Abdominal aortic aneurysm: diagnosis and management

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 29 June 2018 email: AAaneurysm@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the short version and any comments you may have on the evidence presented in the full version. We would also welcome views on the Equality Impact Assessment. We would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. [Insert any specific questions about the recommendations from the Developer, or delete if not needed] See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	**VASGBI (Vascular Anaesthesia Society of Great Britain & Ireland)** **Stakeholder**

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Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	No funding from the tobacco industry
Name of commentator person completing form:	Dr Simon Howell (Chairman of VASGBI) Dr Ronelle Mouton (Chair of VASGBI Research & Audit Committee)
Type	[office use only]

Comment number	**Document** (**full** version, **short** version or the **appendices**	**Page number** Or **'general'** for comments on the whole document	**Line number** Or **'general'** for comments on the whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
1	Short Version	General	General	The Vascular Anaesthesia Society of Great Britain & Ireland (VASGBI) would like to thank

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				the NICE Committee for producing this guideline on the diagnosis and management of abdominal aortic aneurysms. We agree with many of the recommendations and acknowledge the extensive amount of work done by the Committee. Our main concerns: 1. According to the recommendation assessment of "fitness" would be the primary factor determining whether a patients has elective open repair or no surgery. The NICE document provides no guidance on how anaesthetists would make this fitness assessment. Implementation of the guideline would ask our vascular anaesthetists to make significant decisions on patient fitness for elective open abdominal aortic aneurysm (AAA) surgery without reference to any framework or indeed to tools developed in large populations such as the ACS NSQIP calculator. In our view the lack of a framework for risk stratification would increase the risk of substantial variation in practice between vascular centres and contradict the aims of the recently published GIRFT for vascular surgery. 2. If the guideline is implemented in its current form, patients deemed unfit for elective open AAA repair, would not be offered less invasive elective endovascular aneurysm

				repair (EVAR). This recommendation will have a major impact on current UK practice (where 70% of elective AAA repairs are EVAR) and if implemented will be disparate with guidelines and practice in the rest of Europe (European Society of Vascular Surgery). 3. There is a lack of evidence about the "treatment threshold" for elective AAA repair especially for high-risk patients with larger more high-risk aneurysms. The studies that inform treatment thresholds do so with particular reference to the treatment of small aneurysms and cannot be used to inform the management of large aneurysms in higher risk patients. Current recommendations are based on the older EVAR trials (before 2004). There is a need for more high quality evidence from modern EVAR practice to inform treatment thresholds. 4. Significant abandoning of elective EVAR surgery will affect skills and training of vascular teams, including theatre staff, anaesthetic trainees and surgical trainees. This will have practical implications for the delivery of EVAR for ruptured AAA's. 5. There seems to be no allowance for patient choice with regards to elective abdominal aortic aneurysm (AAA) repair and the NICE document provided no data on patient preference. In modern practice patient choice is important for consent and

				the shared decision-making process. We asked for comments from the VASGBI membership in the limited timeframe. We also asked current and previous members of the VASGBI Committee to comment. Their responses are included in this document.
1	Short	Page 8	137 – 147	We agree with the Committee that there are currently no validated risk assessment tools to predict "fitness" and suitability for open AAA surgery. However, the recommendation 1.5.4 (page 10, 183) suggests that this is possible and that patients can be categorised into two distinct groups, either "fit for open AAA repair" or "no intervention". There is no robust evidence for this. VASGBI would support means of fitness testing and developing validated risk models as a research recommendation for this guidance. A post-hoc analysis of the patients in the EVAR1 (fit for open repair) and EVAR2 (unfit for open repair) studies indicated that there was very substantial overlap between the risk profiles of the two groups.

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2	Short	10	183	This recommendation may imply abandoning the elective endovascular aneurysm repair (EVAR) service, a technology that has matured significantly over recent years. This is a significant change from current practice in the UK where about 70% of elective AAA repairs are done endovascularly (National Vascular Registry 2017 report). Furthermore this implementation would put the UK practice at odds with international guidelines and practice in the rest of the developed world, including Europe. We are concerned that there appears to be an assumption that vascular anaesthetists and surgeons would judge who will be “fit” for open repair, but validated tools for this are lacking and risk scores not allowed. There is no clear definition of what is meant by “fitness” for surgery. A middle road, which preserves some clinical options and patient choice, would be more acceptable. A recent study reported that up to 60% of patients fall in a grey area of intermediate fitness (Rose Ga et al., British Journal of Anaesthesia 120(6): 1187-94, 2018). It could be this large group of patients with “intermediate” fitness who might benefit from EVAR. A patient who is considered high risk because of multiple comorbidities may benefit from

				the treatment of a large AAA high risk of rupture e.g. >7.5cm. We note above that there are limited data to inform the management of such patients with much of the evidence on treatment thresholds relating to small aneurysms. In such patients, if the risk of rupture is high, EVAR may prevent a significant number of fatal ruptures. We suggest that further research is required on the benefits of EVAR for large aneurysms in relatively unfit patients. Limiting elective EVAR and increasing open AAA repair would also impact on critical care resources. We expect a significant increase in the demand for critical care beds and this increase would likely be in the older, less robust patients, who would might need longer and higher dependency critical care stay. The UK National Vascular Registry (NVR) captures data on more than 90% of AAA procedures and would be able to provide data to support an economic analysis. *https://www.vascularsociety.org.uk/_userfiles/pages/files/Document%20Library/2017%20NVR%20Annual%20Report.pdf
3	Short	10	193	Recommendation 1.5.7 – consider epidural for open repair We agree that epidurals are commonly used for elective open repair, but this is too strong

				a recommendation without much evidence base. Furthermore, it leaves little room for exploring the benefits (compared to epidural analgesia) of developing regional anaesthesia techniques such as rectus sheath and wound catheters.
4	Short	10	196	We agree with the recommendation that there are benefits for some patients with a ruptured AAA from EVAR. However, the implementation of this would be severely affected if elective EVAR surgery is restricted to only a small number of patients. There are concerns about the impact of the proposed changes in the elective service on retaining operating team skills. For example, how would teams carrying out mainly open AAA repair for planned elective daytime surgery, be able to switch to EVAR under local anaesthesia for emergencies ?
5	Short	13	259	VASGBI funds research in vascular anaesthesia and we are pleased about the recommendations for further research into some areas of our practice. However, there are further areas where we lack evidence: e.g. validated pre operative risk scoring and other methods to test fitness and inform the shared decision making process. Recent papers support the need for reappraisal of the

				current interpretation of cardiopulmonary fitness testing. We strongly recommend including this as a research recommendation in the guidance document.
6	Evidence review K	26	706	There seem to be no allowance for patient choice with regards to elective abdominal aortic aneurysm (AAA) repair and the NICE document provided no data on patient preference. The committee stated that they were not aware of any evidence formally eliciting patient preference over EVAR and open surgery. However, there are some published studies on patient preference. One study reported that 46% of patients prefer EVAR vs 18% preferring open surgery (Reise JA et al., Eur J Vasc Endovasc Surgery 39: 55-61, 2010). Winterborn RJ et al (J Vasc Surg 49: 576-81, 2009) reported that 84% of patients expressed a preference for EVAR. Patient choice is important for consent and the shared decision-making process in modern practice and some allowance should be made for this.
7	Short	24	563	Question 1: We do not agree with the statement: “risk scoring tools are only used in research”. In current practice, risk assessment tools are being used by consultant anaesthetists in preoperative assessment clinics to help aid discussions and to inform

				shared decision-making. However, these tools are used carefully and only as a guideline.
8	Short			Question 3: What would help users overcome any challenges: There are two crucial challenges about defining and determining “fitness” and “treatment thresholds” for elective AAA surgery. Need of validated risk-assessment tools for patients and more evidence for the correct treatment threshold.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a **Word document (not a PDF).**

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- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **page and line number (not section number)** of the text each comment is about.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
- **Do not paste other tables into this table** – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
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You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

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