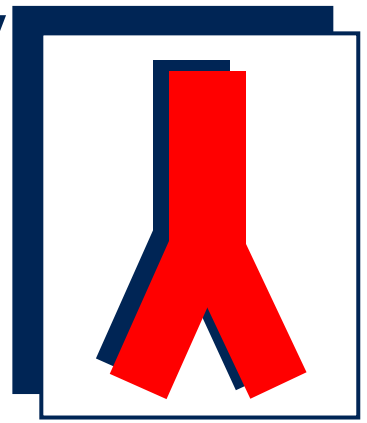


# Will Butcher – Vascular Surgery

## General practitioner – Frequent Questions

More information available at: [www.willbutchervascular.com](http://www.willbutchervascular.com)

### Is Endovascular repair really better than Open Repair for an Abdominal Aortic Aneurysm?



This is a very topical question.

At the moment in Australia the vast majority of vascular surgeons would suggest that where feasible an Endovascular repair (EVAR) should be performed in preference to open repair. There is no doubt that the immediate perioperative mortality and morbidity is lower in patients undergoing EVAR compared to Open surgical repair (OSR), this is a very powerful driver for patients and surgeons.

There have been some long term outcome studies which have recently challenged the assumption that EVAR is in fact better than OSR. They show that the survival benefit enjoyed at the time of repair by EVAR patients is usually lost within 5 years and that ongoing issues with EVAR cause problems for many years. The promise of cost savings with EVAR is also not borne out in research. The National Institute of Clinical Excellence, which is a branch of the NHS tasked with examining cost effectiveness of care has recently issued draft guidance which suggests that, in fit patients, OSR should be the first option for patients with AAA. Superficial analysis of the data certainly supports this view.

I think that there are several points which make the situation a little more complex than initially apparent.

- The most important in my mind is that anatomical suitability for EVAR is not a simple “Go -No go” issue. Frequently patients anatomy is partially suitable, what this means is that it is possible that we can identify a subgroup of suitable who are more suitable than others and might therefore be expected to have fewer long term complications from their EVAR. The corollary to this of course is that we can also predict that there are some patients who, while technically suitable, are more likely to run into trouble in the long term. The enthusiasm for EVAR in the vascular community has resulted in a tendency to adopt an EVAR, if at all possible, approach, and I feel that this is the source of some of the longer term problems.
- The availability of a lower intensity treatment has I believe resulted in a significant lowering of the physiological threshold for AAA repair. To some extent this is valid because many patients not fit for OSR may still be expected to live for many years, certainly long enough to die from their significant AAA. This is increasingly true as we get better at looking after the elderly.
- For some patients the burden of surveillance is much heavier than others. This can be linked to geographical remoteness, anxiety or the desire to travel. These patients may well consider that the risk of an OSR is justifiable to avoid surveillance.
- In the modern age there is often a lot of conflicting information from the internet, social media, apparently well informed outspoken relatives and so on that patients have to juggle and that often interferes with a sensible doctor patient dialogue.
- Fear of treatment (in all forms) is an increasing burden for our society and many patients are prepared to accept relatively minor short term benefit over greater longer term safety. Many patients find the real threat of mortality associated with an OSR unacceptable. The truth is, though, in experienced hands the risk of mortality is very low

So....what is the best thing to do?

What I do is to try and analyse all the competing priorities and try and advise the patient on an acceptable way forward. The first thing to do is establish that the anatomy is either suitable or not suitable for EVAR and if suitable just how suitable exactly. I then establish the patient’s willingness to accept major surgery and their likely tolerance of surveillance. I then try and anticipate their attitude to risk, recognising that there are differing elements to risk in this situation, the risk of immediate mortality and morbidity and then the risk of reintervention. Younger fitter patients will be steered towards OSR as will those with challenging anatomy, elderly, less fit patients will be advised to have an EVAR if suitable. One of the most important considerations is that the surgeon must be truly confident with both types of repair in order to advise the patient appropriately. It is a growing concern in the vascular community that many surgeons are not confident to undertake complex open repair.