Highlights And Key Messages From The UK Guidance Document On AAA Treatment

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Conflict of Interest

• Commercial - none
• Chairman of the NICE Guidelines on the management of Varicose Veins.
• Co author of ESVS guidelines
• Contributor to other guidelines
• Committee Member of AAA guideline

Evidence Based Medicine

• Do you believe in Evidence Based Medicine?
• Do you think cost is important in determining treatment choices?

Core principles of NICE’s work

• Based on the best evidence available
• Expert input
• Patient and carer involvement
• Independent advisory committees
• Genuine consultation
• Regular review
• Open and transparent process
• Social values and equity consideration

Committee decision making

Clinical effectiveness
Cost effectiveness
Extent of uncertainty
Social Value Judgements
Innovation
Equality legislation
Other health benefits

Cost effectiveness is important in determining patient care!

The Society for Vascular Surgery practice guidelines on the care of patients with an abdominal aortic aneurysm

What is the most cost-effective and clinically effective surveillance protocol for the patient with a small aneurysm?

What is the most cost-effective and clinically effective surveillance protocol for the patient after EVAR?
14/11/2018

NICE Guideline Development

- Identified Topic
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- Published Guideline

Stakeholders

- General Practitioner
- Specialist Physician
- Patient
- Stakeholders
- Funders
- Policy makers
- Patients
- Carers
- Funding bodies
- Industry

Membership of Abdominal Aortic Aneurysm guideline committee

Abdominal aortic aneurysm: diagnosis and management

NICE guideline
Draft for consultation, May 2018

DRAFT

1.5 Repairing unruptured aneurysms
1.5.1 Consider aneurysm repair for people with an unruptured abdominal aortic aneurysm (AAA), if it is:
- asymptomatic
- asymptomatic and 5.5 cm or larger
- asymptomatic, larger than 4.0 cm and has grown by more than 1 cm in 1 year.
1.5.2 For people with unruptured AAAs meeting the criteria in 1.5.1, offer open surgical repair unless there are anaesthetic or medical contraindications.
1.5.3 Do not offer endovascular repair (EVAR) to people with an unruptured infrarenal AAA if open surgical repair is suitable.
**Definition**

**Complex EVAR**

Any endovascular strategy that is outside the 'instructions for use' of stent-grafts, typically adopted because of the AAA’s anatomical complexity. This includes using unmodified stent-grafts outside their instructions for use, physician-modified stent-grafts, customised fenestrated stent-grafts, and 'snorkel' or 'chimney' approaches with parallel covered stents.

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**1.6 Repairing ruptured aneurysms**

1.6.1 Consider endovascular repair (EVAR) or open surgical repair for people with a ruptured intramural abdominal aortic aneurysm (AAA). Be aware that:

- EVAR provides more benefit than open surgical repair for most people, especially for women and for men over the age of 70.
- Open surgical repair is likely to provide a better balance of benefits and harms in men under the age of 70.

1.6.2 Consider open surgical repair for people with a ruptured complex AAA.

1.6.3 Do not offer complex EVAR to people with a ruptured AAA if open surgical repair is suitable, except as part of a randomised controlled trial comparing complex EVAR with open surgical repair.

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**1.7 Monitoring for complications after endovascular aneurysm repair**

1.7.1 Enrol people who have had endovascular aneurysm repair (EVAR) into a surveillance imaging programme.

1.7.2 Base the frequency of surveillance imaging on the person’s risk of graft-related complications.

1.7.3 Use contrast-enhanced CT angiography to detect postoperative complications and further aneurysm expansion.

1.7.4 If contrast-enhanced CT angiography is contraindicated, consider contrast-enhanced ultrasound to detect endoleak and further aneurysm expansion.

1.7.5 Do not use colour duplex ultrasound as the main imaging technique to detect endoleaks in people who have had an EVAR.

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**Recommendations for research**

1. **Monitoring frequencies and repair thresholds**

   What are the most effective and cost-effective frequencies for monitoring people with unruptured abdominal aortic aneurysms (AAA) of different diameters, and what is the optimal threshold for repair?

2. **Effectiveness of endovascular aneurysm repair and open surgical repair of unruptured and ruptured abdominal aortic aneurysms**

   What is the effectiveness and cost-effectiveness of complex endovascular aneurysm repair (EVAR) versus open surgical repair in people for whom open surgical repair is suitable for:

   - elective repair of an unruptured AAA or
   - emergency repair of a ruptured AAA?

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**EVAR-1: OSR “dominates” EVAR (cheaper and better survival, more QALYs)**

Long-term cost-effectiveness analysis of endovascular versus open repair for abdominal aortic aneurysm based on four randomised clinical trials.

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**EVAR-2: £450,000 per QALY**

Every £450,000 invested in EVAR is estimated to provide at least 25 additional years of life and 25 additional years of quality-adjusted life years (QALYs) for people with a ruptured AAA.

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**No-brainer: no independent unbiased advisory committee could advise the NHS to purchase EVAR rather than OSR**

11.3 Do not offer endovascular repair (EVAR) to people with an unruptured abdominal AAA if open surgical repair is suitable.
In 21st century we need to spend our money wisely!

Conclusion

Abdominal aortic aneurysm: diagnosis and management

Evidence based guideline

Best for patients at a cost effective threshold

Areas of controversy

“Thats all Folks!”