

Kim Smolderen ([00:03](#)):

Welcome to the Peripheral Artery Disease Podcast titled "improving PAD lifestyle changes in your patients, balancing mind and body." This is the third podcast in a series of podcasts from the American Heart Association PAD Initiative. And this is part of the PAD National Action Plan. My name is Kim Smolderen, I'm a clinical psychologist and outcomes researcher at Yale University. And I've spent much of my career studying patients, dealing with the diagnosis of PAD. Interviewing several hundreds of patients who have shared with me their stories on what it is like to navigate PAD lifestyle changes. And how patients describe that making lifestyle changes can actually be very hard and is a true balancing act in which both mind and body deserve attention to successfully manage their PAD.

Kim Smolderen ([00:56](#)):

Today with me are, Dr. Carlos Mena-Hurtado, interventional cardiologist at Yale University and Steve Hamburger, patient expert and advocate. Speaking about how a big part of PAD management is setting yourself up for success in making those lifestyle changes that go a long way in getting symptoms under control and reduce people's cardiovascular risk. To get us started, I wanted to get this big question and perhaps counterintuitive question for an interventional cardiologist out of the way and ask Carlos. How do we prevent that patient's need leg procedures for PAD after all?

Carlos Mena-Hurtado ([01:37](#)):

Thank you, Kim, for an important question, and thank you to the American Heart Association for setting this series of podcasts that I think will help many of the patients that live in our country with this pathology. You said it right, how do you avoid these patients from getting these procedures or procedures in general? I think that the cornerstone of the management of patients with PAD is lifestyle changes together with exercise. And when I talk about lifestyle changes, I mean, being able to modify all the different risk factors that are associated with PAD. Depending upon how the patient presents, which could be either claudication, which is pain in the leg or critical limb ischemia in which there is usually severe pain associated with tissue loss. The need of revascularization would be more or less important. In those with claudication, the emphasis is in exercise. Certainly doing procedures could help, but I think that, that would be a second or a third option in terms of their management.

Carlos Mena-Hurtado ([02:41](#)):

Those with critical limb ischemia presented at more advanced stages of their disease. And at times those type of patients will need an intervention up front, but if they do, they got to be a pair with the management that I described earlier. But the major emphasis is not centered around procedures. Last but not least, as you will know from the work that we've done together here at Yale, the management of patients with PAD is not only multidisciplinary, but it needs to address all the different facets of the disease that range from diabetes, hypertension, smoking. And as you have highlighted in your research, the mental health burden associated with PAD. Many of these patients live with depression, anxiety and in many instances, because they associated symptoms including pain, substance abuse disorders. And unless you address all these different elements, you are not really going to make a significant dent in the management of these patients. Thank you, Kim, for that question.

Kim Smolderen ([03:42](#)):

So what do you say to a patient that comes with different expectations though? They might look for a quick fix, but as I hear you talk, there is no such thing like a quick fix for PAD. So how do you handle that question?

Carlos Mena-Hurtado (03:55):

Well, I think the part of the problem that we face nowadays is the fact that there is a huge heterogeneity in the way patients with PAD are being treated, not only at our institution but around the country and even the world. Patients present with different flavors and therefore their expectations are very different. Whether it's a good or a bad thing, patients with PAD are treated by multiple specialties. I think it's a good thing. But with that different background in training, it comes different recommendations. Some of them are more procedural oriented, some of them are more knowledgeable about the disease management than others.

Carlos Mena-Hurtado (04:33):

I think that whomever is taking care of these patients up front need to recognize, number one, the signs and symptoms they're bringing to the table. Number two, their expectations. I think patient reported outcomes, which you are an expert on the topic are becoming a major endpoint in the management of these patients. You need to listen and you need to understand what they want because many of these patients it's about their quality of life. So you need to understand what they're bringing to the table.

Carlos Mena-Hurtado (04:59):

Counter offer to that is what our options are, which as I described before our center and medical management, not necessarily revascularization, unless they present within the steering case. So management, the expectation is critical. But for you to be able to address that, you need to have a deep conversation with the patients. And I'm sure Steve is going to walk us through that. But only by having an honest conversation, understanding what matters to the patient and how this disease have affected their lives. We can understand what the actions are going to be.

Kim Smolderen (05:31):

Thank you. So really building that partnership with the patient and building that relationship as to what works for them in the long term disease management for PAD. So switching out to Steve, people tell me that they've had a hard time making lifestyle changes in the context of PAD, even when confronted with this diagnosis, giving up smoking, changing your diets, being more active. It is not like people don't really know that this is important for them to do. It's just finding the motivation to make new habits, changing old habits that are so rooted in our systems that they might need additional support. And so maybe Steve, can you speak to what this experience was like for you?

Steve Hamburger (06:14):

Yes. I was first diagnosed with PAD about 14 years ago. I was having a severe pain in my calves when I was walking. I probably couldn't walk more than two blocks without the experiencing pain in my calves. I had stopped smoking about 20, 25 years prior to that. But I also was a type 2 diabetic, still am a type 2 diabetic, and I also had a high blood pressure issues. So I had a number of things that could contribute to the condition, if you will. When I was first diagnosed with it, I was referred on to a vascular surgeon from my general practitioner and I had ABI test. And then another test that essentially measured the blood flow to my lower extremities. It was found that the artery in my right leg was totally occluded and mildly occluded in my left leg.

Steve Hamburger (07:19):

And my ABI scores showed that I had a severe condition. What prompted me to try to get a diagnosis was I was experiencing pain at rest, at night. And the pain at rest was the trigger. It wasn't the inability

to walk so much as I was a tennis player and still am a tennis player. But it was the pain at rest that really motivated me to try to find out what was happening. Within the context of that, the vascular surgeon recommended that we do a bypass or he do a bypass. And I asked the question of how long would that bypass last? And the answer that I got was three to five years, and that was not an acceptable answer for me. So I was lucky enough to go outside the medical group that I was in and get a second opinion from another vascular surgeon. And that vascular surgeon essentially told me that he couldn't improve my quality of life by doing the bypass. And he happened also to be a tennis player, and he suggested that I implement a walking regimen.

Kim Smolderen ([08:40](#)):

So that was the first time that you were presented with multiple options and also had a better understanding how this might work longer term?

Steve Hamburger ([08:50](#)):

Yes. And so that was when I started to implement a walking regimen and it was something that I did over time. In other words, I just didn't walk out and walk a mile. I'd start, at first I would be at two blocks and then longer and longer until, I could complete the walk and get about 6,000 steps a day.

Kim Smolderen ([09:16](#)):

Was it in a program? And did you get support? What helped you to be successful in getting through the exercise program?

Steve Hamburger ([09:24](#)):

Well, I had a lot of support from my wife who essentially told me she was not going to wheel me around in wheelchair. I also was... I had the concern with regard to everything that I was reading and the out there concern of amputation. But more importantly, I think the thing that motivated me was the pain at rest. I stopped experiencing pain at rest and the management tool for what I call a balancing act. There are a number of things that I do today to balance my PAD symptoms, if you will. But the real key indicator to me is pain at rest.

Kim Smolderen ([10:12](#)):

Right. So that was at the same time an alarm signal that you had to seek care as you told in the beginning, but it also was another symptom to monitor whenever you had to redirect your program or?

Steve Hamburger ([10:30](#)):

Whenever I get pain at rest, it's further motivator. I need to keep doing what I'm doing. And I also, am fortunate enough to different times have a personal trainer that I have a exercise regimen too, that I follow. And so I do about a half hour in a gym setting, three days a week from the days that I don't engage in tennis. So that's something that I need to be doing in support of being active, if you will.

Kim Smolderen ([11:09](#)):

So you mentioned a big part of the changes that you implemented was the exercise regimen, but in the beginning you also mentioned smoking, diabetes management. So did making one change, make it easier to make other changes in those other domains, or did you need extra support for that and how do you manage the multiple areas to watch for?

Steve Hamburger ([11:36](#)):

I called them regimens. So one of the regimens was dietary and I did meet with the dietician with regard to my diabetic condition. And over time, I've watched my diet. And I also, there's another part of the regimen, which is essentially being able to monitor your health. And today with technology, there's lots of things that you can do and support of that. So I used to monitor my type 2 diabetic situation with my A1C. Just recently that in the last year was, out of control. And so now, for example, I'm on a 24/7 have a monitor that I wear, where I'm actually able to see my glucose levels and what's spiking them and then try to alter that condition. So one of the regimens, or one of the components also was monitoring whether that be for your diabetes or whether that's taking your blood pressure randomly to ensure that your blood pressure is on track. But that is another component of the whole process.

Kim Smolderen ([12:58](#)):

Yeah. So it sounds like you are playing a really active part in managing and monitoring those risk factors. Were there any times where you had setbacks and what would you say to patients who experienced setbacks in navigating all these factors? Like what got you through?

Steve Hamburger ([13:18](#)):

I think for myself, it was knowing that I was succeeding with my exercise program and my walking regimen. And that's what motivated me to keep going. It was knowing that I was succeeding in my balancing act. And as the years went by, now, it's been 14 years. And so, I'm still doing this.

Kim Smolderen ([13:43](#)):

Yeah. So they really have formed into habits that you've been able to adopt.

Steve Hamburger ([13:49](#)):

I think that's really a good description, when I say regimens. Regimens become habits, right? And so if you can translate the regimens and they become habits, then that's just part of your lifestyle. And so you've essentially made lifestyle changes in support of managing PAD. And I believe I'm an example of a person that has been able to do that. And I also have a Facebook group that I am involved in and that we've grown. And the reason I do that is that because I believe I'm an example of what one can do with an exercise regimen and not have some form of surgical intervention.

Kim Smolderen ([14:43](#)):

Yeah, a progression of your disease. Well, thank you, Steve, for sharing all these experiences in your story. I think that's a true inspiration for other patients who are dealing with the same issues. I'm going to switch back to Carlos, I have another question for you. We, as healthcare providers working in a healthcare system, you feel like we're equipped to support patients with PAD and their chronic disease management needs. It sometimes feels like the system is working against them, especially as patients have a multitude of risk factors to oversee. And then maybe on top of that, as you alluded to maybe dealing with mental health concerns. So how do you go about, what do you have to navigate as you deal with a patient who has issues in many domains and how you come to coordination of their care?

Carlos Mena-Hurtado ([15:39](#)):

No, that's a very good point, Kim. So a couple of points to make, in the management of patient with peripheral vascular disease. Unfortunately, we are behind other specialties entities, if you will. Even

within cardiovascular medicine have done a much better job, perhaps because not only the volume of the patients are larger, but there have been clinical trials, studies, publish and major journals that have shown elegantly that these care model with coordination and multidisciplinary approach is the key to their success. In PAD, the care unfortunately, is very fragmented and is not only fragmented, but is highly variable. So that, contributes to the patient's confusion. To begin with, they have a disease state that is difficult to manage, that is associated with significant disability and negative effect in their quality of life is difficult on their families, which is another dimension that is incredibly important in the management of these patients.

Carlos Mena-Hurtado ([16:44](#)):

And many of them, unfortunately, as you and I know from this studies, again, that we've done, living in underserved areas. And when all those things come together, is a perfect recipe for disaster. So if I can use examples of programs that are doing a good job or starting to realize this, I think that the one on the Yale is a good program to elaborate on. We have a clinic where multiple specialists come together, including social work, yourself from the mental health perspective, but all the other medical specialties involved. And when a patient comes, depending upon their clinical presentation and where they are in the disease state, they are evaluated by one or other specialty at times, many of them. And all in an effort to coordinate their care and get the patient, the family, and their entire support system on board with what the needs are and what needs to happen.

Carlos Mena-Hurtado ([17:37](#)):

Medications are difficult to get refills, get them to understand them. They need [inaudible 00:17:43], they need wound care. All that stuff meets coordination. Patients cannot easily move and get to this doctor. And many of them don't have a way to transport themselves. So all that stuff is part of the care. So the traditional view that I was trained on, which basically we had someone with PAD or job was revascularize them and send them to the next provider doesn't work. If you are in the management of patients with peripheral vascular disease, you need to get them into a system that is effective in coordinating this. I think that soon we'll have studies showing that this multidisciplinary approach is highly effective and from the cost perspective is very beneficial for our health system.

Kim Smolderen ([18:29](#)):

Yeah. I think you touched upon a few very important points and that we're seeing the start of a paradigm shift as to what PAD care of the future might look like. And that is by default team based care because of the many needs and changes that need to be implemented. Steve, I'm going to give you the opportunity to share any final thoughts you might have and what providers, physicians can learn from you. How can we make patient care for PAD more patient centered?

Steve Hamburger ([19:01](#)):

I think that the vascular surgeon that's working with the patient needs to be able to coordinate with the cardiologist and the physician, the general practitioner that is working with, that's also responsible for the patient. And today with technology, with all of the tests and information available online about the patient, they can become the focal point. But I think it's also difficult that there can be other components to that medical care team. For example, my case, bringing a dietician in, or bringing someone in that can discuss their dietary care. You also want to think that we haven't even mentioned is, just balancing the medications that might be prescribed and that the patient might be taking to ensure that there aren't any contraindicators with the different medications that they may be taking.

Steve Hamburger ([20:15](#)):

Then you have this whole issue of reinforcement of their exercise program. Whether it's a walking program, supervised or unsupervised, and how bring that into play so that, there's reinforcement for that. I think in the end, the reality to me is, it's back to the patient. The patient really has to try to manage these different components, but I think part of it too, is education so that, the patient like we're discussing today, is made aware of these different components of the balancing act. And in fact that they can manage their PAD right. But I think it goes back to the patient to have the initiative, to manage the PAD with the resources that are available to them.

Steve Hamburger ([21:13](#)):

And that's, for example, one of the reasons why I think certain Facebook groups can be very helpful from both the support point of view, as well as providing links to information in one place. As well as the American Heart Association, the National Plan. If you go today to the website and you resource the information that's now available there on PAD, there is a wealth of information that will continue to grow there, that one can access.

Kim Smolderen ([21:52](#)):

Yeah. I think the important part is the action oriented approach, but also setting up the patient for success and making sure that the information is there, the support for the patient and the family and the care coordination aspect and hearing what their priorities are. Thank you, Steve, for summarizing this for us.

Steve Hamburger ([22:18](#)):

I think one other thing, Kim, too, is that I'd like to add is that one of the feedbacks that I got in the Facebook group was to be sure to mention that patients are diagnosed at all different stages of PAD. And some of the things that we talked about today in terms of the balancing act and managing, they can still apply to those different stages. It doesn't have to be in the very beginning of when you're diagnosed. It's really attributable to all the stages of PAD with perhaps, even regard to amputation. You're still going to have certain things that you're trying to do.

Kim Smolderen ([23:07](#)):

Also, as you mentioned before, the monitoring aspect, and maybe a reevaluation, shifting of priorities and continuing to oversee what is important for the patient at that time, thank you for all your insights.

Steve Hamburger ([23:24](#)):

I think the last thing I will just reinforce what you just said. You know, I think with technology today, the monitoring is going to become easier. For example, I've said casually, I monitor my steps, right. I monitor my steps every day, because I have an app on my phone that tells me how many steps I do. I mentioned that I've got, now I have a diabetic monitor that's 24/7, that tells me exactly what my sugar levels are. I think they'll come a day when your blood pressure, you'll be able to see that 24/7 rather than going through procedures to see what it is. But I think with technology, we'll be able to also better monitor our overall conditions too.

Kim Smolderen ([24:11](#)):

Very good point. Well, I want to thank our speakers, Steve and Carlos, and thank you all for listening and participating in this podcast, today. A lot of important items we discussed as it relates to lifestyle changes in PAD, reminding us that support and resources are key when navigating multiple lifestyle changes as Steve is referring to this as a balancing act. And that we really need to take a broader view and that it really needs to take care of both mind and body, motivational aspects of the family system around it and other areas in the socioeconomic environment of the patient. So this podcast is a part of the American Heart Association PAD Initiative, sponsored by Janssen Scientific Affairs and Novo Nordisk.

Kim Smolderen ([25:07](#)):

And in closing, I would like to remind people, if you don't already do this for your patients, ask them how they're doing in regards to their mental health. What support they need and offer referrals for additional support resources in the community, including referral to exercise programs and mental health support as indicated. Which can all contribute to a more holistic treatment plan for navigating and making successful changes for one's lifestyle, for PAD management. To get additional information, please also visit AHA's PAD website for more education, and a really good resource perhaps for your patient might also be the recently released AHA Life's Essential 8. I want to thank you all again, and I hope you've learned more. Thank you.