Quality of Life Following Percutaneous Transluminal Angioplasty for Claudication

Sir,

The recent paper by Cook et al.1 showed that patients undergoing percutaneous transluminal angioplasty (PTA) have lower baseline quality of life (QOL) scores compared to a normal population and that revascularisation improved QOL and walking distance score. We would like to make several points regarding this study. The authors have presumably used published figures for baseline EuroQOL scores in a normal population rather than comparing the 29 patients to an age and sex-matched control group, which would be more relevant. Lower baseline QOL in claudicants compared to controls has recently been reported using the Nottingham Health Profile questionnaire.2

The EuroQOL questionnaire was completed on the ward prior to PTA and it is likely that the stress of admission to hospital would adversely affect the response to QOL parameters. It is possible that patients may also underestimate their subjective walking distance score in order to ensure that the procedure is not cancelled due to spontaneous improvement in symptoms. Perhaps an objective treadmill assessment before and after PTA would more accurately reflect the correlation between improved walking distance and QOL? The authors have failed to include the two patients with failed PTA in their analysis, although we accept that surgery itself may improve QOL. A long-term assessment of the effect of PTA on QOL is needed as restenosis after the 6 week follow-up may significantly reduce the improvement compared to baseline levels, and may possibly lead to a deterioration.

The authors conclude that the low cost and improvement in QOL support the continued use of PTA in claudication. As only 26–40% of claudicants have lesions amenable to angioplasty,3,4 the overall benefit on QOL in the patient group as a whole is decreased. In contrast, supervised exercise training programmes are applicable to all claudicants and are known to increase walking distance.5 The beneficial effect of supervised exercise on QOL has not been reported. Some degree of exercise supervision is essential to provide encouragement and ensure compliance as unsupervised exercise has been reported to effect a minimal improvement in quality of life.6

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References


Cranial Nerve Injuries and Carotid Endarterectomy

Sir,

Cranial nerve injuries following operations on the carotid bifurcation is an easily identifiable problem for patients but not for surgeons, at least not for all of them. In most reported series of carotid surgery, cranial nerve injuries (CNI) are infrequently mentioned, and some authors have expressed the opinion that such injuries, should be reported only if they are permanent.

In the November issue of the Journal,1 D. Bergqvist and his co-workers reported the results of a very thorough prospective study, using the resources of the department of speech therapy on 689 carotid endarterectomies. As was expected, the incidence of cranial

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nerve injuries was 12.5%. In 1981 we performed the same study with a speech therapist. This study had almost identical results to the present Swedish study with a slightly higher incidence of CNI mainly because we included injuries to the mandibular branch of the facial N. and the Greater Auricular N.

Cranial nerve injuries, it seems, are here to stay following carotid surgery, despite the refinements in the technique. The fact that most of them are temporary in nature and resolve within 60 days, does not mean that they should not be included in perioperative morbidity rates which should include all events within the 30 days period following surgery. Furthermore, in deciding the real value of endovascular alternatives, we should include the issue of nerve injuries that D. Bergqvist brought back to our attention.

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References

Quality of Life in Patients with Intermittent Claudication

Sir,

We read with interest the paper by Khaira et al. but question the validity of the method and conclusions. The choice of the age/sex matched controls in this study may have led to false results: Claudicants are well known to have a higher prevalence of cardio- and cerebrovascular disease whereas a surgical waiting list for minor procedures (as was used to supply the control group) has a large proportion of patients in good general health. It is not surprising therefore that the claudicant group had an overall worse quality of life than the control, and although excluding patients with "other ailments" increased the significance in the difference between the two groups there is no indication what these ailments were.

The authors state that "restriction in mobility" was the underlying cause of the difference between claudicants and controls. It cannot however, be assumed that the restriction in mobility was due to claudication and not, for example, stroke or ischaemic heart disease.

We agree wholeheartedly with the call for prospective controlled trials comparing quality of life measurement with traditional efficacy/safety parameters: Generic quality of life instruments are useful as outcome measure if used for pre- and postoperative comparisons. It must be remembered however that a generic instrument (such as the Nottingham Health profile) can only assess quality of life per se, not the impact of claudication on quality of life, because generic instruments do not differentiate between the relative effects of claudication and the coexistent disorders which are so frequent in these patients. If clinicians truly wish to measure the impact of intermittent claudication on quality of life and use this measurement to influence the management of their patients it is essential that a disease-specific instrument is used otherwise the quality of life may be underestimated and the need for intervention overestimated.

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References

Author's Reply

Sir,

We thank Messrs Hicken and Ameli for their interest in our paper. Our aim was to select a control population which had undergone the same pattern of referral (i.e. from GP to hospital specialist) as the patients with intermittent claudication. Previous publications on this subject had used inappropriate controls. In our questionnaire we enquired about problems such as angina, shortness of breath on exertion, stroke, previous heart attacks, and arthritis (i.e. conditions that would limit mobility). We found that the two groups were well matched for these