Peripheral arterial disease (PAD) afflicts 8 to 12 million Americans, but nearly 75% of them are asymptomatic. Physicians rely on history and physical examination to determine which patients require further evaluation. Physical findings that have been associated with arterial disease include a unilaterally cool extremity, skin atrophy and lack of hair, and abnormal pedal pulses, among others. The disease spectrum ranges from exertional calf pain to chronic limb ischemia necessitating amputation. The suspicion of arterial disease often leads to further examination of the lower extremity, skin atrophy and lack of hair, and abnormal pedal pulses, among others. The disease spectrum ranges from exertional calf pain to chronic limb ischemia necessitating amputation. The suspicion of arterial disease often leads to further examination of the lower extremity vascular supply. Measurement of the ankle-brachial index (ABI) is a noninvasive method for detecting PAD and is about 95% sensitive and specific when the diagnostic cutoff is 0.9. In general, the accepted ABI for the presence of PAD is lower than 0.9, and that for severe disease is lower than 0.7.

The present observational case-control study was undertaken based on the clinical observation that many men seem to have hairless lower extremities. Our goal was to determine whether this physical sign is a predictor of PAD.

Methods. After obtaining institutional review board approval, we enrolled 50 subjects from Hershey Medical Center in the study. Twenty-five control subjects were recruited from various outpatient clinics and had documented normal ABI measurements (>0.9). Twenty-five subjects with PAD were recruited from the vascular clinic and had either an ABI lower than 0.9 or abnormal lower extremity arterial duplex findings. Subjects with ABIs lower than 0.9 due to disease other than PAD were excluded.

Subjects with diabetes who had abnormal ABIs were included in the disease group. Due to arterial calcification, the vessels in subjects with diabetes may be less compressible and so might generate falsely elevated indices. Thus, the vascular disease of patients with diabetes is likely worse than the measured value.

Lower extremity hairs were counted on all subjects. First, a measurement was taken from the anterior tibial tuberosity to the proximal portion of the lateral malleolus. The distance was divided by 3, and hairs were counted at a location one-third of the distance proximal to the lateral malleolus. Scissors were used to trim hairs at this location to several millimeters in length. Temporary black hair dye was then applied to the area for approximately 1 minute. Excess dye was removed, and we took 2 pictures of the area using a magnified digital photography technique, which involved pressing the camera lens against the skin to make full contact while the photograph was taken. All photographs were taken with a Nikon D80 camera (Nikon USA Inc, Melville, New York), stored on a memory card, and uploaded to a computer where Photoshop (Adobe Systems Inc, San Jose, California) was used to crop them to standard dimensions of 2572 × 1564 pixels.

Hair count analyses were performed, and data were categorized as either leg hair present (1 or more hairs present in the examined field) or leg hair absent (no hairs present in the examined field). This assessment was performed on data from each of the 50 subjects. Statistical analysis was then completed using a $\chi^2$ analysis.

Results. Of the 50 patients recruited for this study, 25 had existing PAD, and 25 were healthy controls (Table). Subjects in the control group had a mean age of 65 years (age range, 50-80 years). Those in the PAD group had a mean age of 75 years (age range, 55-88 years). Sixty-four percent of patients with PAD had absent leg hair, and 40% of patients without PAD had absent leg hair (Table). Using $\chi^2$ analysis, we found no statistically significant relationship between disease presence and absence of lower extremity hair ($P = .09$).

Comment. Peripheral arterial disease involves atherosclerotic occlusions in the arterial system distal to the aortic bifurcation. It is mainly a disorder of advancing age, and one’s risk of PAD is increased by cigarette smoking, diabetes, hypercholesterolemia, and hypertension. Because many patients are asymptomatic, physicians must recognize the early signs and take appropriate action. The goal of the present study was to determine whether the absence of lower extremity hair is a useful predictor of PAD. No statistically significant difference was found between the numbers of diseased patients without leg hair ($n = 16$) and control patients without leg hair ($n = 10$) ($P = .09$), sug-

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Table. Presence of Lower Extremity Hair in Patients With and Without PAD

<table>
<thead>
<tr>
<th>Lower Extremity Hair</th>
<th>With PAD</th>
<th>Without PAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present</td>
<td>9 (36)</td>
<td>15 (60)</td>
</tr>
<tr>
<td>Absent</td>
<td>16 (64)</td>
<td>10 (40)</td>
</tr>
</tbody>
</table>

Abbreviation: PAD, peripheral arterial disease.

$^a$By $\chi^2$ analysis, no statistically significant relationship was found between disease presence and absence of lower extremity hair ($P = .09$).
gesting that a lack of lower extremity hair is not useful as a solitary predictor of disease. Therefore, we believe that it is best to consider this examination finding in the context of a patient's overall presentation and risk factors for PAD.

Our study has several limitations. The sample size was only 50 patients. In addition, no demographic information (including the presence of comorbidities such as diabetes, hypertension, or smoking) was recorded.

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Author Contributions: All authors had full access to all the data in the study and take responsibility for the integrity of the data and accuracy of the data analysis. Study concept and design: Brueseke, Macrino, and Miller. Acquisition of data: Brueseke, Macrino, and Miller. Analysis and interpretation of data: Brueseke, Macrino, and Miller. Drafting of the manuscript: Brueseke, Macrino, and Miller. Critical revision of the manuscript for important intellectual content: Brueseke and Miller. Administrative, technical, and material support: Brueseke, Macrino, and Miller.

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Results. The accompanying Table and box plot (Figure) summarize data from all men older than 40 years in our cohort (n=419) and show that tumor thickness did not vary significantly with the number of moles (P > .99 in the Kruskal-Wallis nonparametric analysis of variance test). These data suggest that melanomas arising in patients with increased numbers of moles are not inherently more indolent than melanomas arising in patients with an average (or less than average) number of nevi.

Comment. Although these data contrast with those of Swetter et al,¹ taken together these findings suggest that increased public awareness and educational efforts may have led to earlier detection of melanoma. Swetter et al demonstrated that men who were aware of melanoma, understood the importance of skin examinations, and showed an overall interest in their health were more likely to present with thinner tumors. At our own institution, we have noted a substantial decrease in tumor thickness

Table. Tumor Thickness by Number of Moles

<table>
<thead>
<tr>
<th>Group</th>
<th>Patients, No.</th>
<th>Moles, No.</th>
<th>Tumor Thickness, Median, mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9</td>
<td>0</td>
<td>1.40</td>
</tr>
<tr>
<td>2</td>
<td>328</td>
<td>1-25</td>
<td>1.60</td>
</tr>
<tr>
<td>3</td>
<td>85</td>
<td>26-100</td>
<td>1.40</td>
</tr>
<tr>
<td>4</td>
<td>36</td>
<td>&gt;100</td>
<td>1.85</td>
</tr>
</tbody>
</table>