Ultrasonographically Monitored Postocclusive Reactive Hyperemia in the Diagnosis of Peripheral Arterial Occlusive Disease

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OBJECTIVE and quantitative assessment of peripheral arterial occlusive disease has become a desirable goal in recent years with the increasing capability of reconstructive vascular surgery. Although angiography still remains the major preoperative diagnostic procedure, it is primarily an anatomic, rather than a functional, assessment of disease, difficult to quantitate, and associated with a small but real risk and discomfort, which prohibit its routine use as a screening test or serial follow-up check.

On the other hand, determination of the resting flow rate of a compromised vascular bed has limited diagnostic value, because a significantly stenotic inflow system may still permit normal resting flow.1–8 This circumstance has been recognized by a number of authors who have concluded that the postocclusive reactive hyperemia (PORH) response is a more useful criterion than a determination of the resting flow rate.5, 6, 8, 9–15 The usual technique employed for such studies has been venous occlusion plethysmography, with water or air as the communicating medium,16 or the mercury-in-rubber gauge as the sensing device.17 However, these measurements have two drawbacks in common: (1) since venous occlusion must be performed intermittently, no continuous readout is available, and therefore the peak flow-rate may escape detection; and (2) the slopes of the volume increase have to be calculated separately and then plotted. These considerations led us to study the feasibility of applying the ultrasonic Doppler velocity metering system to transcutaneously monitor the PORH response.

Method

The Parks Model 805—Directional Ultrasonic Velocity Meter18 was used to study two groups of subjects. Group I: 25 normal volunteers (age 21-63 years), and Group II: 22 patients (age from 25-73 years) with
unilateral or bilateral arterial occlusive disease documented angiographically. An R-C passive filter with a time constant of 1 sec was added to the output stage of the original instrument in order to obtain the mean velocity value electrically. With the subjects in the supine position, a standard pressure cuff was placed below the knee. The ultrasonic probe was then placed at the level of the femoral artery with the tip aimed cephalad at an angle of approximately 45\(^\circ\), and held in position by a self-locking mechanical clamp. After obtaining the steady-state recording, the cuff was inflated to a suprasystolic pressure for 4 min. The cuff was then suddenly deflated and the PORH velocity response was continuously recorded until the velocity value returned to preocclusion levels. The response was evaluated in two ways (fig. 1): (a) the percentage increase: \(\frac{\text{peak velocity} - \text{initial velocity}}{\text{initial velocity}} \times 100\), and (b) the recovery half time (T\(_{1/2}\)), the time for the mean velocity to return to 50% of its peak response. In an additional series of observations on 10 control subjects, the reproducibility of the PORH response was studied by repeating the occlusion and measurements 20 min after the first determination.

**Results**

**Control Subjects**

The data is tabulated in tables 1-3. In 25 healthy control subjects, the mean percentage increase in 50 measurements was 225.8% with a standard error of the mean (SEM) ± 18.2%. The mean recovery half time was 5.2 secs (SEM ± 1.2). Figure 1 illustrates a typical normal tracing with the respective indices. Comparing the PORH response in the right and left lower extremities, no statistical difference was observed (table 2).

**Reproducibility**

Table 3 summarizes the results of two consecutive measurements, 20 min apart, in ten control subjects. There was no statistically significant difference between the percentage velocity increases of the repeated measurements. On the other hand, the recovery half time was significantly shorter (Δ6.3 sec) in the second test.

**Patients with Arterial Occlusive Disease**

Table 1 also summarizes the results from 22 patients with angiographically documented arterial occlusive disease. The mean percentage increase was 55.0 (SEM ± 6.2), while the recovery half time was significantly prolonged (mean 47.1 sec, SEM ± 1.5). Figure 2 illustrates a pathological PORH response (bilateral iliac artery occlusion), (a) before operation, and (b) after reconstructive vascular surgery. Before the operation there is a smaller percentage increase in the left femoral artery flow velocity with a delayed recovery half time. After the operation a pronounced increase in the postocclusive reactive hyperemia response can be observed in both femoral arteries with a return of the recovery half time to the normal range.

![Figure 1](image)

Typical normal femoral artery velocity response following four minutes of arterial occlusion, indicating the two indices calculated: peak velocity increase and recovery half time. Top curve: Mean blood flow velocity. Bottom curve: Occlusive cuff pressure.

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*Parks Electronics, Beaverton, Oregon.*
**Table 2**

Comparison of Postocclusive Reactive Hyperemia Responses in the Left and Right Lower Extremities of Control Subjects

<table>
<thead>
<tr>
<th></th>
<th>Max. increase in velocity (%)</th>
<th>Recovery time (T½ ± SEM, sec)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>219.1 ± 22.2</td>
<td>25.6 ± 1.6</td>
</tr>
<tr>
<td>Left</td>
<td>233.1 ± 24.2</td>
<td>24.9 ± 1.7</td>
</tr>
<tr>
<td>Significance</td>
<td>Not significant</td>
<td>Not significant</td>
</tr>
</tbody>
</table>

**Discussion**

Noninvasive physiologic tests for peripheral arterial occlusive disease would provide a means of screening, quantitating and sequentially following the progression or results of treatment of such processes. A variety of approaches to this problem have been advocated, including measurements of segmental blood pressure, limb volume, and arterial velocity, under circumstances of rest and activity. However, because of their inability to yield reproducible, quantitative data with simple, inexpensive equipment, none of these approaches has yet reached a stage of widespread clinical usefulness.

Perhaps the most generally useful physiologic approach to noninvasive peripheral vascular physiology is based on the development of transcutaneous Doppler ultrasonic velocity detecting systems. The Doppler effect, which refers to the alteration of frequency of backscattered ultrasound waves in proportion to the velocity of the moving objects they strike, was first utilized for this purpose by Franklin, Schlegel and Rushmer in 1961. This technique, which did not distinguish between forward and reverse velocity signals, was further developed by Rushmer, Baker and Stegal and by Strandness et al., and qualitatively applied to evaluate patients with both arterial and venous disease. The important contribution of McLeod in developing circuitry to detect the direction of velocity changes permitted the subsequent usefulness of the directional Doppler as a quantitative index. While the technique described in this report is based on relative changes in velocity, and does not require quantitative calibration, it does require a device which is directionally sensitive, since backflow of a significant degree is well documented in the normal human femoral artery during diastole, and must be accurately detected and subtracted from the forward flow signal. Since velocity is proportional to flow (when cross-sectional area is constant at the point of measurement), the data obtained are quite analogous to flow estimates obtained by more cumbersome techniques.

The use of the two parameters of postocclusive reactive hyperemia (% increase and recovery halftime) described in this report has permitted a clear separation of patients with symptomatic arterial occlusive disease from the normal controls. Both parameters do not always deviate in proportion,
however, and each would seem to be dependent upon different underlying physiologic mechanisms. The percent increase in flow appears to represent the available increase in functional cross-sectional area, or decrease in resistance, of collateral vessels in the ischemic portion of the limb. The recovery half-time, on the other hand, appears to relate to the development and subsequent relenting of some indicator of cellular ischemia, such as oxygen debt, the release of acid metabolites, or other autonomic control mechanisms. The former may, therefore, represent more of a capacity function, providing inflow is adequate, and the latter a tissue perfusion function. The relative diagnostic importance of each parameter remains to be explored, both in the laboratory and the clinic, and is of particular significance when only one of the parameters is abnormal.

In spite of these limitations, the described technique has proved to be very useful in the objective assessment of arterial occlusive disease, since it is simple and reproducible, and offers a continuous readout of the reactive hyperemia response.

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