Update on SAAAVE

Legislation pending before Congress would provide for Medicare reimbursement for screening procedures that can save lives.

BY TAKAO OHKI, MD, PHD AND CRAIG MCCHESNEY, PUBLISHER

On February 16, 2005, a bipartisan group of legislators led by Senators Christopher Dodd (D-CT) and Jim Bunning (R-KY), and Representatives John Shimkus (R-IL), Gene Green (D-TX, 29th), and Ron Lewis (R-KY) introduced legislation known as the Screening Abdominal Aortic Aneurysms Very Efficiently (SAAAVE) Act of 2005 [S.390/H.R.827]. If enacted, the legislation would provide coverage for a one-time ultrasound screening to identify AAAs under Medicare Part B. Coverage would be limited to a screening by a qualified technologist of any Medicare beneficiary who has a family history of AAAs, manifests risk factors for cardiovascular disease (such as smoking or hypertension), or evidences atherosclerosis. In addition to the ultrasound screening provision, the legislation would also provide for a national education campaign to promote awareness among health care practitioners and the public about the importance of early detection and treatment.

The Medicare program was originally designed to address acute health care problems, not prevention; accordingly, screening programs have not been included unless specifically authorized by Congress. In recent years, the program has evolved to include a number of prevention-related exemptions, such as mammography and colorectal screening, but not aortic aneurysm screening. The SAAAVE legislation, which was originally introduced last summer, has been supported by the National Aneurysm Alliance (NAA), which is a coalition of medical professional societies, including the Society for Vascular Surgery (SVS), American College of Surgeons,

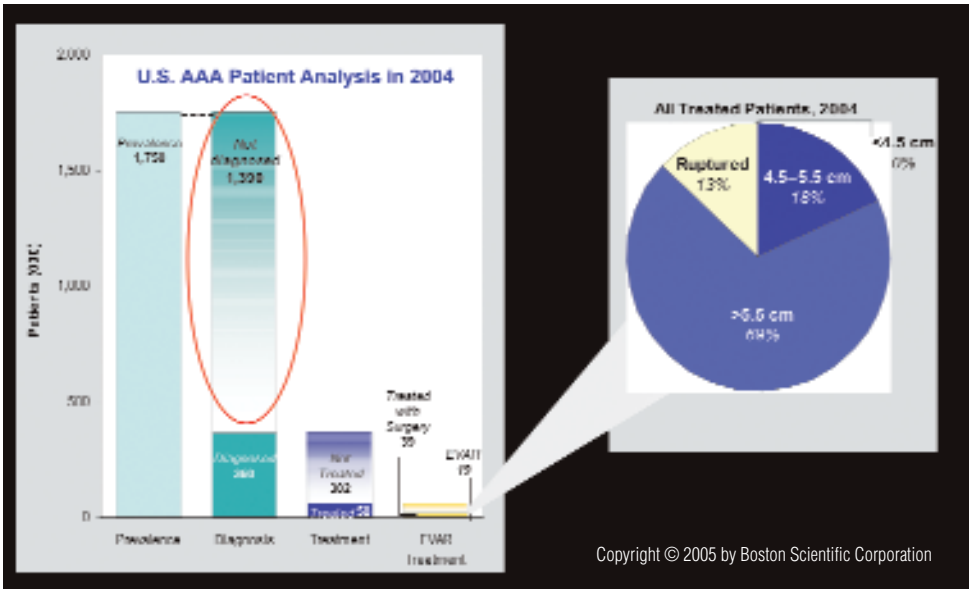

Figure 1. A substantial number of small AAAs go undiagnosed.[1-7]

Society of Interventional Radiology, American Society for Echocardiography, Society for Vascular Ultrasound, New England Society for Vascular Surgery, and the Southern Association for Vascular Surgery, patient advocates, foundations, and medical technology manufacturers. Robert Zwolak, MD, a vascular surgeon at Dartmouth Medical School, is the Chairman of the NAA, which has a single goal: passing SAAAVE.

TASK FORCE RECOMMENDATIONS

On January 31, 2005, thanks to the tireless efforts of Dr. Zwolak and the NAA, the US Preventive Services Task Force issued its recommendation for one-time screening for AAAs by ultrasonography in men aged 65 to 75 who have ever smoked. The Task Force stated that it makes no recommendation for or against screening for AAAs in men 65 to 75 who have never smoked, saying that the balance between net benefits and potential harms of screening were too close to make a general recommendation. This replaces the Task Force's 1996 recommendations, which found insufficient evidence to recommend for or against routine screening of asymptomatic patients. The Task Force also recommended against routine screening of AAAs in women, citing the low incidence of AAA-related deaths in women and the same morbidity and mortality risks. In addition, the Task Force cited short-term psychological harm associated with screening, and the morbidity and mortality associated with unnecessary surgery that would accrue in women found by screening.

RESPONSE FROM THE MEDICAL COMMUNITY

On February 1, 2005, the SVS issued a position statement commending the Task Force for recognizing the value of ultrasound screening for AAAs, but challenging their recommendation against routine screening for AAAs in women. According to the SVS position statement, this recommendation reflects the Task Force's conclusion that the harms of screening women outweigh the benefits. SVS asserts that this conclusion is not substantiated by the literature and that the more appropriate recommendation would be a finding of insufficient data to reach a conclusion about many subsets of women. In particular, SVS urged that AAA screening should be recommended for at least those women who are siblings of known AAA patients.

Dr. Zwolak also challenges some of the Task Force's findings. "While assessing the big picture, the Task Force overlooked a very important minority subgroup, women and men with a positive family history of AAAs. This subset actually has a much higher prevalence of AAAs than the male smokers for whom the Task Force recommended screening. SVS and the NAA will work very hard to get this right in the federal legislation."

IMPACT OF TASK FORCE RECOMMENDATIONS

The Task Force is an autonomous body that does not make recommendations directly to Congress, nor is Congress bound to follow their recommendations. However, the encouraging aspects of the Task Force's recommendations cannot be overlooked. According to Zwolak, "the positive recommendation for AAA screening will have a huge positive impact on Congress. The House and Senate have seen several potential recommendations for screening benefits, and they want and need an objective scientific body to sort out the most valuable contenders. I estimate that two-thirds of the House and Senate offices I visit ask, 'What does the Task Force say about AAA screening?' Now, I will be able to let them know their recommendation." In the present climate of budget cuts and escalating Medicare costs, a positive recommendation will certainly improve the chances for this legislation.

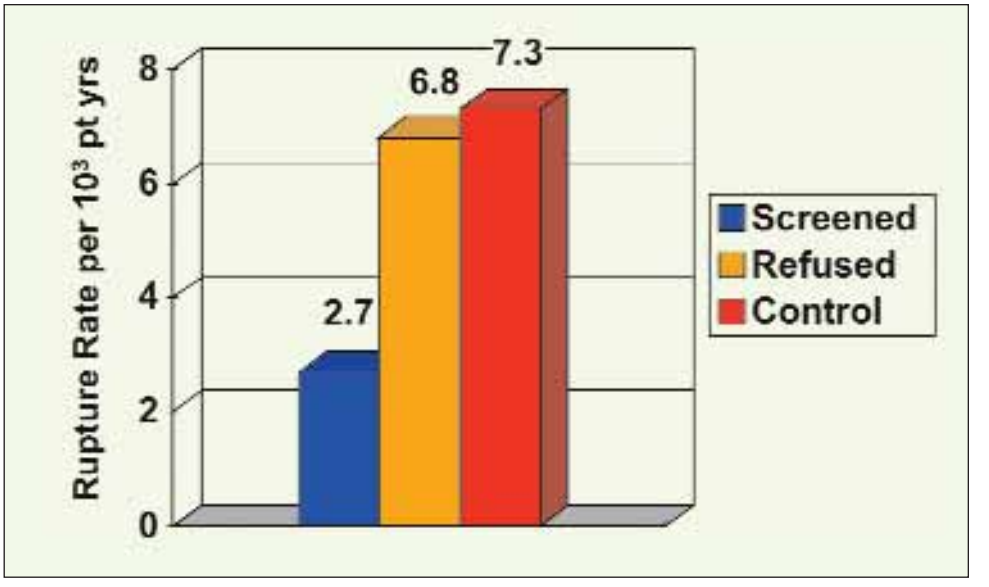

Figure 2. AAA ruptures during the study period in the Huntington study.

THE NEED FOR SCREENING

As noted throughout this issue of *Endovascular Today*, aneurysms remain largely underdiagnosed. It is estimated that of the 1.7 million AAAs that exist in the US, only 20%, or 360,000 are presently diagnosed (Figure 1). Although ultrasound has proven to be 99% effective at detecting small aneurysms, clinical examinations have been proven to detect only 50% of aneurysms <5 cm. A recent study conducted in England and Wales showed that despite the increasing number of elective AAA repairs, the number of ruptured AAAs has also increased by 60% during the last 2 decades.[8] This is probably due to the fact that most AAAs go undiagnosed. As demonstrated in the Huntington Study, early detection of aneurysms resulted in a 49% reduction in ruptures and a 45% reduction in AAA deaths (Figure 2). Thus, introduction of AAA screening is not only expected to dramatically increase the number of diagnosed AAAs and elective AAA surgery, but also to decrease AAA death, as well as reduce the costly emergency surgeries and critical care.

GETTING INVOLVED

Dr. Zwolak urges all interested physicians to get involved: "We need every vascular surgeon, every interventional radiologist, and every other physician who wants to see an end to needless deaths from ruptured AAAs to call his or her Senators and Representative and ask them to support SAAAVE, which is bill number HR827 and S390. Congress is not accustomed to hearing from physicians, and they really do pay attention." For those seeking more details before making a call or sending a letter, Dr. Zwolak recommends contacting Pam Phillips in the SVS Washington office at (202) 672-1501, or visiting the NAA Web site at www.screenAAA.org. The vascular community will anxiously await Congressional action on this important step in improving patient care. ■

Takao Ohki, MD, PhD, is Chief of the Division of Vascular Surgery and Associate Professor of Surgery, Montefiore Medical Center, New York, New York. Dr. Ohki may be reached at (718) 920-4707; takohki@msn.com.

1. 5% Sample Medicare Claims Database.
2. Healthcare Cost and Utilization Project (HCUP), a Federal-state-industry partnership to build a standardized, multi-state health data system.
3. IMS Health.
4. Lederle FA, et al. Prevalence and association of AAA detected through screening. Ann Intern Med. 1997;126:441.
5. Lederle FA, et al. Rupture rate of large AAA in patients refusing or unfit for elective repair. JAMA. 2002;287:2968-2972.
6. Scott RA, et al. AAA in 4237 screened patients: prevalence, development, and management over 6 years. Br J Surg. 1991;78:1122-1125.
7. US Census Bureau.
8. Brown MJ, Sutton AJ, Bell PR, et al. A meta-analysis of 50 years of ruptured AAA. Br J Surg. 2002;89:714-730.