

Keeping in circulation

the official newsletter of the Vascular Disease Foundation



VASCULAR DISEASE
FOUNDATION

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our mission

The Vascular Disease Foundation's mission is "To reduce the widespread prevalence and effects of vascular diseases by increasing public awareness of the benefits of prevention, prompt diagnosis, comprehensive management and rehabilitation."

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Birthmarks, Vascular Malformations and Anomalies

What Are They and What Can Be Done About Them?

Vascular anomalies occur in barely 1% of all births. Yet, because of their rarity, their proper diagnosis and treatment is difficult as most physicians do not see these problems often enough to become knowledgeable about their management.

Vascular anomalies is an all-inclusive term for vascular malformations, vascular tumors and other congenital vascular defects. The more commonly used term, Congenital Vascular Malformation (CVM), implies abnormally formed blood vessels that one is born with. However, in spite of its redundancy CVM is a popular term and it will be used here. This article is intended to explain the various vascular anomalies, which mostly present in childhood, and discuss their management in lay terms.

The significance of birthmarks. The difference between a CVM and a vascular tumor or hemangioma (the medical term), both of which are commonly called "birthmarks" is very important to the child. Although they may initially appear the same, "all birthmarks are not the same." Most birthmarks represent a superficial vascular malformation, consisting of abnormal collections of small blood vessels near the skin. Typically this CVM type of "birthmark" does not go away nor does it enlarge, growing only at the same rate as the child. It thus maintains the same size and appearance indefinitely, is not a health threat, and requires no immediate treatment. Some of them, because of their location, particularly around the face and neck or on some other exposed body part, are unsightly and cosmetically disturbing. Fortunately their characteristic reddish color coincides with the range of certain lasers that can be used for their destruction. Another approach has been to cover them up by tattooing them a skin color. The other type of "birthmark" may appear the same at first but is actually a true vascular tumor or hemangioma. In contrast, this type undergoes rapid growth in the months after its discovery, but then almost miraculously it "involutates", or gets progressively smaller. The majority disappears completely in a few years, leaving a patch of shrunken elastic skin in its wake. This regression normally is completed between two and eight years of age, but not all of them completely disappear. During their growth phase these "juvenile hemangiomas" can be alarming, particularly if they grow in a critical location, such as those on the face impinging on the eye, nose or mouth, in which case they may require early treatment. However, most juvenile hemangiomas do not require treatment. Rather the best advice is to do nothing but wait it out, giving it a chance to go away by itself.

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Birthmarks, Vascular Malformations and Anomalies

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Both of these contrasting types of birthmarks, or the smaller remnants of them which remain, can be greatly improved in appearance by plastic surgery, but this is only occasionally needed and can usually be done later, after the child grows up.

Are there other types of vascular malformations that can be serious? Yes, the two conditions discussed above are on the surface of the body and among the easiest to deal with. Others may be deeper, and more extensive and complex. Vascular malformations can develop from any type of blood vessel and develop in any part of the body although the majority involve the extremities. They represent defects or development problems that occurred during embryonic growth. Depending on the stage of the development at the time this occurs, the result can involve arteries, veins, lymph vessels or combinations of these. In early embryonic development, all blood vessels appear as a diffuse network of simple channels and are not identifiable as the particular type of mature blood vessel they are destined to become. At later stages this network of vessels develops central channels of flow, finally becoming arteries and veins, and the small capillaries of the microcirculation.

Arterial-Venous CVMs

During these early developmental stages, large connecting channels or shunts between future arteries and veins exist, and a defect or arrest occurring at this stage may allow these artery-to-vein connections, or a cluster of them to persist. Such connections are called arteriovenous fistulas (AVFs), or if there is a cluster of them they are called arteriovenous malformations (AVMs). These are potentially the most serious type of CVMs because, in shunting blood from arteries to veins, they bypass the small vessels that make up the normal circulation beyond that point. This not only robs or steals blood that would otherwise pass through to more distant tissues and nourish them, but doesn't allow for a gradual pressure drop from the high arterial pressure to the low pressure on the venous side. Thus these AVFs represent a high flow short-circuit, and depending on their size and location they may respectively force the heart to work harder. They may also cause poor circulation in the limb beyond the point of the AVF. In time, these AVFs tend to get bigger and have greater effect on the circulation. For example, an AVF or AVM in an extremity can "steal" (reduce) blood flow to a foot or hand as much as a blocked artery would. Fortunately, AVFs located in the legs and arms are more common than elsewhere in the body and thus easier to deal with. Those involving pelvic vessels, or vessels to vital organs or the brain can be extremely difficult to treat without injuring the organs or tissues they lie in. Clearly, although AVFs make up only one-third of all CVMs, they attract the most attention because of the more serious nature of the problems they create, and are the CVMs most likely to need interventional treatment.



Venous CVMs

CVMs composed entirely of veins, which are numerically the most common, comprising almost half of the total, are of two basic types. The more primitive ones appear as thin-walled lakes in which venous blood collects and when they develop in groups or clusters they may form a mass consisting of a collection of grape-like clusters of these venous lakes. This type usually does not affect the venous circulation which returns blood to the heart, but these masses of venous malformations can be unsightly, cumbersome or be the site of blood clots (which fortunately are not the kind that travel to the heart or lungs). They are more annoying than being a serious threat, but nevertheless may be worth treating if the mass is large and causes local problems, for example, interfering with walking.

The other type of venous defect involves the large deep or central veins and often interferes with their function. Segments of major veins may be absent or narrowed. Or segments may be greatly widened and expanded (dilated), called a venous aneurysm. Depending on how severely they affect venous return or contribute to deep venous thrombosis (DVT) determines treatment. Most of the venous malformations involve only short venous segments and do not require treatment.

Arterial CVMs

Arterial defects or malformations are the least common type of CVM, being responsible for only 1-2 percent of the total. The most common arterial defect involves a segment that did not develop. The result is that a normal arterial segment is missing and instead blood flows through a normally undeveloped side channel or collateral artery which persists rather than withers. Although this allows bypassing the blockage, the enlarged bypassing segment often becomes more vulnerable to

Birthmarks & Anomalies CONTINUED FROM PAGE 2

compression and injury, developing into an aneurysm or suddenly clotting off. The most common example of this is the so called persistent sciatic artery.

How does one recognize a CVM and what are the appropriate diagnostic approaches? When located in an extremity, CVMs may show up as a birthmark, a visible or palpable mass of blood vessels, or may stimulate the development of collateral blood vessels in the form of varicose veins, or produce an enlargement of the limb or a lengthening of the limb by stimulating its bony growth centers. The localized masses may be of various sizes from small to huge and at their surface the vessels may be vulnerable to injury and bleed or may even break down and ulcerate. AVFs, by “stealing” blood from the circulation beyond them may cause “ischemic” pain, which is the medical term for the pain that results when the circulation is so restricted that the tissues, and the nerves serving them, do not get enough blood.

Years ago the only definitive way to evaluate blood vessel problems was by the injection of a contrast dye in them that would make them visible on x-ray, called an angiogram. However, since most CVMs do not need treatment, or treatment is often delayed until the child grows up and the need for treatment is more obvious, it is now rarely necessary to get angiograms as a first step. They may ultimately be needed, but only when intervention is required and even then are best obtained just before or at the time of such treatment.

Fortunately, great strides have been made in less invasive forms of vascular imaging. The localized superficial CVMs can often be initially studied more simply by a form of ultrasound imaging called a color duplex scan. Larger mass lesions can best be studied by Magnetic Resonance Imaging (MRI) which has the advantage of not only imaging the blood vessels involved by these malformations in multiple planes (view angles), but determining the anatomic extent of the malformation and importantly whether its involvement of surrounding tissues (muscles, nerves, bones and joints) might preclude or complicate surgical treatment.

When and how should these vascular anomalies be treated? As a general rule CVMs should be treated for specific indications: persistent pain, ulceration, bleeding, causing blood clots, obstructing major vessels, causing progressive limb asymmetry by overgrowth, and for cosmetic indications or because the vascular mass is cumbersome and leads to a badly misshapen limb or interferes with extremity function in a mechanical way. Since most of the patients with the worst CVMs present early in life, the timing of any intervention should be done with a mind to interfering the least with the child’s growth and development. Often it is better to delay operating on very young children if possible.

In the past, the only treatment for these vascular anomalies was surgical removal. However only a minority, around 10 to 15 percent, of those CVMs that were significant enough to justify operation could be totally removed by surgery. Even then, removing even the simplest of these vascular malformations could lead to a bloody procedure with considerable blood loss and therefore significant risk.

Surgery may still be appropriate for localized, accessible lesions but in the last few decades techniques using catheters have been developed. Catheters are placed (usually through a groin vessel) and advanced into the lesions and the malformed vessels are blocked, or embolized, with a variety of injectable particles, substances or devices such as polyvinyl foam, biological glues, and absolute alcohol.

These catheter embolization techniques can be used to control these lesions without surgery. They can also shrink larger CVMs to make them more readily treatable by surgery. Laser therapy may also be effective for small localized birthmarks (port wine stains). Patients with a rare venous malformation (Klippel-Trenaunay Syndrome) of the limbs frequently benefit from elastic garments and bandages used for compression of the large veins. After careful evaluation, surgery or less invasive therapy of the enlarged superficial veins can also be helpful.

Congenital vascular malformations can be extremely complex and proper diagnosis and selective treatment at the appropriate time requires experience, skill and judgment. Management is usually best left to those major centers that specialize in treating this type of problem. Most vascular surgeons and other vascular specialists are capable of the initial evaluation and know where and when to refer these patients for interventional treatment when it is required.

About the author: *Robert B. Rutherford, MD, is one of the early pioneers in vascular surgery and is the author of the textbook used to train vascular surgeons. Now retired, Dr. Rutherford is Professor Emeritus and was the Chair of the Division of Vascular Surgery of the University of Colorado Health Sciences Center for over 20 years. The Vascular Disease Foundation is privileged to have Dr. Rutherford serve as a special advisor to its Board of Directors.*



VDF INAUGURATES NATIONAL CORPORATE ADVISORY BOARD

The Vascular Disease Foundation is pleased to announce plans to initiate a National Corporate Advisory Board. The goal of this new board is to reduce the mortality and devastating effects from vascular disease, by providing support, participating in an annual roundtable discussion on vascular health initiatives and help keep vascular health concerns high on the national agenda.

Inaugural members of the new National Corporate Advisory Board include Diomed Holdings, Inc., developer and marketer of the proprietary Endovenous Laser Treatment (EVLT®) for varicose veins, and AstraZeneca, LP a leading pharmaceutical company. Additionally, Diomed will sponsor a portion of the Foundation's website dedicated to venous disease. More than 25 million Americans are affected by some form of venous disease. AstraZeneca is a sponsor of the Foundation's newsletter, *Keeping In Circulation*, and provided a grant used for a new educational brochure on venous thromboembolism.

"We are delighted that Diomed and AstraZeneca have made significant commitments to the Vascular Disease Foundation's future," said Peter Glociczki, M.D., President of VDF's board of directors. We anticipate five or six inaugural members joining this new board before its first meeting in late October.

TO PREVENT HEART ATTACK, STROKE, AMPUTATION, AND DEATH: A NATIONAL "PAD COALITION" IS FORMED

The Vascular Disease Foundation has taken the lead in creating a unique coalition in partnership with 14 other major national public health organizations and professional vascular societies. The inaugural meeting of the PAD Coalition was held on the National Institutes of Health (NIH) campus in Bethesda, MD on June 17, 2004, in cooperation with the National Heart, Lung and Blood Institute (NHLBI) of the NIH. At its inaugural meeting, the Coalition identified as a top priority the need for a unified, long-term national public awareness campaign about peripheral arterial disease (PAD), designed to improve the clinical outcomes of individuals with PAD.

The important daylong meeting brought together vascular healthcare professionals from around the country to create the Coalition's structure. In addition to the Vascular Disease Foundation, participating organizations include the American Association for Cardiovascular and Pulmonary Rehabilitation; American College of Cardiology; American College of Physicians; American Diabetes Association; American Heart Association; American Podiatric Medical Association; American Radiological Nurses Association; Peripheral Vascular Surgery Society; Society for Clinical Vascular Surgery; Society of Interventional Radiology; Society for Vascular Medicine and Biology; Society for Vascular Nursing; Society for Vascular Surgery; and the Society for Vascular Ultrasound.

We are excited about this new collaboration as well as the launching of a multi-year PAD awareness campaign that will result in increased public recognition of the disease, knowledge of its devastating effects and the value of early diagnosis and treatment. To read the press release about the inaugural meeting of the PAD Coalition, visit our web site at www.vdf.org.

Make It Easy

Make it easy to support VDF. Make a recurring donation via our secure online giving solution found at www.vdf.org. You're in charge—you designate the amount you would like the Vascular Disease Foundation to receive every month. You indicate when you would like the funds charged to your credit card or electronically transferred via secure encrypted technology from your bank account. VDF will do the rest and send you an acknowledgment either monthly or once a year, whichever you prefer. *The Vascular Disease Foundation is designated a 501(c)(3) organization for tax purposes by the Internal Revenue Service.*



More Online
Information About
Vascular Disease at
www.vdf.org

Fourth Annual “Keeping In Circulation” Event at the Gardens



For the fourth year in a row, the Vascular Disease Foundation sponsored its annual “Keeping In Circulation” walk and program in Colorado. This year it was held August 24 at The Hudson Gardens. Participants heard excellent presentations about causes and treatments of PAD by Michael Podolak, MD, and learned ideas for prevention, exercise and nutrition from Therese Ida, RN, RD. Attendees also picked up some educational materials, and handouts from Aventis and other sponsors, and all were able to receive free screening and consultation about PAD. Surveys from participants unanimously rated the program as very helpful. It was a fabulous morning to enjoy touring the beautifully landscaped gardens and exercise those just screened legs!

We are grateful to our sponsors for helping to make this yet another successful event. Thanks to **Aventis, Summit Doppler, The Barbara Bridges Family Foundation, The Rutt Bridges Family Foundation, Porter Adventist Hospital, King Soopers, Turning Point Massage Therapy, Arvada West Chiropractic, Vascular Institute of the Rockies.** We gratefully appreciate the volunteers who helped on the day of the event: **Michael Podolak, MD; Therese Ida, MS, RD; Dan Gautier, RVT; Sean Fortin, RVT; Erin Wochos;** and **Lori Steinmetz.**

PARTNER SPOTLIGHT



This issue, we are pleased to focus the spotlight on the American College of Cardiology (ACC). With over 16,000 members, the ACC represents the majority of board certified U.S. cardiovascular physicians. The majority of ACC members spend their professional time providing direct patient care and consultation, as well as performing a wide range of procedures. The ACC was established in 1949 and its mission is to advocate for quality cardiovascular care—through education, research promotion, development and application of standards and guidelines—and to influence health care policy. ACC is represented on the VDF Board of Directors by Dr. Mark A. Creager.

Thank You

GRANTS RECEIVED: The Vascular Disease Foundation has recently received several important grants that enable VDF to continue its invaluable work. We appreciate the contributions from these organizations:

The Rutt Bridges Family Foundation
The Barbara Bridges Family Foundation
Bristol-Myers Squibb/Sanofi-SytheLabo Partnership
Cordis Endovascular Diomed
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In honor of my lovely wife,

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VDF as your charity of
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**Donate your car to VDF—
Call 1-866-332-1778**

RESEARCH REVIEWS

New Section! This issue of *Keeping In Circulation* introduces a new section highlighting clinical research studies. We often are asked how people can find out about clinical trials, so we will plan on highlighting one or two opportunities in each issue.

This section will provide information about scientifically useful studies to individuals with PAD and other vascular diseases, as well as to their families, and those “at risk.” All studies listed will answer an important vascular scientific question and be approved by an Institutional Review Board (IRB). Most often, listed studies will be multicenter (in more than one location), but single center studies may also be listed. However, by listing these studies, the Vascular Disease Foundation is not endorsing the studies, the study center, the study sponsor or the treatment.

To prepare for this new service, last issue of *Keeping in Circulation* featured an overview about clinical trials. This information and more will also be available soon on our web site (www.vdf.org).

The Vascular Disease Foundation and any sponsors disclaim, either explicitly or implicitly, that the drug, biologic or device listed here is safe or effective for the purposes under investigation, or that the test article is known to be equivalent or superior to any other drug, biologic or device. Additionally, no claims are made regarding the scientific utility and conduct of clinical trials or research studies listed.

Research Study on Painful Walking

“My legs are killing me!”

You may think this is only an expression, but if you have leg pain that feels like an ache, burning, cramping or tiredness, you may be experiencing claudication, one of the primary symptoms of peripheral arterial disease (PAD). And PAD increases your risk of heart attack, stroke and death.

Current treatments for PAD and claudication include surgery, angioplasty and exercise. Only two medications are currently available to improve claudication, and these do not always provide pain-free walking.

Three recent studies have shown that cholesterol-modifying medications may diminish claudication symptoms. However, there is still too little information available to prove that this is a reliable and safe new treatment. A national research study is now underway to determine if using this type of medicine can safely and effectively treat claudication.

For all research studies, there should be discussion between the patient and physician about the benefits and risks of participation. For this study, only people 40 years or older with claudication symptoms from PAD for at least 6 months may qualify to participate. Participation involves study-related medical screening and provides study medication and study-related exams at no cost. The national contact number for this study is 1-866-LEG-HURT or visit the study web site at www.leghurt.com.



Having a Vascular Malformation

Irene's Story

Irene is a 46 year old woman who had been bothered by “big veins” in her right hand since she became pregnant with her first child at age 25. At that time she showed her family doctor the enlarged vein on her little finger. He believed it to be a small abscess and opened it in his office to drain it. Unfortunately, it bled a lot and she had to be taken to the emergency room for stitches.



Irene continued to observe her hand which stayed about the same, until her third pregnancy when the veins became even larger. They now extended across the top of her hand, all around her little finger and back to the wrist. A general surgeon operated on the palm side of her hand, tying off some veins, but that didn't seem to help. She later saw a vascular specialist who recommended a dye study (arteriogram). Based on that information, Irene had the veins clotted off or embolized with a special solution. The solution caused some irritation of the veins and left a blue area on the tip of her little finger for about 2 weeks. This all cleared and the veins essentially “disappeared.”

It has now been two years since the procedure. Her “big veins” are still essentially gone. She is pleased with the appearance and with the fact her hand is not tender if she bumps it.

Comment: *Enlarged (varicose) veins appearing in an unusual location may be the result of an obstruction in the venous system but may also indicate a vascular malformation, most commonly an abnormal communication between the arteries and veins which transmits high pressure into the veins, enlarging them. In the above case, the latter was diagnosed and treated by blocking the communications (clotting them off) by injecting a special solution which destroys the lining of the communicating vessels and clots them off.*

Introducing Our New Logo

VDF has a new logo! We have changed the design to provide more flexibility when using our logo in a variety of ways, including on printed materials, our web site, on pens or similar items. Our old logo was harder to reproduce in simpler settings. We also wanted something that over time would be recognizable by itself. For example, most people recognize the Nike “swoosh” even without the name next to it. This new logo offers a more contemporary look, can be easily and less expensively reproduced and will become instantly recognizable.

We think our new logo also conveys some important symbolic significance. The blue and red colors represent veins and arteries. The large and small circles also symbolize a vein or artery. The “V” is for vascular, Vascular Disease Foundation, victory and is a checkmark for health. The white conveys health and prevention. Finally, the small red circle placed above the “V” symbolizes a person and our mission. The Foundation exists to help people learn and improve their vascular health.

We hope you also like our new image!



Renovascular Hypertension

Hypertension (high blood pressure) represents the most common reason for health care office visits in the United States. It is estimated that over 50 million Americans and over 1 billion people worldwide have hypertension. Recently, the seventh report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of Hypertension changed the definition of hypertension to <120/80 mmHg. This will increase the number of Americans who are candidates for aggressive risk factor intervention and drug treatment for newly diagnosed hypertension.

The vast majority of patients with hypertension have primary hypertension. That is, there is no underlying medical reason for hypertension—they just have high blood pressure. Approximately 10% of patients have secondary hypertension, with an underlying reason, which, if identified and treated, would cure or lower the high blood pressure. The most common causes of secondary hypertension include chronic kidney disease and medications, for example: non-steroidal anti-inflammatory drugs (ibuprofen, etc); sympathomimetics (decongestants, anti-histamines); oral contraceptives; anabolic steroids; illicit substances (cocaine); and over the counter dietary supplements (ephedra).

One important secondary cause of hypertension, which has good results from treatment, is renal artery stenosis (RAS). Stenosis means narrowing, or partial blockage of the blood vessel that carries blood to the kidney. RAS may occur in younger (commonly female) patients, due to abnormal development of the artery wall known as fibromuscular dysplasia. The cause of renovascular hypertension in older patients is usually hardening of the arteries or atherosclerosis. Atherosclerosis is the most common cause of RAS. RAS is often found in patients with vascular disease in other areas (for example: coronary, carotid, abdominal aorta, peripheral arteries). In patients with atherosclerosis elsewhere, the likelihood of finding significant RAS is anywhere between 30-50%! RAS is associated with several serious medical conditions, including increasing high blood pressure (a serious predictor of heart attack, stroke, kidney failure, and premature death), kidney failure, and recurrent heart failure.

Atherosclerosis is a progressive disorder. If unrecognized and/or untreated, RAS is also progressive, and gets worse. Over the course of two years after identification of RAS, 11% of the arteries in one medical study went on to complete blockage!

Continued on page 10

Excellence in Care

Congratulations to our new honoree!

CAROLYN ERVIN HORNE, MSN, RN, CCRN

Johnny W. Speight is honoring Carolyn Ervin Horne for the "Excellent care she gave to our family." Carolyn worked with the Speight family for two years. Carolyn is a Vascular Clinical Nurse Specialist in Greenville, North Carolina, and for many years has shown care and compassion for her patients. She has been a volunteer for the Foundation and wrote an article for *Keeping In Circulation* on smoking cessation. (Winter 2002 Vol. 2, No.1).

*To nominate a health care professional, simply send us a note or email with your tax-deductible donation stating who you are honoring and why they deserve the recognition. Checks or credit card charges of any amount are accepted. Be sure to identify the honoree's name, address and phone number so we can let them know of this honor. Also, send us your name and address so we can thank you as well! find out more by contacting the **Vascular Disease Foundation toll-free at 1-888-VDF 4INFO.***

Contact the Vascular Disease Foundation at 1-866-PADINFO or www.vdf.org

RENOVASCULAR HYPERTENSION **cont. from page 9**

RAS is associated with certain clinical clues, which if appreciated by physicians, may result in earlier diagnosis. Some of these clues include:

- Worsening blood pressure control in someone whose blood pressure had previously been well-controlled
- The need for >3 medications at maximal doses for blood pressure control
- Severe high blood pressure with a symptom (heart attack, stroke, aortic dissection—or rupture)
- Development of renal failure when taking certain medications
 - Angiotensin Converting Enzyme Inhibitors (captopril, enalapril, lisinopril, etc)
 - Angiotensin II Receptor Antagonists (losartan, candesartan, irbesartan, etc)
- High blood pressure and artery disease in the coronary, carotid, lower extremity arteries, or with an abdominal aortic aneurysm
- Major difference in kidney size from one side to the other
- Repeated episodes of sudden severe heart failure, especially if the heart squeezing function is normal
- Kidney failure without an obvious cause

There are several excellent non-invasive tests which are commonly used for the diagnosis of RAS, including ultrasound, nuclear imaging tests, magnetic resonance arteriography, and “spiral” computed tomography (CT) scanning. All have their advantages and disadvantages, yet all have high degrees of accuracy.

Treatment of RAS generally falls into three categories:

- Medical Treatment
 - Drug therapy of high blood pressure
 - Antiplatelet therapy (for example: aspirin, clopidogrel)
 - Cholesterol-lowering medications
 - Tobacco cessation

- Control of blood sugar
- Follow-up of RAS to make sure that it is not getting worse
- Open Surgery
 - Endarterectomy—the plaque, that causes renal artery stenosis is removed from the artery
 - Renal bypass—the blocked artery is replaced by a new artery using a vein from the leg or using a synthetic artery



- Endovascular Therapy
 - Balloon Angioplasty (PTRA: percutaneous transluminal renal angioplasty)—a catheter is inserted through the artery at the groin and a balloon is inflated to open up the blocked kidney artery. This technique is most effective in patients with fibromuscular dysplasia
 - Stent—a metal screen (scaffold) is placed in the artery to prevent it from collapsing. This technique is usually used in patients with hardening of the arteries.

The decision regarding which option is best is made by consulting with vascular experts, who take into consideration the level of high blood pressure; the degree of kidney function problems; the overall health of the patient; the risk of the chosen procedure; and the likelihood of improvement. Whether fixing RAS prevents progression to kidney failure is uncertain, and major clinical trials will begin shortly with the hope of answering this important question.

About the author: Michael R. Jaff, DO, FACP, FACC, is the Director of the vascular diagnostic laboratory and vascular ultrasound core laboratory at Massachusetts General Hospital in Boston. He is president of the Society for Vascular Medicine and Biology, and is a noted national speaker.



Combined Federal Campaign Information

If you're a Federal employee, or military personnel, please consider supporting the Vascular Disease Foundation through the Combined Federal Campaign (CFC). The CFC is the annual workplace fundraising drive conducted by Federal employees each fall. Designate VDF as your charity of choice by placing our official campaign number #2527 on your pledge card.

Frequently Asked Questions

Q. I was diagnosed with PAD 20 months ago. Exploratory surgery determined that bypass or a stent could not be done. I have been taking Pletal, Zocor and aspirin along with exercise and have been able to walk a little farther. Are any other medications being used to help with this disease? Will anything be available soon?

A. It's good that you are seeing some progress with your current treatment plan of medications and exercise, and that you are able to walk a little further. There are only three drugs approved by the FDA for treatment of PAD. These are Trental®, Pletal® and Plavix®. Pletal helps the pain of intermittent claudication and improves the blood flow so you can walk further. Trental was the first drug used to improve the blood flow, and is less commonly used today. Plavix is used to prevent blood from sticking together causing little clots and thus can help prevent a heart attack or stroke. Aspirin is also used to keep the blood from sticking together. There are several new medications undergoing clinical trials, but none that are likely to be approved within the next year or two. In this issue we are starting a section on clinical trials plus we will have a section on our web site this fall about current clinical trials. We will keep you posted.

Q. I am a 65 year old woman. I consistently feel a heart beat in and around my belly button. When I tell doctors this, they look at me like I'm crazy and say they don't know why I would feel a heart beat in my navel. It keeps me awake at night. Can you please tell me if this is something that I would need to see a vascular doctor for? If so, what could it possibly be?

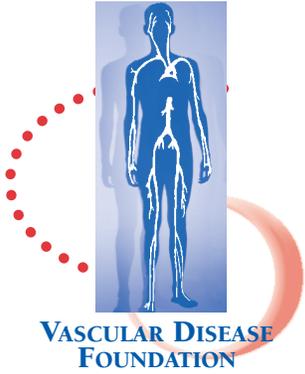
A. Thank you for contacting the Vascular Disease Foundation. We do not think you are crazy. In fact, we recommend you see your doctor soon and have them check for a possible abdominal aortic aneurysm (AAA). Others have described a similar sensation and it turned out to be an AAA. Keep in mind a few things: It can be very serious and fatal if it bursts, so you need to make sure if you do or don't have one. Typically, no intervention is done until the diameter of the AAA is 5 centimeters or so. AAA is more common in males, which is why your doctors may not have thought about it. However, it does occur in females, and especially with a family history. The test to determine if you have an AAA is an ultrasound which can be done by a vascular lab or in some doctor offices. Please refer to our web site or the Spring 2004 issue of *Keeping in Circulation* for additional information about AAA.



NEW BROCHURE

The Vascular Disease Foundation has just printed a new brochure about Blood Clots. The brochure discusses risks, signs, symptoms, diagnosis, prevention and treatment of deep vein thrombosis and pulmonary embolism. Contact us by letter, email or phone to have an individual copy sent to you. Additional copies are available for health care professionals also. We are grateful to AstraZeneca for providing an unrestricted educational grant enabling the Foundation to make these brochures available to the public.

IN THE NEWS . . . The Vascular Disease Foundation is advocating that testing for peripheral arterial disease (PAD) be more readily available. We have recently sent two letters to Medicare recommending that the ankle-brachial index (ABI) be part of the cardiovascular screening portion of a physical examination. This would help identify PAD earlier and treatment could be initiated more quickly, saving pain and death. We hope our message makes a difference!



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