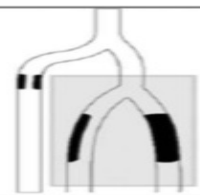
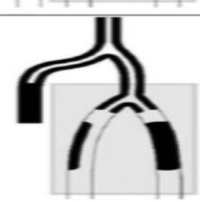
Grade	Category	Clinical description	Objective criteria
0	0	Asymptomatic—no hemodynamically significant occlusive disease	Normal treadmill or reactive hyperemia test
	1	Mild claudication	Completes treadmill exercise; AP after exercise > 50 mm Hg but at least 20 mm Hg lower than resting value
I	2	Moderate claudication	Between categories 1 and 3
	3	Severe claudication	Cannot complete standard treadmill exercise, and AP after exercise < 50 mm Hg
II	4	Ischemic rest pain	Resting AP < 40 mm Hg, flat or barely pulsatile ankle or metatarsal PVR; TP < 30 mm Hg
III	5	Minor tissue loss—nonhealing ulcer, focal gangrene with diffuse pedal ischemia	Resting AP < 60 mm Hg, ankle or metatarsal PVR flat or barely pulsatile; TP < 40 mm Hg
	6	Major tissue loss—extending above TM level, functional foot no longer salvageable	Same as category 5

Abbreviations: AP, ankle pressure; PVR, pulse volume recording; TM, transmetatarsal; TP, toe pressure.

Study/Stent Type	N	CLI/IC	Control Arm	Follow-up, mo	Outcome	p
ACHILLES Sirolimus-eluting	200	CLI + IC	PTA	12	Primary patency 75% vs 57%	0.025
DESTINY Everolimus-eluting	140	CLI	BMS	12	Primary patency 85% vs 54%	<0.001
YUKON-BTX Sirolimus-eluting	161	CLI + IC	BMS	12	Primary patency 81% vs 56%	0.004
IDEAS Drug-eluting	50	CLI + IC	PCB	6	Restenosis 28% vs 58%	0.046

Abbreviations: BMS, bare metal stent; CLI, critical limb ischemia; IC, intermittent claudication; PCB, paclitaxel-coated balloon; PTA, percutaneous transluminal angioplasty.

TASC A lesions Single focal stenosis, ≤5 cm in length, in the target tibial artery with occlusion or stenosis of similar or worse severity in the other tibial arteries.	
TASC B lesions Multiple stenoses, each ≤5 cm in length, or total length ≤10 cm or single occlusion ≤3 cm in length, in the target tibial artery with occlusion or stenosis of similar or worse severity in the other tibial arteries.	
TASC C lesions Multiple stenoses in the target tibial artery and/or single occlusion with total lesion length >10 cm with occlusion or stenosis of similar or worse severity in the other tibial arteries.	
TASC D lesions Multiple occlusions involving the target tibial artery with total lesion length >10 cm or dense lesion calcification or non-visualization of collaterals. The other tibial arteries occluded or dense calcification.	

Infrapopliteal lezyonları olan hastalarda revaskülarizasyon önerileri

Öneriler	Sınıf[a]	Düzey[b]
İnfrapopliteal segment için revaskülarizasyon gerektiğinde ilk olarak endovasküler strateji akla gelmelidir.	IIa	C
İnfrapopliteal lezyonlar için anjiyoplasti tercih edilen teknik olmasına rağmen PTA'nın yetersiz kaldığı durumlarda stentleme düşünülmelidir.	IIa	C

[a] Öneri sınıfı
[b] Kanıt düzeyi.
PTA = perkütan translüminal anjiyoplasti.

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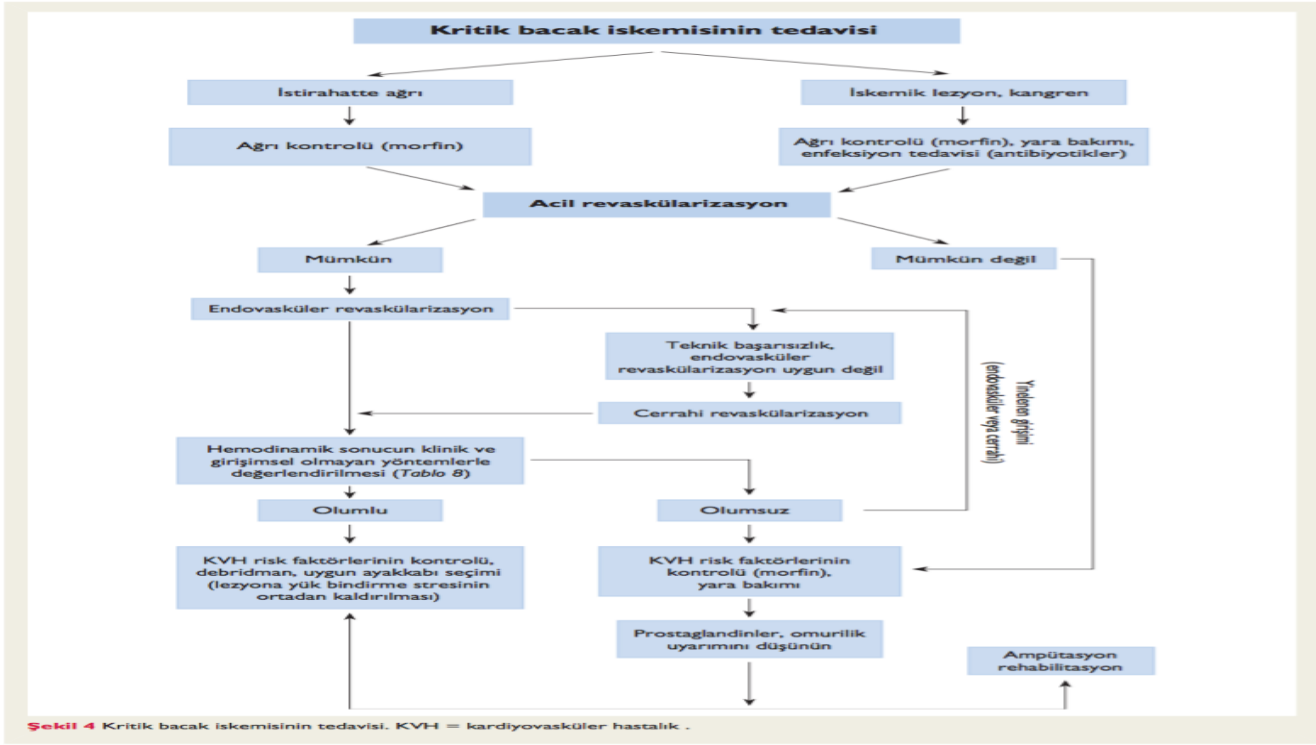

Şekil 4 Kritik bacak iskemisinin tedavisi. KVH = kardiyovasküler hastalık .

Recommendations for Endovascular Revascularization for CLI		
COR	**LOE**	**Recommendations**
I	**B-R**	**Endovascular procedures are recommended to establish in-line blood flow to the foot in patients with nonhealing wounds or gangrene (242, 243).**
IIa	**C-LD**	**A staged approach to endovascular procedures is reasonable in patients with ischemic rest pain (261, 262).**
IIa	**B-R**	**Evaluation of lesion characteristics can be useful in selecting the endovascular approach for CLI (263, 264).**
IIb	**B-NR**	**Use of angiosome-directed endovascular therapy may be reasonable for patients with CLI and nonhealing wounds or gangrene (245, 247-249, 251-253, 255-257).**

Findings That Favor Consideration of Surgical Revascularization	Examples
Factors associated with technical failure or poor durability with endovascular treatment	Lesion involving common femoral artery, including origin of deep femoral artery
	Long segment lesion involving the below-knee popliteal and/or infrapopliteal arteries in a patient with suitable single-segment autogenous vein conduit
	Diffuse multilevel disease that would require endovascular revascularization at multiple anatomic levels
	Small-diameter target artery proximal to site of stenosis or densely calcified lesion at location of endovascular treatment
Endovascular treatment likely to preclude or complicate subsequent achievement of in-line blood flow through surgical revascularization	Single-vessel runoff distal to ankle
Findings That Favor Consideration of Endovascular Revascularization	**Examples**
The presence of patient comorbidities may place patients at increased risk of perioperative complications from surgical revascularization. In these patients, an endovascular-first approach should be used regardless of anatomy	Patient comorbidities, including coronary ischemia, cardiomyopathy, congestive heart failure, severe lung disease, and chronic kidney disease
Patients with rest pain and disease at multiple levels may undergo a staged approach as part of endovascular-first approach	In-flow disease can be addressed first, and out-flow disease can be addressed in a staged manner, when required, if clinical factors or patient safety prevent addressing all diseased segments at one setting
Patients without suitable autologous vein for bypass grafts	Some patients have had veins harvested for previous coronary artery bypass surgery and do not have adequate remaining veins for use as conduits. Similarly, patients may not have undergone prior saphenous vein harvest, but available vein is of inadequate diameter