

### Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:

<https://reachmd.com/programs/cme/case-time-paul-anthony-davis/26787/>

Released: 08/20/2024

Valid until: 08/20/2025

Time needed to complete: 1h 06m

### ReachMD

[www.reachmd.com](http://www.reachmd.com)

[info@reachmd.com](mailto:info@reachmd.com)

(866) 423-7849

---

Case Time! Paul Anthony Davis

### Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

### Dr. Patel:

Hi. This is Manesh Patel, I'm an Interventional Cardiologist at Duke, and excited to have you join us as we go over a case today with a patient with vascular disease. And I'm joined by a friend and a colleague who's really an expert in some of these types of care issues and the science here, Marc Bonaca. Marc, thanks for joining me. You want to introduce yourself?

### Dr. Bonaca:

Yeah, thanks, Manesh. Honor to be here with you. Marc Bonaca, I'm a Cardiologist and Vascular Medicine Specialist at University of Colorado.

### Dr. Patel:

Well, Marc, thanks for joining me. I'm going to present a case of somebody that we've seen in clinic and kind of get your opinion based on the new guidelines. And this is Anthony Davis. He's like a patient we see and not the actual name of a patient that we're seeing, but 74-year-old gentleman who actually has a lot of the comorbidities our PAD patients have. Unfortunately, has CKD with an GFR around 40 mL/cc/minute. And then he's also got diabetes, not surprisingly, unfortunately, he has diabetes. Used to smoke, doesn't smoke, and is actually seen in our clinic because he's had some symptoms that are concerning for potentially claudication or discomfort in his legs. You know, when we talk to him, it seems like often when he's going to Walmart or doing things like that, pushing the cart, and he'll stop, but he does get some pain in his calves. We did an ABI in our clinic, it was 0.65 on the left and 0.72 on the right.

Marc, this is a kind of prototypic vascular patient. Tell me about how you think about him? How he's come to our care? What we can do better about that? And then what kind of medical therapy we might use with him?

### Dr. Bonaca:

Yeah, well, thanks, Manesh. I mean, unfortunately, this is a very typical presentation, and we have to recognize first that this patient has presented with late-stage disease, that clearly he's had atherosclerosis for a long time. And had he been screened with an ankle-brachial index, perhaps interventions could have been deployed before he progressed to the point where he's really limited now. And so I think we have to recognize that first.

You know, when we think about care for a patient like this, we have to think about lifestyle, so diet, exercise, smoking, supervised exercise, cilostazol for some for function. But then really aggressive risk factor assessment and management. So you know, his diabetes favoring maybe GLP1 agonists and SGLT2s, as per the diabetes guidelines; lipids, getting his LDL as low as possible, maybe favoring agents where there has been shown to have limb benefit. And I personally would check a lipoprotein-A in a patient like this. And then, you know, aggressive antithrombotic therapy, you know, weighing benefit and risk. You mentioned the kidney disease and

age, but we've seen, for most patients, that the benefit-risk is in favor of a more potent strategy. So I think we want to really deploy comprehensive, intensive medical therapy to try to prevent progression in this patient.

**Dr. Patel:**

Yeah, no. Thanks, Marc. Exactly. I think some of the key points that we were thinking about in clinic with him, I mean, first is just to think about things that might make him feel better because he's coming in with leg pain, and sometimes we'll come back to that. It's, can we get you in supervised exercise? Some patients, depending on a few features, you might try cilostazol.

The second is, what do we do to make sure this doesn't get any worse? I often talk to patients about, how do we halt the disease here? How do we make sure no more plaque is getting put down? It's pretty hard to do, but that would be this multipronged thing you discuss. You know, in diabetics, there's a little bit more of a evidence now, and you know, saying, hopefully that SGLT2 or GLP1, with more studies coming might help here. He does have CKD, so there's a kind of, maybe a dual indication for him there. Lipids, you talk a lot about it, you can't go too low, and you want to know how low you can go. And you might use agents that some of the PCSK9s and others have actually - and lipid - and statin studies, some of them, have shown us that we can reduce some of those events. And then, Lp(a), I think it's a great point. A lot of our vascular patients have an over-representation of an elevated Lp(a). And finally, antithrombotic therapy, I think a guy like this, you're probably trying to put him on the, you know, dual pathway inhibition, with 2.5 of riva plus aspirin given the stage of disease.

So I think all of that makes sense, but maybe comes back to anatomy and revascularization after that. You know, that's a common conversation, isn't it?

**Dr. Bonaca:**

Yeah. I was going to ask you, I mean, I'm not an interventional cardiologist like you are, and I'll do these procedures, but oftentimes we get into a situation, despite all of our best efforts, that the disease has progressed to the point where people really can't function or live their life. And this is a complex discussion. But I'd send him to someone like you, Manesh, and say, you know, it's time to do something. How do you think about that conversation and maybe the management afterwards? Because, you know, the outcomes after are complex, right?

**Dr. Patel:**

Yeah, you know, one of the things you highlighted, and I hope we do more in our practice, you know, never perfect, but hopefully, is to get them on all those things first, right? You've got to halt the disease. The revascularization procedure, at least in him, at the claudication stage, not at the limb risk with the critical limb ischemia, is for symptom improvement. And so trying to get him to move a little bit more, making sure you actually not just have them on the lipids, as low a lipid as possible, but getting to the way you can get to the best antithrombotic therapy, helps us. Because at that point, then I can offer maybe, based on the anatomy, revascularization, endovascular at least in what I do. I know that if I do that, he's already on the therapy that I'm going to use after, and potentially I'm improving his risk, I just give caution. You know, one of the things I learned in VOYAGER is that the repeat risk in these patients is high, so getting them on these therapies and really making sure they understand that they will feel better, they get a lot of benefit, but have to be on these therapies to prevent recurrent events that we might have.

Well, you know, that's a really fast way to get through Anthony Davis, but hopefully you all have gotten a lot of value out of this conversation as we talk about how we take care of everyone, from diagnosis all the way to the revascularization decision in patients with vascular disease.

Thank you for joining us.

**Announcer:**

You've been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative, GLC and Total CME, LLC and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to [ReachMD.com/CME](https://ReachMD.com/CME). Thank you for listening.