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Overcoming Disparities of Care - Impact of Social Determinants of Health of PAD

Announcer:
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Dr. Jones:
Hello. I'm Schuyler Jones, and I'm an Interventional Cardiologist at Duke University Health System in Durham, North Carolina. It's my pleasure to talk to you today about disparities in care in patients with peripheral artery disease.

As you probably know, the two most common forms of peripheral artery disease are intermittent claudication and chronic limb-threatening ischemia. Intermittent claudication is really defined as ischemic leg pain that occurs with activity and gets better with rest, where chronic limb-threatening ischemia is really defined by ischemic rest pain, tissue loss including ulceration and gangrene, and other severe forms of the disease.

Unfortunately, in the United States, chronic limb-threatening ischemia is common. While it occurs in only 5% or so of all patients with PAD, about 2 million Americans annually have this problem, and it leads to a high rate of major amputation and all-cause mortality. The graphic on this slide shows that in some cases, only about 50% of patients get revascularization, and in most cases of chronic limb-threatening ischemia at 1 year, 1/4 of patients have died, 1/4 of patients have had an amputation, and about 1/4 of patients have ongoing symptoms and signs of ischemia.

We know that revascularization really is the cornerstone of treatment, but in a lot of cases, particularly related to geography, where patients live, but also patient characteristics, including disparities such as race, age, and sex, unfortunately, 30% or more of patients are not considered candidates for revascularization, or do not get revascularization before they get major amputation. The burden to our health system and to our patients is tremendous, and ultimately we have to do better.

Our team at Duke has done a lot of work on lower extremity amputation, including studying geographic variation. This publication from 2012 shows that there's a twofold regional variation in major amputation that really is centered in the southeast United States. Dr. Sreek Vemulapalli wrote a paper that showed that 30 to 50% of these patients do not undergo imaging prior to amputation, and that if we applied high-intensity vascular care, those patients would have fewer amputations. Unfortunately, it's not happening as much.

We've looked at it in our own state. This is North Carolina, and you can see that the dark blue counties have the highest rate of amputation. In our local environment, we have done things including put vascular specialists in these counties with the highest rates of amputation, and that actually - that intensive vascular treatment, tends to lower amputation rates, at least back down to the standard amount.

But the problem with PAD care is it's multifactorial. The disease itself is associated with disparities. Most of these patients are not treated with any statin at all, including those patients with chronic limb-threatening ischemia, where they don't get to see cardiologists, vascular surgeons, or other vascular medicine specialists. And there's still a problem with many of these patients continuing to smoke or

having poorly controlled diabetes.

The disparities are not just on the racial and ethnic lines, they're additionally because of age and sex and socioeconomic status. Medicaid patients who are dual eligible for Medicare have a much higher hospitalization rate and a much higher mortality rate. Black patients in the United States have a much higher rate of major amputation with this disease.

Ultimately, it's all of our charge to need to and be able to care for these patients better. Thank you so much for listening. It's been a pleasure talking with you today.

Announcer:
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