Letter by Golledge Regarding Article, “Sustained Benefit at 2 Years of Primary Femoropopliteal Stenting Compared With Balloon Angioplasty With Optional Stenting”

To the Editor:

I read with interest the 2-year results of the Balloon Angioplasty Versus Stenting With Nitinol Stents in the Superficial Femoral Artery (ABSOLUTE) trial, which investigated the value of nitinol stents in the treatment of superficial femoral artery stenoses or occlusions >30 mm in length in patients who mainly presented with intermittent claudication.1 The outcomes are principally discussed in terms of patency of the target vessel, as has been customary in a number of coronary stent trials. I have concerns that the finding by Schillinger et al1 of a reduction in the rate of restenosis from 69% to 46% in the group randomized to primary stenting will be interpreted as a rationale for widespread deployment of stents in patients with intermittent claudication. Large natural history studies have clearly demonstrated that the primary issues in the outcome of patients with intermittent claudication are an increased risk of cardiovascular death, myocardial infarction, and stroke, along with impaired health-related quality of life, rather than limb loss.2,3 Thus, the primary therapy required in the management of these patients is the medical treatment of atherosclerosis.2 The management of the patients’ leg symptoms is complex for a number of reasons, including the following:

1. Most patients have involvement of multiple lower-limb artery sites.
2. Bilateral disease is very common.
3. Coexisting medical problems, including back, hip, and knee problems, peripheral neuropathy, shortness of breath, and angina often limit the ability of patients to benefit from improved lower-limb blood flow.

All these factors mean that improvement in the patency of an arterial segment or even in lower-limb blood flow may have little impact on a patient’s overall symptoms. In fact, the ABSOLUTE trial demonstrated no significant improvement in treadmill walking distance in the intervention group at 2 years.1 It is vital in the assessment of interventions in patients with intermittent claudication that specific measurement of disease-specific health-related quality of life be made. Intermittent claudication–specific questionnaires have been developed for this purpose.5–5 I congratulate Schillinger and colleagues on their endeavors to scientifically assess the value of different treatment options for peripheral artery disease. However, I would emphasize that the primary management goals in patients with intermittent claudication need to target the high rate of cardiovascular events and the patients’ quality of life.

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