What do people with intermittent claudication believe about walking exercise?

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Intermittent Claudication

- Ischemic leg pain due to peripheral arterial disease
- Affects 9% of UK population
- Increased CV morbidity and mortality
- Reduced walking ability
Current Guidelines

- Type: Supervised treadmill walking
- Frequency: 3 days / week
- Duration: 30 – 50 minutes
- Intensity: achieving moderate leg pain before stopping ("walking through pain")

(Norgren et al., 2007)

- 180% gain in walking ability post-exercise
- Greater improvements vs usual care
- Better long-term outcome vs angioplasty

(Watson et al., 2008; Murphy et al., 2009)
Self-Management of IC

In practice: ~24% of vascular specialists have access to supervised programmes, most patients receive simple walking advice from a healthcare professional (Makris et al., 2013)

- Call for research to explore attitudes and beliefs of people with IC (NICE, 2012)
- Treatment and illness beliefs impact health-behaviours related to self-management (French et al., 2013)
Methods

- Patients with IC recruited from vascular surgery outpatient clinics
- Purposive sampling for sex, age and duration of symptoms
- Brief questionnaire assessment
- In-depth semi-structured interviews
- Framework analysis (Ritchie & Spencer, 1994)
Sample Characteristics

19 Participants (6 female)
Mean age 66 years (range 44 – 79)
53% Reported symptoms >2 years
Explanatory Themes

Purposeful walking exercise is challenging
1. Desire for clearer instructions
2. Barriers to achieving walking intensity
3. Varied outcome expectations of walking

Walking is an overlooked self-management opportunity
4. IC is benign, and leg pain can be overcome
5. IC is severe, and there is nothing I can do
1. Desire for clearer instructions

- Lack of awareness of walking guidelines
- Tailored walking prescriptions desired
- Resulting concern regarding optimal walking regimen

“If a doctor says to me, you know, ‘look, you should do 2 hours, 3 hours a day,’ I would do it. But I don’t know you see.”

(participant 005A, male, 62 years)
2. Barriers to achieving walking intensity

- Difficulty achieving moderate to vigorous intensity exercise
- Varied interpretations of “walking through pain”

“Everyone seems to be keen on the medical side of telling you to walk through it, and I thought, why? ...Very occasionally, you go for a fairly long walk, you just keep going through the agony, and then it does ease off.”

(Patient 007A, male, 69 years)
3. Varied outcome expectations of walking

- Benefits for general health versus for IC
- Linked to changes in vasculature
- Superior to other modes of exercise
- Beliefs not linked to reported behaviour

“I think walking helps generally. Whether it could specifically help my condition now, I don’t know. But I think that if you can walk and the more you walk you’re better all around”  (participant 002A, female, 79 years).
Walking is an overlooked self-management opportunity

4. IC is benign and can be overcome

- Low impact of IC
- Low perceived necessity of treatment
- Participants ‘just get on with it’

“Ninety percent of the time, I don’t even think of it because I’m not doing something that makes it hurt. But ten percent of the time, when I would like to be doing something, I hate it.” (010A, male, 64 years)
5. IC is severe and there is nothing I can do

- High impact of IC
- Emotional response
- Sense of low control over IC
- Revascularisation is only hope

“I just get so frustrated, I cancelled plans. I was going to Germany to look at castles... I was going to go down the Rhine. But where’s the castle? Oh, it’s on top of the hill. And that means walking up hill, and that’s a no-no.”

(003A, male, 52 years)
Key Findings

• Walking is not perceived as treatment and is overlooked as self-management

• Healthcare professionals need to facilitate patient understanding and uptake of walking for IC

• Physiotherapists should provide detailed walking prescriptions
  – Based on guidelines, optimal walking intensity
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References

• Murphy et al.
• Norgren et al. *Eur J Vasc Endovasc Surg.* 2007;33 Suppl 1:S1-75.