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The Value of Non-invasive Techniques for the Assessment of Critical Limb Ischaemia


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Objective: The European Consensus Document (ECD) defines critical ischaemia (CI) according to clinical (Fontaine) and blood pressure parameters. However, clinical symptoms may be non-specific and CI may exist without severely reduced blood pressures. This study prospectively investigated the additive value of transcutaneous oxygen tension (pO2) and toe blood pressure measurements to assess the presence of CI.

Methods: Forty-nine patients with 65 legs clinically classified as Fontaine stages III (n=23) and IV (n=26) were studied. Ankle and toe systolic blood pressures and pO2 were measured to assess the presence of CI (cut-off values were 50, 30 and 30 mmHg, respectively). The surgeon was blinded for the toe pressure and pO2 results. The treatment received within 1 month after presentation was recorded as being either conservative or invasive (vascular surgery or PTA).

Results: An ankle pressure of \(<50\) mmHg classified only 17\% of the legs as having CI. By adding toe pressure and pO2, significantly more legs (63\%; \(p<0.0001\)) were classified as CI, of which 68\% received invasive therapy. Forty-nine percent of the legs with an ankle pressure >50 mmHg were treated invasively, whereas only 32\% of the legs classified as not having CI by means of toe pressure and pO2 underwent invasive therapy. If the need for invasive treatment is used as the "gold standard" for the presence of CI, 54\% of the legs would accurately be classified on the basis of the ankle blood pressure. The combination of toe pressure and pO2 would have yielded 71\% and the ECD criteria 72\% accurately classified legs. The odds ratio for invasive therapy given a pO2 or toe pressure above the cut-off value was 14.

Conclusion: Ankle blood pressure measurements have limited diagnostic value. Adding toe and/or oxygen pressures enhances the detection of CI requiring invasive therapy.

Key Words: Critical limb ischaemia; Diagnosis; Ankle blood pressure; Toe blood pressure; Transcutaneous oximetry.

Introduction

According to the European Consensus Document (ECD) critical limb ischaemia is defined on the combination of clinical findings and non-invasive blood pressure measurements: persistent ischaemic rest pain requiring analgesics for more than 2 weeks or ulceration or gangrene, with an ankle systolic pressure of \(<50\) mmHg and/or a toe pressure of \(<30\) mmHg.\(^1\) The present therapeutic policy of vascular surgeons is based not only upon the definition of the ECD, but also upon surgical risk profile, natural course of the disease, the estimation of imminent limb death and technical surgical possibilities.\(^2\)

A major pillar of the clinical diagnosis of critical limb ischaemia is the Fontaine classification.\(^3\) This classification may be criticised as it does not discern the various causes for pain at rest apart from arterial insufficiency, such as arthritis or neurological disorders. Ankle blood pressure measurements are useful to assess the presence, but not the severity of, leg ischaemia and are unreliable in patients with medial sclerosis,\(^4,5\) especially in diabetics.\(^6\) Toe blood pressure measurement is not generally applied probably due to its limitations, e.g. the variety of cut-off values proposed for critical ischaemia,\(^7\) the frustration of measurements at low temperatures\(^8\) or the impossibility to measure when local ulcers are present or after a distal amputation. Moreover, critical limb ischaemia exists despite an ankle pressure >50 mmHg and a toe pressure of >30 mmHg.\(^9,10\) Thus, the solidity of the definition of critical limb ischaemia, as proposed by the ECD, is questionable.\(^9,11\) This situation gives rise to an individual, non-standardised therapeutic approach, which may lead to inaccurate appreciation of the severity of the ischaemia and/or inappropriate conservative or late surgical treatment. A consensus
is, however, useful to define patient groups in comparative studies.

Other diagnostic tools have been proposed to enhance discrimination of the severity of the disease, including skin microcirculatory investigation (especially transcutaneous oxygen tension measurements), the assessment of peripheral resistance in crural vessels peroperatively or by using pulsogenerator run-off. Yet, most of the latter methods have their shortcomings, being either too complicated, too expensive or time consuming. In this prospective study we investigated what the additional effect of two simple, non-invasive measurements, i.e. toe blood pressure and transcutaneous oxygen pressure measurements, could be on the therapeutic policy in 49 patients having 65 legs with chronic critical limb ischaemia.

**Patients and Methods**

From October 1994 to September 1995 all patients with Fontaine Stages III or IV were included. Patients with an acute arterial occlusion, a congenital arteriovenous malformation or clinical evidence of venous insufficiency were excluded. Thus, 49 patients, 27 males and 22 females, with 65 ischaemic legs consented to participate in the study.

Investigations were performed after acclimatisation in a room with a temperature of 22-23°C. Ankle systolic blood pressures in the dorsal pedal, the posterior tibial, and peroneal artery were measured using a 8 MHz Doppler probe (Stöpler, PV lab) and a cuff around the ankle. The ankle pressure was defined as the highest value among the three ankle arteries measured. The peroneal artery pressure, although rarely used in the assessment of the ankle blood pressure, may contribute substantially to the perfusion of the foot in critical ischaemia through collaterals, and was therefore also taken into account. Critical ischaemia according to the ankle pressure was diagnosed when all three ankle arteries showed a pressure ≤ 50 mmHg. Toe systolic pressures were measured in the big and second toe by means of photoplethysmography and a digital cuff with a width of 1.9 or 2.5 cm, depending on the size of the toe. The toe pressure was defined as the highest of both toe pressures measured. In doing so the reliability was appreciated as an alternative measurement in patients whose big toe was ulcerated or amputated. A cut-off value of 30 mmHg was used. Transcutaneous pO\(_2\) (Radiometer, TCM3) was measured on the dorsum of the foot at an electrode temperature of 44°C. The pO\(_2\) cut-off value used for the detection of critical ischaemia was 30 mmHg. Duplex investigation of the aortoiliac or femoropopliteal arteries was performed when the vascular surgeon decided therapeutic intervention was necessary on the basis of the clinical situation and the ankle pressure measurement.

The vascular surgeon involved was blinded for the results of all non-invasive measurements, except for the ankle blood pressure. The therapeutic decision was registered and was classified as conservative (i.e. local wound care, analgesics, antibiotics, or toe amputation) if the patient had not undergone a therapeutic intervention (i.e. vascular reconstruction or percutaneous transluminal angioplasty [PTA]) within 1 month after the first measurement, since the presence of critical ischaemia was regarded as requiring a decision for intervention within that period. The need for invasive therapy was regarded as the "gold standard" for the presence of critical ischaemia. Patients were classified as critically ischaemic when at least one out of the combination of parameters (ankle + toe pressures [ECD]; toe + oxygen pressure; ECD + oxygen pressure) showed a reading below its cut-off value.

**Statistics**

Statistical analysis of the differences in measurement results between the two Fontaine stages was investigated using the non-parametric Mann-Whitney U-test, differences in the numbers of critically ischaemic legs detected by means of the different parameters was tested using the Wilcoxon matched pairs test. Logistic regression analysis was done to identify independent predictors of invasive therapy. The probability of invasive therapy was expressed as an odds ratio. In this study the odds ratio was the odds of invasive therapy given a test result below the cut-off value divided by the odds for invasive therapy given a test result above the cut-off value. A probability of 0.05 was used for entry into and of 0.10 for removal from the model.

**Results**

The patients' mean age was 72 years (range 47–94 years). The median duration of their symptoms was 2 months (range 2 weeks to 24 months). Twenty-three of the patients were Fontaine stage III and 26 stage IV. The mean ulcer size in Fontaine IV patients was 1.6 cm, ranging from 1 to 3 cm. Diabetes occurred

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in 22 (45%) of the patients, smoking in 22 (45%), hypertension in 19 (40%), cardiac diseases in 14 (29%), cerebrovascular disorders in 12 (24%) and hypercholesterolaemia in 7 (18%) of the patients. Marked differences between legs in Fontaine stages III and IV were found only when measuring pO2 (33 vs. 25 mmHg; p=0.05) and toe pressure in the second toe (42 vs. 24 mmHg; p =0.05). Fontaine III patients underwent fewer interventions than did Fontaine IV patients, but this difference was not statistically significant. Three major amputations were observed in the first month after starting either conservative or invasive therapy. Thirty-six legs (55%) underwent invasive treatment within the 1 month period. Of the remaining 29 legs treated conservatively, 11 underwent Duplex scanning or angiography.

The results of the different parameters and the percentage of legs that showed values below the cut-off value for critical ischaemia are shown in Table 1. The ankle pressure criterion of < 50 mmHg classified only 11 (17%) legs and an ankle-to-brachial pressure index <35% classified only 13 (20%) as critically ischaemic, which was significantly lower than the number of critically ischaemic legs classified with a combination of toe pressure and pO2 (up to 63%). Adding the pO2 parameter to the ECD criteria led to a significantly better detection of critical ischaemia than with the ECD criteria alone (p<0.001). Pressure measurement in the peroneal artery, in addition to the other two ankle arteries, influenced classification in only 3% of the legs. The toe pressure criterion (<30 mmHg) classified 13 more legs (20%) as having critical ischaemia, but failure of the measurement occurred more than when using other parameters (12% of the legs). Additional measurement of the pressure in the second toe changed the classification in only 3% of legs.

The relation between the detection of critical ischaemia by means of the different parameters and the subsequent therapy is shown in Table 2. The diagnostic characteristics of each of the (combined) parameters are presented in Table 3. When ankle pressures were below 50 mmHg, nine out of 11 legs received invasive treatment (positive predictive value [PPV] = 82%). However, 25 out of 51 legs with an ankle pressure above 50mmHg also underwent invasive therapy (negative predictive value [NPV] = 49%). The ECD criteria scored the highest PPV (85%), but its sensitivity was relatively low (61%). When the combination of toe and oxygen pressure parameters showed no critical ischaemia, only nine patients were treated invasively (NPV = 68%). If those two parameters had been added to the ankle pressure given to the surgeon, 30 more legs would have been classified as having critical ischaemia, and only eight legs without critical ischaeemia would have been treated invasively (PPV = 68%). Sixteen legs had a pO2 between 31 and 40 mmHg. If the highest cut-off value of 40 mmHg were used, as is sometimes proposed in the literature, a total of 69% of the legs could have been classified as having critical ischaemia. The sensitivity to detect critical ischaemia would increase to 89% if the higher pO2 cut-off value had been combined with the ECD criteria. This combination, however, would not enhance its predictive values (PPV = 62%; NPV = 69%).

The legs that underwent a major amputation all had critical ischaemia according to the combination of ECD and pO2 parameters. A minor (toe) amputation was
Table 3. Diagnostic characteristics of the various (combinations of) parameters used to detect critical ischaemia requiring invasive treatment.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Accuracy</th>
<th>PPV</th>
<th>NPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankle pressure ABI</td>
<td>25%</td>
<td>90%</td>
<td>54%</td>
<td>82%</td>
<td>51%</td>
</tr>
<tr>
<td>Toe pressure ECD</td>
<td>31%</td>
<td>86%</td>
<td>55%</td>
<td>85%</td>
<td>53%</td>
</tr>
<tr>
<td>pO2</td>
<td>53%</td>
<td>72%</td>
<td>62%</td>
<td>85%</td>
<td>62%</td>
</tr>
<tr>
<td>+ pO2</td>
<td>61%</td>
<td>86%</td>
<td>62%</td>
<td>85%</td>
<td>64%</td>
</tr>
<tr>
<td>+ pO2</td>
<td>61%</td>
<td>69%</td>
<td>62%</td>
<td>76%</td>
<td>64%</td>
</tr>
<tr>
<td>+ pO2</td>
<td>75%</td>
<td>66%</td>
<td>62%</td>
<td>76%</td>
<td>63%</td>
</tr>
<tr>
<td>+ pO2</td>
<td>78%</td>
<td>45%</td>
<td>62%</td>
<td>76%</td>
<td>63%</td>
</tr>
</tbody>
</table>

ECD = European Consensus Document; ABI = ankle-to-brachial blood pressure index; PPV = positive predictive value; NPV = negative predictive value.

performed in three conservatively treated patients, whose pO2 and toe pressure, but not the ankle pressure, showed critically ischaemic values. Logistic regression analysis showed that toe pressure and pO2 contributed significantly (p<0.03 and p<0.05, respectively) to the treatment choice, as opposed to the patient's ankle blood pressure, age, sex or Fontaine stage. Both parameters had an odds ratio of 14, i.e. the chance of receiving invasive therapy because of critical ischaemia in case of a test result below the cut-off value was 14 times higher than in case of a test result above the cut-off value. In contrast, the ankle pressure parameter had an odds ratio of 0.3 and the ankle-to-brachial index 1.0.

Discussion

This study shows that in the detection of critical ischaemia the ankle blood pressure is of limited diagnostic significance as critical ischaemia requiring surgery can exist with an ankle pressure above the cut-off value of 50 mmHg. The addition of toe blood pressure and/or transcutaneous oxygen tension measurements leads to a higher sensitivity. Moreover, adding these parameters results in a higher negative predictive value, i.e. more patients without critical ischaemia according to these parameters are treated conservatively.

In this study a relatively low percentage (up to 63%) of patients belonging to Fontaine stages III and IV were classified as having critical ischaemia using any of the non-invasive parameters, and would therefore, according to the European Consensus, need therapeutic action. However, every patient with Fontaine III or IV due to arterial insufficiency requires therapy. Non-invasive techniques are useful to assess the presence of arterial insufficiency, which may not always be clear from the clinical symptoms. In particular adding the skin oxygen pressure to the ankle and toe pressures appears useful to detect critical ischaemia, which is in accordance with previous studies in atherosclerotic and diabetic patients. The sensitivity to detect critical ischaemia by means of transcutaneous oximetry could be further enhanced by raising the cut-off value to 40 mmHg. The assessment of critical ischaemia by means of non-invasive measurements could also be ameliorated by the combination of several techniques. This amelioration is likely to be due to the fact that toe blood pressure and oxygen tension are local measurements nearer to the ischaemic site, as opposed to the ankle blood pressure. Measurement of peroneal artery pressure or toe pressure in the second digit was not technically difficult, but appeared useful only when other parameters are unattainable.

Taking the need for invasive therapy as a "gold standard" for the presence of critical ischaemia is of course debatable, since the choice for invasive therapy is influenced by other factors, such as non-reconstructability or contra-indications, e.g. concomitant diseases or a poor general condition. This results in patients being treated conservatively, but who do have critical ischaemia. This can be illustrated by the finding that a considerable number of legs (38%) treated conservatively underwent duplex scanning or angiography. This suggests the surgeon did intend to treat invasively. Furthermore, some patients received invasive treatment after the predefined period of 1 month. This may explain the relatively high percentage (18-32%, depending on the diagnostic parameter(s) used; see Table 2) of the legs classified as critically ischaemic, which were treated conservatively.

The treatment of choice is sometimes difficult to assess because of the uncertainty of the Fontaine classification, since rest pain or ulceration may not be due to arterial insufficiency. Hence, duplex scanning and/or angiography are usually performed to assess the need for and type of invasive therapy. The findings of this study are promising as the extra non-invasive data may aid the surgeon in the decision of whether to treat the patient with invasive or conservative treatment. Those patients who do not have critical ischa-
aemia according to these criteria may be spared angio-
graphy and be treated conservatively. However, some
patients without critical ischaemia according to pres-
sure parameters are still treated invasively, solely on
the basis of their clinical situation. For the final answer
we need a prospective study, because the diagnostic
merit of a larger number of non-invasive parameters
is valuable only when also the outcome of the treat-
ment is improved.

In conclusion this study has shown that the detection
of critical ischaemia on the basis of the clinical situation
and the ankle blood pressure can be improved by
adding the toe blood pressure measurement, as pro-
posed by the ECD, and/or the skin oxygen pressure
measurement, a simple, non-invasive technique, using
a cut-off value of 30 mmHg. Ankle blood pressure
measurements alone are insufficient for this purpose.

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