Planning and Preventing Aortic Reintervention With a Multispecialty Approach

Insights from the University of Washington multidisciplinary thoracic aortic program, including the benefits of a patient-centric, team-based approach to complex aortic care and how to approach reintervention and follow-up.

With Christopher R. Burke, MD

Which specialties comprise your aortic care team, and what are each team member's unique responsibilities?

The University of Washington multidisciplinary thoracic aortic program (MTAP) consists of physicians and support personnel from cardiac surgery, vascular surgery, cardiology, and genetics. We also collaborate and interact with staff from anesthesia, critical care, laboratory medicine, and nursing. We recognize that the holistic care of complex aortic patients goes well beyond the expertise of a single surgeon or specialty. By moving beyond a "siloed" approach to caring for these patients, we interact in a much more patient-centric environment as opposed to a procedure-centric one.

How do you set anatomic or territorial boundaries in the aorta at your center?

We don't. Lifelong aortic care requires careful planning for interventions not only in the present but in the future as well. That is why collaboration is so critical. All cases involving arch pathology and beyond are discussed in a multidisciplinary fashion to plan not only the index operation but all subsequent potential interventions.

How do you communicate, and how often do you meet?

We have weekly organized patient care conferences where cases are presented. This allows multiple stakeholders to opine on specific treatment and planning aspects of each case. Care plans are noted by support personnel, and a brief synopsis is added to the chart.

When it comes to the patient journey, how do you ensure comprehensive communication without gaps to patients and/or their families?

This is very difficult, especially for the more acute (eg, aortic dissection) patients, who many times run the risk of being lost to follow-up. We have a growing and robust staff of adjunct providers to maintain a database of patients and care plans, with regular presentation at our MTAP conference. We also make a point to standardize care pathways as much as possible to ensure consistent follow-up and plans. Patients see the individual providers within the MTAP, as opposed to a heavy reliance on nonaortic providers maintaining follow-up care.

How do you work to understand, prevent, and plan for reinterventions?

By combining multiple providers' experiences to help understand the implication and lifelong nature of these aortic pathologies. We recognize that the presence of aortic dissection (or aneurysm) is a life-altering development, and the possibility of multiple reinterventions is ever present. This emphasizes the importance of a collaborative and thoughtful approach for every intervention that maximizes future efficiency for other interventions that may be needed.

What is your protocol for educating patients on the need for follow-up and potential need

for reinterventions, and how has this evolved in recent years?

We make it a strong point to emphasize to patients that many of these aortic conditions are not simply fixed with a single surgery. We also point out that things like genetic testing as well as ongoing medical management are critical to maximizing outcomes in this area. This has been a major realization in recent years as MTAP has evolved at University of Washington. By continuing to personally follow these patients in clinic, we ensure they are receiving proper interval imaging along with medical therapy. We do not place that burden on referring physicians or other specialists who may not typically care for complex aortic patients.

Why is the multispecialty approach beneficial for patient care compared to traditional silos? How did your group work to break down walls between specialties?

Quite simply, we believe that involving the thoughts and opinions of a greater number of smart and thoughtful people will always be better than a single individual. We all bring unique expertise and experience to the table. We have developed an ethos of trust, collegiality, and mutual respect. This can be difficult, especially when strong egos are involved, but once those barriers are broken down and the mission becomes to optimize the best care possible for the patient, we have found it is straightforward to get everyone on board. ■

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