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+1 (929) 224-5068

Supervised exercise therapy versus endovascular revascularization in patients with intermittent claudication

Name: Adriana Babosa Pereira
Affiliation: Physiatrist/Physical Medicine and Rehabilitation at Centro de Medicina de Reabilitação de Alcoitão
Country: Portugal
Email ID: adrianambpereira7@gmail.com

ABSTRACT

The AHA/ACC 2016 and ESC/ESVS 2017 guidelines recommend Cardiovascular Rehabilitation programs (CRP) as a multimodal approach for Peripheral Artery Disease (PAD), in order to obtain symptomatic relief, prevent future cardiovascular ischemic events, and influence prognostic survival. CRP include supervised exercise therapy (SET), in addition to optimal medical therapy and lifestyle modification, representing the first-line treatment for patients with Intermittent Claudication (IC), to prevent functional decline and improve quality-of-life. SET must be offered as a structured program, involving a multidisciplinary team with expertise in exercise for cardiovascular patients, under the coordination of a physiatrist, that must prescribe the appropriate exercise modalities, taking in to account not only cardiovascular diseases but also other medical conditions that influence exercise performance. Exercise intervention in PAD patients is usually based on treadmill and track walking, considered the most effective exercise modalities, performed for 30-45 minutes, 3 times per week for a minimum of 12 weeks. SET has demonstrated to increase ischemic threshold, to improve exercise tolerance and enhance patient functional capacity recognized as a strong and independent predictor of mortality after a cardiovascular event. It also highlighted the excellent safety profile of different SET in patients with PAD, when screened for absolute contraindications to exercise and treated by a team with the appropriate skills to provide the adjusted monitoring level. Endovascular revascularization procedures are readily available techniques, remunerated, and independent of patient motivation. Given their low procedural morbidity and high procedural success they are becoming increasingly attractive and widespread. In clinical practice, endovascular treatment alone is being performed more frequently than SET alone, as recommended, despite endovascular techniques do not improve exercise capacity or lower the risk of revascularization or amputation com- pared with SET. A recent meta-analysis also demonstrated that combined therapy is associated with greater maximum walking distance compared to each treatment alone, and the 1-year reintervention rate reported also seemed lower compared to endovascular treatment alone. Despite carrying a class I recommendation for the initial management of IC, major limitations of SET are poor access in most countries due to reimbursement issues, dependence on patient motivation, and compli- ance. In Portugal, there is still a paucity of Cardiovascular Rehabilitation Units, compared to other European countries, hampering access for patients to this multimodal approach. The lack of knowledge from patients and physicians about these programs also contributes to low referral rates and compromises their widespread use.

The multiple barriers to the implementation of these programs motivate the use of alternatives such as unstructured community- or home-based walking programs that consist of providing recommendations for patients with claudication to simply walk. Whenever SET is not available, the AHA/ACC 2016 Guideline recommends structured Community-based Exercise therapy or Home-based Exercise therapy with the guidance of healthcare providers.

Future studies are needed, focusing on multidi- mensional approaches and clinically relevant long-term outcomes, to determine the most effective management strategy for these patients.

Consideration on reimbursement issues for SET and greater awareness of the medical community on the importance of referring patients to CRP might be critical to improving adherence to these programs.

BIOGRAPHY

Adriana Barbosa Pereira has completed her Master Degree in Pharmaceutical Science ate 23 years from Faculdade de Farmácia da Universidade do Porto and Master Degree in Medicine at the age of 31 years from Faculdade de Medicina da Universidade do Porto, Portugal

He is now physiatrist at department of Physical Medicine and Rehabilitation at Cenytro de Medicina de Reabiltação de Alcoitão, Lisboa, Portugal.

Presenter Name: Adriana Barbosa Pereira
Mode of Presentation: Oral
Contact number: +351 963518503