

Majority respondents (77%) were male. Rest 23% were female. Majority respondents had history of smoking (80.9%) whether majority respondent did not have history of intake of chewable tobacco (68.1%). Majority respondents had comorbidity (95.7%). Rest 4.3% did not have any comorbidity. Majority respondents (96%) did not have family history. Only 4% had family history. In another study, Park, et al. 2014 also found quite similar finding with our study. Majority respondents had claudication (70.2%) and ulceration (80.9%). Whether Rest pain was absent among majority respondent (68.1%). Majority of the respondents did not present with gangrene (87.2%). Majority respondents (83%) walking distance was

<200m. Rest of the respondents (17%) walking distance was >200m. As the study population size was small in our study the relative percentage may not depict actual scenario here.

ABI in right lower limb in majority respondents (48.9%) belonged to 0.8-0.9 group. Only 2.1% belonged to 0.4-0.59 and >1.2 group. In left lower limb majority respondents (34%) belonged to 0.8-0.9 and 0.9-1 group. Only 2.1% belonged to 0.4-0.59 and >1.2 group.

Majority respondents showed reduction of intermittent claudication (70.2%) and improvement of walking distance (68.1%). Rest pain was present among majority respondents (61.7%). (Table-2)

**Table 2. Clinical status of patient after management**

| Clinical status                 | Frequency | Percentage (%) |
|---------------------------------|-----------|----------------|
| Reduced Claudication            | 33        | 70.2           |
| Reduced Rest pain               | 18        | 38.3           |
| Ulcer healing                   | 6         | 12.8           |
| Gangrene improvement            | 0         | 0              |
| Improvement of walking distance | 32        | 68.1           |

After treatment ABI in right lower limb in majority respondents (44.7%) belonged to 0.8-0.9 group. Only 2.1% belonged to 0.4-0.59 and >1.2 group. ABI of left lower limb after management in maximum respondents (36.2%) belonged to 0.9-1 group. Only 2.1% belonged to 0.4-0.59 and >1.2 group<sup>6</sup>

### Discussion:

We found a substantial symptomatic improvement in 70.2% of patients with initially severe claudication and improved walking distance 68.1%, although hemodynamic measurements remained widely unchanged. Nevertheless, the rate of patients with worsening symptoms was low, and limb loss was not observed in this cohort of claudicants.

Our findings suggest that intermittent claudication can be considered as a lifestyle limiting condition rather than an immediate threat to limbs, confirming previous studies. Claudicants therefore may be considered for conservative treatment including risk factor modification, lifestyle modification and drug

therapy in the first instance. Revascularization can be offered as a secondary option in patients without or with insufficient improvement. Remarkably, the ABI even in patients with significant improvement of symptoms did not substantially change.

Previous studies<sup>7,8</sup> showed no major difference in the outcome of conservatively or interventional treated patients, (assessed by maximum walking distance and quality of life after a period of 2 years), where restenosis was the major limitation of angioplasty. Yet, given the advanced age and the relatively high short-term mortality of patients with intermittent claudication,<sup>9,10</sup> symptomatic improvement even for only one or two years may justify interventional treatment in patients suffering from severe life-style limitations.

Other studies,<sup>11,12</sup> suggest that claudicants who initially report only a small deterioration in quality of life have only a modest gain in quality of life by invasive therapy. Nevertheless, if severe symptoms