Anticipating the 2019 AAA NICE Guidelines

Prof. Loftus shares his thoughts on the impending publication of the UK's NICE updated guidelines for abdominal aortic aneurysm treatment and the potential effects they may have on practice and patients.

WITH IAN M. LOFTUS, MD, FRCS

In May 2018, the United Kingdom's (UK) National Institute for Health and Care Excellence (NICE) released a draft of its updated guidelines for abdominal aortic aneurysm (AAA) diagnosis and management for public comment. Although portions of the draft focus on improved detection and surveillance of small aneurysms, improved medical care for patients with AAA, and faster management and transfer of patients who experience rupture, there are also some controversial changes regarding the acceptable use of endovascular aneurysm repair (EVAR) for AAAs and post-EVAR surveillance protocols. In particular, elective EVAR for unruptured AAAs is not recommended within many sections.

Many stakeholders and national vascular societies, including the Vascular Society for Great Britain and Ireland (VSGBI), the British Society of Interventional Radiologists, and the Vascular Anaesthesia Society of Great Britain and Ireland, submitted formal responses to the NICE guideline committee as part of the consultation phase. The guidelines were originally anticipated to be published by the end of 2018, but they have yet to be announced at the time of this writing. We spoke with the current President of the VSGBI, Professor Ian M. Loftus, MD, FRCS, to get his thoughts on these forthcoming guidelines and on where we stand in balancing appropriate precaution and necessary treatment for patients with AAA.

Where do we currently stand with the updated NICE guidelines on AAA diagnosis and management?

The draft guidelines are currently undergoing a process of internal review within NICE. A large number of stakeholders have contacted NICE, raising concerns about the impact that the proposed guidelines would have on patient outcomes. The fundamental concern is the ability of clinicians and patients to decide what is best for their individual circumstances. We expect to hear more later in March, but at the time of this writing, we have not been informed of a definitive date for the final publication; however, we believe it should be expected within the first half of 2019.

What were your impressions of the draft guidelines, and how did you respond as a physician and as an executive in the VSGBI?

My impression was that it was unworkable. Patient choice is a cornerstone of the National Health Service in the UK, and the draft guidelines would effectively remove that for patients with aortic aneurysms. I also felt strongly that this would put the UK vascular service many years behind international practice and accepted standards of care and in direct conflict with the recent American and European guidelines. Of course, the most important issue would be an increase in mortality from aortic aneurysms, which would be inevitable and would cause patients harm. However, there are also broader implications for the future of vascular surgery in the UK, including the impact on training, recruiting, and retaining specialist staff. The VSGBI along with all other major UK stakeholders formally raised concerns through the established NICE consultation process.

Once the final guidelines are published, to what degree do you think it will have shifted from the positions in the original draft based on the feedback provided from various stakeholders?

That is very difficult to predict. There are conflicting challenges of financial pressures within a state-funded health care system, as well as an increasingly elderly population, demanding ever more expensive and technologically advanced health care. We understand that the endovascular boundaries may have been pushed too far in the past,

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and some sensible rationalization of use is appropriate in the very unfit patient. It may also be appropriate to perform more open repair in the young, fit patient. But the middle ground, where individual risk/benefit is often very difficult to predict, remains challenging. We hope we can find a workable solution that puts the patient, and patient choice, as the priority.

Generally, what factors do you believe "fitness" for repair should be based on? Is it possible to create a validated decision-making tool given the data that are currently available and the various patient factors involved? Who should ultimately determine fitness for each case?

It should always be a joint decision within a multidisciplinary setting, with the patient (and relatives) at the center. The experienced vascular anesthetist is an invaluable part of that team. Many of us now work closely with highly specialized "aortic" vascular anesthetists, who understand the specific physiologic and anatomic challenges of endovascular therapies. Many teams have worked on and developed predictive tools, but I don't believe that any of these are good enough to be used in isolation. However, they can provide a guide. The use of such a tool requires intensive testing and updating of the models using contemporary outcomes data. The National Vascular Registry in the UK could provide that data set.

What would be your top revision to the proposed guidelines in terms of imaging surveillance protocols?

It is becoming very clear that patients with favorable anatomy, treated within the instructions for use of the established aortic stent grafts, require less surveillance. This should be ultrasound-based surveillance in most cases, not CT. With further research, we expect to be able to predict a cohort of patients who could be removed from surveillance altogether. Research to help guide rationalization of surveillance should be one of the major research priorities highlighted in the final guidelines.

What do you think would be the best way to collect further urgently needed data on complex EVAR?

I do not think a clinical trial is appropriate or feasible. We simply don't have equipoise. In the UK, we have started recruiting patients to a national registry (UK-COMPASS), which is government funded and will investigate long-term outcomes for patients undergoing treatment for juxtarenal aneurysms. For other areas of the aorta, we need to use our established National Vascular Registry, which is linked to other national data sets, to provide long-term, meaningful outcomes data that are preferably device-specific with appropriate interaction with industry. ■

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