Will Butcher – Vascular Surgery

General practitioner – Frequent Questions

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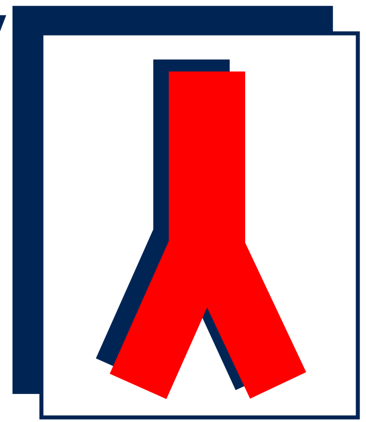

FAQ: My patient has an abdominal aortic aneurysm, what should I do?

The majority of Abdominal aortic aneurysms (AAA) are found on routine abdominal examination (physical, ultrasound, CT Scan) usually for an unrelated condition. In some cases the aneurysm will be large enough to cause imminent concern, however, the majority do not.

The balance of risk in AAA surgery suggests that at approximately 55mm the risk of AAA surgery is overtaken by the risk of the AAA and surgery is offered. At less than this the risk of surgery outweighs the risk of conservative care. As such patients with AAA greater than 55mm should be referred for relatively urgent care. If there is new onset back or abdominal pain or the aneurysm is more than 6.5cm this referral should be extremely urgent, ideally you should speak with a vascular surgeon before the patient leaves your rooms.

The majority of incidentally found AAA are less than 55mm and unless thought to be symptomatic can be treated with significantly less anxiety. The first thing to establish is the need for surveillance. In general, I recommend a new scan after 6 months, and then annually until the aneurysm reaches 50mm. At 50mm the AAA should be referred to a vascular surgeon for care. Alternatively, the patient may be referred to a vascular surgeon early and he or she will manage the surveillance.

AAA is evidence of significant arterial disease and therefore it is important that this group of patients is offered optimal medical therapy. This involves:

- Antiplatelets therapy with aspirin or clopidogrel (not both).
- 40mg of a preferred 'statin (if tolerated), irrespective of cholesterol level, a target of under 4.5 is appropriate. Even in a patient due for surgery there is evidence that as little as a few days of 'statin therapy reduces perioperative risk.
- Optimal management of hypertension (ACE inhibitors are thought to be particularly beneficial)
- Smoking cessation
- Optimal diabetic control
- Lifestyle modification: weight loss and exercise therapy

Decisions not to Survey AAA

In some cases, because of age or infirmity it is agreed that a patient is unlikely to ever be a candidate for intervention and as such it is appropriate not to commence or to withdraw the patient from surveillance. Ideally this decision should be agreed with the patient and family members and documented in the patients medical record. A letter to the local public hospitals where the patient is likely to be taken in the event of collapse may also be appropriate to prevent a precipitous decision offering the patient surgery that they do not wish.