DISCUSSION

Dr Ronald L. Dalman (Stanford, Calif). A very nicely presented, important topic. This area is obviously crying out for some standardization and guidance, as it has been for the last 20 years, unfortunately. Do all your patients who undergo catheter-directed thrombolysis go to the intensive care unit (ICU) for monitoring, or do you have an intermediate stepdown area for monitoring patients receiving thrombolytic therapy in a lower-cost environment?

Dr Fedor Lurie. In the four hospitals included in the study, all the patients go to the ICU. The cost of the interventional unit was added to the ICU cost.

Dr Dalman. Because there are other options. I don’t know that every patient needs to be in the ICU when they are receiving catheter-directed thrombolysis.

So for the average patient now, based on these data, has this changed your practice at all for the nonembolic acute limb ischemia patients? Have you used these data to change your practice, or how are you currently managing those patients?

Dr Lurie. That is a key question. The data itself do not guide us to change any specific aspect of our practice except to look at the administrative policies that can affect the ICU stay, such as inability to transfer patients from the ICU at certain times.

Dr Peter Henke (Ann Arbor, Mich). I agree with Ron, this is really understudied and needs standardization, as was mentioned.

But nonembolic acute limb ischemia can occur from a variety of different etiologies. Can you give us an idea of what some of those were. Were they just all acute-on-chronic peripheral arterial disease (PAD), for example, or trauma, dissection, those type of things? Because that may affect the management choice.

Dr Lurie. One of the reasons we selected to study the patient population that we have an access to the medical records was to carefully select specific etiology. The majority of those patients had a thrombotic ischemia, except five who had iatrogenic thrombosis. Twenty-one patients with thrombosis of a native artery had clinical manifestation of PAD prior to acute ischemia, and 90 patients had thrombosis of a bypass graft. So I would think that the results are mostly applicable for thrombotic ischemia in patients with or without PAD.

Dr John Blebea (Tulsa, Okla). Encompassing a multitude of patients at four different hospitals, were you able to analyze and define the selection of patients, and specifically, how was it decided that these patients underwent surgery vs endovascular interventions? Secondly, did you examine outcomes based on experience or specialty of the physician for these procedures?

Dr Lurie. To address the second part, we did not do an analysis per provider. We can, but then we will end up with very small numbers that will be unlikely meaningful.

Addressing the first part of this question, I would like to emphasize that the focus of this study is to look at what is happening actually in the community settings. Patient selection and decisions of which treatment modality to use as the initial option was done by community practitioners in the absence of institutional guidelines. The overall clinical outcomes were good. So one can suspect that the selection of patients was appropriate.

One factor that I can tell you that we looked at, for example, in the subgroup of patients with occluded grafts, thrombolysis was used more frequently than other options, which is in line with the recommendations of the Surgery vs Thrombolysis for Ischemia of the Lower Extremity (STILE) trial.