

Vascular surgeons and best medical therapy: Missed opportunities?

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Multiple guidelines recommend the use of best medical therapy (BMT) as secondary prevention for patients with peripheral arterial disease (PAD) but prescription and adherence are generally sub-optimal.¹ The issue is not specific to vascular surgeons. Patients referred with suspected peripheral arterial disease are only started on antiplatelet agents and statins by their primary care physician in about half of cases.² Following coronary artery bypass grafting, 1 in 5 patients are discharged without a statin prescription.³ Using a series of structured interviews through an implementation science lens, Xu et al. have identified a number of potential obstacles to improve BMT prescription patterns.⁴

Two particular issues stand out. The healthcare workers interviewed (11 of 12 were doctors) were all aware of the significance of PAD in terms of potential morbidity and mortality. They were also aware of the importance of secondary prevention. There was less clarity regarding the existence of guidelines or which guidelines to follow. One vascular surgeon commented that “there are so many guidelines”. Another interviewee noted that “there is the European Society of Vascular Surgery, the Society for Vascular Surgery, there is the American Heart Association, and I’m sure there are more.” A quick search does reveal a plethora of other guidelines. In such a crowded space, it becomes difficult for individual practitioners to stay current with all the guidance, let alone make a determination as to which set is most applicable to their patient cohort. Regional variations in reimbursement and drug availability may also influence guideline adherence.

The other issue highlighted is the challenge created by the shared care required by patients with PAD. Many of them are also receiving care from endocrinologist, cardiologist and nephrologist. With multiple overlapping specialties, some feel it is best “not to rock the boat in other ways” by initiating or amending BMT, especially if PAD was not the primary reason for admission for these patients. With only 12 interviewees, meaningful analysis of responses by speciality is

not possible but one wonders whether vascular surgeons may be more likely to avoid “rocking the boat” than colleagues with training in general internal medicine?

Vascular surgical training focuses on the acquisition and optimal application of advanced technical skills. The prescription of best medical therapy at best tends to be regarded as a footnote issue. A recent national training needs assessment in vascular surgery considered only training in technical procedures with no consideration of training options around BMT provision.⁵ While vascular surgery training remains focused on procedural skills, the potential role of BMT is evolving, with emerging evidence suggesting it may become the cornerstone of management of at least some vascular surgery presentations of systemic atherosclerosis.⁶

The interviewees presented a range of potential measures that might improve prescribing patterns. Internal teaching, smartphone apps and educational posters were all suggested but are unlikely to address the core underlying issues—too many guidelines and too little vascular surgical confidence. Development of a multidisciplinary global task force to harmonise BMT guidelines between the major societies would be helpful. More importantly, vascular surgeons should take the lead in managing patients whose initial atherosclerotic presentation is in vascular beds that are outside the heart or brain. It is incumbent on vascular surgery as a speciality to be as comfortable with BMT prescription as our medical colleagues. Training in BMT requires increased emphasis in vascular surgery training programmes and collaboration with medical colleagues if we are to improve our patients’ outcomes.

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