

REVIEW

The Effect of Structured Patient Education on Physical Activity in Patients with Peripheral Arterial Disease and Intermittent Claudication: A Systematic Review

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WHAT THIS PAPER ADDS

This article describes the first comprehensive systematic review of patient education interventions for physical activity (PA) improvement for individuals with intermittent claudication (IC). The current evidence is inconclusive regarding the effect of patients' education on PA of individuals with IC. Further research is warranted to establish the effects and optimal design of education interventions.

Objectives: The aim was review the components and effects of patient education interventions to improve physical activity (PA) in patients with peripheral arterial disease (PAD) and intermittent claudication (IC), and patients' experiences of these interventions.

Data sources: CINAHL, Cochrane Library, Ovid, ProQuest, AMED, MEDLINE, PsycINFO, Web of Science Core Collection, and PEDRO, and Trial registers and directory of Open Access repository websites and Web of science conference proceedings were searched. Hand searching of reference lists of identified studies was also performed to identify studies that reported the effect of patient education interventions on daily PA and/or walking capacity in individuals with PAD and IC, or studies investigating patients' experiences of such interventions.

Methods: A systematic search was conducted in June 2016 (updated in March 2017). Primary outcomes were daily step count and self reported PA; the secondary outcome was absolute claudication distance. There was substantial heterogeneity in terms of modalities of patient education in the included studies; hence a narrative synthesis was implemented.

Results: Six studies (1087 participants) were included in the review. Findings from a small number of high quality trials demonstrated potential for PA improvement with structured education interventions. Nevertheless, evidence is currently inconclusive regarding the effect on daily PA and walking capacity of patients with IC. Patients reported that they valued the interventions studied, finding them acceptable and important in improving their PA, motivating and empowering them to self manage their condition.

Conclusions: The evidence from the review is limited and inconclusive regarding the effectiveness of structured education for increasing PA in patients with PAD and IC. More rigorous trials are needed before recommendations can be made. Future interventions should consider the key criteria for a structured patient education programme, and also report patients' experiences and perceptions.

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INTRODUCTION

Peripheral arterial disease (PAD) is a growing public health burden. PAD leads to arterial stenosis and consequently inadequate blood flow to the peripheries.^{1,2} This commonly presents as pain in the lower limb(s) precipitated by exercise and relieved by rest,³ defined as intermittent claudication (IC). Patients with IC experience functional decline and limitation in physical activity (PA),⁴ further raising the risk of a cardiovascular event in a vascular system already

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compromised by the underlying atherosclerosis.^{1,3} Therefore, patients with PAD present with an increased risk of cardiovascular and cerebrovascular events similar to those with coronary heart disease.⁵

Lower daily PA levels have been recognised as a strong predictor of increased morbidity and mortality in this population.⁶ Supervised exercise programmes (SEPs) are recommended as a primary therapy for this population,⁷ and have been shown to improve the treadmill walking distances of patients with IC.^{8,9} However, most studies reporting such improvements did not investigate daily PA, and those that have did not find improvements in daily PA.⁹ Reduced self efficacy, attributed to poor understanding of the disease and uncertainty regarding the importance of walking has been identified as a major barrier to exercise uptake in this population.^{10,11} These findings suggest that a patient centred self management approach to improving PA, including structured patient education, may be beneficial in this population.

Although the current literature supports educating patients with IC about their disease pathology and the importance of walking,^{10,11} neither evidence of effectiveness nor patients' perceptions of interventions have been established. The aim of this review was to examine the effect of patient education on improving PA in individuals with PAD and IC and the experiences and perceptions of patients of these interventions.

METHODS

The protocol for this review was registered with the International Prospective Register of Systematic Reviews (CRD42015027314) and has been published elsewhere.¹²

Eligibility criteria

Studies reporting the effect of patient education interventions on daily PA and/or walking capacity in individuals with PAD and IC, or studies investigating patients' experiences of such interventions were included in this review. Diagnosis of PAD could be objective (e.g., an ankle brachial index (ABI) < 0.9), by questionnaire, or clinical diagnosis. Original English language research manuscripts in peer review journals and conference proceedings were included. Studies were included only if they reported on structured patient education interventions and/or components particularly related to PAD and IC. For the purposes of this review, the key criteria used to define structured education in diabetes were adopted.¹³ To be included, a patient education intervention should (a) aim to empower and inform patients, and to support self management of their PAD/IC by building sufficient knowledge and skills to do so; (b) include topics about the nature of PAD/IC, and day to day living and management of PAD/IC including the importance of physical activity and walking; (c) have embedded quality assurance processes including having a structured curriculum, having trained educators, being quality assured, and being audited.

Outcomes

Daily PA (daily step count and self reported change in daily PA) was the primary outcome. Secondary outcomes included treadmill -measured walking capacity (absolute claudication distance [ACD]), pain intensity, quality of life (QoL), and qualitative data regarding patients' experiences with interventions.

Information sources, search strategy, study records, and data management

A systematic search was conducted in June 2016 (updated in March 2017). Nine databases (CINAHL, Cochrane Library, Ovid, ProQuest, AMED, MEDLINE, PsycINFO, Web of Science Core Collection, and PEDRO), trial registers, and directory of Open Access repository websites were searched by the first author (U.O.A.) using key words: patient education, lifestyle education, behaviour change intervention, peripheral arterial disease, intermittent claudication, physical activity, and home based exercise combined with specific search terms and strategies for each database.¹² Reference lists of identified studies were also searched. Titles, abstracts, and the full text of selected studies were independently screened by two authors from a pool of three (U.O.A., C.A.S., P.M.D.) using previously defined eligibility criteria.¹² Differences of opinion regarding inclusion or exclusion were resolved by discussion between authors and reflection in consultation with the second author (P.M.D.).

Data collection processes

The Cochrane Consumers and Communication Review Group Data Extraction Template¹⁴ and the Supplementary Guidance for Inclusion of Qualitative Research¹⁵ were adapted to extract data from the included studies. The Cochrane Collaboration risk of bias tool was used to determine and summarise the risk of the included studies.¹⁶ Assessment was made in each of the included studies and graded as "high risk" or "low risk" following a well described procedure.¹⁷ Studies were subsequently rated as low quality trials (i.e., having high risk of bias) or high quality trials (i.e., having low to moderate risk of bias) if there were three or more, or fewer than three identifiable sources of bias respectively (see Table 2). Two reviewers (U.O.A., C.S.) performed the data extraction and made judgements regarding the risk of bias independent of each other. Again any disagreement was resolved by discussion between the reviewers and consultation with the second author (P.D.).

RESULTS

Study inclusion

The search initially identified 5707 studies (Fig. 1), of which six studies contributing data on 1087 participants were included in the final analysis. Meta-analysis was not possible due to wide variations in interventions and substantial methodological and clinical heterogeneity in the included studies. The results of this review are reported using narrative synthesis.

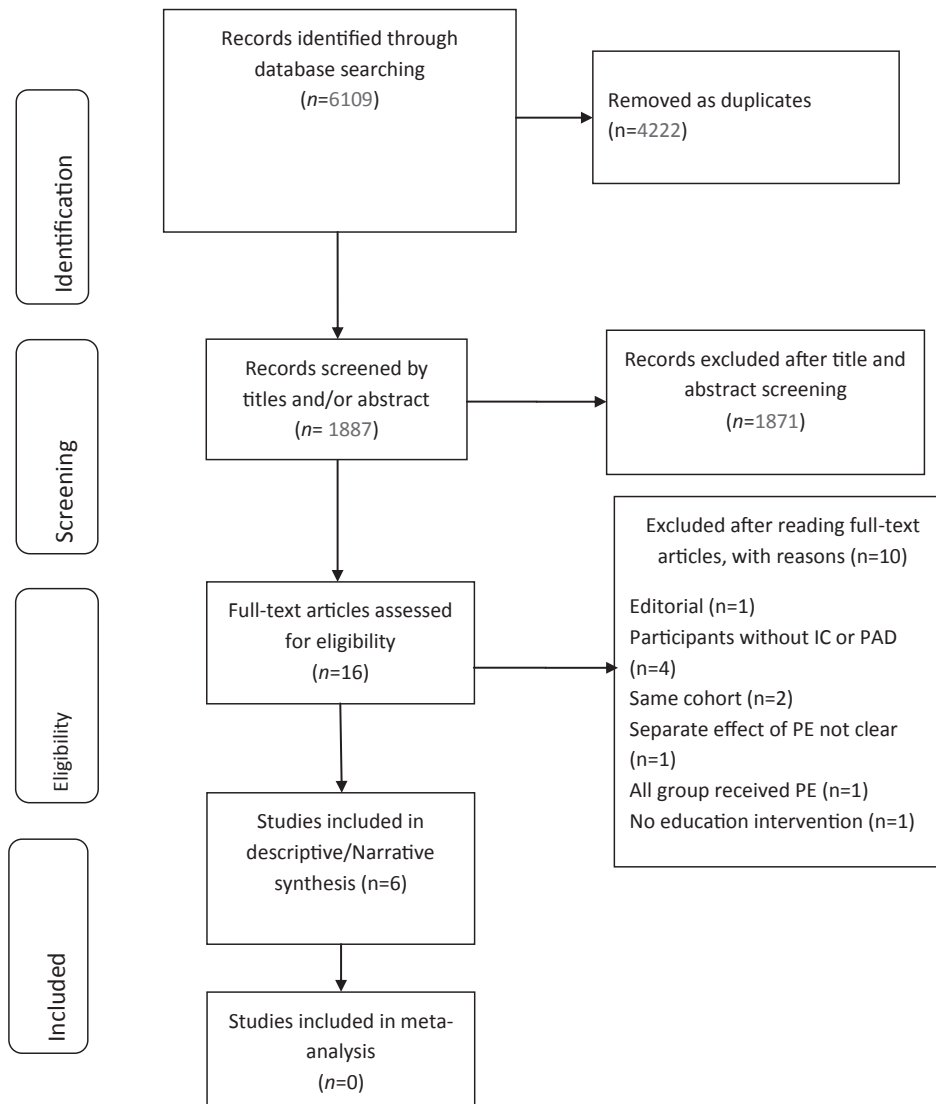


Figure 1. Patient education review PRISMA flow diagram.

Characteristics of included studies

Study design, participants, and quality appraisal. Five of the included studies were randomised controlled trials (RCTs),^{18–22} and one was a pre-test–post-test design.²³ The number of participants in each study ranged from 23¹⁹ to 882.²⁰ The basis for IC diagnosis in most ($n = 4$) studies was post-exercise ABI ≤ 0.9 .^{18,20,22,23} The clinical characteristics between the intervention and control groups were similar at baseline for all included studies, except for one²² where the control group had a higher resting heart rate and weight (Table 1). Overall, four of the six trials were rated as high quality^{18–20,22} (Table 2). No study was assessed to have a risk of bias related to selective reporting. Sources of bias in the included studies included lack of blinding of outcome assessment ($n = 5$),^{18–21} lack of allocation concealment ($n = 3$),^{18,19,23} lack of participants and/or personnel blinding ($n = 3$),^{21–23} and not being powered to detect an effect size ($n = 4$) (see Table 3).^{18,19,21,22}

Components of interventions in included studies

The included studies had wide variation in the intervention components used, but all included an education session, exercise prescription, and some behavioural change techniques (BCTs) (Table 1). Information provision, goal setting, action planning, and feedback were reported in all included studies. Other reported BCTs included motivational interviewing ($n = 3$), barrier identification/problem solving ($n = 5$), feedback on performance ($n = 2$), and prompting self monitoring of behavioural outcome ($n = 4$). Intervention duration ranged from 6 weeks¹⁹ to 4 months.¹⁸ Most studies ($n = 4$) instructed patients to walk through moderate to severe leg pain. Control participants either received usual care,^{18,19,22} an active control (7 minute video)²¹ or no intervention.²⁰ One study did not include a control group.²³

Outcomes reported in included studies. Five studies^{18–20,22,23} reported walking capacity outcomes, and four^{18–21} reported outcomes of daily PA. Walking capacity

Table 1. Characteristics of included studies.

| Study (country), design, quality, attrition | Participants | Descriptions of Interventions | Outcomes, follow-up | Conclusion |
|---|--|--|--|--|
| Cunningham et al. ¹⁸ (UK) RCT High quality 3% | Total $n = 58$, IC in at least one leg Post-exercise ABI < 0.7 | Intervention: Usual care + Information on PAD and walking, motivational interviewing, PA goal setting, action planning, self monitoring and feedback, barrier identification with problem solving. Delivered at patients' homes by via a trainee health psychologist 2×1 h sessions Control: Usual care (walking advice + consultation with vascular surgeon) | Daily steps (pedometer) Walking ability (patient report) ICQ (disease specific quality of life) Medical Outcome Study Short-Form (generic health related quality of life) Outcomes assessed at baseline and 4 months | Brief psychological intervention significantly improved walking behaviour in patients with IC in comparison with usual care |
| Tew et al. ¹⁹ (UK) Pilot RCT High quality 4.35% | Total $n = 23$ Stable Rutherford IC Classification 1–3 for ≥ 3 months | Intervention: Usual care plus one off 3 h session of group patient centred structured education including patient story, PAD/IC and walking information provision, PA feedback, barrier identification with problem solving, goal setting, action planning, and self monitoring. Delivered at in clinical research facility followed by twice-weekly phone calls for 6 weeks. Control: Usual care | Daily step (accelerometer) ICD, 6 minute walk test WELCH questionnaire ICQ (disease specific quality of life) EQ-5D (generic health related quality of life) Self efficacy Acceptability (exit interview) Outcomes assessed at baseline and 6 weeks | Education programme is feasible, acceptable, and potentially useful for improving walking capacity and quality of life |
| Fowler et al. ²⁰ (Australia) RCT High quality 15% | Total $n = 882$ ABI ≤ 0.9 Clinical diagnosis of PAD Definite IC or atypical IC on Edinburgh Claudication Questionnaire | Intervention: Educational package + mobility program (supervised or home based) + smoking cessation where applicable Control: No intervention | ICD PA pattern (Patient report) Medical Outcome Study Short-Form (generic health related quality of life) Outcomes assessed at baseline, 2 months, and 12 months | Intervention for early PAD based on increased PA and smoking cessation results in a greater max walking distance 12 months later |
| Collins et al. ²¹ (USA) Pilot RCT Low quality 13.7% | Total $n = 51$, Diagnosis of PAD ABI > 0.5 and ≤ 0.955 . | Intervention: Communication intervention beginning with completion of guide and followed by 15–20 minute of motivational interviewing, provision of information related to PAD/IC and walking, barrier identification and problem solving strategies, patient tailored walking prescription. Delivered by medical student Control: Video Intervention | PA pattern and time (patients report) ICD and ACD WIQ Outcomes assessed at baseline, and 12 weeks | Patients watching video on the use of PA in PAD improved participants walking speed |

Continued

Table 1-continued

| Study (country), design, quality, attrition | Participants | Descriptions of Interventions | Outcomes, follow-up | Conclusion |
|--|---|---|---|--|
| Prevost et al. ²³ (France) Pre-test–post-test design Low quality 4.17% | Total $n = 48$ Level II Leriche and Fontaine IC Atypical symptom ABI < 0.9 | Intervention: Educational classes, implementation of secondary prevention, and a personalised program of reconditioning exercises Control: No intervention | ICD and ACD Medical Outcome Study Short-Form (generic health related quality of life) Pain intensity Patients experiences via exit questionnaire (12 months only) Outcomes assessed at baseline, 3 months and 12 months | Educational therapeutic program results in a significant improvement in functional and QoL parameters during the first 3 months in patients with IC and persists even patients are no longer coached |
| Mays et al. ²² (USA) Pilot RCT High quality 20% | Total $n = 25$ Patients without walking limiting comorbidities except IC Severe cardiac ischaemia ≤ 3 months previous myocardia infarction TIA or stroke < 1 month treatment with cilostazol or pentoxifylline Endovascular therapy 4–6 weeks prior baseline or stable IC without revascularisation in the last 4–6 weeks (ABI ≤ 0.9) | Intervention: Initial in hospital walking exercise (2 weeks, 3 days/week) followed by community based walking exercise (12 weeks) with training, monitoring and coaching (TMC) components. Control: Usual care (standard advice to walk) | ICD and ACD WIQ Medical Outcome Study Short-Form (generic health related quality of life) Outcomes assessed at baseline and 14 weeks | Community based walking exercise with TMC improves ICD and walking performances other than ACD |

ACD = absolute claudication distance; ABI = ankle brachial index; EQ-5D = EuroQoL EQ-5D-5L; IC = intermittent claudication; ICD = initial claudication distance; ICQ = intermittent claudication questionnaire; NS = not significant; PA = physical activity; RCT; randomised control trial; WIQ = walking impairment questionnaire; WELCH = Walking Estimated Limitation Calculated by History questionnaire.

Table 2. Risk of bias in individual studies.

| Authors | Selection bias Random sequence generation | Allocation concealment | Performance bias Participants and personnel blinding | Detection bias Blinding of outcome assessments | Bias due to attrition Incomplete outcome data | Reporting bias Selective reporting | Other bias | Summary of risk of bias | Quality index ^b |
|---------------------------------|--|------------------------|---|---|--|---------------------------------------|-----------------------|-------------------------|----------------------------|
| Cunningham et al. ¹⁸ | No | Yes | No | Yes | No | No | Trial was not powered | Low | High |
| Tew et al. ¹⁹ | No | No | No | No | Yes | No | Pilot study | Low | High |
| Fowler et al. ²⁰ | No | No | No | Yes | No | No | NA | Low | High |
| Collins et al. ²¹ | No | Yes | Yes | Yes | No | No | Pilot study | High | Low |
| Prevost et al. ²³ | Yes | Yes | Yes | Yes | No | No | NA | High | Low |
| Mays et al. ²² | No | No | Yes | Yes | No | No | Pilot study | Low | High |

The Cochrane Collaboration tool for assessing risk of bias was used to determine and summarise possible sources of risk of bias in included studies (Cochrane 2011) (yes indicates the presence or potential presence of a source of bias).

^a Summary risk of bias in included studies was presented.

^b Studies were subsequently rated as low quality trials (i.e. having high risk of bias) or high quality trials (i.e., having low to moderate risk of bias) if there was ≥ 3 or < 3 identifiable sources of bias respectively.

outcomes included treadmill walking distances and time, 6 minute walking distance, WELCH score, walking impairment questionnaire speed, distance, and stair climbing scores. Daily PA was assessed objectively in two studies: daily step counts using a pedometer¹⁸ and accelerometer.¹⁹ Three studies^{18,19,23} reported outcomes on patients' experiences to interventions. Other outcomes reported included pain intensity,²³ self efficacy and self esteem,¹⁹ and QoL.^{19,20,22,23}

Effect of interventions in included studies

Except where specified otherwise, the effects of intervention are reported as comparison of the intervention versus the control.

Daily physical activity outcomes

Self report daily physical activity outcome. Two studies provided data on self report of daily PA.^{20,21} A high quality trial²⁰ showed no difference between the percentage of participants who engaged in walking for recreation three or more times per week (36.8 vs. 31.4%; $p = .14$), engaged in more than usual activity (10.2 vs. 9.0%; $p = 0.73$), or belonged to an exercise group (14.0 vs. 10.1%) at 2 months. However, after 12 months follow-up, a greater percentage were walking three or more times per week (33.8 vs. 25.0%; $p = 0.01$), engaged in more activity than usual (11.1 vs. 5.9%; $p = 0.03$), or belonged to an exercise group (16.5 vs. 1.8%; $p < .001$). The other trial was of low quality²¹ and reported no change in time spent in various levels of activity.

Objectively measured daily physical activity outcome. Data on daily step counts were available from two high quality trials.^{18,19} At 4 months, Cunningham et al.¹⁸ reported a greater increase in daily step count (1575; 95% CI 732–2419; $p < .001$). In contrast, Tew et al.,¹⁹ did not find improvement in daily step count of their patients after a 6 week intervention (440; 95% CI –827 to 1708; $p > .05$).

Walking capacity. Five studies^{18–20,22,23} reported outcomes on walking capacity. One pre-test–post-test study²³ reported significant improvement in ACD: increases of 63% at 3 months, and 84% at 6 months compared with baseline. Similarly, one high quality pilot RCT¹⁹ reported a significant increase in ACD at 6 weeks (173; 95% CI 23–332) Another high quality trial²⁰ found no change in the number of people whose ACD improved, remained the same, or deteriorated at the 2 month follow-up. However, a significantly greater number of patients were found to have improved their maximum walking distance ($p = 0.003$) at 12 months.

Quality of life and other outcomes. Five trials^{18–20,22,23} reported outcomes related to QoL. Generally, outcomes of both general and disease specific QoL were mixed. One high quality trial showed improvement in SF-36 (0.40 vs. –0.30; $p = 0.002$) but no change in intermittent claudication questionnaire (ICQ) score ($p > .05$) at 4 months.¹⁸ In contrast, another high quality pilot trial¹⁹ reported

Table 3. Data extraction of finding from included studies (except where specified, results are presented as intervention group compared with control group).

| Authors | Change in daily PA behaviour | PA capacity/ability measures | Pain, self efficacy, and perceived control over illness | Quality of life |
|---------------------------------|---|--|--|---|
| Mays et al. ²² | | At 14 weeks: Pain free walking time ($p = NS$); Greater increase in claudication onset time (5.8 ± 1.5 min to 7.4 ± 1.6 min vs. 4.7 ± 1.4 min $\rightarrow 4.1 \pm 1.5$ min; $p = 0.045$); Greater improvement in walking impairment (42.3 ± 7.7 min $\rightarrow 60.6 \pm 7.2\%$ vs. $49.1 \pm 7.7 \rightarrow 44.6 \pm 7.2\%$; $p = 0.001$) | | At 14 weeks: General QoL ($p = NS$) |
| Prevost et al. ²³ | | Significant % increase in ICD from baseline (277% at 3 months, 203% @ 6 months, 141% @ 12 months; $p < 0.001$) Significant % increase in ACD from baseline (63% @ 3 months; 84% @ 6 months; 65% @ 12 months; $p < 0.01$) | Decrease in pain intensity at 3, 6, 12 months from baseline ($5.89 \rightarrow 4.73^a \rightarrow 4.34^{**} \rightarrow 4.53^a$) Improved from baseline in time of release of pain at 6 months, and 12months ($3.95 \rightarrow 2.01^{**} \rightarrow 2.83^{**}$) | Improvement from baseline in physical composite score of SF-36 at 3, 6, and 12 months ($36.0 \rightarrow 40.8 \rightarrow 41.9 \rightarrow 42.9$; $p < 0.01$) Improvement from baseline in the mental composite of SF-36 at 3 and 6 months ($41.6 \rightarrow 45.5 \rightarrow 44.7 \rightarrow 44.2$; $p < 0.05$) |
| Cunningham et al. ¹⁸ | At 4 months: Greater increase in daily steps (1358 vs. -227 ; $p < 0.001$) | At 4 months: Greater pain free walking distance ^a (1.00 vs. 0.00; $p = 0.008$) | | At 4 months: Improvement in general QoL (0.40 vs. -0.30 ; $p = 0.002$) Disease specific QoL ($p = NS$) |
| Tew et al., 2015 ¹⁹ | At 6 weeks: Daily steps ($p = NS$) | At 6 weeks: Improvement in Six minute walk distance (44.9; CI 6.9 to 82.9); Greater increase in ACD (173; CI 23 to 322); ICD $p = NS$ Greater improvement in self reported walking ability WELCH score (21.8; CI 8.6 to 35.0); WIQ Speed (21.0; CI 3.8 to 38.1), WIQ distance (30.7; CI 6.4 to 55.0), WIQ stair climbing (30.7; CI 6.4 to 55.0) | At 6 weeks: Improvement in walking performance efficacy (29.5; CI 12.6 to 46.4) Greater improvement in perceive control over illness (2.4; CI 0.0 to 4.7) | At 6 weeks: Greater improvement in disease specific QoL (-10.6 ; CI -18.9 to -2.3) General QoL ($p = NS$) |

At 2 months: HQoL(NS)
At 12th month
HQoL(NS)

At 2 months: Self report maximum walking distance before the onset of pain ($p = NS$)
At 12th month: Improvement in self report maximum walking distance before the onset of pain ($p = 0.04$)

At 2 months: % of patients walking for recreation ≥ 3 /week ($p = NS$); % of patients engaging in vigorous PA ($p = NS$); % of patient belonging to exercise group ($p = NS$)
At 12th month: Greater % of patient walking for recreation ≥ 3 /week (33.8 vs. 25; $p = 0.01$); % of patients engaging in vigorous PA ($p = NS$); Greater % of belonging to exercise group (16.5 vs. 1.8, $p < 0.001$)

Collins et al. 2009²¹
At 12 weeks: Activity patterns in various levels of physical activity ($p = NS$)

Δ = change; ACD = absolute claudication distance; Cont = control; COT = claudication onset time; FCD = functional claudication distance; grp = group; HQoL = health related quality of life; ICD = initial claudication distance; Int = intervention; MWD = maximum walking distance; NS = not significant; PA = physical activity; PWD = peak walking distance; QoL = quality of life; WIQ = walking impairment questionnaire.

** $p < 0.01$

^a Results adjusted for confounding variables.

improvement in ICQ (-10.6 ; 95% CI -18.9 to -2.3) but not general QoL (EQ-5D utility score 0.05; 95% CI -0.09 to 0.19). Two high quality trials reported no change in health related QoL at 2 months (0.83 vs. 0.85; $p = 0.33$), and at the 12 month follow-up (0.83 vs. 0.84; $p = 0.13$),²⁰ or in general QoL at 14 weeks.²² A low quality trial, however, reported post-intervention improvement in the physical component of the SF-36 score at both 3 month (40.8 vs. 36.0; $p < .01$) and 12 month follow-up (42.3 vs. 36.0; $p < .01$) compared with baseline.²³ For this trial, there was also an improvement in the mental composite score at 3 months (45.2 vs. 41.6; $p < .05$) but not at 12 months (44.2 vs. 41.6; $p > .05$).

A high quality trial reported an improved walking performance self efficacy (mean adjusted difference 29.5; 95% CI 12.6–46.4) and perceived control over illness (mean adjusted difference 2.4 95% CI 0.0–4.7).¹⁹ A low quality trial²³ reported a decrease in pain intensity at 3 months compared with baseline (5.89 vs. 4.73, $p < .05$), which remained stable during the following 9 months (5.89 vs. 4.53; $p < .05$). Also, the time taken for claudication pain to disappear improved 6 months from the baseline (3.95 vs. 2.01; $p < .05$), and remained stable for the following 6 months (3.95 vs. 2.83; $p < .05$).

Patient experiences with interventions. Three studies^{18,19,23} reported qualitative findings related to the experiences of patients with education interventions. Sixteen qualitative findings were extracted from the papers and grouped into eight categories. These categories were then merged to create three synthesised themes: acquiring knowledge; receiving pragmatic and tailored care; and gaining confidence and self monitoring (Tables 4 and 5). Although verbatim quotes were not available from the included papers, each synthesised theme is described below, with some examples that reflect the patients' experiences as reported in the included papers.

Acquiring knowledge. Acquiring knowledge entails patients being provided information about their pathology and the systemic nature of IC, being informed of the importance of secondary prevention, and risk factor modification including the importance of PA. Tew et al.¹⁹ reported that patients valued a 6 week programme of pragmatic group based structured patient education because it provided them with greater understanding of their condition, and empowered them to walk more.

Receiving pragmatic and tailored care. Patients valued the idea of a group based intervention that also gave the opportunity for individual attention. Prévost et al.²³ reported that 97% of the participants were satisfied with the quality, duration, topics discussed, and the group nature of the session. Similarly, 95% reported that they were satisfied with the scope, quality, and benefit of individual discussion.

Gaining confidence and self monitoring. Gaining confidence encompassed developing a positive self attitude, overcoming uncertainties, and feeling empowered; for example gaining confidence to self monitor their daily step counts with a pedometer: patients were presented with the opportunity to self monitor their progress and they

Table 4. Category Label and description of patients' experiences with intervention.

| Category label | Category description |
|-------------------------------------|---|
| Receiving information about disease | Participants valued participation in the intervention because it provided them with greater understanding of their condition (T); Patient valued intervention because it provided them with extra information about their illness(C). 97% were very satisfied with the topic discussed (P) |
| Receiving information about walking | Patients reported that they valued the intervention because it provided them with understanding of the importance of walking(C); Patients reported that they valued the intervention because it provided them with understanding of how walking will help(C); Patient said intervention were worthwhile and that they valued it because it provided them with extra information about walking (C) |
| Being motivation and empowered | Patients reported being satisfied with their improvement in attitude towards walking with their claudication and their physical self confidence (P); Patients reported being satisfied with their improvement in their physical self confidence (P); Participants valued participation because it enabled them to walk more (T); Patients said they valued intervention because it provided them with extra encouragement and motivation(C) |
| Benefit of group education session | 97% reported that they were very satisfied with the benefit of group education session (P) |
| Self monitoring | The use of pedometer was valued as it was seen as useful tool for self monitoring (T) |
| Goal setting | Patient reported that intervention were worthwhile because it provided them clarity on what to do (C); |
| Pedometer as useful tool | Patients valued the pedometer and seen as a valuable tool for motivation, self monitoring, and goal setting (T) |
| Receiving personalised care | 95.5% reported very satisfied with the scope, quality, and benefit of individual discussion (P); patients valued the intervention because it provided personalised plan(C) |

T = Tew et al.¹⁹; C = Cunningham et al.¹⁸; P = Prevost et al.²³

Table 5. Developing synthesis findings from the categories.

| Synthesised finding | Category |
|--|--|
| Acquiring knowledge | Receiving information about disease; receiving information about for walking; goal setting; pedometer as useful tool |
| Pragmatic and tailored care | Benefit of group education session; receiving personalised care |
| Gaining confidence and self monitoring | Being motivation and empowered; pedometer as useful tool; self monitoring; pedometer as useful tool |

considered this an important component for meeting their physical activity goal. Prévost et al.²³ reported that their participants were very satisfied with the improvement in their attitude towards walking with claudication and their physical self confidence and valued the use of a pedometer as a tool for motivation, self monitoring, and goal setting.

DISCUSSION

Six trials evaluating a range of patient education interventions for improving PA in patients with PAD and IC were reviewed. The included studies were mostly of high methodological quality. The major sources of risks of bias were lack of blinding of outcome assessment, performance bias, and lack of allocation concealment. The combined evidence from four studies indicated that structured patient education intervention increased the maximum walking capacity^{19,23} and improved daily PA,^{18,20} however, a similar number of studies demonstrated no change in the

maximum walking capacity^{20,22} and free living PA.^{19,20} Generally, although the daily step count tended to improve only after longer periods of follow-up (4 months upwards), there was no such trend for the outcomes related to maximum walking distance. Evidence from five trials^{18–20,22,23} showed marked variability regarding QoL measures. Useful interventions from the patients' perspective included those that provided them with information about their condition, were designed to enhance group interaction while maintaining individual discussion, and provided them with confidence and self monitoring.

Related reviews have been conducted on behaviour change techniques²⁴ and home based exercise programmes²⁵ for PA improvement in this population. Galea et al.²⁴ reported limited evidence from one high quality RCT to support BCTs for improving maximum and pain free walking capacities, and for increasing daily PA among people with IC. Similarly, Al-Jundi et al.²⁵ reported that there is "low level" evidence that home based exercise programmes can improve walking capacity and QoL in patients with IC. However, the reviews were limited to RCTs of BCT,²⁴ or primarily reported outcomes related to walking capacity rather than daily PA.^{24,25} No review has considered the qualitative experiences of patients with these interventions. Further, although these reviews include studies with patient education modalities, study eligibility did not specifically consider the key criteria for a structured patient education.¹³

Possible explanations for the contrasting findings in the current review may be related to the heterogeneity of study design. One of the studies²³ employed a pre-test—post-test design and therefore lacked a control group, and had high

risk of bias including selection, detection, and performance bias. In another trial,²¹ it was difficult to completely rule out possible contamination of the control group as both groups received some form of patient education. One study²² included patients who underwent vascular intervention in the weeks prior to the intervention and one patient who did not report claudication pain during treadmill testing. Furthermore, the large variations in patient education modalities and components warranted different contact time, duration of intervention, time point of outcome assessment, and intervention components, possibly resulting in wider outcome variability.

The high quality pilot trial by Tew et al.,¹⁹ which applied a 6 week structured education intervention, demonstrated potential for increasing PA early in the programme, and was particularly rigorous with blinded outcome assessment, demonstrating improvement in walking capacity at 6 weeks. Although no change in daily step count was observed, it is possible that the effect of behaviour change interventions takes longer to be noticeable. There could be other factors that mediate a slow response to adapting PA change in patients with PAD and IC, even when the disease pathology is understood. One possible barrier is the claudication pain which these patients experience even when they are motivated to walk. Current NICE guidelines recommend “encouraging claudicants to exercise to the point of maximum pain.”⁷ Perhaps for patients with IC to gain the benefit of secondary prevention, concomitant pain management may be desirable to delay the onset and reduce the intensity of pain. By delaying peak maximum pain and empowering patients through education, the potential therapeutic value of walking could not only be realised early in the programme, but may be sustained.

Structured exercise programmes are the recommended exercise therapy for IC; however, based on the small number of included trials, most exercise programmes either do not incorporate patient education, or do not typically comply with criteria definitions of a structured education programme.¹² Although “usual care” patient education is included in the NICE SEPs recommendations for secondary preventions in IC, the development and implementation of the education components in SEPs interventions are not sufficiently reported to allow a judgement of their fidelity. Therefore, it is often not known how education was delivered, whether educators were sufficiently trained, whether education interventions were delivered as intended, and/or whether sufficient topics were included to enhance patient self management skills. These elements are important as not only do they underpin the potential effectiveness of education programmes, they may be crucial in translating gains in a hospital based SEPs intervention to sustained improvement in daily physical activity at the end of the 3 month SEP, which is crucial in managing chronic diseases such as PAD/IC.

Only three of the included papers reported patient experience with interventions. In these trials, patients reported that they valued interventions that improved their understanding of the disease pathology of PAD and IC, and provided them with information of the importance of

walking and how walking helped. For these patients, gaining confidence, self monitoring ability, and skills were key to their accepting and perhaps adhering to interventions. Other important components according to the patients were the benefits from socialising in a group session without losing the opportunity for individualised care. The interventions that included these components demonstrated improvement in both maximum walking capacity^{19,23} and free living PA.¹⁷

Several limitations are recognised regarding the conclusions in this review. First, the planned meta-analysis could not be implemented because of heterogeneity in the included studies. Secondly, although four of the six included papers were of high quality, three were pilot trials assessing outcomes after a relatively short time. For instance, Tew et al.¹⁹ only had 13 or nine participants in each group and assessed outcomes after just a 6 week intervention. This means that an inadequate sample and early assessment of outcome could limit the statistical power. Thirdly, the time point of outcome assessments were so varied that it was difficult to establish a reference time point to assess outcome performance even in a narrative synthesis. Fourthly, lack of a control group or use of an active control group meant that the specific efficacy of the intervention versus the usual care or nothing could not be clearly ascertained. In addition, the review design itself has inherent limitations: non-English language literature and unpublished literature were not searched or reviewed.

The limited evidence from four trials is inconclusive regarding the effect of structured patient education to improve daily PA and walking capacity of patients with IC. Interventions that provided patients with information about their disease pathology and walking, providing motivation and empowering patients, were valued and seen by patients as important in improving their PA. Structured education programmes may prove to be an essential part of exercise programmes for patients with IC, but rigorous trials are required before this can be recommended. Future interventions should consider the key criteria for a structured patient education programme. In addition, reporting on patient constructs of their experiences and perceptions to the interventions should always be factored in and reported so that holistic evaluation of effective components from the patients’ perspective can be undertaken.

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CONFLICT OF INTEREST

None.

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