benefits of revascularization has been the subject of a number of studies.

Endovascular interventions. Long-term antiplatelet therapy remains a cornerstone to reduce atherothrombotic events and to improve patency and limb salvage rates after peripheral interventions.^{35,135} Contemporary management involves the choice between single antiplatelet therapy and DAPT. Aspirin has been a mainstay of treatment because it is efficacious and cost-effective. Clopidogrel is also effective as a single agent.^{35,567} Use of DAPT after intervention has become standard in the treatment of CAD^{134,568} and has migrated to other arenas of vascular intervention. Clopidogrel is a prodrug requiring conversion by cytochrome P450 enzymes, the activity of which may be affected by genetic polymorphisms or drug-drug interactions. It has been estimated that between 4% and 30% of individuals treated with conventional doses of clopidogrel do not attain the full antiplatelet response.⁵⁶⁹ Of note, it has been reported that patients with PAD may have a higher prevalence of resistance to clopidogrel than coronary intervention patients.¹³⁶

Despite an absence of level 1 evidence, DAPT is frequently employed for 1 to 6 months after peripheral interventions.^{134,136} The Clopidogrel and Aspirin in the Management of Peripheral Endovascular Revascularization (CAMPER) study was designed to compare aspirin with DAPT but was stopped because of poor enrollment.^{137,570} The MIRROR trial was a double-blind RCT comparing clinical outcomes of aspirin and placebo vs aspirin and clopidogrel for 6 months after FP intervention. Of the 80 patients who were randomized, 42% had CLTI.¹³⁶ Decreased target lesion revascularization was observed in patients randomized to the DAPT arm, although there was no significant difference in patency rate. A meta-analysis suggested that DAPT might be associated with a reduced risk of major amputations after revascularization, with increased bleeding risk vs monotherapy.²⁹⁷ A propensity-adjusted analysis from the Vascular Quality Initiative associated DAPT use with improved survival after revascularization for CLTI.⁵⁷¹ The efficacy of DAPT may depend on multiple factors, including procedure-related, anatomic, and patient factors. Subgroups of patients who may derive more benefit from DAPT include those with complex disease patterns, those with prior failed interventions, and those at lower risk of bleeding complications (eg, younger patients). Adequately powered RCTs are needed to better define the risks and benefits of DAPT after peripheral intervention as well as optimal dosing and duration of treatment.

The phosphodiesterase inhibitor cilostazol has antiplatelet and antiproliferative properties, and several studies have suggested that it may reduce the incidence of restenosis after catheter interventions. Iida et al⁵⁷² reported that cilostazol treatment reduced angiographic restenosis after FP intervention (angioplasty with provisional stenting) in an open label randomized trial of 200 patients, of whom 90% had intermittent claudication. A meta-analysis suggested an association between cilostazol use and reduced rates of in-stent restenosis after FP stenting in “high-risk” patients, pooling studies that included 75% claudicants.⁵⁷³ Conversely, an open label RCT found no effect of cilostazol treatment in reducing restenosis after IP interventions for severe limb ischemia.⁵⁷⁴ No clear recommendation can be made at present regarding the potential benefit of cilostazol after endovascular interventions for CLTI.

Vein and prosthetic bypass grafts. After vein graft implantation, patency of the graft is likely to be enhanced by lifestyle modifications and medical therapy. Most studies of vein graft patency include patients with both CLTI and claudication. Meta-analyses from prospective studies^{130,131} along with multiple case series demonstrate a consistent association between the avoidance of smoking and enhanced vein graft patency. Statin medications have not been evaluated in randomized trials for enhancement of vein graft patency, although some retrospective studies suggest that they may be of benefit.^{125,126} In a cohort study, statin use was not associated with better limb outcomes, although overall survival was improved.¹²⁹

Although antiplatelet agents are commonly used, there is inconclusive evidence that they specifically enhance lower extremity vein graft patency. A Dutch trial of 2690 patients randomized to oral anticoagulants (target international normalized ratio of 3-4.5) or 80 mg of aspirin per day after lower extremity bypass found better vein graft patency at 12 and 24 months for the oral anticoagulants on subgroup analysis.⁵⁷⁵ However, there were twice as many bleeding complications in the anticoagulant-treated patients. In contrast, a multicenter U.S. trial comparing warfarin plus aspirin with aspirin alone found no improvement in vein graft patency and a higher rate of bleeding in the combined treatment arm.⁵⁷⁶ A study of 56 patients with poor-quality venous conduits compared aspirin alone with a combination of aspirin and warfarin and found improved patency in the aspirin plus warfarin group.⁵⁷⁷ Finally, a systematic review found no effect of aspirin or dipyridamole compared with placebo on vein graft patency at 1 year.^{127,128} Vein graft patients receiving aspirin or aspirin plus clopidogrel have similar patency, and there is a higher rate of mild to moderate bleeding with DAPT.¹³² A more recent systematic review concluded that antiplatelet therapy has a beneficial effect on primary patency of peripheral bypass grafts compared with placebo or no treatment.¹²⁸ It appears, then, that there is limited evidence to support a specific antithrombotic regimen in patients after vein bypass grafting for CLTI. Single antiplatelet therapy, recommended as standard for long-term PAD management, should be continued in these patients. Treatment with warfarin may be considered in patients with high-risk vein grafts (eg, spliced vein conduit, poor runoff) who are not at increased risk for bleeding.

In contrast, there is consistent evidence supporting the use of antiplatelet therapy in patients who have undergone prosthetic bypass grafting. Two Cochrane reviews have supported the use of aspirin and other antiplatelets in maintaining lower extremity bypass graft patency, and greater benefits have been seen with prosthetic grafts.^{127,128} Other studies have demonstrated similar findings.¹³³ In particular, one randomized trial (Clopidogrel and Acetylsalicylic Acid in Bypass Surgery for Peripheral Arterial Disease [CASPAR]) showed that DAPT with clopidogrel and aspirin led to significantly improved patency in prosthetic grafts but not in venous grafts.¹³² However, this was accompanied by an increased risk of mild to moderate bleeding. Another study demonstrated that the use of anticoagulants such as vitamin K antagonists did not improve the prosthetic graft patency, although they were beneficial in venous conduits.^{575,578} In a single-center study, investigators suggested the use of therapeutic vitamin K antagonists to prolong the patency of prosthetic grafts with low velocities.⁵⁷⁹

Surveillance and reintervention

After endovascular treatment. Despite the high initial technical success rates of endovascular interventions, early failure of these minimally invasive procedures is

common.^{100,365,580-583} This has led to high rates of secondary interventions and questions of clinical efficacy to support them.

Currently, guidelines support DUS surveillance and prophylactic reintervention for asymptomatic vein graft stenosis to promote long-term patency.^{138,584-589} Conversely, strategies for surveillance and guidelines for reintervention after angioplasty have primarily been left up to the individual practitioner. There are many determinants of failure after angioplasty, including indication (claudication vs CLTI), lesion length, lesion severity (occlusion vs stenosis), calcification, location, concomitant inflow and outflow vessel disease, use of stents, and residual stenosis or recoil at the time of the initial procedure. As a result, predicting which interventions are more prone to failure has proved challenging, and there is scarce evidence to support indications for repeated interventions in CLTI.

Modalities for surveillance include clinical follow-up visits (assessment of symptoms, inspection of the extremity, pulse examination), ABI measurements, and DUS scan (PSV measurement and velocity ratio). Other imaging modalities, such as DSA, CTA, and MRA, are not reasonable for surveillance because of invasiveness, cost, and limited access as well as exposure to ionizing radiation and contrast dye and potential risks from the procedure itself.

Surveillance by clinical follow-up alone may be insufficient to detect restenosis as patients may remain asymptomatic until the target artery has occluded, akin to bypass grafts. Likewise, ABI measurement alone has limited value, given the difficulty in determining the level of restenosis, the limitation in diabetics with calcified vessels, and the variability of correlation when there is a drop in ABI (>0.15) with lesion severity.^{590,591} The addition of DUS provides anatomic information using direct visualization of the vessel as well as physiologic information based on spectral waveforms, pressure, and velocity measurements. The combination of PSV and velocity ratio measurements offers high positive predictive value for identifying moderate and severe restenosis when it is correlated with angiography.^{592,593}

The value of DUS in a postprocedural surveillance program needs to be balanced by the potential harm associated with performing unnecessary procedures on asymptomatic restenotic lesions that may have an otherwise benign natural history. The cost associated with maintaining such a program should also be considered. One strategy is to pursue DUS surveillance at regular intervals (3-6 months) and to consider reintervention for severe recurrent asymptomatic lesions ($>70\%$) before they progress to complete occlusion. This approach is supported by data suggesting that restenotic lesions are markers of subsequent failure.^{142,594,595}

Several studies have shown that reintervention on occluded lesions brings higher rates of distal embolization and subsequent reocclusion in comparison to intervening on restenotic but patent vessels.^{596,597} Although these seem to be reasonable incentives for surveillance, DUS may not identify all of these lesions before failure; for example,

not all angioplasty site reocclusions are preceded by severe restenotic lesions.^{141,598,599} To date, there are inadequate data demonstrating clinical benefit of a DUS surveillance program after endovascular intervention for CLTI. Still, there are likely to be subgroups of patients who may benefit more than others from close surveillance and early reintervention. These may include patients who have experienced multiple failed angioplasties; patients who have previously undergone failed bypasses or for whom conduits are unavailable; patients who had presented with severe ischemia (eg, Wifl grade 3), unresolved tissue loss, or appearance of new inflow lesions; and patients with known poor runoff or long target vessel occlusions that are prone to failure.

Vein and prosthetic bypass grafts. Vein grafts primarily fail when stenotic lesions develop within the venous conduit or at anastomotic sites of the conduit to the inflow and outflow arteries. Stenotic lesions can also develop in the outflow artery remote from the distal anastomotic site. Approximately one-third of lower extremity vein grafts develop lesions that threaten graft patency, and most occur within 2 years of graft placement. Vein grafts are never entirely free of the risk for development of intragraft or anastomotic stenosis. The risk of vein graft stenosis is greater with smaller caliber conduits, with nonsaphenous or spliced venous conduits, and in grafts with anastomosis to more distal (tibial or pedal) arteries. Surveillance of lower extremity autologous vein grafts is based on this natural history and assumes that a patent, hemodynamically uncompromised reconstruction is optimal for wound healing and limb viability. Secondary reconstructions for thrombosed lower extremity vein grafts are technically more complex and less durable than revision of a failing but patent bypass.

Vein graft surveillance programs may be solely clinical or clinical and vascular laboratory based. The TASC II working group recommended that patients treated with lower extremity vein grafts be observed for at least 2 years with a surveillance program consisting of an interval history to detect new symptoms, pulse examination, and measurement of resting and postexercise ABI, when possible.¹⁵⁶ Most vascular laboratory-based surveillance programs focus on DUS detection of stenotic lesions within the graft or at the anastomotic sites. Although there is considerable information on DUS surveillance of lower extremity vein grafts for CLTI, there are few prospective data.

The Vein Graft Surveillance Randomised Trial (VGST), a prospective trial from the United Kingdom, randomized 594 patients with patent vein grafts 30 days after surgery to either clinical surveillance or combined DUS surveillance and clinical surveillance. The majority of operations (two-thirds) were femoral-popliteal bypasses for CLTI. Conduits were ipsilateral reversed saphenous vein in $>90\%$. Thus, technical complexity of surgery in the VGST may not reflect that of open reconstructions performed for CLTI in the modern endovascular era. At 18 months, the investigators found no differences in primary, primary assisted, or

secondary patency between the two surveillance strategies.⁵⁸⁹ A smaller study from Sweden randomized 156 patients with lower extremity arterial reconstructions to intensive surveillance, including DUS scanning ($n = 79$), or routine clinical surveillance ($n = 77$). There were 40 polytetrafluoroethylene grafts, equally distributed between the two groups. Only two grafts in each group were performed for claudication, and two-thirds were to the popliteal artery. Among the vein grafts in the study, there was improved assisted primary and secondary patency in the intensive surveillance group that had DUS scanning.⁵⁸⁵

The benefit of a vein graft surveillance program with DUS scanning is suggested in large single-institution case series as well as in one large multi-institution prospective study.^{79,138,140,600,601} These studies and others have demonstrated large differences between primary patency and assisted primary patency of vein grafts monitored with a DUS-based surveillance program.¹³⁹ They also demonstrate that electively revised vein grafts have excellent long-term patency, even comparable to that of grafts that have never undergone revision. In contrast, salvage of vein grafts that have already thrombosed is associated with markedly reduced secondary patency. Improved quality of life has been associated with maintained patency of vein grafts performed for CLTI.²³³ Despite these observations, it must be acknowledged that the clinical benefit of DUS-based surveillance after vein bypass for CLTI is still unclear. A systematic review found low-quality evidence for DUS surveillance of infrainguinal vein grafts.⁶⁰²

The underlying principle of clinical surveillance of vein grafts is that recurrence of symptoms, change in pulse status, or decrease in ABI >0.15 indicates an at-risk graft that should be considered for revision. It is also suggested that vein grafts with $>70\%$ stenosis identified by DUS scanning be considered for revision as such lesions are unlikely to improve and associated grafts have an adverse natural history.^{138,600} These lesions are defined by an associated PSV of >300 cm/s, a PSV ratio (defined as PSV at the lesion divided by PSV in a proximal segment) of >3.5 , or a midgraft PSV <45 cm/s. Vein graft stenoses treated with open surgical techniques (patch angioplasty or interposition grafting) have excellent long-term patency and associated limb salvage.¹³⁹ The technical success and short-term patency of surveillance-detected lesions treated with catheter-based techniques are high, although long-term data are lacking. In general, longer lesions and lesions detected within 3 months of graft implantation are best treated surgically. Short lesions and those treated after 3 months of graft implantation may be treated either surgically or with catheter-based techniques, primarily balloon angioplasty, and possibly with drug-coated balloons.^{603,604} With either mode of treatment, recurrence of stenosis within the vein graft or its anastomoses is possible. Thus, continued surveillance after reintervention is indicated to detect recurrent and new stenotic lesions. After treatment of a vein graft stenosis, the treated graft should undergo surveillance at intervals similar to those for primarily placed grafts.¹³⁹ Treatment of recurrent lesions in previously

revised vein grafts can also provide continued long-term patency and limb salvage.¹³⁹

Long-term patency of infrainguinal prosthetic bypass grafts is inferior to that of venous bypass grafts. Evidence as to the efficacy of prosthetic graft surveillance programs is more inconclusive. In one study, 69 patients with infrainguinal prosthetic bypasses were assessed by ultrasound after 4 weeks and every 3 months thereafter (total follow-up was 3 years).⁶⁰⁵ The ultrasound examination appeared to be of limited value, with 12 of 14 failing grafts not correctly predicted. In a retrospective analysis of 118 above-knee prosthetic grafts, most bypass occlusions again occurred without previously detected lesions.⁶⁰⁶ A quarter of patients developed a graft-related stenosis detected by ultrasound. Successful intervention of the stenotic lesions was associated with a lower bypass occlusion rate of 21% at 2 years (vs 41% for the entire series). Hence, in the authors' opinion, ultrasound surveillance was justified. In another study of 89 grafts in 66 patients (FP and femorotibial), specific criteria for DUS proved predictive for patency of prosthetic tibial bypasses but not of popliteal bypasses.⁶⁰⁷ These criteria included PSV >300 cm/s at graft anastomoses, adjacent PSV ratio >3.0 , uniform PSVs <45 cm/s, and monophasic flow throughout the graft.

One study sought to describe modes of failure and associated limb loss after infrainguinal polytetrafluoroethylene bypass grafting as well as benefits of warfarin on graft patency.⁵⁷⁹ The study involved 121 patients (86% with CLTI) with 131 infrainguinal (above-knee and below-knee) bypasses. Of these, 77% of the below-knee bypasses had anastomotic adjuncts (vein cuff or patch). Postoperative DUS was performed at 1 month, 4 months, and 7 months and then twice yearly. Multivariate analysis showed that low graft flow (midgraft velocity <45 cm/s) was more commonly associated with graft failure than stenosis detected by DUS. Therapeutic anticoagulation with warfarin increased patency in patients with low-flow grafts but not in patients with high-flow grafts.⁵⁷⁹

A consensus document from Mohler et al⁶⁰⁸ supports surveillance of prosthetic reconstructions at baseline and at 6-month intervals, similar to vein reconstructions. DUS imaging criteria were recommended for patients after femoral-femoral bypass grafting, particularly for those with a PSV >300 cm/s in the inflow iliac artery and a midgraft velocity <60 cm/s predictive of graft failure.⁶⁰⁹ When DUS-directed intervention was performed, patency at 5 years (assisted patency) was 88%. Patency appeared to be improved in comparison to most reports in the literature of patency without surveillance. DUS surveillance of prosthetic grafts does not reliably detect correctable lesions that precede failure as it does in vein bypass grafts. Instead, surveillance may serve as a predictor of graft thrombosis by the detection of midgraft velocities below 45 cm/s. Prosthetic grafts with low velocity may benefit from warfarin to improve patency, which may justify surveillance. The use of warfarin was recommended if the mean graft velocity was below 60 cm/s to reduce the incidence of expanded polytetrafluoroethylene bypass graft thrombosis.⁵⁷⁹ No specific

recommendations can be made, however, regarding surveillance and reintervention for prosthetic grafts, and this information can only serve as a guideline.

Recommendations 10		
10.1 Continue best medical therapy for PAD, including the long-term use of antiplatelet and statin therapies, in all patients who have undergone lower extremity revascularization.		
Grade	Level of evidence	Key references
1 (Strong)	A (High)	Abbruzzese, ¹²⁵ 2004 Henke, ¹²⁶ 2004 Brown, ¹²⁷ 2008 Bedenis, ¹²⁸ 2015 Suckow, ¹²⁹ 2015
10.2 Promote smoking cessation in all CLTI patients who have undergone lower extremity revascularization.		
Grade	Level of evidence	Key references
1 (Strong)	A (High)	Hobbs, ¹³⁰ 2003 Willigendael, ¹³¹ 2005
10.3 Consider DAPT (aspirin plus clopidogrel) in patients who have undergone infrainguinal prosthetic bypass for CLTI for a period of 6 to 24 months to maintain graft patency.		
Grade	Level of evidence	Key references
2 (Weak)	B (Moderate)	Brown, ¹²⁷ 2008 Belch, ¹³² 2010 Gassman, ¹³³ 2014 Bedenis, ¹²⁸ 2015
10.4 Consider DAPT (aspirin plus clopidogrel) in patients who have undergone infrainguinal endovascular interventions for CLTI for a period of at least 1 month.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Cassar, ¹³⁴ 2005 Bhatt, ¹³⁵ 2006 Tepe, ¹³⁶ 2012 Strobl, ¹³⁷ 2013
10.5 Consider DAPT for a period of 1 to 6 months in patients undergoing repeated catheter-based interventions if they are at low risk for bleeding.		
Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Cassar, ¹³⁴ 2005 Tepe, ¹³⁶ 2012 Strobl, ¹³⁷ 2013
10.6 Observe patients who have undergone lower extremity vein bypass for CLTI on a regular basis for at least 2 years with a clinical surveillance program consisting of interval history, pulse examination, and measurement of resting APs and TPs. Consider DUS scanning where available.		
Grade	Level of evidence	Key references
Good practice statement		
10.7 Observe patients who have undergone lower extremity prosthetic bypass for CLTI on a regular basis for at least 2 years with interval history, pulse examination, and measurement of resting APs and TPs.		
Grade	Level of evidence	Key references
Good practice statement		
10.8 Observe patients who have undergone infrainguinal endovascular interventions for CLTI in a surveillance program that includes clinical visits, pulse examination, and noninvasive testing (resting APs and TPs).		
Grade	Level of evidence	Key references
Good practice statement		
10.9 Consider performing additional imaging in patients with lower extremity vein grafts who have a decrease in ABI ≥ 0.15 and recurrence of symptoms or change in pulse status to detect vein graft stenosis.		
Grade	Level of evidence	Key references
Good practice statement		
10.10 Offer intervention for DUS-detected vein graft lesions with an associated PSV of >300 cm/s and a PSV ratio >3.5 or grafts with low velocity (midgraft PSV <45 cm/s) to maintain patency.		
Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Mills, ¹³⁸ 2001

10.11 Maintain long-term surveillance after surgical or catheter-based revision of a vein graft, including DUS graft scanning where available, to detect recurrent graft-threatening lesions.

Grade	Level of evidence	Key references
1 (Strong)	B (Moderate)	Landry, ¹³⁹ 2002 Nguyen, ¹⁴⁰ 2004

10.12 Consider arterial imaging after endovascular intervention for failure to improve (wound healing, rest pain) or a recurrence of symptoms to detect restenosis or progression of pre-existing disease.

Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Bui, ¹⁴¹ 2012

10.13 Consider reintervention for patients with DUS-detected restenosis lesions $>70\%$ (PSV ratio >3.5 , PSV >300 cm/s) if symptoms of CLTI are unresolved or on a selective basis in asymptomatic patients after catheter-based interventions.

Grade	Level of evidence	Key references
2 (Weak)	C (Low)	Humphries, ¹⁴² 2011

Management of the limb after revascularization

Treatment of lower extremity tissue loss both acutely and in the longer term is complex and mandates a team approach. Physicians, surgeons, and nurses must work collaboratively rather than in individual silos of care.⁶¹⁰⁻⁶¹² In these cases, wound healing is protracted, with the median time to healing ranging from 147 days for forefoot wounds to 188 days for midfoot wounds and 237 days for hindfoot wounds.⁶¹³ The likelihood and duration of healing are also determined by the presence of concomitant infection and ischemia.¹⁹²

The Threatened Limb Classification System from the SVS has been validated in several studies.^{68-70,164,166} It is a promising, pragmatic means to assess the likelihood of morbidity for at-risk legs and to communicate severity. The structure of the WIfI system is designed using a scale of none (0), mild (1), moderate (2), or severe (3), similar to the TNM system in cancer assessment.^{10,68,69,164} The system can be visualized as three intersecting rings of risk, enabling the team to collectively identify which risk is more dominant at any given time.

Tissue loss-dominant conditions. The primary issue after revascularization in CLTI is often management of tissue loss (wound healing). Therapy is based primarily on appropriate débridement, offloading, and a simple moisture-retentive dressing strategy.²³³ Pressure offloading is one of the single most important and yet neglected aspects of therapy. Whereas the total contact cast remains the gold standard for offloading noninfected, nonischemic wounds, other techniques may also be considered, depending on available resources.^{614,615}

More significant degrees of tissue loss may require a strategy of filling the defect followed by skin grafting.^{616,617} Once the wound heals and the patient is no longer "tissue loss dominant," care then shifts to maximizing ulcer-free and activity-rich days in diabetic foot remission.⁶¹⁸ This may include protecting the tissue by external (shoes, insoles, and inflammation monitoring) and internal (reconstructive surgery, physical therapy, and rehabilitation) means.⁶¹⁹⁻⁶²² The role and timing of foot amputations (eg, digital, forefoot, or midfoot) are discussed in Section 9.

Ischemia-dominant conditions. The management and monitoring of ischemia play a central role in healing as well

as in recurrence and involve regular vascular assessment and monitoring for potential intervention.

Infection-dominant conditions. Infection is often the primary factor leading to amputation, accentuated by tissue loss and ischemia. Addressing this triad involves surgical and medical therapy based on established criteria. Each member of the wound care team must work to categorize, stage, and grade the severity of each component of the “wound triad” initially and at all follow-up encounters. Appropriate and regular documentation of the wound status is crucial, including diagrams and photographs to document progress. Often, one or more of these conditions can be found to be more “dominant” and can then be targeted for care. These conditions are dynamic and will change over time. During follow-up, recurrence may be related to tissue loss (deformity, inappropriate shoes, or change in activity). As a result, nonhealing may be due to ongoing or recurrent ischemia, and intervening in the development of an infection may require additional surgical or medical intervention.

Recommendations 10 (continued)		
10.14 Provide mechanical offloading as a primary component for care of all CLTI patients with pedal wounds.		
Grade	Level of evidence	Key references
1 (Strong)	A (High)	Elraiyah, ¹⁴³ 2016
10.15 Provide counseling on continued protection of the healed wound and foot to include appropriate shoes, insoles, and monitoring of inflammation.		
Grade	Level of evidence	Key references
1 (Strong)	A (High)	Elraiyah, ¹⁴³ 2016

11. STUDY DESIGNS AND TRIAL END POINTS IN CLTI

IDEAL: A framework for research

The evidence base underpinning the surgical and endovascular management of CLTI is weak compared with that available for coronary interventions and pharmacologic cardiovascular risk reduction. In addition, methodologies (phase 1 to 4 trials) that have been successfully used by the pharmaceutical industry to generate level 1 evidence cannot be easily transferred to the evaluation of revascularization strategies for CLTI, and so different approaches are required. The Idea, Development, Exploration, Assessment, and Long-term study (IDEAL) framework provides a system for evaluating new surgical and interventional therapies that can be adapted for use in CLTI (Table 11.1).⁶²³⁻⁶²⁷

Recommendations 11		
11.1 Use a research framework such as the IDEAL for gathering new data and evidence on the surgical and endovascular management of CLTI.		
Grade	Level of evidence	Key references
Good research statement		-

Depending on the stage of surgical innovation, the IDEAL framework describes a wide range of different methodologies that can be used to provide varying levels of evidence that serve different purposes. However, once the assessment stage has been reached, RCTs remain by far the most reliable means of comparing the clinical effectiveness and cost-effectiveness of alternative treatment strategies and should be the method of choice whenever it is practically and financially feasible. Funding of such trials by governmental or professional organizations to assess existing or new technologies further enhances the value of the resulting data by avoiding actual or perceived commercial sponsor bias. Still, RCTs have limitations, including cost, long completion times, potentially incomplete applicability to populations of patients outside the defined inclusion criteria, and restricted ability to address epidemiologic study questions.

As a result, a number of alternative methodologic approaches are available and can be employed in certain circumstances.⁶²⁸ For example, large administrative databases and prospective registries (particularly population-based ones) have the benefit of relative low cost, simplicity, and improved external validity, although they can carry a substantial risk of treatment bias and confounding. Given that the observed treatments are typically not randomly assigned but rather chosen on the basis of a mix of the patient’s characteristics and the provider’s inclination, reliable comparisons between dissimilar groups can be a problem. Additional risks include important sampling errors and improper or imprecise assignment of causality to a particular observed end point, although some of these limitations can be mitigated by employing multivariate analysis. Still, the increasing use of registries designed to capture the outcomes of patients with vascular disease reflects their value in identifying trends in practice patterns. Added value can be found in capturing the experience of particular subsets of patients undergoing defined treatments or techniques. However, because registries are highly dependent on robust follow-up and capture of detailed information of the patient on a consistent basis, they are also susceptible to reporting and attrition bias that can paint an unreliable picture with regard to the clinical effectiveness and cost-effectiveness of a particular treatment strategy.

Recommendations 11 (continued)		
11.2 Encourage funders, journal reviewers, and editors to prioritize prospective, multicenter, controlled, and preferably randomized studies over retrospective case series, studies using historical controls, or other less rigorous research methodologies.		
Grade	Level of evidence	Key references
Good research statement		-

Objective performance goals OPGs

The SVS Critical Limb Ischemia Working Group developed a standardized set of outcome measurements, OPGs, derived from CLTI patients undergoing open bypass in several RCTs.¹⁶² The OPGs include major adverse limb events (MALE) and postoperative death as a measure of early safety and AFS

Table 11.1. Idea, Development, Exploration, Assessment, and Long-term study (IDEAL): Stages of surgical and endovascular innovation for chronic limb-threatening ischemia (CLTI)

Stage	1. Idea	2a. Development	2b. Exploration	3. Assessment	4. Long-term study
Patients	Single digit, highly selected and homogeneous	Few; selected and homogeneous	Many; more heterogeneous	Many; expanded but well-defined indications	All eligible
Vascular specialists	Very few; innovators	Few; innovators and early adopters	Many; innovators, early adopters, early majority	Many; early majority	All eligible
Output	Description	Description	Measurement and some comparison	Comparison	Regional and international variance; quality assurance; risk stratification and adjustment
Procedure	Inception	Development	Refinement	Fully evolved	Fully evolved
Method	Structured case report	Prospective development study	Prospective cohort study; feasibility or explanatory RCT	RCT	Registries and databases
Outcomes	Proof of concept; technical achievement; disasters; notable successes	Technical success; emphasis on safety and reproducibility	Safety; objective clinical and patient-reported outcomes	Objective clinical and patient-reported outcomes; cost-effectiveness	Rare events; long-term outcomes; quality assurance
Ethical approval	Yes, usually	Yes, always	Yes, always	Yes, always	Yes, always

RCT = Randomized controlled trial.

to define longer term clinical effectiveness. Additional safety and efficacy OPGs were created for specific outcome variables of interest, and risk-stratified guidelines based on clinical, anatomic, and conduit criteria were identified for defined subgroups. The main aim of the OPG initiative was to establish benchmark values against which novel endovascular therapies could be initially evaluated without undertaking full RCTs. However, without good-quality RCTs, OPGs cannot be refreshed and, over time, will increasingly come to rely on historical controls. As such, RCTs are still required to determine both the clinical effectiveness and cost-effectiveness once safety and efficacy OPGs have been met.

Recommendations 11 (continued)		
11.3 When RCTs are not feasible, use the OPG benchmarks from the SVS's Critical Limb Ischemia Working Group to evaluate the efficacy of novel endovascular CLTI techniques and devices.		
Grade	Level of evidence	Key references
Good research statement		-

RCTs

An appropriately designed RCT remains the optimal means of providing critical confirmatory evidence before the widespread adoption of novel interventions.⁶²⁹⁻⁶³¹ The paucity of such studies in CLTI,^{13-15,632} however, underscores the many challenges that aspiring investigators face, particularly in trying to complete trials on time and on budget.

Trial design. The adaptive features of a pragmatic trial design allow investigators greater flexibility with regard to specific treatment decisions. They will also generally lead to results that are more universally applicable, particularly in time-intensive and laborious studies that unfold during a period

of potentially changing treatment paradigms. Conversely, a nonpragmatic design can more definitively generate supportive evidence for a particular technology or treatment scheme. It can also facilitate direct comparisons within a given revascularization strategy. One should determine to what degree a particular study is targeting real-world applicability and balance the theoretical, statistical, and practical impact of choosing one design over another.

Inclusion and exclusion criteria. Therapeutic goals can differ according to whether the CLTI patient presents with ischemic rest pain only or with minor or major tissue loss. More important, the goals in all CLTI patients differ significantly from those in patients presenting with IC. Therefore, it should be clear that it is rarely if ever appropriate to combine IC patients and CLTI patients in the same study. Similarly, it is clearly inappropriate to extrapolate data gathered in patients with IC to those with CLTI and vice versa.

Because CLTI represents a wide spectrum of disease, it is important that trials describe patients who are enrolled in terms of limb threat (Sections 1 and 3) and anatomic burden of disease (Section 5). Amputation rates are significantly higher in patients with tissue loss than in those with rest pain. This makes the group of patients with tissue loss a potentially more attractive one for a study in terms of being able to demonstrate the clinical effectiveness and cost-effectiveness of a new intervention with an achievable sample size and within a realistic time. However, as the severity of tissue loss progresses, opportunities to detect therapeutic benefit may begin to decrease as some patients with advanced disease will inevitably progress to amputation or death regardless of the intervention provided. As such, the CLTI patient group, in which there is a real prospect of showing true benefit for a new intervention, may be more limited than is often initially appreciated.

Recommendations 11 (continued)		
11.4 To facilitate sufficient enrollment, limit RCT exclusion criteria to those that are deemed essential to trial integrity.		
Grade	Level of evidence	Key references
Good research statement		-
11.5 Design RCTs, prospective cohort studies, and registries that are specific to CLTI.		
Grade	Level of evidence	Key references
Good research statement		-
11.6 Use an integrated, limb-based threatened limb classification system (eg, WIfI) and a whole limb anatomic classification scheme (eg, GLASS) to describe the characteristics and outcomes of CLTI patients who are enrolled.		
Grade	Level of evidence	Key references
Good research statement		-

Outcomes

Efficacy vs effectiveness. It is important to distinguish between clinical efficacy and clinical effectiveness. Clinical efficacy is the patient benefit observed under ideal circumstances. Does the procedure work in a selected group of homogeneous patients when it is performed by a selected group of clinicians? This is best demonstrated by an explanatory trial. Clinical effectiveness is the patient benefit observed from a procedure in the real world. It is best demonstrated by a pragmatic trial. With regard to CLTI, although the majority of published (usually industry-funded) trials fall into the clinical efficacy category, the results are often presented and overinterpreted as if they represent clinical effectiveness. This has incorrectly led to new treatments being adopted as the standard of care solely on the basis of limited evidence gathered in highly selected patients and centers.

Types of end points. Most CLTI trial end points can be broadly divided into the following categories:

1. Objective clinical: AFS, MALEs
2. Subjective clinical: patient-reported outcomes measures (PROMs), including generic and disease-specific HRQL instruments⁶³³
3. Hemodynamic: ankle and toe pressures and indices
4. Anatomic: patency; target lesion, vessel, and limb revascularization

To describe the overall quality of revascularization for CLTI, RCTs should use a menu of outcomes derived from all four of the categories (Table 11.2).

It is also important for RCTs to include a full health economic analysis for the cost-effectiveness of the comparator interventions to be determined. This is preferably based on quality-adjusted life-years. It is then up to each health care system to determine whether and how such data should be used in relation to individual “willingness to pay” thresholds, which are typically based on economic, societal, and political considerations. For example, in the United Kingdom, bearing in mind the proportion of

gross domestic product that the country has decided to spend on health care and the Department of Health’s agreed social value judgments, the National Health Service will not usually fund interventions that are associated with an incremental cost-effectiveness ratio in excess of £20,000 per quality-adjusted life-year. This figure represents the United Kingdom’s willingness to pay threshold.

Objective clinical outcomes. AFS has been recommended as a suitable primary CLTI efficacy end point by TASC II, the U.S. FDA, the UK National Institute for Health and Care Excellence, and the SVS Critical Limb Ischemia Working Group. It has been used in a number of CLTI RCTs, including Project of Ex-vivo Vein graft Engineering via Transfection III (PREVENT III),⁶³⁴ all three BASIL trials, and BEST-CLI. As with most end points, however, AFS has its limitations. For example, AFS does not distinguish between transfemoral and transtibial amputation, and because the performance and timing of amputation can be discretionary and not easily blinded, AFS does not necessarily capture the full clinical impact of particular revascularization strategies. Thus, the severity of pain and use of analgesia, the success of healing of minor amputations and tissue loss, and the requirement for reintervention are all important clinical parameters not characterized by AFS. In addition, its appropriateness in patients with rest pain only has been questioned, and as a composite, AFS life tables do not distinguish between effect of the intervention on limb salvage and overall mortality. Therefore, whereas it is reasonable to use AFS and other related composite end points, such as MALEs, as the determinants of sample size calculations, they should be accompanied by a range of single, composite, objective, and subjective clinical end points.

Subjective outcomes. Given the growing appreciation of the importance of the patients’ perception of their treatment experience, incorporating HRQL and PROMs into trial designs is strongly recommended. A number of well-validated generic HRQL instruments are now available in a range of languages. These include the 12-Item Short-Form Health Survey and the EuroQoL-5 Dimension questionnaire as well as more disease-specific instruments, such as the Vascular Quality of Life tool. Some researchers have advocated that future RCTs be based on anticipated PROMs and HRQL benefits.

Hemodynamic outcomes. Measuring hemodynamic parameters in CLTI patients can be challenging because CLTI is defined in part by the hemodynamic consequences of the disease (Section 1). Thus, it is important to attempt to describe the outcome of various interventions for CLTI in terms of their impact on hemodynamic measures, including ankle and toe pressures and indices.

Anatomic outcomes. Anatomic outcomes such as patency have been widely used in regulatory trials designed to obtain premarketing authorizations despite the well-recognized problematic relationship between these outcomes and clinical success. The related outcome measures of clinically driven target lesion and target vessel revascularization are inappropriate in the context of CLTI, given the

Table 11.2. Bypass vs Angioplasty in Severe Ischaemia of the Leg (BASIL-2), Balloon vs Stenting in Severe Ischaemia of the Leg (BASIL-3), and Best Endovascular vs Best Surgical Therapy for Patients with Critical Limb Ischemia (BEST-CLI) trial end points

End points	BASIL-2 and BASIL-3	BEST-CLI
Primary	AFS	MALE-free survival
Secondary	Freedom from all-cause mortality In-hospital and 30-day morbidity and mortality MALE MACE Relief of ischemic pain Psychological morbidity HRQL: generic and disease-specific instruments Reintervention and crossover intervention rates Healing of tissue loss (ulcers, gangrene) Extent and healing of minor amputations Hemodynamic changes; absolute APs and TPs, ABI, TBI HRQL (VascuQoL and EQ-5D) Health economic analysis	Freedom from all-cause mortality RAFS Freedom from MALE and POD AFS Freedom from myocardial infarction Freedom from stroke Freedom from reinterventions (major and minor) in index leg No. of reinterventions (major and minor) per limb salvaged Freedom from hemodynamic failure Freedom from clinical failure Freedom from CLTI HRQL (VascuQoL and EQ-5D) Health economic analysis

ABI = Ankle-brachial index; AFS = amputation-free survival; APs = ankle pressures; CLTI = chronic limb-threatening ischemia; EQ-5D = EuroQol-5 Dimension questionnaire; HRQL = health-related quality of life; MACE = major adverse cardiac event; MALE = major adverse limb event; POD = perioperative death; RAFS = reintervention- and amputation-free survival; TBI = toe-brachial index; TPs = toe pressures; VascuQoL = Vascular Quality of Life questionnaire.

frequency of complex multilevel disease and the high degree of subjectivity surrounding decisions to reintervene. Patency as an outcome metric is further limited by the lack of consensus with regard to definitions after endovascular interventions. The role of patency and other anatomic end points within CLTI trial methodology needs to be better defined.

Recommendations 11 (continued)		
11.7 Describe outcomes in CLTI trials using a combination of objective and clinically relevant events, subjective PROMs and HRQL assessments, and anatomic and hemodynamic end points.		
Grade	Level of evidence	Key references
Good research statement		-
11.8 Require regulatory trials aimed at obtaining premarket approval for devices for use in CLTI to study CLTI patients and to present data on objective and clinically relevant end points, PROMs and HRQL assessments, and anatomic and hemodynamic end points.		
Grade	Level of evidence	Key references
Good research statement		-

Follow-up. Determining the end points as well as the frequency and time during which they will be collected will depend on the study aims, design, and budget. Given the importance of evaluating the impact of comparator interventions on the natural history of CLTI, a follow-up period of at least 2 to 3 years is strongly recommended as it is unlikely that 6-month or 12-month follow-up periods will provide adequate assessment of clinical durability.

Clinical outcomes can be measured either in absolute proportions or by cumulative outcome estimates using the Kaplan-Meier analysis. Absolute proportions provide the

most transparent and reliable outcome measure. Unfortunately, because they evaluate identical follow-up periods in all participants, they also limit follow-up to the observation period of the last included patient. In contrast, cumulative estimates can integrate variable follow-up periods, thereby avoiding loss of available information. These estimates, however, are based on specific assumptions and are therefore vulnerable to attrition bias.^{635,636} Consequently, incomplete follow-up might lead to relevant but easily missed false outcome estimates that can affect study groups differently.⁶³⁷ To evaluate the risk of attrition bias, completion of follow-up should be measured independently of the study design and systematically declared against a predefined study end date using the follow-up index or the C index.

Recommendations 11 (continued)		
11.9 Follow up patients in trials for a time sufficient (this will usually be >2 years) to allow appropriate comparison of the impact of the different interventions on the natural history of CLTI. Measure and declare completeness of follow-up coverage to quantify risk of attrition bias.		
Grade	Level of evidence	Key references
Good research statement		-

Time-to-event analysis. Given the chronic and recurrent nature of CLTI, there is a compelling need to develop end points that move beyond the historical paradigm of a simple time-to-first-event analysis. End points such as AFS can reliably capture the centrally important end-stage events of limb amputation and death. Likewise, MALE and other end points focused on reintervention or other patient-related outcomes can capture the early clinical impact of

treatment failure. Unfortunately, these and other time-to-first-event end points collectively may present an incomplete assessment of the total impact various CLTI treatment strategies over time.

The primary goal of a time-integrated measure for CLTI disease severity should be to more accurately assess long-term relief from commonly occurring multiple events in a manner that is analogous to disease-free survival after cancer treatment. Without such a time-integrated approach, even an otherwise well designed CLTI trial may prove to be an incomplete and potentially misleading assessment of overall clinical effectiveness and cost-effectiveness. As an example, consider two CLTI patients with ulceration.

- Patient 1 has an endovascular intervention that heals his wound but after 2 months has recurrent symptoms and restenosis with a second intervention at 4 months. He develops another recurrence with pain and two gangrenous digits at 6 months. The patient subsequently requires a bypass graft at 7 months and a transmetatarsal amputation of the foot, resulting in clinical stabilization for 2 years. Outcomes: no death; no major amputation; time to first reintervention, 4 months; time to initial healing, 2 months; time to MALE, 7 months.
- Patient 2 receives a bypass graft that heals his wound by 3 months. At 7 months, he presents with an asymptomatic graft stenosis and undergoes a surgical revision (3-cm interposition graft). He remains clinically stable for 2 years. Outcomes: no death; no major amputation; time to first reintervention/MALE, 7 months; time to initial healing, 3 months.

Patient 1 had clinical recurrences and two reinterventions and spent most of the year with symptoms. Patient 2 had a prophylactic reintervention and spent most of the year symptom free. A CLTI trial using only AFS and MALE as end points would have failed to differentiate these two notably different clinical experiences.

Recommendations 11 (continued)		
11.10 Include a time-integrated measure of clinical disease severity (such as freedom from CLTI) in the CLTI trial design to describe the total impact of comparator CLTI interventions.		
Grade	Level of evidence	Key references
Good research statement		-

Sample and effect size

CLTI patients who are entered into the “nonactive treatment” (placebo) group in RCTs often have outcomes that are better than expected compared with similar patients who are treated outside of research conditions. This makes it more difficult to demonstrate differences in clinical

effectiveness and cost-effectiveness among the comparator interventions for CLTI. As a result, researchers must avoid the potential pitfall of basing the power calculation for their trial on an unrealistically large effect size. It is widely agreed that it is poor science and unethical to embark on a trial when there is no realistic prospect of answering the question being posed. An overpowered trial is equally undesirable as it is a misuse of resources, and patients may be disadvantaged by continuing to receive a treatment that is likely of little or no value or even potentially harmful to them. Despite this understanding, the CLTI literature is characterized by studies that present highly questionable, post hoc, subgroup analyses. To guard against this, all CLTI protocols along with full statistical analysis plans should be published in peer-reviewed journals to allow independent, public, and transparent scrutiny.

Recommendations 11 (continued)		
11.11 Publish all CLTI trial protocols together with the full statistical analysis plans in peer-reviewed journals to allow independent, public, and transparent scrutiny and to prevent nonreporting of negative trials.		
Grade	Level of evidence	Key references
Good research statement		-

Beyond the pivotal RCT

Given the challenges inherent in evaluating the wide array of novel endovascular modalities for CLTI, comparative trials of varying size and scope can be effective in establishing the utility of a particular technique, device, or overall revascularization strategy. As described within the OPGs, focused superiority or noninferiority RCTs can also be used to test a novel intervention against more established alternatives, and the safety and efficacy of new technologies can be effectively studied in a timely fashion. However, once the pivotal RCTs have been successfully completed, it is important that ongoing surveillance be rigorously undertaken with the use of well-designed, large, prospective, observational studies, including disease- or procedure-based national registries. Of note, some countries require manufacturers and importers to submit reports of device-related deaths, serious injuries, or malfunctions to the appropriate regulatory bodies.

Also important is cooperation among publicly and industry-funded investigators in designing and performing RCTs. Currently, this is happening with the BASIL and BEST-CLI trials, which will serve to facilitate subsequent individual patient data analyses, meta-analyses, and subgroup analyses. Ultimately, this type of data sharing will provide a powerful framework for refining OPGs and validating the use of tools to better define patient, limb, lesion, and anatomic risk in CLTI patients, such as Wifi and GLASS.

Strength of recommendation and level of evidence

Multiple methods to systematically assess the quality of research have been proposed and used by various bodies.

Recommendations 11 (continued)		
11.12 Conduct postmarketing surveillance data collection using well-designed, large observational studies and registries.		
Grade	Level of evidence	Key references
Good research statement		
11.13 Share clinical trial data to allow subsequent individual patient data analyses, meta-analyses, and subgroup analyses; updating of OPGs; and validation of decision-making tools, such as the Wifi system and GLASS.		
Grade	Level of evidence	Key references
Good research statement		

Whereas each method has its advantages and disadvantages, the continued use of multiple methodologies that each produces slightly different strengths of recommendation on any given topic leads to inconsistency and confusion. As a result, there is a strong movement globally to use the GRADE system as a means of rating the level of evidence and thereby defining the appropriate strength of resulting recommendations.⁶³⁸ The GVG on CLTI also endorse the use of GRADE. Thus, it is in the best interests of public and commercial researchers who want their research to have maximum impact on practice to ensure that their studies are designed in such a way as to score well using the GRADE criteria.

Recommendations 11 (continued)		
11.14 Assess the quality of evidence in CLTI research using frameworks such as GRADE that consider multiple certainty domains and are not based solely on study design.		
Grade	Level of evidence	Key references
Good research statement		

Research priorities for study design and trial end points in CLTI	
Recommendations	
11.1	Design well-constructed RCTs that address clinically relevant issues regarding the management of CLTI.
11.2	Clarify angiosome-based vs indirect tibial revascularization.
11.3	Identify the relative value of endovascular vs surgical therapy.
11.4	Validate specific anatomic scenarios outlined within GLASS.
11.5	Validate the Wifi system across specific grade levels.
11.6	Develop a reliable, real-time assessment tool for postintervention foot and wound perfusion.
11.7	Develop consensus definitions of postintervention patency and standardized patency-based end points relevant to CLTI interventions and trials.

12. CREATING A CENTER OF EXCELLENCE FOR AMPUTATION PREVENTION

The major causes of amputation are related to diabetes and CLTI. Of the 200 million people worldwide with PAD, CLTI affects at least 2% to 3%.¹ Whereas revascularization is the

treatment of choice in preventing limb loss, procedure bias, lack of specialty training, market forces, and lack of consensus definitions remain major obstacles in achieving the best possible outcomes for CLTI care.⁶³⁹

The CLTI patient is particularly complex. Patients with PAD have an increased risk of CAD and cerebrovascular disease and an elevated risk of 5-year mortality.⁶⁴⁰ Historically, CLTI was primarily sequelae of smoking and a diet high in saturated fats. However, in the last few decades, the rise in CLTI has followed the global epidemic of diabetes. Because of this changing epidemiology, this section focuses mainly on establishing and monitoring teams for the patient with diabetes-related CLTI, but the concepts presented herein can be applied to all CLTI teams.

Diabetes-related CLTI is only one part of diabetic foot syndrome, which is a common but complex group of complications from diabetes. These include neuropathy, ulceration, Charcot foot, soft tissue and bone infection, and PAD including CLTI and gangrene. It is well known that diabetes increases the risk of myocardial infarction by 50% and stroke by 25%; however, the greatest increased risk is for a foot or leg amputation.⁶¹⁸ Diabetic foot syndrome is also a costly comorbidity representing approximately one-third of the total cost of diabetes.⁶⁴¹ One study found the mean 1-year cost from a public payer perspective in the United States to be \$44,200.⁶⁴² Roughly 75% of the cost was due to inpatient hospitalizations, for which the average length of stay for DFU and lower extremity amputation exceeded that of myocardial infarction, stroke, and diabetic ketoacidosis.⁶⁴³⁻⁶⁴⁵

The patient with diabetic foot syndrome has a poor prognosis. It is frequently associated with loss of quality of life, work, independence, and income for both the patient and the primary caregiver. The relative 5-year mortality rate after a lower extremity amputation is a staggering 70%.⁶⁴⁶ For patients with DFU, it is 55%; and for patients with PAD alone, the 5-year relative mortality rate is 32%.⁶⁴⁷ Thus, although diabetes is an endocrine disease, common complications of diabetes are related to microvascular or macrovascular disease. For this reason, diabetic foot syndrome should be more appropriately thought of as part of the cardiovascular complications of diabetes.

Many institutions and government agencies have responded to the growing complexity, options, and subspecialization of treating medical conditions by creating disease-specific Centers of Excellence. A Center of Excellence is a virtual or physical location with a team of highly skilled experts who are often involved in research and innovation to advance their field.⁶⁴⁸ Whereas there have been experts in the field of PAD who have opined on what a Center of Excellence for CLTI, diabetic foot care, or amputation prevention might encompass, there are currently no governmental agencies or professional societies that have established such guidelines.

Center of Excellence

In 2010, building on the work of the International Working Group on the Diabetic Foot, three tiers of care were

Table 12.1. The three tiers of care for amputation prevention and diabetic foot care centers

Clinical level of care	Setting	Potential clinicians	Role
Basic model of care	General practitioner’s office, health center, small community hospital	General practitioner Internist Endocrinologist Podiatrist Diabetic nurse Physical therapist	Close collaboration with a referral center
Intermediate model of care	Regional hospital or multidisciplinary clinic	Endocrinologist Vascular surgeon Interventionalist Orthopedic surgeon Podiatric surgeon Diabetic nurse Wound nurse Physical therapist Diabetes educator Nutritionist	Active collaboration with other departments in the hospital and extramural facilities
Center of Excellence	Large teaching hospital, tertiary referral center	Endocrinologist Vascular surgeon Interventionalist Podiatric surgeon Orthopedic surgeon Infectious disease specialist Orthotist Diabetes educator Nutritionist Wound nurse Physical therapist	Collects and reports outcomes; facilitates regional education

Adapted from Rogers LC, Andros G, Caporusso J, Harkless LB, Mills JL Sr, Armstrong DG. Toe and flow. *J Am Podiatr Med Assoc* 2010;100:342-8.

proposed for an amputation prevention team—basic, intermediate, and Center of Excellence (Table 12.1).⁶⁴⁹ The basic model of care is performed in an office setting with a general practitioner, internist, or endocrinologist and a specialist nurse. An intermediate model of care is set in a hospital or multidisciplinary clinic and consists of various specialists to heal wounds and to prevent limb loss. This model is similar to a wound care center in the United States or a diabetic foot clinic in Europe. A Center of Excellence model is typically found in a tertiary care hospital with a predetermined team of specialists operating under clinical practice pathways, policies, and procedures. The Center of Excellence has advanced diagnostics and can intervene rapidly to prevent limb loss.

Currently, in many countries, there are no criteria required to designate oneself a Center of Excellence for health care. Anyone or any institution can use the terminology, and doing so does not guarantee that excellent care is being delivered. Based on experience in creating Centers of Excellence, a set of criteria are proposed to determine Center of Excellence designation in CLTI and amputation prevention, as outlined in Table 12.2.

Team setting, components, and function

No single specialist possesses all the necessary skills to manage diabetic foot syndrome. Therefore, it is important to create a team of specialists with the required skills.

Table 12.2. Criteria for Center of Excellence designation in chronic limb-threatening ischemia (CLTI) or amputation prevention

Center of Excellence criteria	Description
Multidisciplinary team of specialists	Specialists who can surgically and medically manage PAD and infections and provide the general or intensive medical care needed for the complex CLTI patient
Protocol-driven care	A team that follows written, evidence-based clinical practice pathways, policies, and procedures
Outcomes monitoring and reporting	Establishes a process for data collection and reports that data to the community or in the literature
Methods of improvement	Establishes a process for continual improvement based on outcomes and new techniques or therapies
Educational resource	Serves as an educational resource for the medical community through mentoring, publishing, and symposia

PAD = Peripheral artery disease.

Whereas some of the services required to treat CLTI and to prevent amputation can be performed in the outpatient setting, many needed services are intensive and require access to an acute care hospital.

An understanding of the natural history of amputation in diabetes can assist in determining how to build an effective team (Fig 12.1).⁶⁵⁰ Diabetes leads to peripheral neuropathy, although the timing of its onset is related to long-term control of blood glucose level. Peripheral neuropathy leads to unfelt repetitive trauma and in combination with foot deformity causes DFU.⁶⁵¹ Approximately half of these patients have significant PAD with their DFU. Still, more often than not, infection serves as the final event leading up to the amputation.⁶⁵²

Fitzgerald et al⁶¹⁰ described the seven essential skills for limb salvage teams. These were modified to identify nine skills needed for the comprehensive management of diabetic foot. Table 12.3 lists the essentials skills as well as the type of specialist who should be added to the team to complete a given task. The simplest method to construct a team for a Center of Excellence is to ensure that each of these skills is covered by an expert on the team. In addition, several authors have described an irreducible minimum to the team that includes vascular surgery and surgical podiatry. These two specialties have been nicknamed the “toe and flow” team.^{610,649}

Team-driven protocols

It is simply not enough to have a designated team. The team must be used in an effective manner, and outcomes should be monitored in a structured fashion. Fig 12.2 illustrates a useful pathway in setting up the structure of the team, establishing goals, and ensuring that the goals are met. Published CPGs from medical and surgical societies establish best practices, but they are not always feasible for practice in all settings. Current CPGs exist for PAD in diabetes, diabetic foot infections, DFUs, offloading of DFUs, inpatient management of the diabetic foot and the Charcot foot, and prevention of diabetic foot problems.^{158,653-658} Whereas these CPGs can serve as a template, localities are encouraged to create their own clinical practice pathways specific to the facility or system in which they practice.

The clinical practice pathways are used to identify the team structure and patient flow, when to engage various members, and what to do if the patient is not improving as expected. Policies and procedures are then created to assist providers and staff in complying with the pathway. Quality assurance goals are also created for measurable policies and procedures. Certain outcomes are self-explanatory, such as limb salvage rate, whereas others should be followed to ensure the quality of care delivered by the Center of Excellence. These can include the high-low amputation ratio,⁶⁵⁹ median days to heal for foot wounds, healing percentage, and quality of life measures. Table 12.4 lists the most important measurable outcomes for limb salvage and their calculation. These data may not always be easy to track. Existing electronic health record systems are lacking

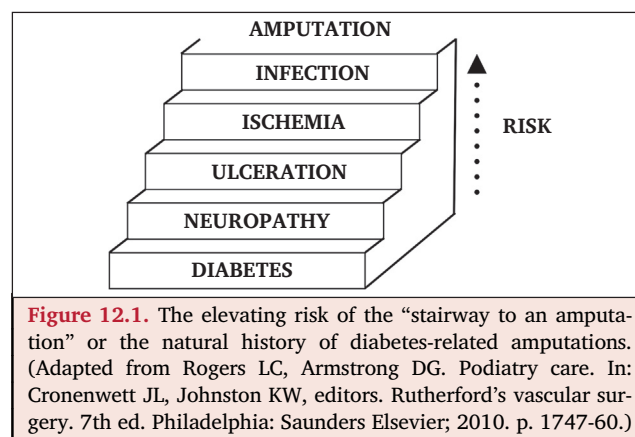


Figure 12.1. The elevating risk of the “stairway to an amputation” or the natural history of diabetes-related amputations. (Adapted from Rogers LC, Armstrong DG. Podiatry care. In: Cronenwett JL, Johnston KW, editors. Rutherford’s vascular surgery. 7th ed. Philadelphia: Saunders Elsevier; 2010. p. 1747-60.)

in their ability to track and to report most of these or other custom measures. Centers of Excellence often resort to developing their own software or keeping track of data manually in spreadsheets.

Finally, performance improvement plans must be drafted and initiated when the quality assurance goals are not met. Fig 12.3 shows an example of how this system would be applied to vascular disease screening in DFUs.

Team impact

In 2005, the World Health Organization and the International Diabetes Federation declared that up to 80% of diabetes-related amputations are preventable.^{660,661} Currently, the only intervention to address this has been the formation of multidisciplinary teams to prevent unnecessary amputations. In fact, the multidisciplinary team to prevent diabetes-related amputations dates back to at least 1934, when Elliott P. Joslin, an endocrinologist in Boston, established his team to treat diabetic gangrene.⁶⁶²

In the United States, an organized team in a public hospital reduced lower extremity amputations 72% during 2 years. In the Veterans Affairs medical centers, several factors were significant in the reduction of lower extremity amputations, including use of a specialized team and establishment of a high-risk foot clinic.^{663,664} In a military medical center, amputations were reduced by 82% as a result of a specialized limb preservation service.⁶⁶⁵ Another report showed a reduction improvement in diabetes-related foot outcomes with an integrated interdisciplinary team in a large academic medical center.⁶⁶⁶ In several other studies, adding podiatry to the team was found to be helpful in reducing amputations and significantly reducing the cost associated with diabetic foot.^{641,663,667,668}

The impact of a limb salvage team is not limited to any geographic area. In The Netherlands, investigators reported a 34% nationwide reduction in amputations after setting up multidisciplinary teams.⁶⁶⁹ In Brazil, the establishment of >20 interdisciplinary foot clinics nationwide is leading to improved care.⁶⁷⁰ In Italy, investigators reported a reduction in hospitalizations and amputations in the diabetic foot after implementing a multidisciplinary referral team.^{670,671} In Spain, a

Table 12.3. The nine essential skills to prevent amputations in diabetes and the possible specialty responsible

Essential skills	Possible team members
The ability to perform hemodynamic and anatomic vascular assessment	Vascular surgeon Interventionalist (cardiologist or radiologist) Vascular medicine
The ability to perform a peripheral neurologic workup	Neurologist Endocrinologist Podiatrist
The ability to perform site-appropriate culture technique	Infectious disease specialist Surgeon Wound nurse Physical therapist
The ability to perform wound assessment and staging or grading of infection and ischemia	Vascular surgeon Podiatrist Surgeon Infectious disease specialist Wound nurse Physical therapist
The ability to perform site-specific bedside and intraoperative incision and drainage or débridement	Podiatric surgeon Orthopedic surgeon Plastic surgeon Surgeon Vascular surgeon
The ability to initiate and to modify culture-specific and patient-appropriate antibiotic therapy	Infectious disease specialist Endocrinologist Primary care physician Vascular surgeon Podiatrist Surgeon
The ability to perform revascularization	Vascular surgeon Interventionalist (cardiologist or radiologist)
The ability to perform soft tissue or osseous reconstruction of deformities and defects	Podiatric surgeon Plastic surgeon Orthopedic surgeon Surgeon
The ability to perform appropriate postoperative monitoring to reduce risks of reulceration and infection	Podiatrist Wound nurse

Adapted from Fitzgerald RH, Mills JL, Joseph W, Armstrong DG. The diabetic rapid response acute foot team: 7 essential skills for targeted limb salvage. *Eplasty* 2009;9:e15.

multidisciplinary foot team reduced amputations during 3 years compared with the previous 6 years.⁶⁷² The United Kingdom has also seen reduced amputations secondary to better-organized diabetic foot care with specialized clinics that follow multidisciplinary care pathways and protocols.^{673,674} Lastly, in Finland, a decrease in major amputations was correlated with rising interest in limb salvage and an increase in distal vascular procedures.⁶⁷⁵ In a subsequent study, researchers reported a reduction in amputations and length of stay when inpatient care was reorganized.⁶⁷⁶

Summary

Centers of Excellence can be implemented with a well-organized team approach to diabetic foot syndrome and, in particular, the foot with CLI. Creating an integrated team

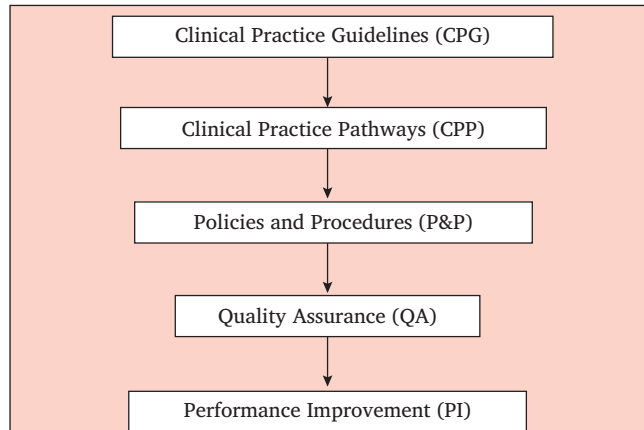


Figure 12.2. A schematic on how to organize the diabetic foot care within a multidisciplinary team.

whose primary focus is limb salvage and that receives all referrals for suspected CLTI is key. Teams can improve processes, time to intervention, and outcomes. The setting and structure of the team will ultimately depend on the availability and local need. However, to be most successful, Centers of Excellence should have team members who are capable of performing the nine essential skills as outlined in Table 12.3.

Table 12.4. Major outcome measures for chronic limb-threatening ischemia (CLTI) and amputation prevention

Quality assurance measure	Calculation
Limb salvage rate	$\frac{\text{No. of total patients} - \text{No. of major amputations (BKA or AKA)}}{\text{No. of total patients}}$
Major to minor amputation ratio	$\frac{\text{No. of major amputations performed (BKA or AKA)}}{\text{No. of limb-sparing amputations performed}}$
Healing percentage, all wounds	$\frac{\text{No. of wounds healed}}{\text{Total No. of wounds} - \text{palliative care patients}}$
Healing percentage, DFUs	$\frac{\text{No. of DFUs healed}}{\text{Total No. of DFUs} - \text{palliative care patients}}$
Median days to heal, all wounds	Calculate days to heal for all wounds. Exclude amputated and palliative care patients.
Median days to heal, DFUs	Calculate days to heal for all DFUs. Exclude amputated and palliative care patients.
Noninvasive vascular study, DFUs	$\frac{\text{No. of NIVSs performed}}{\text{No. of new DFU patients}}$
Revascularization success, open bypass	$\frac{\text{No. of open bypass patients} - \text{No. of open bypass failures}}{\text{No. of open bypass patients}}$
Revascularization success, endovascular	$\frac{\text{No. of endovascular patients} - \text{No. of endovascular failures}}{\text{No. of endovascular patients}}$

AKA = Above-knee amputation; BKA = below-knee amputation; DFUs = diabetic foot ulcers; NIVSs = noninvasive vascular studies. Palliative care patients are defined as those in whom healing is not the treatment goal, that is, terminal or hospice patients.

PAD Screening in Diabetic Foot Ulcers

CPG: Society for Vascular Surgery Guidelines*

CPP: Specific pathway adapted to local best practices for vascular disease screening

P&P: All lower extremity ulcers in those with diabetes will undergo screening for peripheral arterial disease by ankle brachial index, toe brachial index, or skin perfusion pressure. Positive tests will be referred to the vascular specialist for evaluation.

QA: 90% of patients with lower extremity ulcers and diabetes will have a screening test

PI: If QA measure is not met, start performance improvement plan:

- Assess outcomes to determine impact
- Determine where is the breakdown in compliance
- Reorient staff to the CPP, Policy, and QA expectations
- Retrain staff on performance and documentation of screening tests
- Reassess compliance in 3 months

Figure 12.3. An example of using the organized care model for peripheral artery disease (PAD) screening in diabetic foot ulcers (DFUs). CPG = Clinical practice guideline; CPP = clinical practice pathway; P&P = policies and procedures; PI = performance improvement; QA = quality assurance.

Centers of Excellence have published pathways and policies and procedures to determine the function and involvement of various members. Equally important to setting up the team is measuring the Center's performance. This is best accomplished with concrete quality assurance goals and the implementation of a performance improvement plan to be used when these goals are not met.

13. GLOBAL PERSPECTIVES IN CLTI

The preceding sections of this guideline make recommendations regarding the diagnosis and treatment of CLTI based on data published in peer-reviewed journals and, where such data are lacking, consensus expert opinion. Vascular specialists managing CLTI across the globe serve the needs of diverse communities and cultures, working within a wide range of health care environments. Most vascular specialists will strive to keep up to date with the published evidence base and are greatly facilitated in doing so through the use of modern information technology systems. However, the reality is that most publications on CLTI are written in English, and the data contained therein overwhelmingly derive from relatively few countries, mainly HICs (western Europe, North America, Japan), that have mature, well-resourced health and social care systems as well as clinical research infrastructure. Most vascular specialists treating patients with CLTI do not, of course, work in such favorable environments. As such, they often have to adapt foreign "evidence-based recommendations" to their own particular situation to provide the best possible care to their patients with the resources available. The GVG authors recognize this and, specifically, that some of the recommendations contained within this guideline are likely to remain

aspirational for many vascular specialists working in diverse health care settings across the globe. The authors therefore thought it important to examine the state of CLTI care from a broader perspective. To that end, a questionnaire enquiring about the presentation, diagnosis, and management of CLTI was sent to vascular specialists ($n = 50$) working in a range of lower, middle, and higher income countries. This section primarily comprises a description of the responses received ($n = 22$), supported by published locoregional data where available. The authors and the Steering Committee of the GVG appreciate and recognize these contributors for providing survey responses for this Section (Table 13.1).

Whereas the information provided may not be considered the highest quality from an epidemiologic perspective, a number of important global issues emerged from the responses. This brief overview highlights the urgent need for better data on the impact of CLTI and how it is managed around the world. The majority of responses derive from a few key opinion leaders from Latin America, Asia, and Africa; thus, the following discussion may not reflect concerns of other populations, providers, and nations.

Definition and classification

Clinical criteria, history, and examination are the mainstays of CLTI diagnosis across the world, with the use of adjunctive hemodynamic and perfusion measurements appearing to be highly variable. ABI testing was used by all except one respondent. However, although all respondents regularly dealt with diabetic vascular disease and the acknowledged limitations of APs in that setting, only two used TPs; none used TcPO₂ routinely. All (except one who exclusively used Wifl) used either the Fontaine or Rutherford classification for staging, approximately in equal numbers. About one-third of respondents described employing Wifl in addition to another clinical classification system. In summary, therefore, across most of the world, there appears to be limited adherence to any one published definition or staging system for CLTI.

Epidemiology and risk factors

Although accurate country-specific epidemiologic data are sparse, there seems little doubt that the increasing prevalence of DM (Fig 13.1) together with the growing use of tobacco and population aging is resulting in a significant increase in CLTI and amputations across much of the world, especially in LMICs.⁶⁷⁷

In 2013, Fowkes et al¹ undertook a meta-analysis of 34 studies to compare the prevalence and risk factors between HICs and LMICs. This is well outlined in Section 2 of this document, but it is worth recalling some of the key presented data. They concluded, "Globally, 202 million people were living with peripheral artery disease in 2010, 69.7% of them in LMIC, including 54.8 million in Southeast Asia and 45.9 million in the western Pacific Region. During the preceding decade, the number of individuals with peripheral artery disease increased by 28.7% in LMIC and 13.1% in HIC.

Table 13.1. Contributors

Country	Name	Affiliation
Argentina	Dr Juan Esteban Paolini	President, Argentine Association of Angiology and Cardiovascular Surgery, Caba
Brazil	Dr Tulio Pinho Navarro	Vascular and Endovascular Surgery, Belo Horizonte-MG
China	Dr Jinsong Wang	Vascular and Endovascular Surgery, Guangzhou, Guangdong
Colombia	Dr Alberto Munoz	Vascular and Endovascular Surgery, Bogota; Secretary General, WFVS-ALCVA (Latin American Society for Vascular Surgery and Angiology)
Costa Rica	Dr Roger Jimenez Juarez	Vascular and Endovascular Surgery, San Jose
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Tanzania	Dr Zulfiqarali G. Abbas	Consultant physician, Dar es Salaam; Chairman, Pan-African Diabetic Foot Study Group; Vice President, D-Foot International
Uruguay	Dr Marcelo Diamant	President of ALCVA (Asociación Latinoamericana de Cirugía Vascular y Angiología); vascular and endovascular surgeon

All the respondents are vascular surgeons.

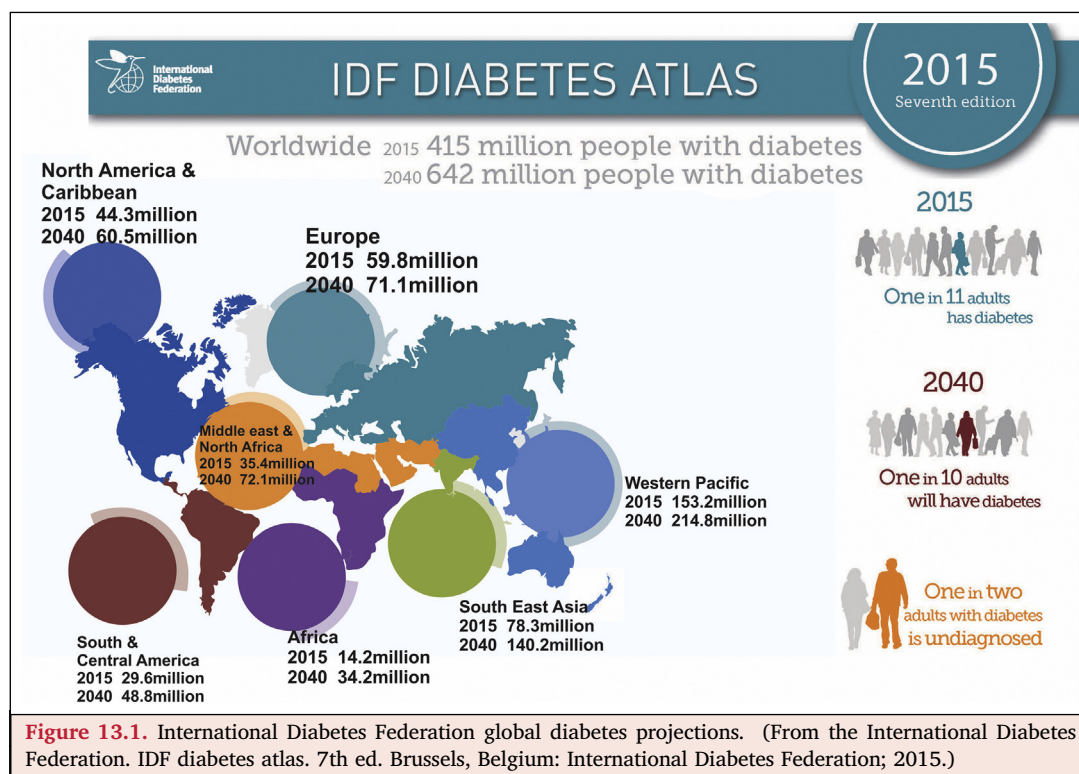
Also of note is the percentage of increase of PAD is higher in women than men in LMIC which is opposite of HIC." The increase in PAD burden observed in women and in the younger, economically productive age groups is especially worrisome (Table 13.2).

The data on country-specific incidence of PAD and CLTI are sparse in these LMICs, unlike in HICs. There are no relevant epidemiologic data from large regions, but the updated data from Abbas are tabulated for perspective, reflecting PAD in diabetics in sub-Saharan Africa (Table 13.3).

Lacking firm epidemiologic data, recent estimates of CLTI prevalence have used extrapolations from demographic and other available disease prevalence data, yielding global estimates of between 20 and 40 million individuals afflicted. About two-thirds of these are projected to be in LMICs.

Unfortunately, documented data to support this are difficult to find in any indexed, peer-reviewed journals.

According to the survey respondents, the risk factors for CLTI in their regions are largely as expected, but DM is a predominant cause, more than in HICs. The prevalence reported by respondents varied from 40% to 90%. Interestingly, a cultural preference for walking barefoot or a lack of appropriate footwear is a significant problem in some countries. Approximately 60% to 80% of all the PAD patients seen by the respondents present with CLTI. The average age was around 65 years, and about 70% were men. Most respondents reported that 70% to 100% of CLTI patients presented with tissue loss; in three countries, it was <50%. Primary amputation was performed in 10% to 40% of CLTI patients, this being mainly (25%-90%) because of delayed presentation or referral. Only two countries



reported a primary amputation rate of <10%. Post-procedural amputation rates were reported at around 5% to 10%, although two countries reported much higher rates (60%-70%) because of late presentation or aggressive disease patterns encountered.

Diagnostic evaluation

DUS appears to be used almost universally, although three respondents preferred to proceed directly to other imaging modalities. Only five respondents performed DSA as their primary imaging modality. The remainder opted for MRA and CTA in about equal numbers. In patients with renal impairment, DSA was preferred by most, with half opting for iodinated contrast agents with appropriate renal protection measures and the other half favoring CO₂ angiography. Two respondents performed only noninvasive testing in such patients before intervention.

Medical and noninterventional management (with or without revascularization)

Respondents reported widespread routine use of antiplatelet and lipid-lowering agents. ACEIs, vasoactive drugs (such as cilostazol and pentoxifylline), and anticoagulants were used selectively. IV prostanoids and vasodilators were used by some as adjuncts to revascularization and in those with nonreconstructible disease. Use of arterial assist devices (compression pump), HBOT, and SCS was uncommon. Lumbar sympathectomy was performed by a third of respondents, possible in patients with Buerger's disease (not specified).

Anatomic classification, risk stratification, and predictors of limb salvage

The almost uniform answer to the question How satisfied are you with present systems? was "somewhat satisfied." Interestingly, only six respondents used TASC to inform decisions about revascularization strategies and procedures in patients with CLTI. There was strong support for a new approach to patient and limb risk stratification and for a new anatomic classification system.

Revascularization

Although, overall, there has been a shift toward endovascular intervention, there is considerable variation in practice across the respondents—varying from 5% to 80% for both endovascular and "open" procedures! All stated that the preferred conduit for both above-knee and below-knee bypass continues to be autogenous vein. Prosthetic grafts are used selectively above the knee, but none advocate their use for distal bypass. None of the respondents endorsed "routine stenting" in the femoral-popliteal region, and all endovascular options (balloon angioplasty, DCB, stenting) are used selectively. Balloon angioplasty is preferred for endovascular intervention in infrapopliteal vessels; four respondents selectively use DCB, but none were in favor of stents below the knee.

Postprocedural surveillance and follow-up

All the respondents said they had defined follow-up protocols for patients undergoing infrainguinal revascularization. All patients (surgical and endovascular) are observed at least

Table 13.2. Estimated number of people living with peripheral artery disease (PAD)

Age, years	Rate of change (%), 2000-2010		
	HICs	LMICs	Worldwide
25-29	3.02	11.91	10.34
30-34	-1.52	7.62	5.82
35-39	-4.12	22.49	16.19
40-44	-3.28	32.05	22.59
45-49	7.14	25.83	20.51
50-54	12.15	42.40	32.37
55-59	31.31	55.53	47.49
60-64	16.85	29.90	25.06
65-69	4.90	20.29	14.35
70-74	8.02	29.73	20.05
75-79	11.68	41.36	26.75
80-84	51.98	45.77	48.92
85-89	34.80	47.86	39.84
≥90	37.22	58.82	44.09
Total	13.08	28.67	23.51

HICs = High-income countries; LMICs = Low- and middle-income countries.

Adapted from Fowkes FG, Rudan D, Rudan I, Aboyans V, Denenberg JO, McDermott MM, et al. Comparison of global estimates of prevalence and risk factors for peripheral artery disease in 2000 and 2010: a systematic review and analysis. *Lancet* 2013;382:1329-40.

every 3 months for a year and then at variable intervals thereafter. Clinical evaluation and ABI are the mainstays of surveillance. Use of other noninvasive methods (PVR, DUS) is variable. Specific protocols for vein and prosthetic bypass grafts seem to be standardized per available data in a minority of centers. Approach to surveillance-detected lesions is similarly variable but mostly dictated by the patient's symptoms rather than by the result of physiologic testing. Arteriography is reserved for clinically significant lesions. Postprocedural drug therapy, for example, with antiplatelet and lipid-lowering agents, appears concordant with current published recommendations. Because most CLTI patients had tissue loss, almost all the centers provided intensive wound services within their department as part of a multidisciplinary team approach. Nearly all agreed that wound infection is a significant determinant of outcome after revascularization and possible cause of amputation even after successful revascularization.

Health economics

CLTI has a serious adverse economic impact on patients, their families, and wider communities right across the world but especially so in LMICs. Although these countries are often grouped together, the division between middle income and lower income is variable and imprecise. Furthermore, there is often considerable inequality within each LMIC, and respondents reported that most patients with CLTI (30%-90%) appear to come from the poor socio-economic backgrounds. The following data from the Indian National Sample Survey Office could represent the situation in many LMICs⁶⁷⁸:

Table 13.3. Prevalence (%) of peripheral artery disease (PAD) in diabetics

Country	1990-2000	2000-2010	2010
Benin	NA	NA	42
Ethiopia	11.6	NA	NA
Ivory Coast	NA	NA	22
Malawi	15	NA	NA
Nigeria	NA	54	52
South Africa	10.2	8.2	30
Sudan	10	NA	NA
Tanzania	12.5	21	26
Uganda	NA	NA	39
Zambia	NA	NA	41

NA = Not available.

Adapted from Abbas ZG, Archibald LK. Recent international development: Africa. In: Boulton AJ, Cavanagh P, Rayman G, editors. *The foot in diabetes*. 4th ed. Hoboken, NJ: John Wiley & Sons; 2006. p. 379-385. Updated by Dr Abbas (Tanzania) with review of regional data and literature.

1. Only 18% of the urban population and 14% the of rural population are covered by some form of health insurance.
2. Governmental health expenditure is <2% of gross domestic product overall.
3. People in villages mainly depend on "household income or savings" (68%) and "borrowings" (25%) to fund hospitalization expenses.
4. Around 1% of the poor in rural areas have to sell their physical assets to meet health expenditure, and >5% seek help of friends and relatives. This is also in line with earlier studies showing that millions are pushed into poverty each year by medical expenditure and that such expenses are among the leading causes of indebtedness among the poor.
5. In cities, people rely much more on their income or savings (75%) than on borrowings (18%) to fund their treatment. Previous studies have repeatedly shown that India has one of the most privatized health care systems in the world, with out-of-pocket expenses accounting for the bulk of medical spending.

In India, the cost of IP bypass is U.S. \$1500 to \$3000, and costs of balloon angioplasty are similar. The use of a stent or DCB would add another U.S. \$500 to \$1000, and wound care adds at least U.S. \$500. Such out-of-pocket expenses are probably unaffordable for most CLTI patients. Importantly, these costs depend on recycling of single-use devices like sheaths, angioplasty balloons, and guidewires. Without such practice, the cost would increase by at least 50%, and far fewer patients, especially poorer ones, would have access to treatment, resulting in much greater loss of life and limb. Recycling of single-use devices (not just vascular devices) is common in Asia, Africa, Latin America, and eastern Europe, and proper regulation of the practice, including appropriate consent procedures, is important to mitigate patient harm.⁶⁷⁹

Summary of global perspectives

Based on the responses to the questionnaire and the limited published and unpublished data at times, we can draw the following conclusions.

1. CLTI is a significant and increasing global problem, especially in LMICs, where the incidence in women appears to be rising more quickly than in men.
2. Diabetes and unabated smoking are the major causes of CLTI globally.
3. Although vascular specialists try to follow the published evidence base, economic and social constraints mean that the approach to CLTI must be tailored to the working environment.
4. CLTI and diabetic foot problems are associated with high amputation rates in LMICs because of delayed presentation and referral and limited access to affordable care.
5. Economic constraints are an important limitation in the adoption of advanced vascular technologies, and practical issues such as recycling of single-use devices require oversight from a public health perspective.
6. Few countries maintain national registries or other CLTI data sets.
7. Most countries do not have a standardized approach to CLTI, with considerable locoregional variation in practice.
8. Most countries do not have well-organized and supported vascular societies where best practice and research can be shared and disseminated.

Dissemination and implementation

A large number of vascular specialists from around the world have contributed to the GVG, and that global involvement sets the present guideline document apart from all previous consensus statements. The paradigms and tools, such as Wifl, PLAN, and GLASS, set out in the GVG will, it is hoped, meet the needs of the global vascular community as expressed by our questionnaire respondents. However, some guideline recommendations will not be achievable by vascular specialists working in LMICs. The GVG recommendations should not, therefore, be viewed as an inflexible global “standard of care.” Following publication, it will be important to disseminate the GVG as quickly and widely as possible, simultaneously through a range of different channels, and to obtain validation and feedback from the global community. Dissemination will be assisted by publication of the full GVG as a supplement to the *Journal of Vascular Surgery* and *European Journal of Vascular and Endovascular Surgery*, publication of an executive summary with the recommendations in a range of other journals in a number of different languages, presentations at conferences, and free online access to the documents linked from societies’ web pages.

ADDENDUM

As this guideline goes to press (April, 2019), the safety of paclitaxel-eluting devices for the treatment of peripheral

arterial disease has come under intense scrutiny. The GVG Steering Committee, recognizing the importance of this issue to the vascular community, has unanimously approved the statement below. Given time constraints, this statement was not reviewed by the entire GVG Writing Group. This statement was approved by the three major sponsoring societies (ESVS, SVS, WFVS).

STATEMENT ON THE SAFETY OF PACLITAXEL-ELUTING DEVICES FOR THE TREATMENT OF CLTI

Recently the safety of paclitaxel (PTX)-eluting devices for the treatment of patients with peripheral arterial disease (PAD) has come into question. A meta-analysis of randomized controlled trials investigating these devices in the femoral and/or popliteal arteries identified an increased mortality at two years and beyond in patients treated with the PTX devices versus controls.⁶⁸⁰ These trials largely enrolled patients with intermittent claudication, with a small minority (11%) being within the spectrum of CLTI. Ongoing efforts from regulatory bodies and other independent groups seek to further clarify the validity of these observations. In the interim the US Food and Drug Administration has urged caution in the use of PTX devices for treatment of PAD.

The GVG Steering Committee believes that the risks and benefits of treatments for CLTI, including drug-eluting devices, need to be examined with appropriately controlled, prospective studies that are specific to the CLTI population. In this regard, the execution of randomized controlled-trials involving PTX-eluting devices in CLTI, with appropriate safety monitoring and regulatory oversight, are important to the vascular community. Such trials should incorporate appropriate informed consent discussions with subjects, including the potential increased risk of mortality, and should mandate long-term follow-up for at least 2 years. Outside of such trials, given the indeterminate risk and efficacy of these devices in patients with CLTI, and the availability of alternative modalities, we believe appropriate caution should be exercised.

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APPENDIX

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Supplementary Table (online only). Summary of Evidence						
Study	Population	Intervention	Comparison	Methodologic quality	Results	
<i>Recommendations 1.1 and 1.2</i>						
de Graaff, ¹ 2003	96 patients (128 legs) with clinically suspected CLI	Clinical judgment and AP	TcPO ₂ - and TP-guided management	Unblinded RCT. The randomization was performed by computer and was prestratified for the presence of DM and bilateral symptoms of CLI.	No significant difference was seen in terms of pain score, number of amputations, or death.	
Wang, ² 2016	Noninvasive screening tests for the prediction of wound healing and the risk of amputation in DFUs	Various tests	Various tests	Systematic review and meta-analysis of 37 observational studies	For the TcPO ₂ test, the pooled DOR was 15.81 (95% CI, 3.36-74.45) for wound healing and 4.14 (95% CI, 2.98-5.76) for the risk of amputation. ABI was also predictive but to a lesser degree of the risk of amputations (DOR, 2.89; 95% CI, 1.65-5.05) but not of wound healing (DOR, 1.02; 95% CI, 0.40-2.64). It was not feasible to perform meta-analysis comparing the remaining tests. The overall quality of evidence was limited by the risk of bias and imprecision (wide CIs due to small sample size).	
Brownrigg, ³ 2016	Prognostic markers in the prediction of wound healing or amputation among patients with foot ulcers in DM	Various tests	Various tests	Systematic review and meta-analysis of 11 observational studies on 9 markers of PAD	Skin perfusion pressure ≥ 40 mm Hg, TP ≥ 30 mm Hg (and ≥ 45 mm Hg), and TcPO ₂ ≥ 25 mm Hg were associated with at least a 25% higher chance of healing. AP < 70 mm Hg and fluorescein toe slope < 18 units each increased the likelihood of major amputation by around 25%.	
Beropoulos, ⁴ 2016	302 nondiabetic CLI patients treated by endovascular means	The prognostic value of Wifl	None	Retrospective unadjusted analysis of prospectively collected data	The AFS at 12 months was 87%, 81%, 81%, and 62% in the very-low-risk, low-risk, moderate-risk, and very-high-risk groups, respectively ($P = .106$). The difference was statistically significant between the very-low-risk and high-risk groups (HR, 3.4; 95% CI, 1.1-10.3; $P = .029$).	
Ward, ⁵ 2017	93 patients who presented to a public hospital with CLI	The prognostic value of Wifl	None	Retrospective adjusted analysis	On multivariable analysis, increasing Wifl amputation score (OR, 1.84; 95% CI, 1.0-3.39) was associated with increased risk of 1-year major amputation rate.	
Darling, ⁶ 2016	596 limbs of patients with a first-time lower extremity revascularization for CLTI	The prognostic value of Wifl	None	Retrospective adjusted analysis	Wifl mean score was predictive in the entire cohort (HR, 1.4; 95% CI, 1.1-1.7), the bypass-only cohort (HR, 1.5; 95% CI, 1.1-1.9), and the endovascular-only cohort (HR, 1.4; 95% CI, 1.0-1.8)	
<i>Recommendations 3.4, 3.5, and 3.6</i>						
Lijmer, ⁷ 1996	441 patients with suspected PAD	Noninvasive tests for assessing PAD	None	Retrospective adjusted analysis with blinded readers	For assessing PAD (lesions $\geq 50\%$), determining an ABI is justified (ROC area, 0.95 ± 0.02). For disease localized to the AI segment, performing a single test, the femoral pulsatility index, is sufficient (ROC area, 0.80 ± 0.04). For disease including the FP and IP segments, a combination of tests is necessary.	

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
Aboyans, ⁸ 2008	510 ambulatory patients (37% had DM)	Noninvasive tests for assessing PAD	None	Cross-sectional study, unblinded assessment, adjusted analysis	A strong association was found between DM and high ABI (OR, 16.0; $P < .001$). When ABI ranges were compared with TBI and Pk-PT results, those with ABI ≤ 0.9 and ABI ≥ 1.4 presented similar patterns of abnormalities. Pk-PT or TBI or both were abnormal in >80% of cases in both ABI ≤ 0.9 and ≥ 1.4 groups. The ABI vs TBI relationship appeared linear in nondiabetic patients but had an inverted J shape in diabetic patients, suggesting that high ABI masked leg ischemia.
Saluan, ⁹ 2018	556 patients from the Cohorte des Patients ARTériopathes hospitalized for PAD. Patients with CLI were enrolled according to the TASC II definition and followed up for at least 1 year.	Comparison of major amputation rate according to initial AP, systolic TP, and forefoot TcPO ₂	3 comparative tests	The cohort selection was considered adequate (consecutive sampling) and low risk for selection bias, but outcome assessment was not adjusted or blinded.	AP failed to identify 42% of patients with CLI. After 1 year, 27% of medical and 17% of surgical patients had undergone major amputation. TP <30 mm Hg predicted major amputation in the whole sample and in the medical group (OR, 3.5 [1.7-7.1] and 5 [2-12.4], respectively), but AP did not. TcPO ₂ <10 mm Hg also predicted major amputation (OR, 2.3 [1.5-3.5] and 3.8 [2.1-6.8]). The best predictive thresholds for major amputation were systolic TP <30 mm Hg and TcPO ₂ <10 mm Hg. None of these methods performed before surgery was able to predict outcome in the revascularized patients.
<i>Recommendations 3.7 and 3.8</i>					
Larch, ¹⁰ 1997	50 patients with FP obstruction were examined immediately before planned PTA	Color DUS	DSA	Consecutive sample, 2 readers, cross-sectional design	The sensitivity of color DUS for detecting a hemodynamically relevant arterial lesion (stenosis or occlusion) was 100% in the PT artery, 78% in the AT artery, and 92% in the peroneal artery.
Visser, ¹¹ 2000	31 diagnostic studies	Gadolinium-enhanced MRA	Color-guided DUS	Diagnostic meta-analysis, medium risk of bias, adjusted analysis	Pooled sensitivity for MRA (97.5%; 95% CI, 95.7%-99.3%) was higher than that for DUS (87.6%; 95% CI, 84.4%-90.8%). Pooled specificities were similar: 96.2% (95% CI, 94.4%-97.9%) for MRA and 94.7% (95% CI, 93.2%-96.2%) for DUS.
Adriaensen, ¹² 2004	73 patients with symptomatic PAD	CT	DSA	Randomized, unblinded	Further imaging was recommended more often after CT than after DSA ($P = .003$). Analysis of trends demonstrated increasing confidence in CT and stable confidence in DSA.
Collins, ¹³ 2007	Symptomatic lower limb PAD	DUS	MRA and CTA	Systematic review and meta-analysis of 113 observational studies of moderate quality	For the detection of stenosis >50% in the whole leg, MRA (14 studies) had the highest diagnostic accuracy, with sensitivity ranging from 92% to 99.5% and specificity from 64% to 99%. CTA (7 studies) was slightly inferior to MRA, with a sensitivity ranging from 89% to 99% and specificity

Continued

Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
					from 83% to 97%, but better than DUS (28 studies), which had a sensitivity ranging from 80% to 98% and specificity from 89% to 99%.
Hingorani, ¹⁴ 2004	33 inpatients with chronic lower extremity ischemia	MRA	Contrast arteriography and duplex arteriography	Consecutive sample, prospective operative follow-up, unblinded	No differences were noted between intraoperative findings and arteriography. Two of the 3 differences between duplex arteriography and contrast arteriography were thought to be clinically significant, whereas 9 of the 12 differences between MRA and contrast arteriography were thought to be clinically significant. On the basis of these data in this series, MRA does not yet seem to be able to obtain adequate data on IP segments, at least not for this highly selected population. When severe tibial calcification or very low flow states are identified, contrast arteriography may be necessary for patients undergoing duplex arteriography.
Hingorani, ¹⁵ 2008	906 patients undergoing lower extremity revascularization	Duplex arteriography (207 intraoperatively, 699 preoperatively)	Contrast arteriography	Consecutive series, comparative, nonrandomized, low risk of bias overall	Additional contrast arteriography imaging was required for procedural planning in 102 patients. The areas not visualized well included iliac (73), femoral (26), popliteal (17), and IP (221). Factors associated with increased need to obtain contrast arteriography included DM ($P < .001$), IP calcification ($P < .001$), older age ($P = .01$), and limb-threatening ischemia ($P < .001$).
Met, ¹⁶ 2009	957 patients with IC or CLI	CTA	DSA	Systematic review and meta-analysis of 20 nonrandomized studies of moderate quality	The sensitivity of CTA for detecting >50% stenosis or occlusion was 95% (95% CI, 92%-97%), and specificity was 96% (95% CI, 93%-97%). CTA correctly identified occlusions in 94% of segments, the presence of >50% stenosis in 87% of segments, and absence of significant stenosis in 96% of segments.
Recommendation 4.1					
The Study Group of Critical Chronic Ischemia of the Lower Extremities, ¹⁷ 1997	522 patients with chronic CLI	Various predictors	None	Prospective observational study with linkage to census information, unblinded	Besides age ≥ 70 years (RR, 1.94; 95% CI, 1.37-2.70), only a history of stroke (RR, 1.82; 95% CI, 1.19-2.79) and major amputation (RR, 1.90; 95% CI, 1.30-2.80) were significantly associated with mortality.
Recommendation 4.2					
Faglia, ¹⁸ 2014	553 diabetic patients admitted because of CLI	Various predictors, ACE and statin	None	Prospective observational study, consecutive sample	Multivariate analysis confirmed the independent role of age, history of stroke, renal insufficiency, and dialysis. Combined treatment with ACE and statin appeared to reduce mortality.
Armstrong, ¹⁹ 2014	739 patients with claudication or CLI who	Adherence to all four guideline-	Less adherence	Propensity weighting, consecutive cohort, and	After adjustment for baseline covariates, patients adhering to

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
	underwent diagnostic or interventional lower extremity angiography	recommended therapies (aspirin, statins, ACE inhibitors, and smoking cessation)		outcome adjustment; low risk of bias	all four guideline-recommended therapies had decreased MACEs (HR, 0.64; 95% CI, 0.45-0.89), MALEs (major amputation, thrombolysis, or surgical bypass; HR, 0.55; 95% CI, 0.37-0.83), and mortality (HR, 0.56; 95% CI, 0.38-0.82) compared with patients receiving fewer than four of the recommended therapies.
Recommendation 4.3					
Antithrombotic Trialists' Collaboration, ²⁰ 2002	Meta-analysis: 287 studies involving 135,000 patients in comparisons of antiplatelet therapy vs control and 77,000 in comparisons of different antiplatelet regimens	Antiplatelet	Control	Meta-analysis of randomized trials of various risk of bias	Allocation to antiplatelet therapy reduced the combined outcome of any serious vascular event by about one-quarter; nonfatal myocardial infarction was reduced by one-third, nonfatal stroke by one-quarter, and vascular mortality by one-sixth (with no apparent adverse effect on other deaths). Absolute reductions in the risk of having a serious vascular event per 1000 were 36 among patients with previous myocardial infarction, 38 among patients with acute myocardial infarction, 36 among those with previous stroke or transient ischemic attack, 9 among those with acute stroke, and 22 among other high-risk patients.
Antithrombotic Trialists' Collaboration, ²¹ 2009	Meta-analysis of 6 primary prevention trials and 16 secondary prevention trials	Aspirin	No aspirin	Meta-analysis of individual participant data from randomized trials at varying risk of bias	In the primary prevention trials, aspirin allocation yielded a 12% proportional reduction in serious vascular events (0.51% aspirin vs 0.57% control per year; $P = .0001$). Aspirin allocation increased major gastrointestinal and extracranial bleeds (0.10% vs 0.07% per year; $P < .0001$). In the secondary prevention trials, aspirin allocation yielded a greater absolute reduction in serious vascular events (6.7% vs 8.2% per year; $P < .0001$), with a nonsignificant increase in hemorrhagic stroke but reductions of about a fifth in total stroke (2.08% vs 2.54% per year; $P = .002$) and in coronary events (4.3% vs 5.3% per year; $P < .0001$). In both primary and secondary prevention trials, the proportional reductions in the aggregate of all serious vascular events seemed similar for men and women.
Recommendation 4.4					
CAPRIE Steering Committee, ²² 1996	19,185 patients with atherosclerotic vascular disease manifested as recent ischemic stroke, recent myocardial infarction, or symptomatic PAD	Clopidogrel (75 mg once daily)	Aspirin (325 mg once daily)	Randomized, blinded, international trial at low risk of bias	Patients treated with clopidogrel had an annual 5.32% risk of ischemic stroke, myocardial infarction, or vascular death compared with 5.83% with aspirin.

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
Hiatt, ²³ 2017	13,885 patients with symptomatic PAD, with an ABI of ≤ 0.8 or prior revascularization of the lower limbs	Ticagrelor (90 mg twice daily)	Clopidogrel (75 mg once daily)	Double-blinded randomized trial at low risk of bias	Patients in both groups had similar rates of reduction in cardiovascular (CV) events (CV death, myocardial infarction, ischemic stroke) and rates of major bleeding. CV events occurred in 740 of 6955 (10.6%) patients receiving clopidogrel (HR, 1.02; 95% CI, 0.92-1.13; $P = .65$), acute limb ischemia occurred in 1.7% of the patients (HR, 1.03; 95% CI, 0.79-1.33; $P = .85$), and major bleeding occurred in 1.6% (HR, 1.10; 95% CI, 0.84-1.43; $P = .49$).
Recommendation 4.5					
Anand, ²⁴ 2018	7470 patients with PAD of the lower extremities (previous peripheral bypass surgery or angioplasty, limb or foot amputation, IC (with objective evidence of PAD), of the carotid arteries (previous carotid artery revascularization or asymptomatic carotid artery stenosis of at least 50%) or CAD with an ABI of < 0.9	Oral rivaroxaban (2.5 mg twice a day) plus aspirin (100 mg once a day), rivaroxaban twice a day (5 mg with aspirin placebo once a day), or aspirin once a day (100 mg and rivaroxaban placebo twice a day)	3 arms	Multicenter, blinded patients and investigators, RCT at low risk of bias	Rivaroxaban plus aspirin compared with aspirin alone reduced the composite end point of CV death, myocardial infarction, or stroke (126 [5%] of 2492 vs 174 [7%] of 2504; HR, 0.72; 95% CI, 0.57-0.90; $P = .0047$) and MALEs including major amputation (32 [1%] vs 60 [2%]; HR, 0.54; 95% CI, 0.35-0.82, $P = .0037$). Rivaroxaban plus aspirin combination increased major bleeding compared with the aspirin alone group (77 [3%] of 2492 vs 48 [2%] of 2504; HR, 1.61; 95% CI, 1.12-2.31; $P = .0089$).
Recommendation 4.6					
Anand, ²⁵ 2007	2161 patients with PAD	Antiplatelet agent + oral anticoagulant agent	Antiplatelet therapy alone	RCT	Treating 1000 patients with combination therapy compared with antiplatelet therapy alone for 3 years would lead to 24 fewer CV events but 28 more episodes of life-threatening bleeding, a net increase in serious adverse outcomes.
Recommendation 4.7					
Mills, ²⁶ 2011	Meta-analysis of 10 RCTs enrolling 41,778 patients	High-dose statin	Low- or medium-dose statin	RCTs at low risk of bias	No difference in mortality or CV mortality. High dose reduced composite end points of CV death and nonfatal myocardial infarction and the composite of fatal and nonfatal stroke.
MRC/BHF Heart Protection Study, ²⁷ 2002	20,536 adults (aged 40-80 years) with coronary disease, other occlusive arterial disease, or DM	40 mg simvastatin daily	Placebo	Blinded randomized trial	All-cause mortality was significantly reduced (1328 [12.9%] deaths among 10,269 allocated to simvastatin vs 1507 [14.7%] among 10,267 allocated to placebo; $P = .0003$) because of a highly significant 18% proportional reduction in the coronary death rate (587 [5.7%] vs 707 [6.9%]; $P = .0005$), a marginally significant reduction in other vascular deaths (194 [1.9%] vs 230 [2.2%]; $P = .07$), and a nonsignificant reduction in nonvascular deaths (547 [5.3%] vs 570 [5.6%]; $P = .4$).
Meade, ²⁸ 2002	1568 men (aged 35-92 years) with lower extremity arterial disease	400 mg bezafibrate daily	Placebo	Double-blinded randomized trial	Bezafibrate did not reduce the incidence of coronary heart disease and stroke (RR, 0.96;

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					95% CI, 0.76-1.21). There were 90 and 111 major coronary events in the active and placebo groups, respectively (RR, 0.81; 95% CI, 0.60-1.08), of which 64 and 65 were fatal (RR, 0.95; 0.66-1.37) and 26 and 46 were nonfatal (RR, 0.60; 95% CI, 0.36-0.99). Beneficial effects on nonfatal events were greatest in men aged <65 years at entry, in whom benefit was also seen for all coronary events (RR, 0.38, 95% CI, 0.20-0.72). There were no significant effects in older men. There were 60 strokes in those receiving active treatment and 49 in those receiving placebo (RR, 1.34; 95% CI, 0.80-2.01). There were 204 and 195 deaths from all causes in the two groups, respectively (RR, 1.03; 95% CI, 0.83-1.26). Bezafibrate reduced the severity of IC for up to 3 years.
Leng, ²⁹ 2000	7 RCTs (698 patients with lower limb atherosclerosis)	Lipid-lowering therapy		Systematic review of 7 RCTs at low risk of bias	The follow-up period varied from 4 months to 3 years. The overall quality of the included trials was high. The trials were heterogeneous in terms of inclusion criteria, type of drugs used, and outcomes measured. Lipid-lowering therapy produced a marked but nonsignificant reduction in mortality (OR, 0.21; 95% CI, 0.03-1.17) but little change in nonfatal events (OR, 1.21; 95% CI, 0.80-1.83). In two trials, there was a significant overall reduction in disease progression on angiography (OR, 0.47; 95% CI, 0.29-0.77). The changes in ABI and walking distance were inconsistent, although trials showed a general improvement in symptoms that could not be combined in a meta-analysis.
Aung, ³⁰ 2007	18 randomized controlled trials (10,049 patients with PAD)	Lipid-lowering therapy		Systematic review of 18 RCTs	The pooled results from all eligible trials indicated that lipid-lowering therapy had no statistically significant effect on overall mortality (OR, 0.86; 95% CI, 0.49-1.50) or on total CV events (OR, 0.8; 95% CI, 0.59-1.09). However, subgroup analysis, which excluded PQRST, showed that lipid-lowering therapy significantly reduced the risk of total CV events (OR, 0.74; CI, 0.55-0.98). This was primarily due to a positive effect on total coronary events (OR, 0.76; 95% CI, 0.67-0.87). Greatest evidence of effectiveness came from the use of simvastatin in people with a blood cholesterol level ≥ 3.5 mmol/L (Heart Protection Study). Pooling of

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
					the results from several small trials on a range of different lipid-lowering agents indicated an improvement in total walking distance (WMD, 152 m; 95% CI, 32.11-271.88) and pain-free walking distance (WMD, 89.76 m; 95% CI, 30.05-149.47) but no significant impact on ABI (WMD, 0.04; 95% CI, -0.01 to 0.09).
Rodriguez, ³¹ 2017	509,766 patients (aged 21-84 years) in the Veterans Affairs health care system with two or more visits for atherosclerotic CVD in preceding 2 years	High-intensity statin therapy (n = 150,928) or low-intensity statin therapy (n = 33,920)	No statin (n = 92,625)	Retrospective cohort	During a mean follow-up of 492 days, there was a graded association between intensity of statin therapy and mortality, with 1-year mortality rates of 4.0% (5103/126,139) for those receiving high-intensity statin therapy, 4.8% (9703/200,709) for those receiving moderate-intensity statin therapy, 5.7% (1632/28,765) for those receiving low-intensity statin therapy, and 6.6% (4868/73,728) for those receiving no statin ($P < .001$). After adjustment for the propensity to receive high-intensity statins, the HR for mortality was 0.91 (95% CI, 0.88-0.93) for those receiving high- vs moderate-intensity statins. The magnitude of benefit of high- vs moderate-intensity statins was similar for an incident cohort HR of 0.93 (95% CI, 0.85-1.01). For patients aged 76 to 84 years, the HR was 0.91 (95% CI, 0.87-0.95). Patients treated with maximal doses of high-intensity statins had lower mortality (HR, 0.90; 95% CI, 0.87-0.94) compared with those receiving submaximal doses.
Recommendation 4.8					
SPRINT, ³² 2015	9361 persons with a systolic blood pressure of 130 mm Hg or higher and an increased CV risk but without DM	Systolic blood pressure target <120 mm Hg	Target of <140 mm Hg	Randomized trial at low risk of bias	Significantly lower rate of the primary composite (CV) outcome in the intensive-treatment group than in the standard-treatment group (1.65% per year vs 2.19% per year; HR with intensive treatment, 0.75; 95% CI, 0.64-0.89; $P < .001$). All-cause mortality was also significantly lower in the intensive-treatment group (HR, 0.73; 95% CI, 0.60-0.90; $P = .003$).
Bavry, ³³ 2010	2699 PAD patients observed for a mean of 2.7 years	Blood pressure target	NA		All-cause death, nonfatal myocardial infarction, or nonfatal stroke occurred least frequently among PAD patients treated to an average systolic blood pressure of 135 to 145 mm Hg and an average diastolic blood pressure of 60 to 90 mm Hg. PAD patients

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					displayed a J-shaped relationship with systolic blood pressure and the primary outcome, although individuals without PAD did not. PAD patients may require a different target blood pressure than those without PAD.
ACCORD Study Group, ³⁴ 2010	4733 participants with type 2 DM	Intensive therapy, targeting a systolic pressure of <120 mm Hg	Standard therapy, targeting a systolic pressure of <140 mm Hg	Low risk of bias, precise	Targeting a systolic blood pressure of <120 mm Hg compared with <140 mm Hg did not reduce the rate of a composite outcome of fatal and nonfatal major CV events.
Moise, ³⁵ 2016	The objective of this study was to project the potential value of adding intensive systolic blood pressure goals in high-risk patients to the JNC7 or JNC8 guidelines in a contemporary population of untreated hypertensive individuals aged 35 to 74 years.	NA	NA	Simulation and state-transition (Markov cohort) model of incidence, prevalence, mortality, and costs of CVD	Adding intensive systolic blood pressure goals for high-risk patients prevents an estimated 43,000 and 35,000 annual CVD events incremental to JNC8 and JNC7, respectively. Intensive strategies save costs in men and are cost-effective in women compared with JNC8 alone. At a willingness to pay threshold of \$50,000 per quality-adjusted life-years gained, JNC8 + intensive had the highest probability of cost-effectiveness in women (82%), and JNC7 + intensive the highest probability of cost-effectiveness in men (100%). Assuming higher drug and monitoring costs, adding intensive goals for high-risk patients remained consistently cost-effective in men but not always in women.
Recommendation 4.9					
Nathan, ³⁶ 2005	1441 patients with type 1 DM	Intensive therapy	Conventional therapy	Randomized trial at low risk of bias	Intensive treatment reduced the risk of any CVD event by 42% (95% CI, 9%-63%; $P = .02$) and the risk of nonfatal myocardial infarction, stroke, or death from CVD by 57% (95% CI, 12%-79%; $P = .02$).
van Dieren, ³⁷ 2014	7768 patients with type 2 DM	Intensive glycemic control	Standard control	Randomized trial at low risk of bias	Feasible intensive control of DM There was no significant reduction in macrovascular disease, but a trend was seen toward fewer myocardial infarctions with more intensive glucose control.
Selvin, ³⁸ 2004	13 observational studies (1699 patients with type 1 DM and 7435 patients with type 2 DM)	NA	NA	Meta-analysis of 13 prospective cohort studies	The pooled RR for CVD was 1.18; this represented a 1-percentage point increase in glycosylated hemoglobin level (95% CI, 1.10-1.26) in persons with type 2 DM. Results in persons with type 1 DM were similar but had a wider CI (pooled RR, 1.15; 95% CI, 0.92-1.43).
Recommendation 4.10					
Palmer, ³⁹ 2016	301 clinical trials (1,417,367 patient-months)	Glucose-lowering drugs	Other glucose-lowering drugs	Meta-analysis of trials at overall low risk of bias	Compared with metformin, sulfonylurea (SMD, 0.18; 95% CI, 0.01-0.34), thiazolidinedione (SMD, 0.16; 95% CI, 0.00-0.31), dipeptidyl peptidase 4 inhibitor (SMD, 0.33; 95% CI, 0.13-0.52), and α -glucosidase inhibitor (SMD,

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
					0.35; 95% CI, 0.12-0.58) monotherapy was associated with higher hemoglobin A1c levels. Sulfonylurea (OR, 3.13 [95% CI, 2.39-4.12]; RD, 10% [95% CI, 7%-13%]) and basal insulin (OR, 17.9 [95% CI, 1.97-162]; RD, 10% [95% CI, 0.08%-20%]) were associated with greatest odds of hypoglycemia.
Recommendation 4.11					
Nawaz, ⁴⁰ 1998	33 inpatients receiving metformin	Contrast angiography		Retrospective case series	Twenty-nine patients had a normal serum creatinine concentration before the procedure and none had a rise after angiography. Four patients had an abnormal serum creatinine concentration before angiography; all four patients showed significant deterioration and all four patients died, two of unrelated causes and two of acute renal failure and acidosis.
Goergen, ⁴¹ 2010	Systematic review of 5 CPGs on use of contrast medium in patients taking metformin	Contrast angiography	NA	NA	Recommendations were inconsistent regarding need to withhold metformin in patients with normal vs abnormal renal function. Not all guidelines included a specific time period. A 48-hour withholding period was the most common recommendation. Supporting evidence was of low quality, and connection between evidence and recommendations was unclear.
Recommendation 4.12					
Blomster, ⁴² 2016	20 countries worldwide participating in the Action in Diabetes and Vascular Disease: Preterax and Diamicron Modified-Release Controlled Evaluation (ADVANCE) trial (6466 never-smokers, 1550 daily smokers, and 3124 former smokers)	Smoking	Nonsmoking	Prospective observation of a trial, low risk of bias	Daily smoking was associated with increased risk of major CV events and mortality. Men and women had similar HRs for most subcomponents of outcomes.
Newhall, ⁴³ 2017	Vascular surgery practices	Brief smoking cessation intervention	Control sites	Cluster randomized trial at low risk of bias	Compared with usual care, patients in the intervention group were more likely to express interest in quitting and to acknowledge their addictive behaviors, and when resurveyed 3 months after intervention, they had larger declines in nicotine dependence and health effects domains.
Athyros, ⁴⁴ 2013	1600 patients with established coronary heart disease, mean follow-up 3 years (RCT of statins)	Atorvastatin	No atorvastatin	Low risk, RCT	The relative effects of statins were similar in smokers and nonsmokers (absolute effects were higher in smokers).
Blomster, ⁴² 2016	11,140 patients with type 2 DM aged ≥ 55 years and in CV risk at the time of randomization.	NA	NA	Low risk, cohort	Daily smoking was associated with increased risk of all primary and secondary outcomes with the exception of major cerebrovascular disease.
Degenais, ⁴⁵ 2005	8905 men and women in the Heart Outcomes Prevention Evaluation (HOPE) trial, with either	NA	NA	Observational cohort	Patients were observed for 4.5 years. Smokers, compared with never-smokers, had adjusted RRs for CV death of 1.65 (95%

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
	CVD or DM with at least one additional risk factor (2728 never-smokers, 5241 former smokers, 936 current smokers)				CI, 1.28-2.14), for myocardial infarction of 1.26 (95% CI, 1.01-1.58), for stroke of 1.42 (95% CI, 1.00-2.04), and for total mortality of 1.99 (95% CI, 1.63-2.44).
<i>Recommendation 4.13</i>					
Kondo, ⁴⁶ 2011	25,464 healthy Japanese men, with no known diseases and not taking medications for hypertension, DM, or dyslipidemia	NA	NA	Observational cohort	Fewer total CVD events were observed with an increasing duration of quitting, with a statistically significant reduction in mortality with quitting for ≥ 4 years.
Newhall, ⁴³ 2017	156 smokers at 8 vascular surgery clinics	Surgeon-delivered intervention protocol: cessation counseling, medications, and referral to quit line	Usual smoking cessation care	Cluster randomized trial without baseline assessment	More patients in the intervention group reported "a lot" or "some" interest in quitting after their initial appointment with the vascular surgeon (95.4% vs 85.7%; $P = .05$). At 3-month follow-up, 37% of those with a strong desire to quit were successful compared with 23% of those with a weak desire.
<i>Recommendations 6.3, 6.4, and 6.5</i>					
Schanzer, ⁴⁷ 2008	Patients who underwent infrainguinal vein bypass surgery for CLI; two data sets were used: the PREVENT III randomized trial ($n = 1404$) and a multicenter registry ($n = 716$)	Infrainguinal vein bypass surgery	None	Retrospective analysis of prospectively collected data. For a given risk category, the AFS estimate was consistent between the derivation and validation sets.	Stratification of the patients in three risk categories yielded three significantly different Kaplan-Meier estimates for 1-year AFS (86%, 73%, and 45% for low-, medium-, and high-risk groups, respectively).
Bradbury, ⁴⁸ 2010	2020 patients with severe lower limb ischemia due to infrainguinal disease who survived for 2 years after intervention (BASIL trial)	Bypass surgery first	Balloon angioplasty first	Multivariate Cox model based on RCT at low risk of bias evaluating the effect of baseline variables	Baseline factors that were significant were BASIL randomization stratification group, below-knee Bollinger angiogram score, BMI, age, DM, creatinine level, and smoking status. The factors that contributed to the Weibull predictive model were age, presence of tissue loss, serum creatinine concentration, number of AP measurements detectable, maximum AP measured, history of myocardial infarction or angina, history of stroke or transient ischemia attack, below-knee Bollinger angiogram score, BMI, and smoking status.
Meltzer, ⁴⁹ 2013	4985 individuals after bypass surgery for CLI from the National Surgical Quality Improvement Program	Bypass surgery	None	Retrospective data analysis from a registry with adequate outcome and exposure ascertainment; derivatization and validation cohorts	Higher model scores were significantly associated with higher rates of mortality, all major morbidities, and 30-day major morbidity and mortality.
Simons, ⁵⁰ 2016	7754 patients with CLI from the national SVS VQI database	Bypass surgery	None	Retrospective data analysis from a registry with adequate outcome and exposure ascertainment	Three prediction models had similar discriminative performance: BASIL, Finland National Vascular (Finnvasc) registry, and modified PREVENT III. A novel VQI-derived model had improved discriminative ability with a C index of 0.71.

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Supplementary Table (online only)-continued						
Study	Population	Intervention	Comparison	Methodologic quality	Results	
Biancari, ⁵¹ 2007	3925 patients status post infrainguinal surgical revascularization procedures	Infrainguinal surgical revascularization procedures	None	Retrospective data analysis from a registry with adequate outcome and exposure ascertainment; derivatization and validation cohorts	In the validation data set, the 30-day postoperative mortality/amputation rates in patients with scores of 0, 1, 2, 3, and 4 were 4.8%, 7.5%, 10.1%, 15.9%, and 22.2%, respectively ($P < .0001$); mortality rates were 0.7%, 2.3%, 4.2%, 5.5%, and 14.8%, respectively ($P < .0001$); and major amputation rates were 4.6%, 5.3%, 6.4%, 11.0%, and 14.0%, respectively ($P = .011$).	
Recommendation 6.10						
Lavery, ⁵² 2008	162 patients with large, chronic, nonischemic diabetic foot wounds after partial foot amputation.	NA	NA	Reanalysis of RCT, moderate risk of bias	Early changes in percentage of wound area reduction were predictive of final healing at 16 weeks.	
Sheehan, ⁵³ 2003	203 patients with DFUs	NA	NA	Reanalysis of RCT, moderate risk of bias	The percentage change in foot ulcer area after 4 weeks of observation is a robust predictor of healing at 12 weeks.	
Snyder, ⁵⁴ 2010	250 control group patients from two RCTs of human fibroblast-derived dermal substitute for treating DFUs	NA	NA	Reanalysis of data from two RCTs	Regardless of baseline size category, DFUs with <50% persistent area of reduction at 4 weeks were less likely to heal by 12 weeks than DFUs with ≥50% persistent area of reduction ($P \leq .001$). Sensitivity and specificity were higher with cutoff of 4 weeks than weeks 1 to 3.	
Cardinal, ⁵⁵ 2008	241 DFUs from patients enrolled in RCTs on topical wound treatments	NA	NA	Reanalysis of data from two RCTs	Wound margin advance, initial healing rate, percentage wound surface area reduction, and wound healing trajectories (all $P < .001$) were powerful predictors of complete wound healing at 12 weeks. Wounds with poor healing progress by these criteria at 4 weeks were highly likely to remain unhealed after an additional 8 weeks of treatment.	
Recommendation 6.11						
Abu Dabrh, ⁵⁶ 2015	13 studies enrolling 1527 patients with CLI	Natural history	None	Meta-analysis of observational studies at increased risk of bias	During a median follow-up of 12 months, all-cause mortality rate was 22% (CI, 12%-33%) and major amputation rate was 22% (CI, 2%-42%). Worsened wound or ulcer was found at 35% (CI, 10%-62%). The quality of evidence was low because of increased risk of bias and inconsistency.	
Recommendations 6.6, 6.12, 6.13, and 6.14						
Cull, ⁵⁷ 2014	139 patients with foot wounds who presented for lower extremity revascularization	NA	NA	Retrospective analysis of prospectively collected data	The Wiffl clinical stage was predictive of 1-year limb amputation (stage 1, 3%; stage 2, 10%; stage 3, 23%; stage 4, 40%) and wound nonhealing (stage 1, 8%; stage 2, 10%; stage 3, 23%; stage 4, 40%).	
Zhan, ⁵⁸ 2015	201 patients with threatened limbs	Amputation	Limb salvage	Retrospective cohort, consecutive sample, unadjusted analysis, no blinded outcome adjudication	The amputation group had a significantly higher prevalence of advanced stage 4 patients ($P < .001$), whereas the limb salvage group presented predominantly as stages 1 to 3. Patients in clinical stages 3 and 4 had a significantly higher incidence of amputation ($P <$	

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					.001), decreased AFS ($P < .001$), and delayed wound healing time ($P < .002$) compared with those in stages 1 and 2.
Darling, ⁵⁹ 2015	596 limbs of patients undergoing an IP angioplasty for CLI	Angioplasty	NA	Retrospective cohort identified using administrative codes, consecutive sample, adjusted analysis, no blinded outcome adjudication	One-unit increase in the Wifi composite score is associated with a decrease in wound healing (HR, 1.2; 95% CI, 1.1-1.4) and an increase in the rate of stenosis (HR, 1.2; 95% CI, 1.1-1.4) and major amputations (HR, 1.4; 95% CI, 1.2-1.8).
Causey, ⁶⁰ 2016	143 patients hospitalized for threatened limb	NA	NA	Retrospective analysis of prospectively gathered registry data of consecutive patients	Increased Wifi stage was associated with MALEs ($P = .018$), reduced limb salvage ($P = .037$), and decreased AFS ($P = .048$). PREVENT III risk score category was associated with mortality ($P < .001$) and AFS ($P < .001$).
Robinson, ⁶¹ 2017	280 threatened limbs.	NA	NA	Retrospective analysis of prospectively gathered registry data of consecutive patients, adjusted analysis	Increasing Wifi stage was associated with decreased 1-year Kaplan-Meier limb salvage (stage 1, 96%; stage 2, 84%; stage 3, 90%; and stage 4, 78%; $P = .003$) and AFS ($P = .006$).
Recommendation 6.17					
Seeger, ⁶² 1987	51 patients who had lower extremity revascularization	Real-time imaging of the saphenous and cephalic veins	Patients who had similar procedures in the 12 months before the use of vein mapping	Pre-post nonrandomized study	Preoperative mapping was found to be accurate in 50 of 51 patients (98%). Vein size as determined by B-mode ultrasound correlated well with angiograms, $R = 0.85$ overall with $R > 0.9$ in the last 7 months of the study. Wound complications occurred in 2% of the patients who had preoperative mapping and in 17% of the historical controls.
Wengerter, ⁶³ 1990	239 IP reversed great saphenous vein graft bypasses placed for critical ischemia during a 7-year period	NA	NA	Nonrandomized prospective cohort study, unblinded	A pattern of increasing graft patency and limb salvage was noted as the minimum external diameter increased from <3.0 mm to ≥ 4.0 mm.
Schanzer, ⁶⁴ 2007	1404 North American patients with CLI	Lower extremity bypass	NA	Secondary analysis of RCT	Vein diameter and conduit type were the dominant technical determinants of early and late graft failure.
Recommendations 6.20, 6.21, 6.22, 6.23, and 6.24					
Harward, ⁶⁵ 1995	450 patients undergoing lower extremity arterial reconstruction	NA	NA	Retrospective unblinded cohort study	The majority of complications and deaths occurred in patients undergoing aortic inflow plus complex outflow procedures (profundaplasty or composite bypass conduits), in which the morbidity and mortality rates were 84.2% and 47.4%, respectively, compared with rates of 45.7% and 2.9% ($P < .01$) after all other inflow/outflow procedures. The increased difficulty of these complex procedures is reflected in the significantly greater blood loss and operative times (1853 mL and 10.0 hours) compared with similar values (1125 mL and 7.7 hours; $P < .01$) for all other inflow/outflow procedures.

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
Zukauskas, ⁶⁶ 1995	1953 aortofemoral reconstructions were performed during a 6-year period	NA	NA	Retrospective unblinded cohort study	Single-stage multisegment reconstruction for multilevel arterial occlusive disease is a safe and effective method of treating critical limb ischemia.
Recommendation 6.25					
Jongkind, ⁶⁷ 2010	Meta-analysis of 19 nonrandomized studies (1711 patients)	Endovascular approach	NA	Uncontrolled studies	Technical success was achieved in 86% to 100% of the patients. Clinical symptoms improved in 83% to 100%. Mortality was described in seven studies and ranged from 1.2% to 6.7%. Complications were reported in 3% to 45% of the patients. The most common complications were distal embolization, access site hematomas, pseudoaneurysms, arterial ruptures, and arterial dissections.
Ye, ⁶⁸ 2011	Meta-analysis of 16 endovascular treatment studies (958 patients)	Endovascular approach	NA	Retrospective, uncontrolled studies	Technical success was achieved in 92.8% of patients (95% CI, 89.8%-95.0%; 749 cases). Primary patency at 12 months was 88.7% (95% CI, 85.9%-91.0%; 787 cases). Subgroup analyses demonstrated a technical success rate of 93.7% (95% CI, 88.9%-96.5%) and a 12-month primary patency rate of 89.6% (95% CI, 84.8%-93.0%) for TASC C lesions. For TASC D lesions, these rates were 90.1% (95% CI, 76.6%-96.2%) and 87.3% (95% CI, 82.5%-90.9%), respectively.
Deloose, ⁶⁹ 2017	120 patients with TASC II A and B iliac lesions	Endovascular treatment		Multicenter prospective cohort	The primary patency rate for the total patient population was 97.4%. The primary patency rates at 12 months for the TASC II class A and TASC II class B (C) lesions were, respectively, 98.3% and 96.6%.
Recommendation 6.26					
Indes, ⁷⁰ 2013	Meta-analysis of 29 open bypass studies (3733 patients) and 28 endovascular treatment studies (1625 patients) in AI occlusive disease	Direct open bypass	Endovascular treatment	Mostly observational comparative studies	Mean length of hospital stay was 13 days for open bypass vs 4 days for endovascular treatment procedures ($P < .001$). The open bypass group experienced more complications (18.0% vs 13.4%; $P < .001$) and greater 30-day mortality (2.6% vs 0.7%; $P < .001$). At 1 year, 3 years, and 5 years, pooled primary patency rates were greater in the open bypass group vs the endovascular cohort (94.8% vs 86.0%, 86.0% vs 80.0%, and 82.7% vs 71.4%, respectively; all $P < .001$); the same was true for secondary patency (95.7% vs 90.0% [$P = .002$], 91.5% vs 86.5% [$P < .001$], and 91.0% vs 82.5% [$P < .001$], respectively).
Chiu, ⁷¹ 2010	29 bypass studies	Bypass	Endovascular treatment	Systematic review of mostly observational studies	Operative mortality rate was 4.1% for AFB, 2.7% for IFB, and 2.7% for AI endarterectomy. Systematic morbidity rate was 16%,

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					18.9%, and 12.5%. Local morbidity rate was 6.3% for AFB, 5.7% for IFB, and 2.4% for AI endarterectomy. Graft-related morbidity/intervention failure rates were 3.1%, 4.2%, and 3.8%. Eight studies reported infection rates after AFB, with a combined rate of 0.4%. The 5-year patency rates for patients with CLI were 79.8% for AFB, 74.1% for IFB, and 81.7% for AI endarterectomy.
Ricco, ⁷² 2008	143 patients with unilateral iliac artery occlusive disease and disabling claudication	Crossover bypass	Direct bypass		Primary patency at 5 years was higher in the direct bypass group than in the crossover bypass group (92.7% ± 6.1% vs 73.2% ± 10%; <i>P</i> = .001). Assisted primary patency and secondary patency at 5 years were also higher after direct bypass than after crossover bypass (92.7% ± 6.1% vs 84.3% ± 8.5% [<i>P</i> = .04] and 97.0% ± 3.0% vs 89.8% ± 7.1% [<i>P</i> = .03], respectively). Patency at 5 years after crossover bypass was significantly higher in patients presenting with no or low-grade SFA stenosis than in patients presenting with high-grade (≥50%) stenosis or occlusion of the SFA (74.0% ± 12% vs 62.5% ± 19%; <i>P</i> = .04). In both treatment groups, patency was comparable using polytetrafluoroethylene and polyester grafts. Overall survival was 59.5% ± 12% at 10 years.
Recommendation 6.27					
Kang, ⁷³ 2008	65 limbs in 58 patients with occlusive disease of the CFA	CFA endarterectomy	NA	Retrospective, unblinded, adjusted analysis	Technical success was achieved in 100% of the cases. The 1- and 5-year primary patencies were 93% and 91%, respectively.
Ballotta, ⁷⁴ 2010	117 patients	CFA endarterectomy	NA	Retrospective, unblinded, unadjusted analysis	There were no perioperative deaths or major complications. The 7-year rates of freedom from further revascularization and survival were 79% and 80%, respectively.
Recommendation 6.28					
Chang, ⁷⁵ 2008	171 patients (mean age, 67 ± 10 years; 38% female; 35% diabetic)	CFA endarterectomies and iliac stent/stent grafting	NA	Retrospective, noncomparative, nonblinded	Technical success occurred in 98% of patients. Clinical improvement was seen in 92% of patients. Mean ABI increased from 0.38 ± 0.32 to 0.72 ± 0.24. Median length of stay was 2 days (range, 1-51 days). The 30-day mortality was 2.3%, and 5-year survival was 60%. The 5-year primary, primary assisted, and secondary patencies were 60%, 97%, and 98%, respectively. Endovascular reintervention was required in 14% of patients; inflow surgical procedures were required in 10%. By logistic regression

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
analysis, use of stent grafts compared with bare stents was associated with significantly higher primary patency (87% ± 5% vs 53% ± 7%; $P < .01$).					
<i>Recommendation 6.29</i>					
Baumann, ⁷⁶ 2011	98 patients with symptomatic obstructions of the CFA	Endovascular therapy	NA	Consecutive series, adjusted analysis	Primary sustained clinical improvement rates at 3, 6, 12, and 24 months were 55%, 55%, 40%, and 0% in CLI patients and 81%, 75%, 68%, and 52% in claudicants, respectively. Limb salvage rates at 24 months were 94% in CLI patients and 100% in claudicants.
Bonvini, ⁷⁷ 2011	97 patients with symptomatic obstructions of the CFA	Endovascular therapy	NA	Prospectively maintained single-center database; retrospective analysis, unblinded and unadjusted	Failures—defined as a final angiographic result with a >30% residual stenosis—were observed on 26 occasions (7.2%). In-hospital major (ie, requiring surgery) and minor (ie, treated percutaneously or conservatively) complications occurred in 5 (1.4%) and 18 (5.0%) procedures, respectively.
Gouëffic, ⁷⁸ 2017	117 patients with de novo atherosclerotic lesions of the CFA	Stenting	Surgery	Randomized trial, moderate risk of bias	Primary outcome (mortality and complications) occurred in 16 of 61 patients (26%) in the surgery group and 7 of 56 patients (12.5%) in the stenting group (OR, 2.5; 95% CI, 0.9-6.6; $P = .05$). The mean duration of hospitalization was significantly lower in the stenting group (3.2 ± 2.9 days vs 6.3 ± 3 days; $P < .0001$). At 24 months, the sustained clinical improvement, the primary patency rate, and the target lesion and extremity revascularization rates were not different in the two groups.
Siracuse, ⁷⁹ 2016	1014 patients with PAD	Isolated CFA intervention with or without a deep femoral artery intervention	NA	Retrospective unblinded, noncomparative	Survival was 92.9% at 1 year and 87.2% at 3 years. AFS, freedom from loss of patency or death, and reintervention-free survival were 93.5%, 83%, and 87.5% at 1 year, respectively. Multivariable predictors of mortality were tissue loss, COPD, ESRD, urgent case, and age, whereas aspirin use and nonwhite race were protective. Tissue loss, rest pain, COPD, ESRD, stent use, nonambulatory status, and female sex were predictive of major amputation, whereas aspirin use, P2Y12 antagonist use, statin use, and initial technical success were protective.
<i>Recommendations 6.32, 6.40, and 6.41</i>					
Almasri, ⁸⁰ 2018	44 studies that enrolled 8602 patients with CLTI	All infrainguinal revascularization procedures	NA	Noncomparative meta-analysis	Prosthetic bypass outcomes were notably inferior to vein bypass in terms of amputation and patency outcomes, especially for below-knee targets at 2 years and beyond. DESs demonstrated improved

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					patency over BMSs in IP arteries (primary patency, 73% vs 50% at 1 year), which was at least comparable to balloon angioplasty (66% primary patency), albeit within an anatomically restricted cohort of CLTI patients. Survival, major amputation, and AFS at 2 years were broadly similar between endovascular interventions and vein bypass, with prosthetic bypass having higher rates of limb loss.
<i>Recommendations 6.33, 6.34, 6.35, 6.36, and 6.37</i>					
See Abu Dabrh, ⁵⁶ 2015; Zhan, ⁵⁸ 2015; Darling, ⁵⁹ 2015; Causey, ⁶⁰ 2016; Robinson, ⁶¹ 2017					
<i>Recommendation 6.38</i>					
Chae, ⁸¹ 2016	Meta-analysis of 727 patients with arterial occlusive disease in diabetic feet	Angiosome-targeted angioplasty	Non-angiosome-targeted angioplasty	Four nonrandomized comparative studies at increased risk of bias	Overall limb salvage (OR, 2.209; $P = .001$) and wound healing rates (OR, 3.290; $P = .001$) were significantly higher in patients who received angiosome-targeted angioplasty. The revision rate was not significantly different (OR, 0.747; $P = .314$).
Jongsma, ⁸² 2017	Meta-analysis of 19 cohort studies with 3932 patients with CLI	Direct revascularization according to the angiosome concept	Indirect revascularization	Nonrandomized studies at low risk of bias	Direct revascularization significantly improved wound healing (RR, 0.60; 95% CI, 0.51-0.71), major amputation (RR, 0.56; 95% CI, 0.47-0.67), and AFS rates (RR, 0.83; 95% CI, 0.69-1.00).
Biancari, ⁸³ 2014	Systematic review and meta-analysis of 9 cohort studies (1290 legs)	Direct revascularization according to the angiosome concept	Indirect revascularization	Retrospective studies at increased risk of bias	The risk of unhealed wound was significantly lower after direct revascularization (HR, 0.64; 95% CI, 0.52-0.8; I^2 , 0%; four studies included) compared with indirect revascularization. Direct revascularization was also associated with significantly lower risk of major amputation (HR, 0.44; 95% CI, 0.26-0.75; I^2 , 62%; eight studies included). Pooled limb salvage rates after direct and indirect revascularization were 86.2% vs 77.8% at 1 year and 84.9% vs 70.1% at 2 years, respectively. The analysis of three studies reporting only on patients with DM confirmed the benefit of direct revascularization in terms of limb salvage (HR, 0.48; 95% CI, 0.31-0.75; I^2 , 0%).
Sumpio, ⁸⁴ 2013	Systematic review of 11 case series (1616 patients, 1757 limbs)	Revascularization		Mostly retrospective case series at increased risk of bias	Ten studies compared direct and indirect revascularization. Five studies reported that limb salvage rate was higher with direct revascularization than with indirect revascularization (93% vs 72%; $P = .02$). Five of eight studies that reported wound healing rates found a significant increase with direct revascularization compared with indirect revascularization; however, length of follow-up varied between these studies. Mean time to healing was not significantly different in direct

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
					revascularization compared with indirect revascularization when analyzed by three studies. One study found a significant increase in AFS in direct revascularization compared with indirect revascularization (evaluated by three studies). Seven studies with a predominantly diabetic population reported limb salvage as a primary outcome, and three found a significant increase with direct revascularization compared with indirect revascularization.
Azuma, ⁸⁵ 2012	228 patients (249 limbs) with CLTI	Bypass	NA	Retrospective consecutive case series	The complete healing of ischemic wounds was achieved in 211 limbs (84.7%). ESRD (OR, 0.127; $P < .001$), DM (OR, 0.216; $P = .030$), Rutherford category 6 with heel ulcer/gangrene (OR, 0.134; $P < 0.001$), Rutherford category 6 except heel (OR, 0.336; $P = .025$), and low albuminemia (OR, 0.387; $P = .049$) were negative predictors of wound healing. Regarding the angiosome, the healing rate in the indirect revascularization group was slower than in the direct revascularization group, especially in patients with ESRD ($P < .001$). However, the healing rates of the direct and indirect revascularization groups were similar after minimizing background differences with propensity score methods ($P = .185$).
Recommendation 6.39					
Almasri, ⁸⁰ 2018	44 studies that enrolled 8602 patients with CLTI	All infrainguinal revascularization procedures	NA	Noncomparative meta-analysis	Prosthetic bypass outcomes were notably inferior to vein bypass in terms of amputation and patency outcomes, especially for below-knee targets at 2 years and beyond. DESs demonstrated improved patency over BMSs in IP arteries (primary patency, 73% vs 50% at 1 year), which was at least comparable to balloon angioplasty (66% primary patency), albeit within an anatomically restricted cohort of CLTI patients. Survival, major amputation, and AFS at 2 years were broadly similar between endovascular interventions and vein bypass, with prosthetic bypass having higher rates of limb loss.
Schillinger, ⁸⁶ 2006	104 patients with severe claudication or CLTI due to stenosis or occlusion of the SFA	Stenting	Angioplasty	RCT	Secondary stenting was performed in 17 of 53 patients (32%) in the angioplasty group, in most cases because of a suboptimal result after angioplasty. At 6 months, the rate of restenosis on angiography was 24% in the stent group and 43% in the

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					angioplasty group ($P = .05$); at 12 months, the rates on DUS were 37% and 63%, respectively ($P = .01$). Patients in the stent group were able to walk significantly farther on a treadmill at 6 and 12 months than those in the angioplasty group.
Saxon, ⁸⁷ 2008	197 patients with symptomatic PAD of SFA	PTA	Angioplasty plus stent graft	Multicenter RCT	The stent graft group had a significantly higher technical success rate (95% vs 66%; $P < .0001$) and 1-year primary vessel patency rate at DUS (65% vs 40%; $P = .0003$). A patency benefit was seen for lesions at least 3 cm long. At 12 months, chronic limb ischemia status was 15% further improved for the stent graft group ($P = .003$). There were no significant differences between treatment groups with regard to the occurrence of early or late major adverse events.
Dake, ⁸⁸ 2011	474 patients with FP PAD (236 primary DES; 238 angioplasty)	DES	PTA, provisional BMS	Multinational RCT	There were 120 patients who had acute PTA failure and underwent secondary random assignment to provisional DES ($n = 61$) or BMS ($n = 59$). Primary end points were the 12-month rates of event-free survival and patency in the primary DES and PTA groups. Compared with the PTA group, the primary DES group exhibited superior 12-month event-free survival (90.4% vs 82.6%; $P = .004$) and primary patency (83.1% vs 32.8%; $P < .001$), satisfying the primary hypotheses. In the secondary evaluations, the primary DES group exhibited superior clinical benefit compared with the PTA group (88.3% vs 75.8%; $P < .001$); the provisional DES group exhibited superior primary patency (89.9% vs 73.0%; $P = .01$) and superior clinical benefit (90.5% and 72.3%; $P = .009$) compared with the provisional BMS group; and the stent fracture rate (both DES and BMS) was 0.9% (4/457).
Rosenfield, ⁸⁹ 2015	476 patients with symptomatic IC or ischemic pain while at rest and angiographically significant atherosclerotic lesions	Angioplasty with a paclitaxel-coated balloon	Standard angioplasty	Single-blinded, multicenter RCT	At 12 months, the rate of primary patency among patients who had undergone angioplasty with the drug-coated balloon was superior to that among patients who had undergone conventional angioplasty (65.2% vs 52.6%; $P = .02$). The proportion of patients free from primary safety events was 83.9% with the drug-coated balloon and 79.0% with standard angioplasty ($P = .005$ for noninferiority). There were no significant between-group

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Supplementary Table (online only)-continued						
Study	Population	Intervention	Comparison	Methodologic quality	Results	
					differences in functional outcomes or in the rates of death, amputation, thrombosis, or reintervention.	
Recommendation 6.42						
Mills, ⁹⁰ 1992	214 consecutive infrainguinal bypass grafts (209 reversed vein and 5 polytetrafluoroethylene grafts)	DUS	NA	Prospective evaluation of consecutive sample, unblinded and not adjusted	The 30-day primary patency was 99% (129/130) for FP grafts and 93% (78/84) for femorodistal grafts. Secondary patency was 100% (130/130) and 96% (81/84), respectively. Primary patency was 89% (16/18) for those grafts that required intraoperative revision based on arteriographic findings.	
Bandyk, ⁹¹ 1994	368 patients after carotid endarterectomy, infrainguinal vein bypass, or visceral or renal reconstruction	DUS	NA	Uncontrolled and nonrandomized series	DUS identified technical (residual plaque, stricture) or intrinsic defects (platelet thrombus, distal thrombosis) requiring revision in 37 (10%) of the reconstructions; low (<0.5%) complication rate.	
Recommendation 7.1						
Ubbink, ⁹² 2013	Six studies comprising nearly 450 patients with inoperable chronic CLI	SCS	Standard care	Controlled nonblinded studies	Overall, no significantly different effect on ulcer healing was observed with the two treatments. Complications of SCS treatment consisted of implantation problems (9%; 95% CI, 4%-15%) and changes in stimulation requiring reintervention (15%; 95% CI, 10%-20%). Infections of the lead or pulse generator pocket occurred less frequently (3%; 95% CI, 0%-6%). Overall risk of complications with additional SCS treatment was 17% (95% CI, 12%-22%), indicating a number needed to harm of 6 (95% CI, 5-8). Average overall costs (one study) at 2 years were €36,500 (SCS group) and €28,600 (conservative group). The difference (€7900) was significant ($P < .009$).	
Recommendation 7.2						
Karanth, ⁹³ 2016	Cochrane review showing no trials; critical lower limb ischemia due to nonreconstructible PAD	LS	Standard care	NA	No trials	
Recommendation 7.3						
Abu Dabrh, ⁹⁴ 2015	19 studies enrolling 2779 patients with CLI	Medical therapies (PGE1 and angiogenic growth factors) and devices (pumps and spinal cord stimulators)	Control interventions	Meta-analysis of randomized and nonrandomized studies at increased risk of bias	None of the non-revascularization-based treatments were associated with a significant effect on mortality. IPC (OR, 0.14; 95% CI, 0.04-0.55) and spinal cord stimulators (OR, 0.53; 95% CI, 0.36-0.79) were associated with reduced risk of amputation. The quality of evidence was low because of increased risk of bias and imprecision.	
Recommendation 7.4						
Vietto, ⁹⁵ 2018	33 randomized controlled trials with 4477 participants	Prostanoids	Other agents or placebo	Meta-analysis of randomized trials at increased risk of bias	Low-quality evidence suggests no clear difference in the incidence of CV mortality between patients receiving	

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					prostanoids and those given placebo (RR, 0.81; 95% CI, 0.41-1.58). High-quality evidence suggests that prostanoids have no effect on the incidence of total amputations compared with placebo (RR, 0.97; 95% CI, 0.86-1.09). Adverse events were more frequent with prostanoids than with placebo (RR, 2.11; 95% CI, 1.79-2.50; moderate-quality evidence).
Recommendation 7.5					
Smith, ⁹⁶ 2012	8 trials enrolling 269 participants	Naftidrofuryl	Other agents or placebo	Meta-analysis of randomized trials at increased risk of bias	The effect of naftidrofuryl was statistically nonsignificant on pain, rest pain, skin necrosis, or mean ankle systolic pressure.
Recommendation 7.6					
Kranke, ⁹⁷ 2015	12 trials enrolling 269 participants	HBOT	Usual care	Meta-analysis of randomized trials at increased risk of bias	HBOT increased ulcer healing rate in diabetics without significant effect on other outcomes. Data specifically in CLI were limited.
Game, ⁹⁸ 2016	Systematic review of 30 studies, including 13 HBOT trials	HBOT		11 RCTs and 2 retrospective cohort studies at increased risk of bias	Studies have conflicting results. It is not yet clear which patients would benefit from HBOT.
Santema, ⁹⁹ 2018	120 patients with DM with an ischemic wound	HBOT	Usual care	RCT	After 12 months, 28 index wounds were healed in the standard care group vs 30 in the standard care with HBOT group (RD, 3%; 95% CI, -14 to 21). AFS was achieved in 41 patients in the standard care group and 49 patients in the standard care with HBOT group (RD, 13%; 95% CI, -2 to 28). In the standard care with HBOT group, 21 patients (35%) were unable to complete the HBOT protocol as planned. Those who did had significantly fewer major amputations and higher AFS (RD for AFS, 26%; 95% CI, 10-38).
Recommendation 8.1					
Abu Dabrh, ⁹⁴ 2015	19 studies enrolling 2779 patients with CLI	Medical therapies (PGE1 and angiogenic growth factors) and devices (pumps and spinal cord stimulators)	Control interventions	Meta-analysis of randomized and nonrandomized studies at increased risk of bias	None of the non-revascularization-based treatments were associated with a significant effect on mortality. IPC (OR, 0.14; 95% CI, 0.04-0.55) and spinal cord stimulators (OR, 0.53; 95% CI, 0.36-0.79) were associated with reduced risk of amputation. The quality of evidence was low because of increased risk of bias and imprecision.
Peeters Weem, ¹⁰⁰ 2015	Meta-analysis of 10 studies (499 patients)	Bone marrow-derived cell therapy	Placebo	Randomized controlled trials	No significant differences were observed in major amputation rates (RR, 0.91; 95% CI, 0.65-1.27), survival (RR, 1.00; 95% CI, 0.95-1.06), and AFS (RR, 1.03; 95% CI, 0.86-1.23) between the cell-treated and placebo-treated patients. The

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Supplementary Table (online only)-continued						
Study	Population	Intervention	Comparison	Methodologic quality	Results	
					ABI (mean difference, 0.11; 95% CI, 0.07-0.16), TcPO ₂ measurements (mean difference, 11.88; 95% CI, 2.73-21.02), and pain score (mean difference, -0.72; 95% CI, -1.37 to -0.07) were significantly better in the treatment group than in the placebo group.	
Recommendation 9.1						
Elsherif, ¹⁰¹ 2018	223 diabetic patients who underwent either digital or transmetatarsal amputation	Transmetatarsal amputation	Digital amputation	Nonrandomized comparative observational study, consecutive sample	The median time to major amputation was (400 ± IQR 1205 days) in the digital amputation group compared with 690 ± IQR 891 days in the transmetatarsal amputation group (<i>P</i> = .974); 29.9% of digital amputations and 15.7% of transmetatarsal amputations in diabetic patients required minor amputations or revision procedures (<i>P</i> = .04). Median length of hospital stay was (20 days; IQR, 27 days) in the digital amputation group and (17 days; IQR, 17 days) in the transmetatarsal amputation group (<i>P</i> = .17). Need for readmission was 48.1% in digital amputation patients compared with 50% in transmetatarsal amputation patients (<i>P</i> = .81). Quality of time spent without symptoms of disease or toxicity of treatment was (315 days; IQR, 45 days) in the digital amputation group and (346 days; IQR, 48 days) in the transmetatarsal amputation patients (<i>P</i> = .099).	
Recommendation 9.2						
Siracuse, ¹⁰² 2015	110,279 patients undergoing major vascular surgery	DNR status	No DNR	Nonrandomized sample from National Surgical Quality Improvement Program database; propensity score matching, no blinding	Compared with a matched cohort of high-risk non-DNR patients, those with DNR orders suffered equivalent rates of postoperative morbidity but markedly increased mortality.	
Aziz, ¹⁰³ 2015	16,678 patients underwent emergency vascular operations	DNR status	No DNR	Nonrandomized sample from National Surgical Quality Improvement Program database; propensity score matching, no blinding	DNR patients were more likely to have higher rates of graft failure (8.7% vs 2.4%; adjusted <i>P</i> < .01) and failure to wean from mechanical ventilation (14.9 % vs 9.9%; adjusted <i>P</i> < .001). DNR status was associated with a 2.5-fold rise in 30-day mortality (35.0% vs 14.0%; 95% CI, 1.7-2.9; adjusted <i>P</i> < .001).	
Recommendation 9.3						
Reed, ¹⁰⁴ 2008	33 Patients who had undergone BKA or AKA after failed lower extremity revascularization	NA	NA	Survey with 39% nonresponse rate	If faced with a similar scenario, 85% (28/33 patients) of amputees would do everything to save the leg; 54% (18/33) of patients actively used a prosthesis, and 91% (30/33) resided at home.	
Recommendation 9.4						
Rollins, ¹⁰⁵ 1985	54 patients underwent 56 profundaplasties for limb salvage	NA	NA	Uncontrolled surgical case series	After profundaplasty, ischemic ulcers healed in 9 of 17 (53%) patients. Rest pain was relieved in 6 of 19 (32%), and areas of	

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					ischemic necrosis healed in 7 of 20 (35%). Cumulative patency of the deep femoral artery was 49% at 3 years but fell to 21% at 5 years, whereas cumulative limb salvage was 49% and 36%, respectively. Eleven of the required 28 amputations were performed in the immediate postoperative period. Profundaplasty was used to lower the amputation level and to preserve the knee joint in six patients. The other five early amputations occurred in severely ischemic limbs without distal vessels suitable for bypass. The profundaplasty remained patent in all 19 patients who underwent BKA, and 16 (84%) became ambulatory with a prosthesis.
Miksic, ¹⁰⁶ 1986	282 PFA reconstructions	NA	NA	Uncontrolled surgical case series	An inflow correction was necessary in 60.3% of PFA reconstructions. Factors that bear on the success or failure of profundaplasty were evaluated. These were AI inflow, extent of disease in the PFA, runoff in the distal popliteal-tibial system, and extent of the ischemic lesion. Of the failures, most were due to established gangrene, obstructions throughout the whole length of the PFA, or poor popliteal-tibial runoff system. The cumulative limb salvage at 2 years was 86.8% in limbs subjected to an inflow correction procedure and profundaplasty but only 56.5% in repair of the PFA alone.
Recommendation 9.5					
Ayoub, ¹⁰⁷ 1993	32 patients with TKAs for ischemia	NA	NA	Uncontrolled consecutive surgical case series	Average length of stay was 8.7 days. One patient required a revision to AKA. There were no other major complications.
Taylor, ¹⁰⁸ 2008	309 BKA patients	NA	NA	Uncontrolled consecutive surgical case series	Patients with CAD (OR, 0.465; 95% CI, 0.289-0.747), cerebrovascular disease (OR, 0.389; 95% CI, 0.154-0.980), and impaired ambulatory ability before BKA (OR, 0.310; 95% CI, 0.154-0.623) were less likely to have a successful outcome (wound healing, maintenance of ambulation, and survival for at least 6 months) with BKA. Patients with impaired ambulation combined with another factor had only a 20% to 23% probability of successful outcome, and patients with all three had a 10.4% probability of success.
Recommendation 9.6					
Webster, ¹⁰⁹ 2012	Individuals undergoing their first major lower limb amputation because of vascular disease or DM	NA	NA	Uncontrolled surgical case series	At 4 months, unsuccessful prosthetic fitting was significantly associated with depression, prior arterial

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
					reconstruction, DM, and pain in the residual limb. At 12 months, 92% of all patients were fitted with a prosthetic limb, and individuals with transfemoral amputation were significantly less likely to have a prosthesis fitted. Age older than 55 years, diagnosis of a major depressive episode, and history of renal dialysis were associated with fewer hours of prosthetic walking.
<i>Recommendation 9.7</i>					
Glaser, ¹¹⁰ 2013	1715 patients undergoing lower extremity amputation (exclusive of trauma or tumor)	NA	NA	Uncontrolled surgical case series	Cox proportional hazards regression analysis revealed that ESRD (HR, 3.9; 95% CI, 2.3-6.5), chronic renal insufficiency (HR, 2.2; 95% CI, 1.5-3.3), atherosclerosis without diabetic neuropathy (HR, 2.9; 95% CI, 1.5-5.7), atherosclerosis with diabetic neuropathy (HR, 9.1; 95% CI, 3.7-22.5), and initial major amputation (HR, 1.8; 95% CI, 1.3-2.6) were independently predictive of subsequent contralateral major amputation.
Bradley, ¹¹¹ 2006	107 vascular amputees (mean age, 70 years) referred for prosthesis provision	NA	NA	Cross-sectional study, unblinded unadjusted	On analysis, 41% were prescribed a statin and 39% were prescribed a statin and 60% an antiplatelet agent. Whereas 39% of these patients were receiving both drugs, 32% had been prescribed neither.
<i>Recommendations 10.1, 10.2, 10.3, 10.4, and 10.5 (also see evidence for 4.7 and 4.8)</i>					
Bedenis, ¹¹² 2015	16 studies with 5683 randomized participants Nine different treatment groups were evaluated: aspirin or aspirin and dipyridamole (DIP) vs placebo or nothing (six studies); aspirin or aspirin-DIP vs pentoxifylline (two studies); aspirin-DIP vs indobufen (one study); aspirin or aspirin-DIP vs vitamin K antagonists (two studies); aspirin-DIP vs low-molecular-weight heparin (one study); ticlopidine vs placebo (one study); aspirin vs PGE1 (one study); aspirin vs naftidrofuryl (one study); and clopidogrel and aspirin vs aspirin alone (one study).	Antiplatelets	Other approaches	Meta-analysis of trials at low to moderate risk of bias	Graft patency was improved in the aspirin or aspirin-DIP treatment group (OR, 0.42; 95% CI, 0.22-0.83; $P = .01$; 952 participants).
Abbruzzese, ¹¹³ 2004	172 patients underwent 189 primary autogenous infrainguinal arterial reconstructions	Statins	No statins	Retrospective comparative study, not blinded, adjusted analysis	Perioperative mortality (2.6%) and major morbidity (3.2%) were not different between groups. There was no difference in primary patency

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					(74% ± 5% vs 69% ± 6%; $P = .25$), limb salvage (92% ± 3% vs 90% ± 4%; $P = .37$), or survival (69% ± 5% vs 63% ± 5%; $P = .20$) at 2 years. However, patients taking statins had higher primary-revised (94% ± 2% vs 83% ± 5%; $P < .02$) and secondary (97% ± 2% vs 87% ± 4%; $P < .02$) graft patency rates at 2 years. Of all factors studied by univariate analysis, only statin use was associated with improved secondary patency ($P = .03$) at 2 years. This was confirmed by multivariate analysis.
Henke, ¹¹⁴ 2004	293 patients (338 infrainguinal bypass procedures)	NA	NA	Retrospective case series	Statin drugs were taken by 56% of patients, ACE inhibitors by 54% of patients, and antiplatelet agents or warfarin sodium (Coumadin) by 93% of patients. Statin drug use was independently associated with increased graft patency (OR, 3.7; 95% CI, 2.1-6.4) and with decreased amputation rate (OR, 0.34; 95% CI, 6.15-0.77). Kaplan-Meier analysis showed that only ACE inhibitors were associated with lower mortality ($P = .05$).
Suckow, ¹¹⁵ 2015	2067 infrainguinal bypass patients, from the Vascular Study Group of New England registry (67% with CLTI)	NA	NA	Retrospective analysis of prospectively collected data	Despite higher comorbidity burdens, long-term survival was better for patients taking statins in crude (RR, 0.7; $P < .001$), adjusted (HR, 0.7; $P = .001$), and propensity-matched analyses (HR, 0.7; $P = .03$). In subgroup analysis, a survival advantage was evident in patients taking statins with CLI (5-year survival rate, 63% vs 54%; log-rank, $P = .01$) but not with claudication (5-year survival rate, 84% vs 80%; log-rank, $P = .59$). Statin therapy was not associated with 1-year rates of major amputation (12% vs 11%; $P = .84$) or graft occlusion (20% vs 18%; $P = .58$) in CLI patients. Perioperative myocardial infarction occurred more frequently in patients taking a statin in crude analysis (RR, 2.2; $P = .01$) but not in the matched cohort (RR, 1.9; $P = .17$).
Brown, ¹¹⁶ 2008	Systematic review of randomized and nonrandomized studies of patients undergoing infrainguinal bypass surgery	Antiplatelet treatment	No antiplatelet treatment	Moderate risk of bias overall	The administration of a variety of platelet inhibitors resulted in improved venous and artificial graft patency compared with no treatment. However, analyzing patients for graft type indicated that those patients receiving a prosthetic graft were more likely to benefit from administration of platelet inhibitors than patients treated with venous grafts.

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
Willigendael, ¹¹⁷ 2005	Meta-analysis of data from 29 studies	NA	NA	Moderate risk of bias overall	The effect of smoking on graft patency in the randomized clinical trials and other prospective studies had a 3.09-fold (2.34-4.08; $P < .00001$) increase in graft failure. There is a dose-response relationship, with decreased patency in heavy smokers compared with moderate smokers. Smoking cessation restores patency rates toward the never-smokers group.
Hobbs, ¹¹⁸ 2003	Review of systematic reviews on smoking cessation strategies	Smoking cessation interventions	Usual care	Moderate risk of bias overall	Cochrane reviews have shown benefits of nicotine replacement therapy as well as a small but significant benefit from brief physician advice compared with no advice (OR, 1.69). More frequent advice may be marginally more effective.
Belch, ¹¹⁹ 2010	851 patients undergoing unilateral, below-knee bypass graft	Clopidogrel plus aspirin	Placebo plus aspirin	Randomized placebo-controlled multinational trial	The primary efficacy end point was a composite of index graft occlusion or revascularization, above-ankle amputation of the affected limb, or death. In the overall population, the primary end point occurred in 149 of 425 patients in the clopidogrel group vs 151 of 426 patients in the placebo (plus aspirin) group (HR, 0.98; 95% CI, 0.78-1.23). In a prespecified subgroup analysis, the primary end point was significantly reduced by clopidogrel in prosthetic graft patients (HR, 0.65; 95% CI, 0.45-0.95; $P = .025$) but not in venous graft patients (HR, 1.25; 95% CI, 0.94-1.67; not significant). A significant statistical interaction between treatment effect and graft type was observed (P [interaction] = .008). Although total bleeds were more frequent with clopidogrel, there was no significant difference between the rates of severe bleeding in the clopidogrel and placebo (plus aspirin) groups (2.1% vs 1.2%).
Gassman, ¹²⁰ 2014	165 bypasses in patients with multiple comorbidities (79% CLTI)	Preoperative aspirin	NA	Case series	Preoperative and postoperative aspirin use was associated with increased 2-year secondary prosthetic graft patency over control (preoperative, 78% vs 44% [$P < .002$]; postoperative, 72% vs 50% [$P < 0.01$]). Preoperative aspirin use was associated with an improvement in the rate of amputation (OR, 0.44; 95% CI, 0.198-0.997) and stenosis (OR = 0.45; 95% CI, 0.217-0.956).
Bhatt, ¹²¹ 2006	15,603 patients with clinically evident CVD or multiple risk factors	Clopidogrel plus low-dose aspirin	Placebo plus low-dose aspirin	Large randomized controlled trial	The primary efficacy end point was a composite of myocardial infarction, stroke, or death from CV causes. The rate of the

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					primary efficacy end point was 6.8% with clopidogrel plus aspirin and 7.3% with placebo plus aspirin (RR, 0.93; 95% CI, 0.83-1.05; $P = .22$). The respective rate of the principal secondary efficacy end point, which included hospitalizations for ischemic events, was 16.7% and 17.9% (RR, 0.92; 95% CI, 0.86-0.995; $P = .04$), and the rate of severe bleeding was 1.7% and 1.3% (RR, 1.25; 95% CI, 0.97-1.61; $P = .09$). The rate of the primary end point among patients with multiple risk factors was 6.6% with clopidogrel and 5.5% with placebo (RR, 1.2; 95% CI, 0.91-1.59; $P = .20$), and the rate of death from CV causes also was higher with clopidogrel (3.9% vs 2.2%; $P = .01$). In the subgroup with clinically evident atherothrombosis, the rate was 6.9% with clopidogrel and 7.9% with placebo (RR, 0.88; 95% CI, 0.77-0.998; $P = .046$).
Cassar, ¹²² 2005	132 patients with claudication undergoing endovascular revascularization	Clopidogrel plus aspirin	Placebo plus aspirin	Double-blinded, placebo-controlled RCT	Clopidogrel plus aspirin inhibits platelet function more than aspirin alone. Platelet function in the clopidogrel group was significantly suppressed compared with baseline at 1 hour, 24 hours, and 30 days after endovascular intervention (stimulated fibrinogen binding by 53.9%, 51.7%, and 57.2%, respectively; all $P < .001$).
Strobl, ¹²³ 2013 Tepe, ¹²⁴ 2012	80 patients with PAD endovascularly treated	Preinterventional and postinterventional therapy with aspirin and clopidogrel	Aspirin and placebo	Blinded trial at low risk of bias	At 6 months, clopidogrel patients had significantly lower rates of target lesion revascularization compared with placebo patients (2 [5%] vs 8 [20%]; $P = .04$). After stopping clopidogrel-placebo after 6 months, there was no significant difference in target lesion revascularization at 12 months after treatment (9 [25%] clopidogrel vs 12 [32.4%] placebo; $P = .35$). Mortality was 0 vs 1 in the placebo group at 6 months ($P = .32$) and 0 vs 3 at 12 months ($P = .08$). Dual antiplatelet therapy reduces peri-interventional platelet activation and improves functional outcome without higher bleeding complications.
Cassar, ¹²² 2005	132 patients after lower limb angioplasty	Clopidogrel and aspirin	Placebo and aspirin	Blinded trial at low risk of bias	Clopidogrel and aspirin inhibited platelet function more than aspirin alone in patients with claudication before and after angioplasty.
Recommendation 10.10					
Mills, ¹²⁵ 2001	156 autogenous infrainguinal vein grafts in 142 patients	DUS surveillance	NA	Uncontrolled and not blinded	The incidence of graft thrombosis was 3% per year (mean follow-up, 27.5

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
					months). Intermediate lesions developed in 32 grafts (20%). Among these 32 grafts with intermediate stenoses, 63% progressed to critical and were revised, and 32% resolved or stabilized.
Recommendation 10.11					
Landry, ¹²⁶ 2002	330 surgical graft revisions were performed on 259 extremities in 245 patients	Reversed lower extremity vein grafts	NA	Retrospective noncomparative analysis	The assisted primary patency rate of all grafts, the limb salvage rate for patients undergoing surgery for limb salvage indications, and the survival rate of all patients were 87.4%, 88.7%, and 72.4%, respectively, 5 years after the original bypass grafting procedure; 85.7%, 83.4%, and 67.8%, respectively, 7 years after the original bypass grafting procedure; and 80.4%, 75.4%, and 53.4%, respectively, 10 years after the original bypass grafting procedure. A total of 180 revisions (55%) were performed during the first year, 110 revisions (33%) were performed between the first year and the fifth year, and 40 revisions (12%) were performed on grafts older than 5 years. Lower extremity vein grafts revised within the first year after bypass grafting had lesions within the graft in 78%, in the native arterial inflow in 10%, and in the native arterial outflow in 12%. This differed significantly from the location of lesions in revisions performed between 1 year and 5 years and after 5 years (graft, 63% and 62%; inflow, 20% and 19%; outflow, 17% and 19% ($P > .05$, χ^2 test).
Nguyen, ¹²⁷ 2004	188 vein grafts, from a total series of 1260 bypasses, undergoing revision of stenotic lesions	Revision procedures performed for repair of stenotic lesions in infrainguinal vein bypass grafts	NA	Retrospective noncomparative series	There was no difference in patency rate for different revision procedures, type of vein graft, indication for the original procedure, or patients with DM or renal disease. The overall limb salvage rate was $83.2\% \pm 3.5\%$ 5 years after graft revision. With Cox proportional hazards analysis of time to failure of the revision procedure, the outflow level of the original bypass and the time of revision proved to be important predictors of durability of the graft revision. Revision of popliteal bypass grafts resulted in a 60% 5-year primary patency rate, whereas revision of tibial grafts resulted in a 42% 5-year primary patency rate ($P = .004$; HR, 2.06). Five-year secondary patency rates were 90% and 76%, respectively ($P = .009$; HR = 3.43). The timing of the graft revision proved to be an

Supplementary Table (online only)-continued

Study	Population	Intervention	Comparison	Methodologic quality	Results
					additional predictor. Grafts revised within 6 months of the index operation had lower primary patency than those with later revisions (42.9% vs 80.7%; HR, 1.754; $P = .0152$).
Recommendation 10.12					
Bui, ¹²⁸ 2012	94 limbs (85 patients) underwent endovascular therapy for SFA-popliteal disease	NA	NA	Prospective nonrandomized study, consecutive sampling, unblinded	The initial scan findings were normal in 61 limbs (65%), and serial DUS results remained normal in 38 (62%). In 17 limbs (28%), progressive stenoses were detected during surveillance. The rate of thrombosis in this subgroup was 10%. Moderate stenoses were detected in 28 (30%) limbs at initial scans; of these, 39% resolved or stabilized, 47% progressed to severe, and occlusions developed in 14%. Five (5%) limbs harbored severe stenoses on initial scans, and 80% of lesions resolved or stabilized. Progression to occlusion occurred in one limb (20%). The last DUS showed that 25 limbs harbored severe stenoses; of these, 13 (52%) were in symptomatic patients and thus required reintervention regardless of DUS findings. Eleven limbs (11%) eventually occluded. Sensitivity and specificity of DUS to predict occlusion were 88% and 60%, respectively.
Recommendation 10.13					
Humphries, ¹²⁹ 2011	122 infrainguinal interventions for CLI in 113 patients (53% male; mean age, 71 years)	Early DUS	Normal DUS	Nonrandomized prospective comparative study, unblinded or adjusted	There were 50 patients who had an abnormal finding on early DUS and 40 patients who had a normal finding. In patients with a normal DUS finding, the amputation rate was 5% vs 20% in the group with an abnormal finding ($P = .04$). Primary patency was 56% in the group with a normal finding and 46% in the group with an abnormal finding ($P = .18$). Early DUS was able to identify a residual stenosis not seen on completion angiography in 56% of cases.
Recommendations 10.14 and 10.15					
Elraiyah, ¹³⁰ 2016	19 interventional studies, of which 13 were randomized controlled trials, including data from 1605 patients with DFUs using an offloading method	Offloading approaches	Usual care	The risk of bias in the included studies was moderate.	This analysis demonstrated improved wound healing with total contact casting over removable cast walker, therapeutic shoes, and conventional therapy. There was no advantage of irremovable cast walkers over total contact casting. There was improved healing with half-shoe compared with conventional wound care. Therapeutic shoes and insoles reduced relapse rate in

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Supplementary Table (online only)-continued					
Study	Population	Intervention	Comparison	Methodologic quality	Results
					comparison with regular footwear. Data were sparse regarding other offloading methods.

ABI = Ankle-brachial index; ACE = angiotensin-converting enzyme; AFB = aortofemoral bypass; AFS = amputation-free survival; AI = aortoiliac; AKA = above-knee amputation; AP = ankle pressure; AT = anterior tibial; BASIL = Bypass vs Angioplasty in Severe Ischaemia of the Leg; BKA = below-knee amputation; BMI = body mass index; BMS = bare-metal stent; CAD = coronary artery disease; CFA = common femoral artery; CI = confidence interval; CLI = critical limb ischemia; CLTI = chronic limb-threatening ischemia; COPD = chronic obstructive pulmonary disease; CPGs = clinical practice guidelines; CT = computed tomography; CTA = computed tomography angiography; CV = cardiovascular; CVD = cardiovascular disease; DES = drug-eluting stent; DFUs = diabetic foot ulcers; DIP = dipyridamole; DM = diabetes mellitus; DNR = do not resuscitate; DOR = diagnostic odds ratio; DSA = digital subtraction angiography; DUS = duplex ultrasound; ESRD = end-stage renal disease; FP = femoropopliteal; HBOT = hyperbaric oxygen therapy; HR = hazard ratio; IC = intermittent claudication; IFB = iliofemoral bypass; IP = infrapopliteal; IPC = intermittent pneumatic compression; IQR = interquartile range; JNC = Joint National Committee; LS = lumbar sympathectomy; MACEs = major adverse cardiac events; MALEs = major adverse limb events; MRA = magnetic resonance angiography; NA = not applicable; OR = odds ratio; PAD = peripheral artery disease; PFA = profunda femoris artery; PGE1 = prostaglandin E1; Pk-PT = posterior tibial artery peak flow velocity; PREVENT III = Project of Ex-vivo Vein graft Engineering via Transfection III; PT = posterior tibial; PTA = percutaneous transluminal angioplasty; RCT = randomized controlled trial; RD = risk difference; ROC = receiver operating characteristic; RR = relative risk; SCS = spinal cord stimulation; SFA = superficial femoral artery; SMD = standardized mean difference; SVS = Society for Vascular Surgery; TASC II = TransAtlantic Inter-Society Consensus II; TBI = toe-brachial index; TcPO₂ = transcutaneous oximetry; TKA = through-knee amputation; TP = toe pressure; VQI = Vascular Quality Initiative; Wifl = Wound, Ischemia, and foot Infection; WMD = weighted mean difference.

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