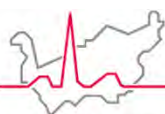




Hôpital du Valais  
Spital Wallis

# **Approche thérapeutique du claudiquant**

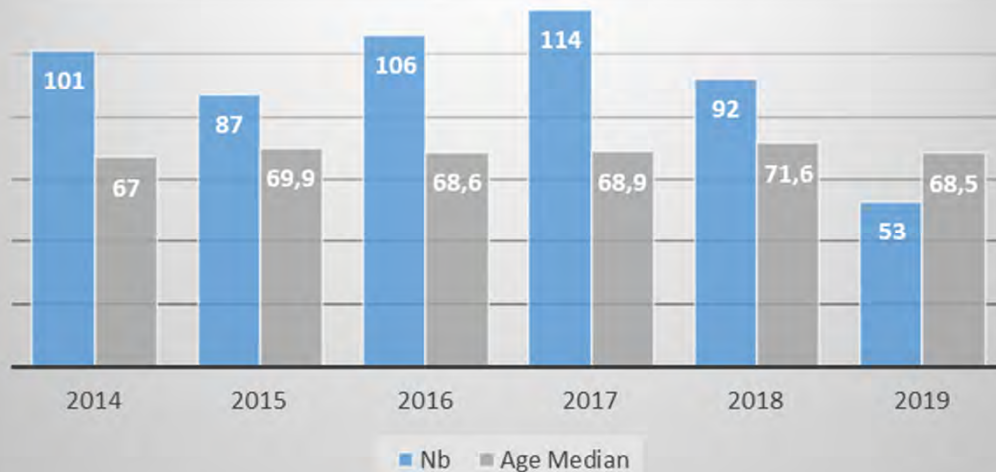
Dr Daniel Danzer



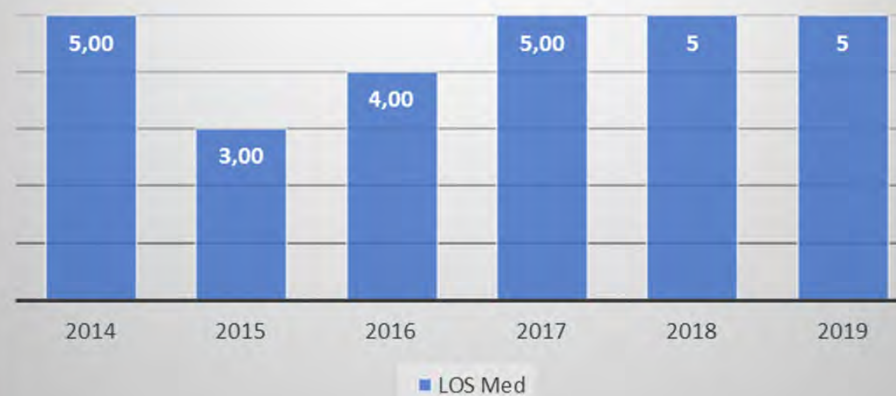
Hôpital du Valais  
Spital Wallis

## Activité stationnaire pour le claudicant

### Patient/année et âge



### Durée de séjour



“In the management of patients with IC, endovascular revascularisation does not provide significant benefits compared with supervised exercise alone in terms of improvement in functional performance or QoL.”

**Cochrane 2018**

## Recommendations for the management of patients with intermittent claudication

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
On top of general prevention, statins are indicated to improve walking distance. <sup>30,278</sup>	I	A
In patients with intermittent claudication:		
• supervised exercise training is recommended <sup>273,287–289</sup>	I	A
• unsupervised exercise training is recommended when supervised exercise training is not feasible or available.	I	C
When daily life activities are compromised despite exercise therapy, revascularization should be considered.	IIa	C
When daily life activities are severely compromised, revascularization should be considered in association with exercise therapy. <sup>288,290</sup>	IIa	B

<sup>a</sup>Class of recommendation.

<sup>b</sup>Level of evidence.



# Claudication en région alpine ≠ aux plaines?

Etudes scientifiques et pragmatisme?

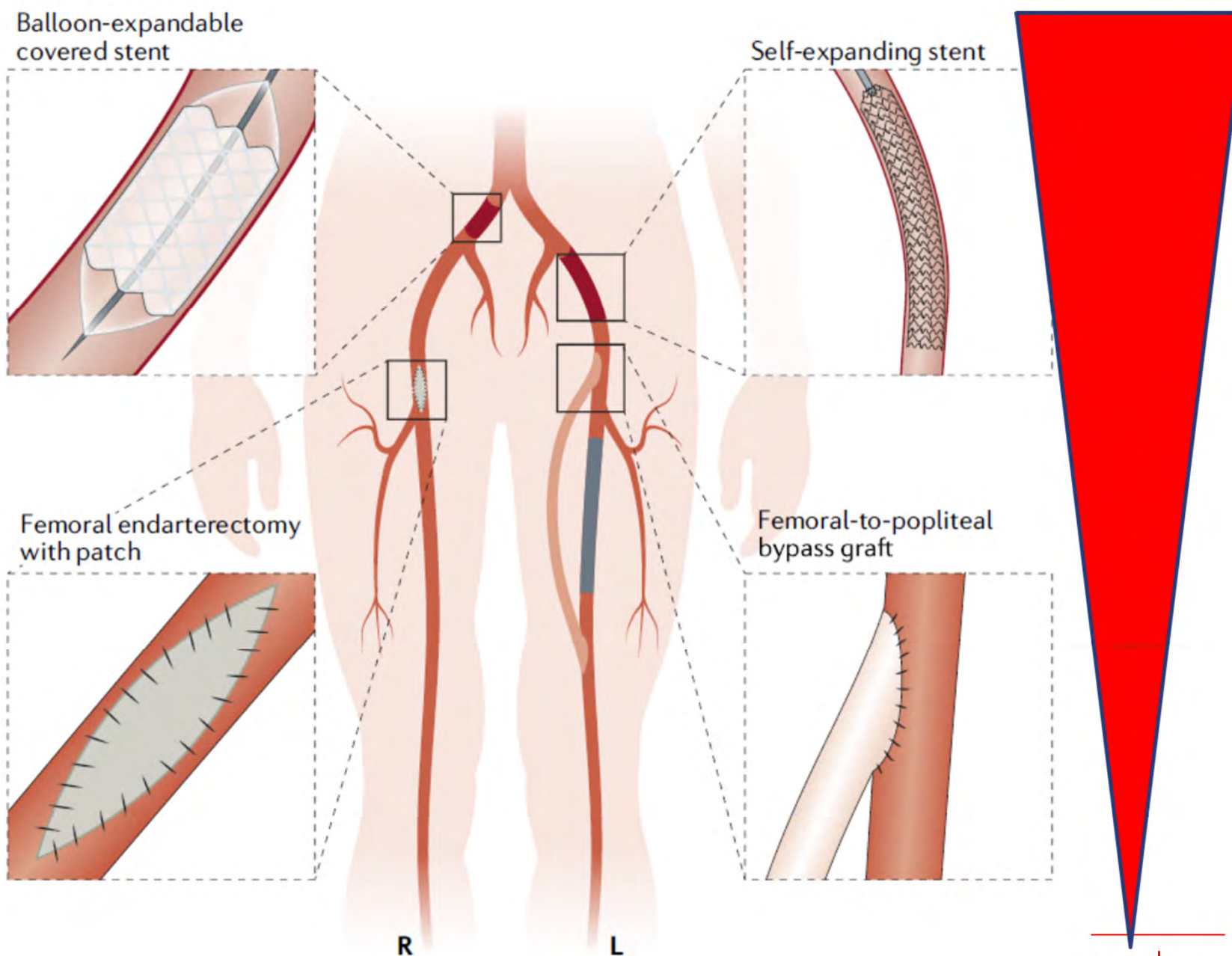




## Différents claudicants?

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- **TT premier reste l'exercice (supervisé)**
  - **Même résultats pour tous ?**
    - Sur le plan anatomique : oui
    - Mais :
      - Applicable ?
      - Patient âgé ? (études âge moyen ~60ans)
      - Et les patients exclus des études ?
  - **Notre but**
    - Améliorer la qualité de vie (pas sauvetage de membre)
    - Ne pas préteriter le futur du patient
- **Durabilité**



## Ré-interventions conséquences ?...

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From the Society for Vascular Surgery

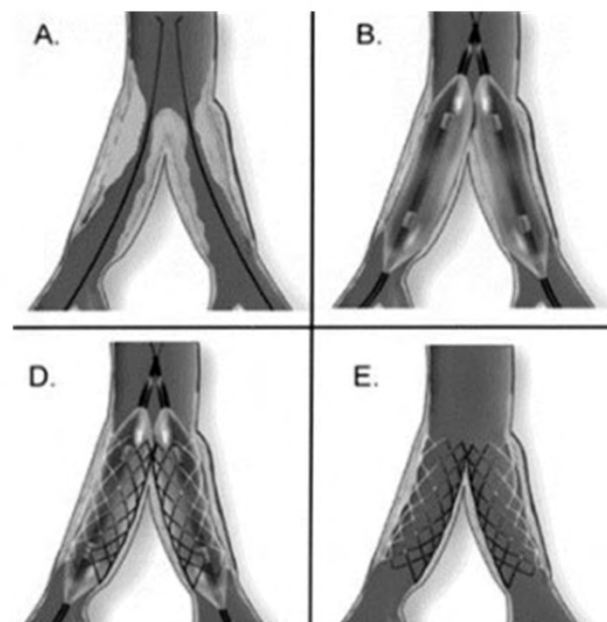
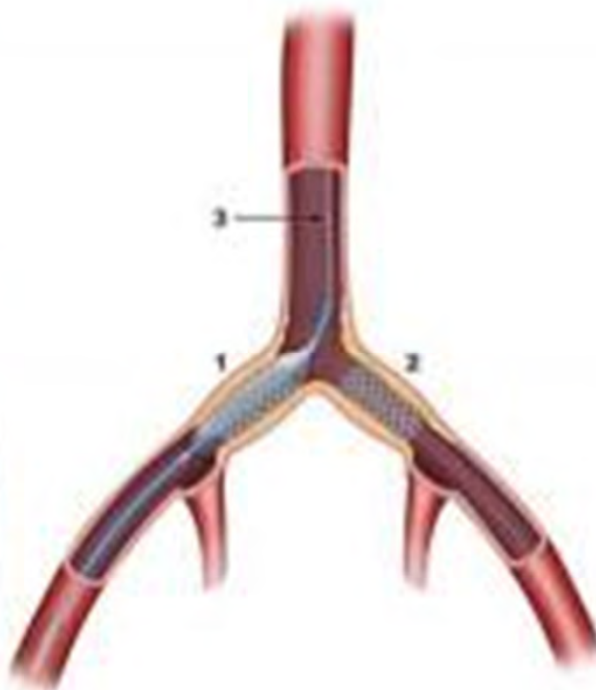
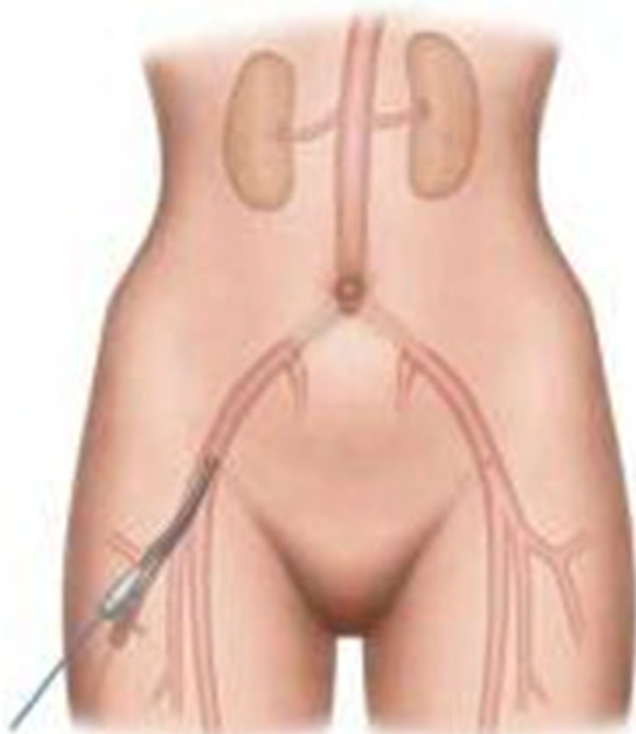
Prior failed ipsilateral percutaneous endovascular intervention in patients with critical limb ischemia predicts poor outcome after lower extremity bypass

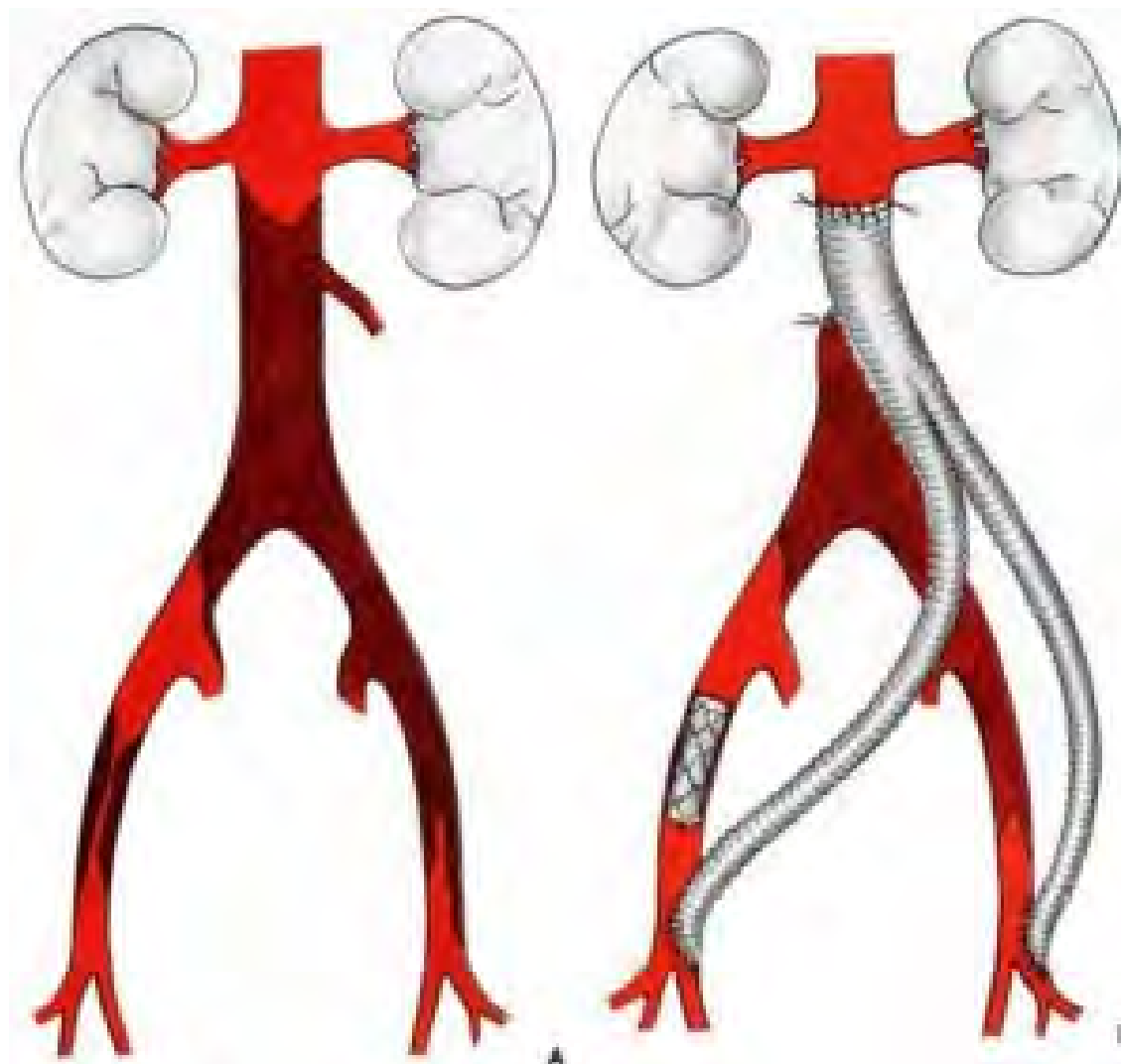
Brian W. Nolan, MD, MS,<sup>a</sup> Randall R. De Martino, MD,<sup>a</sup> David H. Stone, MD,<sup>a</sup> Andres Schanzer, MD,<sup>b</sup> Philip P. Goodney, MD, MS,<sup>a</sup> Daniel W. Walsh, MD,<sup>a</sup> and Jack L. Cronenwett, MD,<sup>a</sup> for the Vascular Study Group of New England, *Lebanon, NH; and Worcester, Mass*

...Et pourquoi pas chez le claudicant ?!



# Segment iliaque





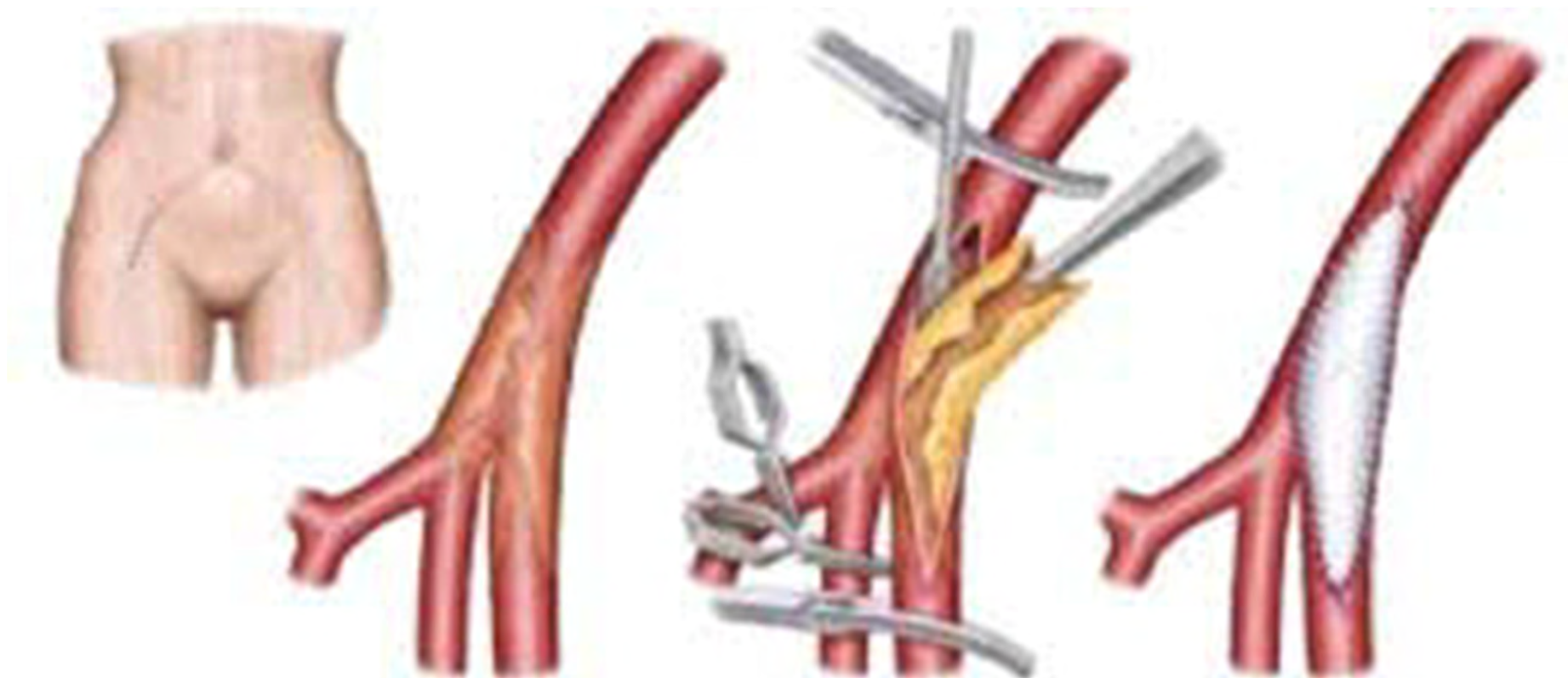
# Revascularisation iliaque

**TABLE 5**  
Clinical Outcomes

	Endovascular Treatment	Direct/Open Bypass	p
Mortality at 30 days	0.7% (0.3% to 1.2%)	2.6% (2.0% to 3.4%)	<0.001
Poor runoff (SFA occlusion)*	24.6% (17.4% to 32.5%)	50.0% (36.7% to 63.6%)	<0.001
Primary patency*			
1 year	86.0% (82.1% to 89.3%)	94.8% (92.0% to 97.0%)	<0.001
3 year	80.0% (74.5% to 84.7%)	86.0% (80.0% to 91.0%)	<0.001
5 year	71.4% (63.8% to 78.3%)	82.7% (78.2% to 86.7%)	<0.001
Secondary patency*			
1 year	90.0% (86.0% to 93.0%)	95.7% (92.6% to 98.0%)	0.002
3 year	86.5% (81.0% to 91.2%)	91.5% (86.4% to 95.5%)	<0.001
5 year	82.5% (75.7% to 88.4%)	91.0% (87.5% to 94.0%)	<0.001
ABI			
Preop	0.48 (0.31–0.69)	0.47 (0.35–0.53)	0.018
Postop	0.86 (0.61–0.94)	0.77 (0.67–0.95)	<0.001
Increase	0.38 (0.13–0.50)	0.29 (0.23–0.49)	<0.001
Length of stay, d	4 (1–15)	13 (6–25)	<0.001

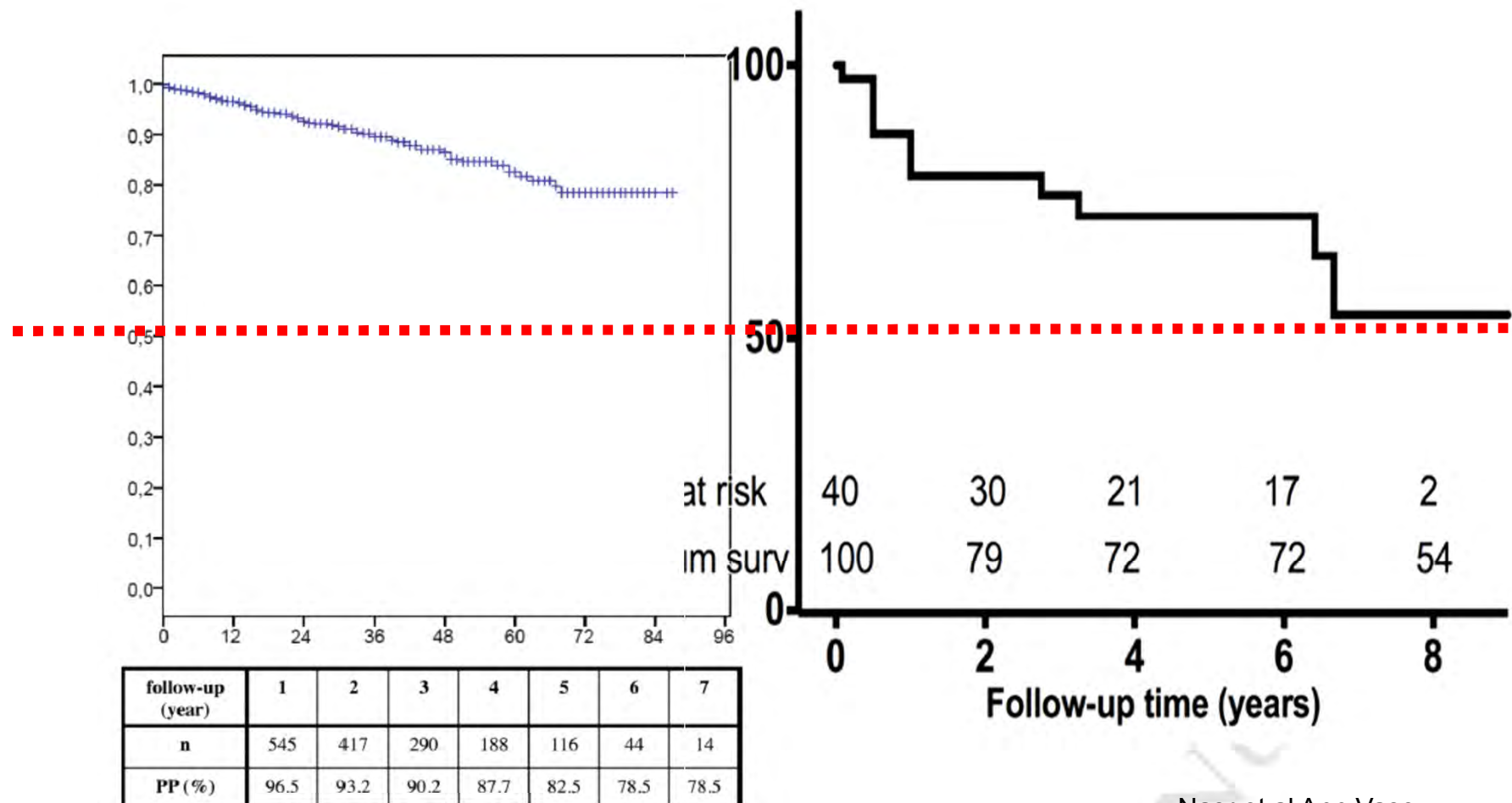


# Carrefour fémoral



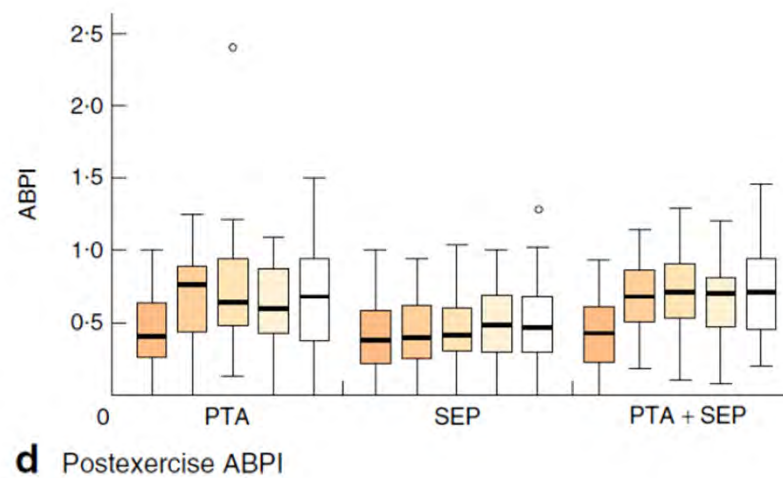
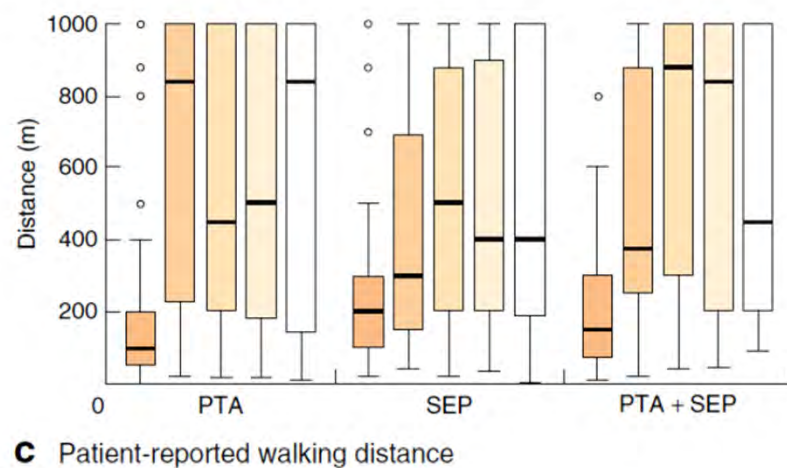
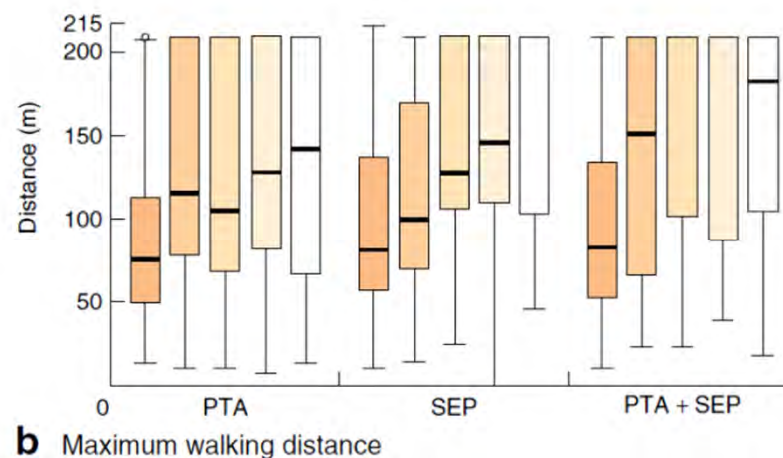
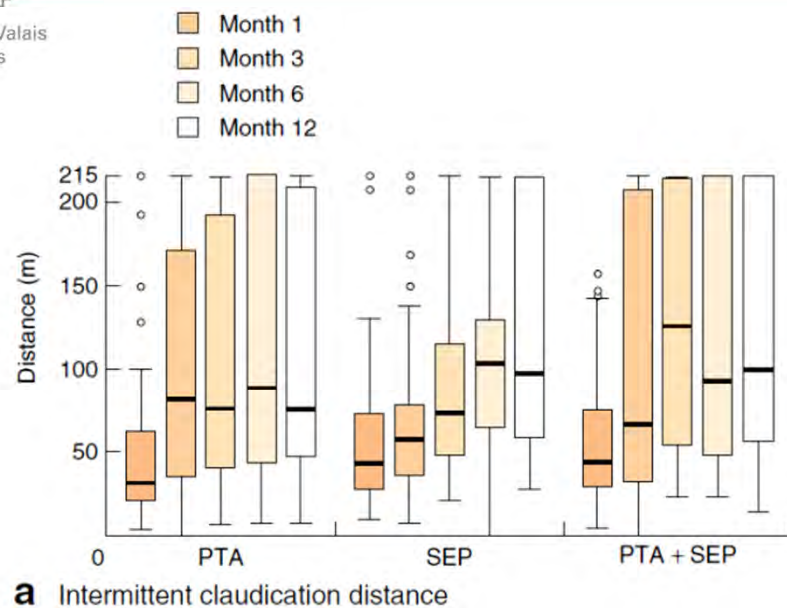


## TEA fem open vs Endo



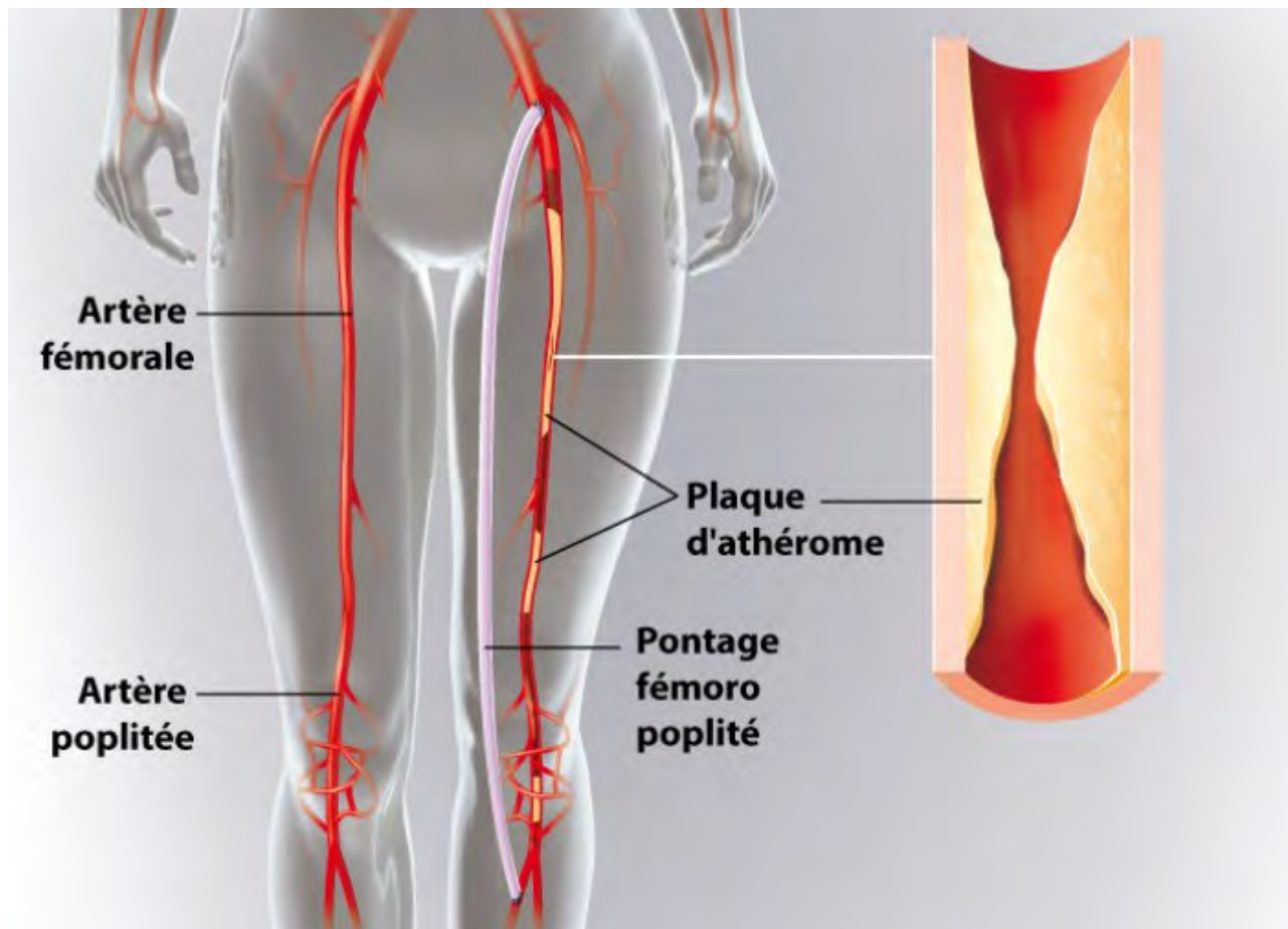


## Segment fem pop

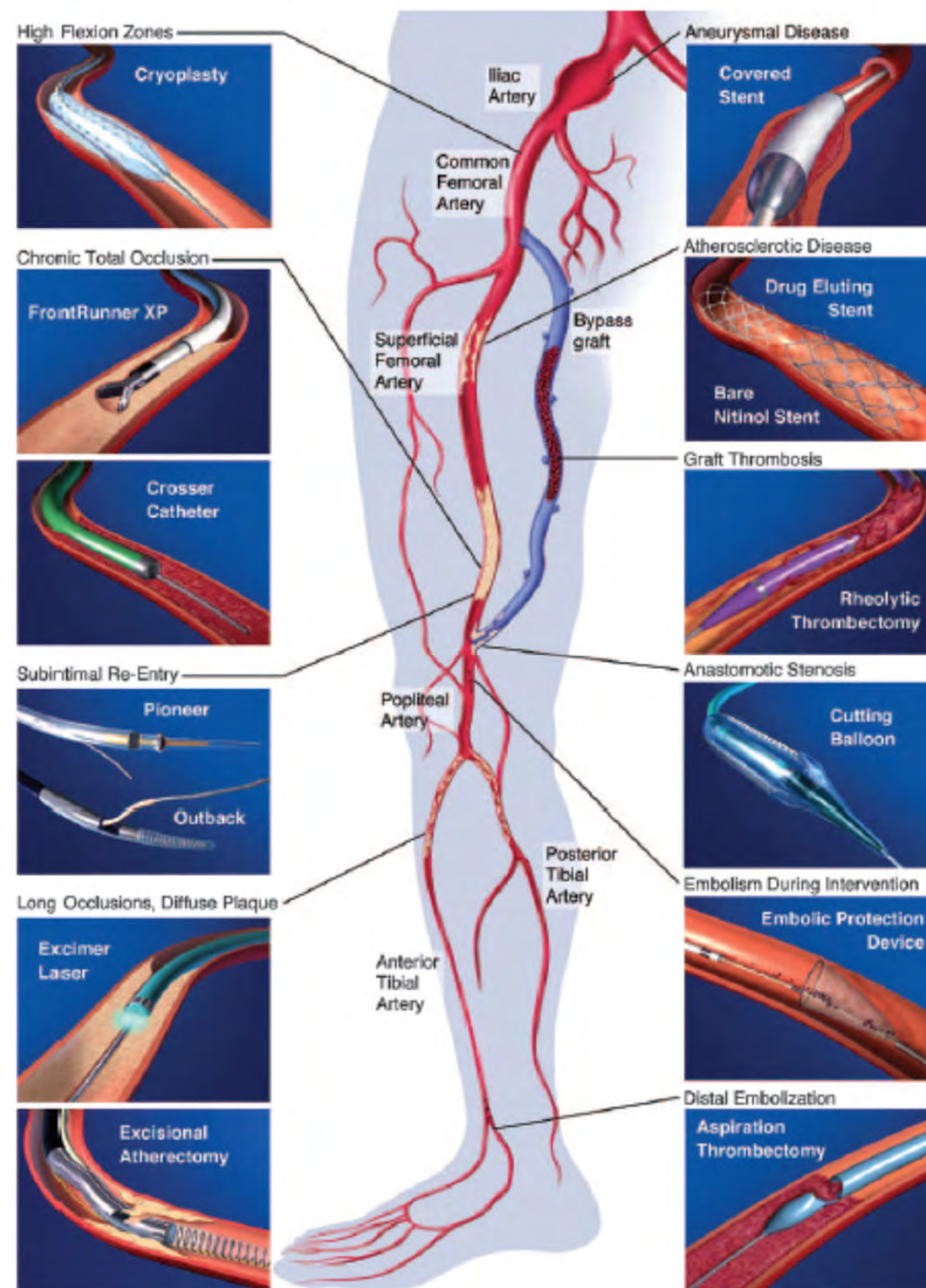


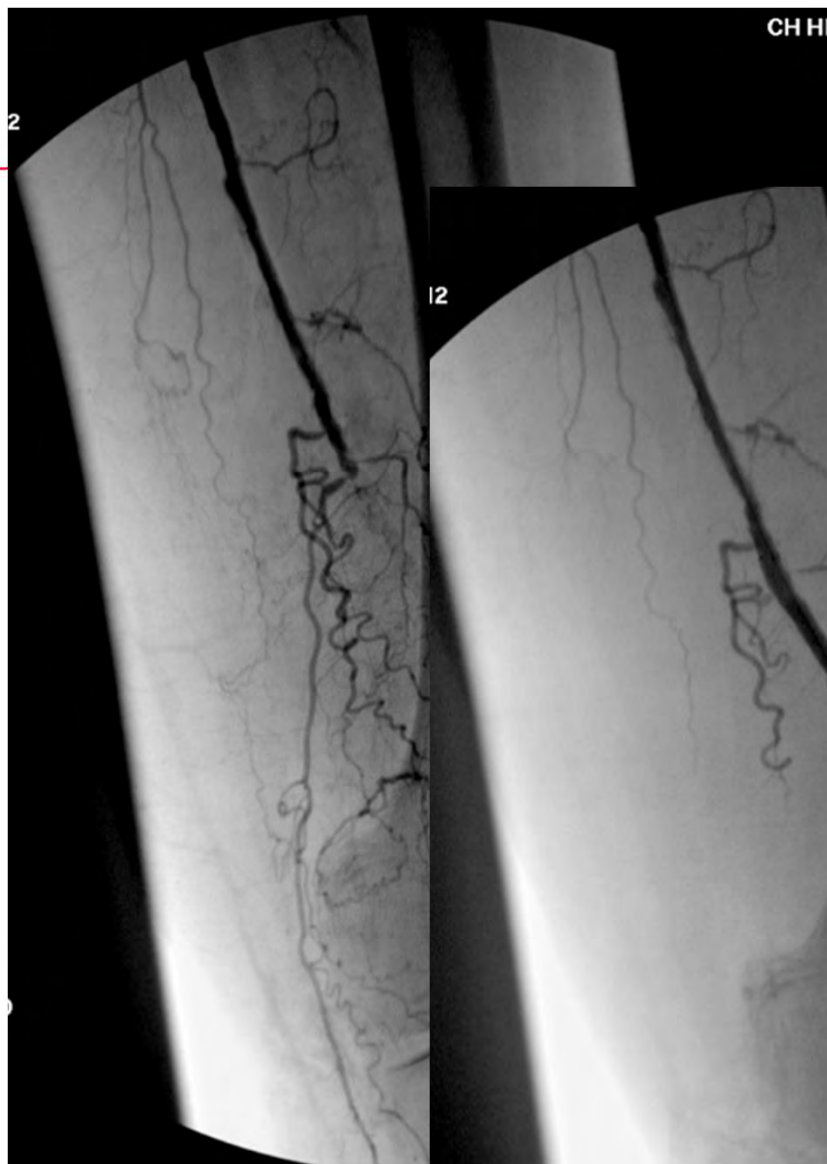
Mazari et al BJS 2012



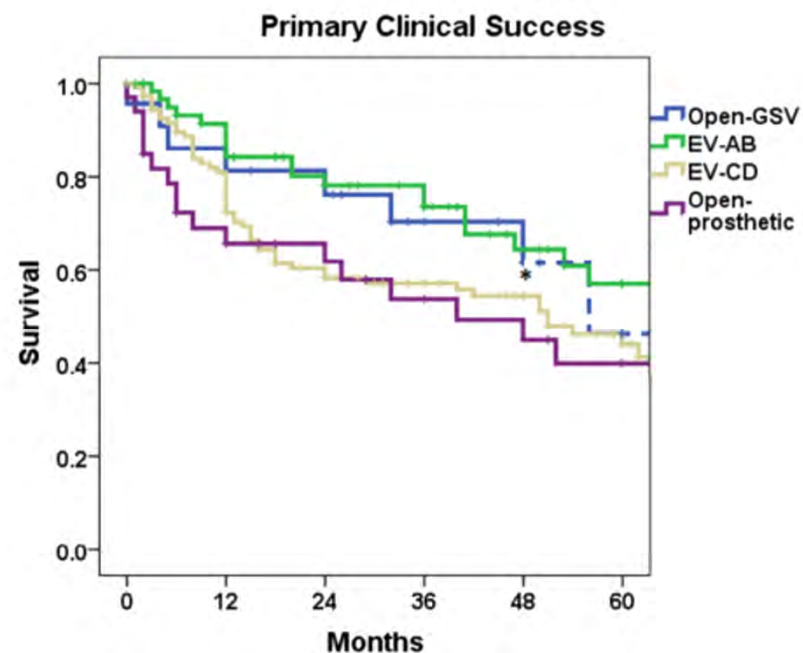
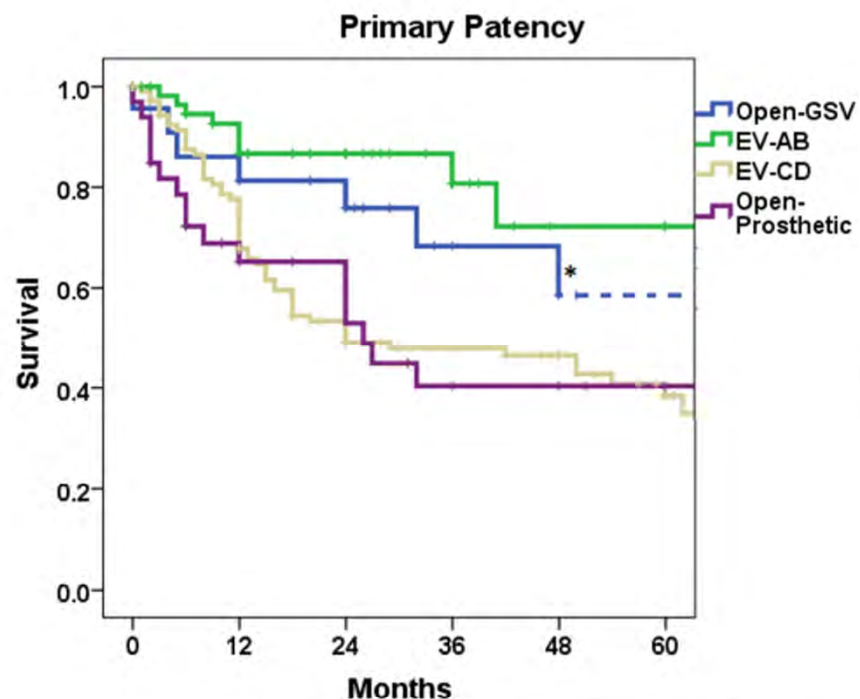








# Approches différentes résultats différents



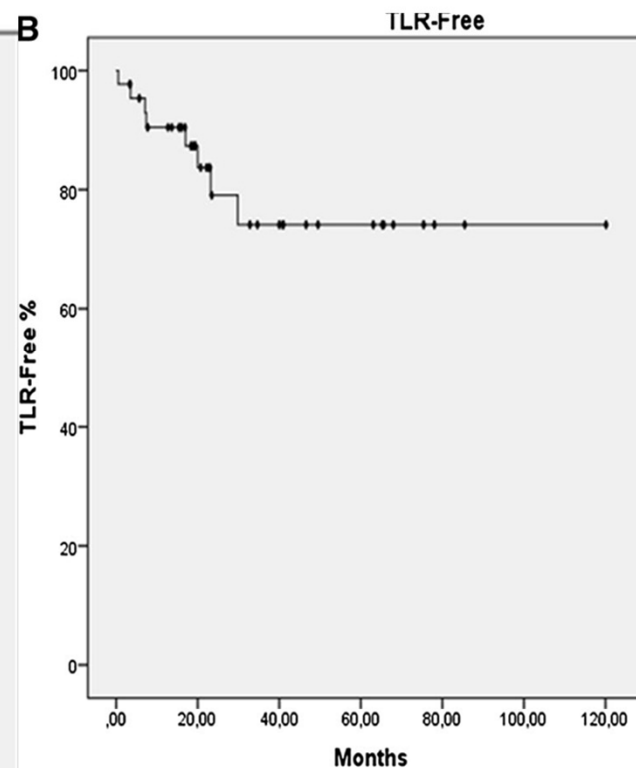
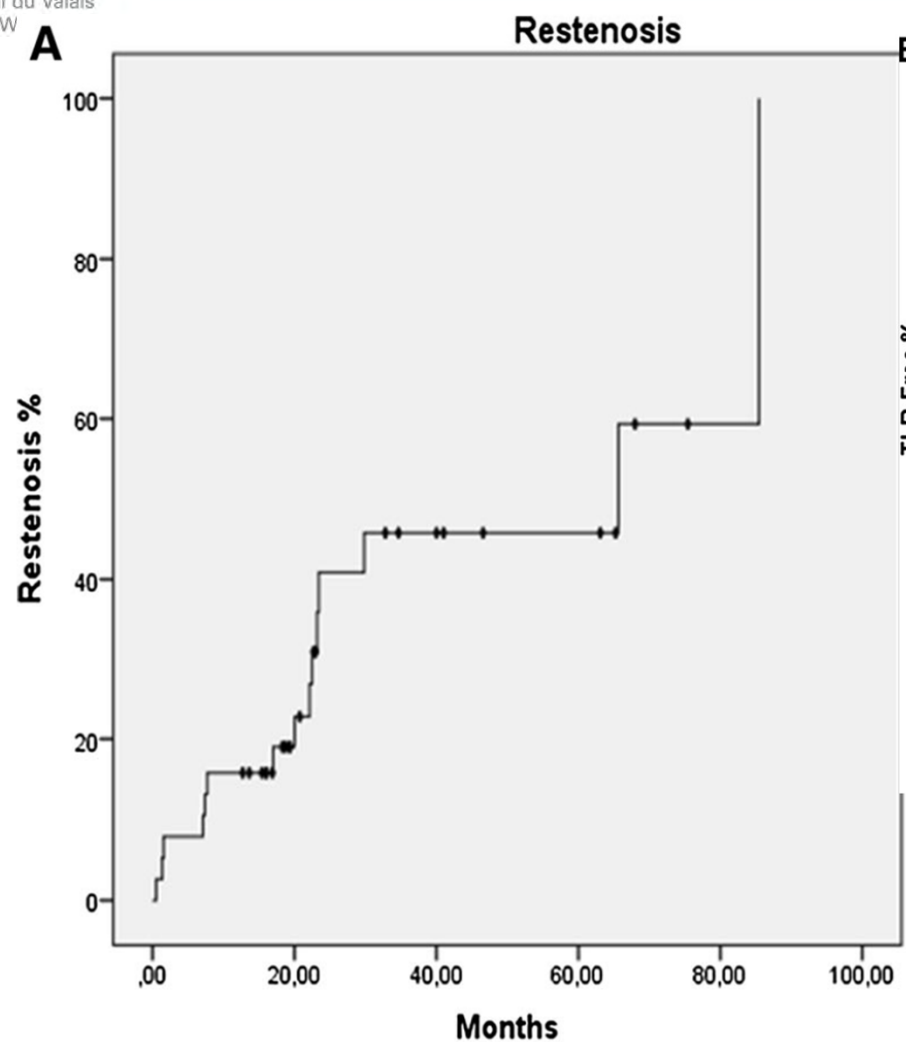
	12 mos	24 mos	36 mos	48 mos	60 mos
No. at risk					
<i>Open-GSV</i> (N=23)	17	14	7	6	3
<i>Open-Prosthetic</i> (N=33)	18	15	8	7	5
<i>EV-AB</i> (N=62)	46	36	28	15	14
<i>EV-CD</i> (N=109)	78	49	35	27	17

20%des patients endo -> bypass

Khan et al Ann Vasc 2018



# Segment poplité tt endovasculaire

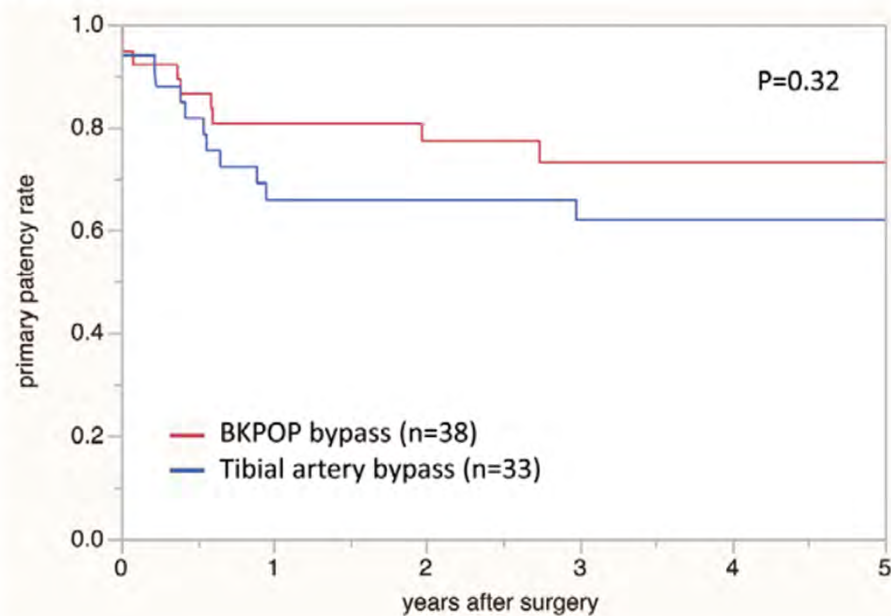


Spiliopoulos et al CIRSE 2018

septembre 19

# Chirurgie infrageniculée du claudicant

**A**



	1 year	2 year	3 year	4 year	5 year
BKPOP bypass	80.8 $\pm$ 6.6 n=27	77.4 $\pm$ 7.1 n=24	73.1 $\pm$ 7.9 n=17	73.1 $\pm$ 7.9 n=13	73.1 $\pm$ 7.9 n=9
Tibial artery bypass	65.8 $\pm$ 8.4 n=21	65.8 $\pm$ 8.4 n=19	62.0 $\pm$ 8.7 n=17	62.0 $\pm$ 8.7 n=16	62.0 $\pm$ 8.7 n=14

Mii et al Circ J 2016

septembre 19

- **Prise en charge «chirurgicale» du claudicant:**
  - Facteur de risques
  - Privilégier approche conservatrice surtout chez le jeune
  - Se faire dans le sens cranio caudal
  - Tenir compte de l'espérance de vie
  - Accepter la récurrence comme potentielle fatalité et en tenir compte dès le départ -> Plan B en cas d'échec





