

5 PRESENTATION TO PRIMARY CARE

Of the 249 patients who had a procedure (revascularisation and/or amputation), the majority presented to a hospital, contacted their GP or called 999 (188/249; 75.5%). Those who presented directly to a hospital had a median time to procedure of 1.2 days compared with those patients who went to primary care first. Their median time to procedure was longer at 2.3 days (F5.1). There were 16/58 vascular networks where it was reported that a referral service/pathway was integrated with primary care.

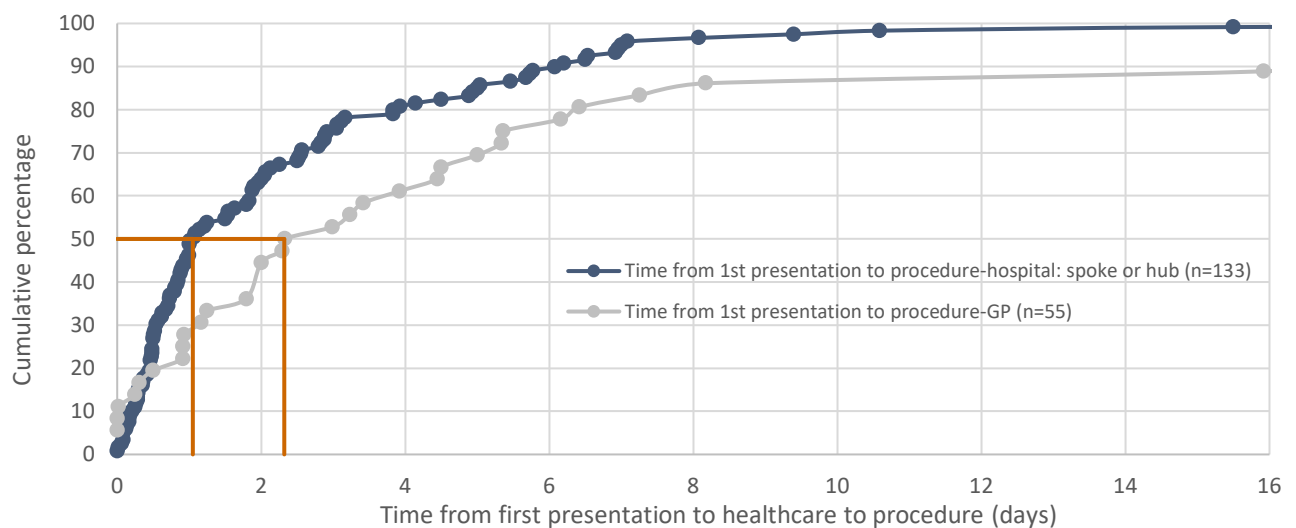


Figure 5.1 Time from first presentation to healthcare to time of first procedure

Case review data

The NICE clinical knowledge summary on peripheral arterial disease (PAD) is available to all healthcare professionals.^[3] In the section ‘What are the clinical features of ALI’, it documents the ‘6Ps’ of ALI, which every medical student is taught:

Pain constant, usually unrelieved by over-the-counter analgesics

Pallor (or cyanosis or mottling)

Paraesthesia or reduced sensation or insensate limb

Paralysis or reduced power

Perishingly cold (poikilothermia)

Pulselessness ankle pulses are absent

What is less well taught or remembered, is that not all of the ‘6Ps’ need to be present to make a diagnosis of ALI and that it is rare to have all of them even in cases of severe ischaemia.^[3,27] Detailed local written guidance to assist in the recognition and initial management of ALI was available in 36/111 (32.4%) primary care organisations. It was noteworthy that in 41/111 (36.9%) this was unknown. There are additional NICE resources available to primary care, such as the ALI template produced by Arens/Emis (medical software used in primary care).

Details of what the local guideline covered were not sought but GPs were asked “*What would you expect to happen in your practice if a patient presented with ALI?*”

There were 79/111 (71.2%) primary care organisations where it was expected that the '6Ps' would be recorded, yet they were recorded in only 21/48 (43.8%) patients. Other aspects of clinical assessment were inconsistently performed or recorded, e.g. examining the limb in 30 patients and documenting a pain score in fewer than five patients. A Rutherford category was not recorded for any patients in primary care. Most GPs predicted that the patient would be referred to the nearest emergency department or vascular hub, but this occurred in 27/48 patients and 12/48 patients respectively, demonstrating some disconnection between expected standards and the reality of clinical practice (F5.2).

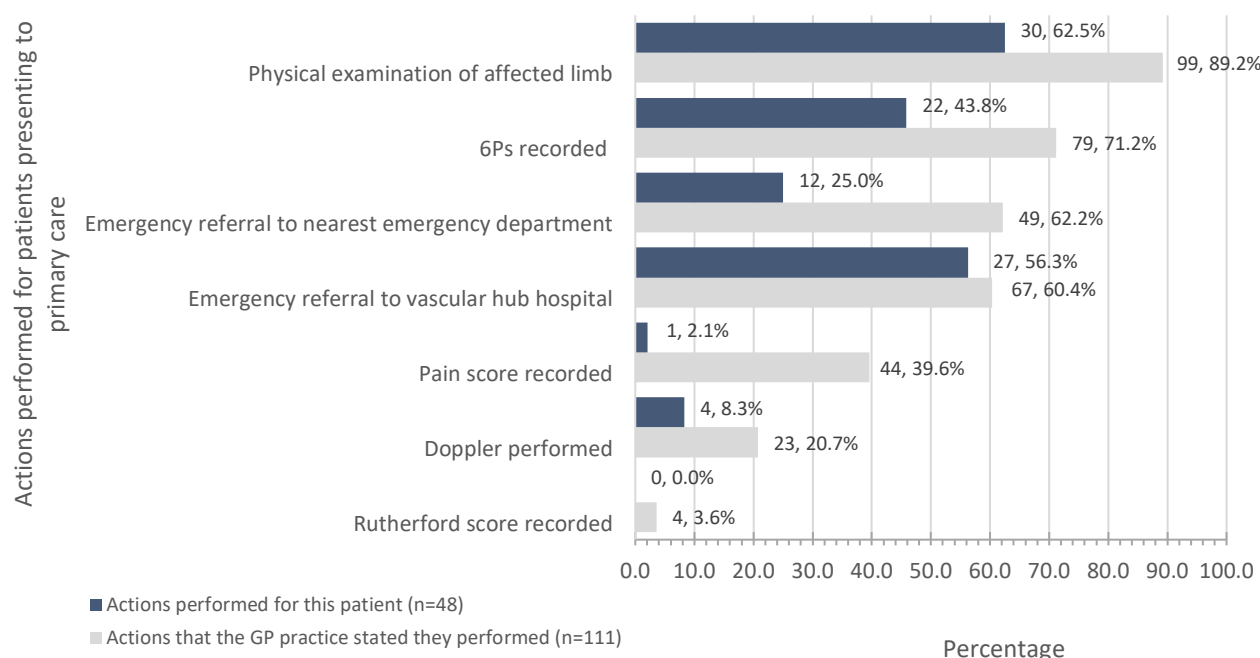


Figure 5.2 Primary care: assessment, diagnosis and actions. Actions that this GP practice stated they performed for patients with ALI; $n=111$, patients with ALI seen at this GP practice; $n=48$

Primary care questionnaire data

Pain was the most frequently recorded of the '6Ps' (42/48) (T5.1). It is important to record the absence as well as the presence of the '6Ps' as not all will be present in every patient. Review of the case notes did not allow differentiation between information not collected and symptoms that were not present.

Table 5.1 Signs of ALI at presentation to primary care	Number of patients	%
Pain	42	87.5
Pallor	17	35.4
Pulseless limb	15	31.3
Perishingly cold (poikilothermia)	15	31.3
Paraesthesia	10	20.8
Swollen limb	6	12.5
Paralysis	3	6.3
Unknown	2	4.2

Answers may be multiple; $n=48$

Primary care questionnaire

Acute limb ischaemia was diagnosed or suspected in 21/48 patients attending primary care. In 27/48 ALI was not diagnosed, but other vasculitis, cellulitis, or deep vein thrombosis were.

Patients with these conditions often present with painful, swollen limbs. Limb swelling is not usually described as a feature of ALI; however, leg swelling was present in 6/48 patients in our study including two who had no other symptoms.

Making a correct diagnosis of ALI in primary care is not essential, provided it is recognised that the patient requires urgent assessment. Most patients (41/45) had an emergency transfer to hospital, including two thirds (28/45) who were sent directly to the vascular hub from primary care. The need to expedite care was not identified in 4/45 patients, who were advised to return home and go to the emergency department if their symptoms deteriorated (T5.2).

Table 5.2 Directions given following attendance in primary care	Number of patients
Emergency transfer to a vascular hub	28
Emergency transfer to the nearest emergency department	13
Advice to return to place of residence and to attend the nearest emergency department if symptoms got worse	4
Subtotal	45
Unknown	3
Total	48

Primary care questionnaire