MyCardioAdvocate™

Peripheral Artery Disease & Cardiovascular Risk

When leg pain is actually a warning sign from your heart

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Why This Matters

Your legs hurt when you walk. You slow down, rest, and the pain fades. You assume it is aging, arthritis, or a pulled muscle. You mention it in passing at your next visit—or you don't mention it at all. What you may not realize is that this symptom could be your body's earliest warning that atherosclerosis—the same disease that causes heart attacks and strokes—is silently narrowing the arteries in your legs. Peripheral artery disease (PAD) affects more than 8.5 million Americans and over 200 million people worldwide. It is one of the most underdiagnosed and undertreated cardiovascular conditions. Patients with PAD have a 2- to 6-fold increased risk of heart attack, stroke, and cardiovascular death compared to those without it. Yet fewer than half of PAD patients receive guideline-directed medical therapy, and many are never even screened.

PAD is the canary in the coal mine—a peripheral signal of a systemic disease. When plaque narrows the arteries supplying your legs, it is almost certainly doing the same thing in your coronary arteries and carotid arteries. Ignoring PAD is not just risking your limbs; it is risking your life. This brief is for anyone who has leg pain with walking, risk factors for atherosclerosis, or a diagnosis of PAD—and wants to understand what it really means and what to do about it.

Why PAD Flies Under the Radar

- **Symptom misattribution:** Leg pain with walking (claudication) is dismissed as arthritis, neuropathy, spinal stenosis, or simply 'getting older'—by patients and clinicians alike
- **Asymptomatic majority:** Up to 50% of PAD patients have no classic leg symptoms at all; the disease is truly silent in many individuals
- **ABI not routinely performed:** The ankle-brachial index (ABI) is the gold standard screening test, takes 15 minutes, is painless and inexpensive—yet is rarely performed in primary care
- **Fragmentation of care:** PAD falls between cardiology, vascular surgery, podiatry, and primary care; no single specialty consistently 'owns' it
- **Ethnic and socioeconomic disparities:** Black Americans have 2–3x higher prevalence of PAD, yet are less likely to receive screening or revascularization
- **Smoking cessation fatigue:** Clinicians repeat 'stop smoking' without connecting it to a tangible diagnosis; PAD makes the cardiovascular consequence of smoking visible and personal
- **Limb-focused mindset:** When PAD is diagnosed, treatment often focuses on the legs alone—missing the critical message that PAD is a systemic cardiovascular disease requiring comprehensive risk reduction

What Changed in 2026

2024–2026 Guideline Updates Affecting PAD Management

ABI screening recommended for symptomatic patients and those with CV risk factors (COR 1). Structured exercise therapy now COR 1 for claudication (supervised preferred over unsupervised). Dual-pathway inhibition (low-dose rivaroxaban + aspirin, per COMPASS trial) for stable PAD patients with high ischemic risk. Lipid targets aligned with 2026 ACC/AHA goals: LDL-C <55 mg/dL for very high-risk (PAD qualifies). SGLT2 inhibitors under investigation for limb outcomes. GLP-1 receptor agonists may benefit PAD patients with diabetes and obesity.

- **ABI screening:** Recommended for all patients with exertional leg symptoms, non-healing wounds, or significant atherosclerotic risk factors (diabetes, smoking, age >65)
- **Structured exercise:** Supervised exercise therapy (SET) improves walking distance by 50–200% and is now first-line therapy for claudication, ahead of revascularization in stable patients
- **COMPASS trial integration:** Low-dose rivaroxaban (2.5 mg twice daily) + aspirin reduced major adverse cardiovascular events (MACE) and major adverse limb events (MALE) in stable PAD; now in guidelines
- **Aggressive lipid lowering:** PAD is classified as very high-risk ASCVD; LDL-C goal <55 mg/dL, ApoB goal <80 mg/dL per 2026 lipid guidelines
- **Smoking cessation pharmacotherapy:** Varenicline, bupropion, and nicotine replacement should be offered proactively—smoking cessation is the single most impactful lifestyle modification in PAD

MyCardioAdvocate Checklist

1. Know Whether You Have Been Screened

■ Have I ever had an ankle-brachial index (ABI) test?

The ABI compares blood pressure in your ankle to blood pressure in your arm. A ratio below 0.90 indicates PAD. The test is painless, takes about 15 minutes, and requires no needles or contrast dye. If you have diabetes, a smoking history, are over 65, or have exertional leg symptoms, ask your clinician whether an ABI is appropriate. Many patients with PAD have never been screened.

2. Distinguish PAD Symptoms From Other Causes

■ Does my leg pain occur with walking and reliably improve with rest?

Classic claudication is reproducible: it occurs at a predictable walking distance, affects the calves (most commonly), and resolves within 2–5 minutes of standing still. Atypical symptoms include thigh or buttock pain, fatigue, heaviness, or numbness with exertion. Spinal stenosis pain is worse going downhill and better leaning forward (shopping cart sign). Arthritis pain is present at rest and worse with initial movement. A careful history is the first step.

3. Treat PAD as a Systemic Disease

■ Am I on optimal medical therapy for atherosclerosis, not just for my legs?

PAD is not a leg problem—it is an atherosclerosis problem that happens to present in the legs. If you have PAD, you need comprehensive cardiovascular risk reduction: high-intensity statin, antiplatelet therapy (aspirin or clopidogrel), blood pressure control (<130/80 mmHg), diabetes management (if

applicable), and absolute smoking cessation. Many PAD patients are treated as if only their legs are at risk.

4. Engage in Structured Exercise

■ Have I been referred to a supervised exercise program?

Supervised exercise therapy (SET) is the most effective non-invasive treatment for claudication. It involves walking on a treadmill to the point of moderate pain, resting, then repeating—for 30–60 minutes, 3 times per week, for 12+ weeks. This promotes collateral blood vessel formation and improves walking distance by 50–200%. If SET is not available, a structured home-based walking program is the next best option. Exercise is first-line therapy—ahead of stenting in stable PAD.

5. Understand When Revascularization Is Appropriate

■ If surgery or stenting has been recommended, have I tried medical therapy and exercise first?

Endovascular intervention (angioplasty, stenting) or surgical bypass is reserved for patients with lifestyle-limiting claudication that has not improved with optimal medical therapy and structured exercise, or for critical limb-threatening ischemia (rest pain, non-healing wounds, gangrene). Revascularization does not replace risk factor modification—it complements it. Ask your clinician: Have we exhausted conservative options? What is the expected durability of this procedure?

6. Monitor for Progression and Polyvascular Disease

■ Am I being monitored for coronary artery disease and carotid disease as well?

Patients with PAD have a 40–60% prevalence of concurrent coronary artery disease and 25–30% prevalence of significant carotid stenosis. If you have been diagnosed with PAD, ask whether you need cardiac stress testing, carotid ultrasound, or coronary artery calcium scoring. PAD is a polyvascular disease—it rarely travels alone.

Pro Tip

Pro Tip: If you have PAD and are still smoking, nothing else you do will matter as much as quitting. Smoking cessation reduces the risk of amputation by up to 50% and is the single most impactful intervention for slowing PAD progression. Ask your clinician about varenicline or combination nicotine replacement therapy—willpower alone has a 5% success rate; pharmacotherapy triples it. And if you have been diagnosed with PAD but are not on a statin and an antiplatelet agent, ask why. These are not optional—they are the floor of guideline-directed therapy.

CPR Opportunities — Shared Decision-Making

The 2026 guidelines introduce the **CPR Framework**: **C**alculate risk, **P**ersonalize the discussion, **R**eclassify with imaging. The following topics represent gray areas in PAD management where a patient-centered discussion with your clinician is especially important.

Anticoagulation in Stable PAD: Aspirin Alone vs. Dual Pathway Inhibition

The Gray Area: You have stable PAD, no recent event, and are on aspirin alone. Your clinician mentions the COMPASS trial, which showed that adding low-dose rivaroxaban (2.5 mg twice daily) to aspirin reduced MACE and major adverse limb events—but increased bleeding. Should you add it?

What the data suggests: COMPASS showed a 24% relative reduction in MACE and a 46% reduction in major adverse limb events with dual pathway inhibition. However, major bleeding increased (primarily GI). The net clinical benefit favored dual therapy in most subgroups, but not all patients are candidates—those with high bleeding risk, prior GI hemorrhage, or concurrent anticoagulation for atrial fibrillation may not benefit. This is a genuine shared decision: discuss your ischemic risk, your bleeding risk, and your values regarding prevention vs. medication burden with your clinician.

Revascularization vs. Conservative Management for Claudication

The Gray Area: You have moderate claudication that limits your walking to 2 blocks. A vascular specialist recommends angioplasty and stenting. But you have not yet tried a supervised exercise program or optimized your medical therapy. Is the procedure premature?

What the data suggests: Multiple trials (including CLEVER and ERASE) demonstrate that supervised exercise therapy achieves comparable or superior functional outcomes to endovascular intervention at 6–12 months for stable claudication, without procedural risk. Guidelines recommend SET as first-line therapy, with revascularization reserved for lifestyle-limiting symptoms refractory to conservative management. However, access to SET programs is limited, insurance coverage varies, and some patients prefer the immediacy of intervention. Discuss: Have I given exercise a fair trial? What are the durability and risks of the proposed procedure?

On the Horizon

Several emerging developments may reshape PAD management in the coming years. **SGLT2 inhibitors**, originally developed for diabetes and heart failure, are under active investigation for their potential to improve limb perfusion and reduce adverse limb events—early signals are intriguing but not yet definitive. **Gene therapy** for therapeutic angiogenesis (stimulating new blood vessel growth in ischemic limbs) continues in clinical trials, though prior approaches have not met primary endpoints. **Vorapaxar**, a protease-activated receptor-1 (PAR-1) antagonist, showed benefit in PAD subgroups of the TRA 2P-TIMI 50 trial but carries significant bleeding risk and is not widely used. **Wearable ABI devices** and remote monitoring technology may enable earlier detection and ongoing surveillance outside the clinic. And **GLP-1 receptor agonists** (semaglutide, tirzepatide), already transforming obesity and diabetes care, may offer ancillary vascular benefits in PAD patients with metabolic comorbidities—a rapidly evolving area to watch.

Key Takeaways

- PAD affects over 8.5 million Americans and is a powerful predictor of heart attack, stroke, and cardiovascular death—yet it is dramatically underdiagnosed and undertreated.
- The ankle-brachial index (ABI) is a simple, painless, inexpensive screening test that should be performed in at-risk patients—but rarely is.

• PAD is a systemic atherosclerotic disease, not a leg problem. Treatment must include comprehensive cardiovascular risk reduction: statin, antiplatelet, blood pressure control, and smoking cessation.

• Supervised exercise therapy is the most effective conservative treatment for claudication and should be tried before revascularization in stable patients.

• Dual pathway inhibition (rivaroxaban + aspirin) offers additional protection for high-risk PAD patients but requires balancing ischemic and bleeding risk—a shared decision.

• If you have PAD, you likely have atherosclerosis elsewhere. Ask about coronary and carotid screening.

Next Steps

• If you have exertional leg symptoms, ask your clinician about ABI testing.

• If diagnosed with PAD, confirm you are on a high-intensity statin, antiplatelet agent, and blood pressure medication as appropriate.

• Ask about referral to a supervised exercise therapy (SET) program—this is first-line treatment.

• If you smoke, ask about pharmacotherapy for smoking cessation (varenicline, bupropion, NRT).

• Discuss whether dual pathway inhibition (low-dose rivaroxaban + aspirin) is appropriate for your risk profile.

• Ask whether you need evaluation for concurrent coronary artery disease or carotid disease.

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