AN INTERVIEW WITH…

Ian M. Loftus, MD, FRCS

Prof. Loftus discusses the pros and cons of surgeon-level outcome reporting, paths for enhanced cost-effectiveness in endovascular aneurysm repair, and more on the forthcoming NICE aortic aneurysm guidelines.

What is your primary goal as President of the Vascular Society of Great Britain and Ireland? What is the most urgent need to bring forth and work toward a resolution on?

There are two major issues currently facing vascular surgery in the United Kingdom (UK), which I hope to address during my tenure. My primary goal is to see a resolution to the controversial proposed National Institute for Health and Care Excellence (NICE) guidelines on the management of patients with aortic aneurysms. The NICE guidelines, if implemented as proposed, would have major implications for the management of patients with aneurysms, as well as for the broader provision of vascular services. We are working together to find a workable solution.

Second, we have a government-funded process called "Getting It Right First Time (GIRFT)," which is looking at more efficient (and safer) ways of providing vascular services. This includes measures aimed at reducing length of stay, minimizing readmission rates, and streamlining pathways of care, particularly for patients with critical limb ischemia. In collaboration with GIRFT, the Vascular Society is launching a quality improvement programme this year for patients with critical limb ischemia.

The GIRFT process will almost certainly lead to further rationalization and centralization of vascular services, a controversial and at times difficult process, but one that has clearly improved provision of services in some areas.

At the 2018 VEITHsymposium, you spoke about the National Health Service–mandated surgeon-level outcome reporting being a harmful development. Can you explain this system, and how it is harmful?

I have always supported transparency in clinical services, especially surgery. It is vital that patients, relatives, and those who fund health care services are fully aware of the activity and outcomes from interventions within individual teams and hospitals. In the UK, we have been publishing unit- and surgeon-level activity and outcomes data for a number of years. This was mandated across surgical specialties by the government. The focus is almost entirely on surgeons' short-term mortality data, which is open to misinterpretation and misunderstanding. In vascular surgery, the team and the institution are much more important than the individual surgeon. This is largely missed in the current system, along with vital information on longer-term outcomes. My major concern is the potential for risk aversion and patients being denied treatment because they are perceived as high risk. There is some evidence of this, but further work is needed to understand the impact on patient outcomes and the individual surgeon's case mix.

What type of evidence would be more helpful in better serving patients?

We need much more work on contemporary risk prediction models in vascular surgery. This includes careful analysis of the risk profiles of patients undergoing surgery linked to outcomes (especially long-term survival and quality of life), as well as analysis of those patients denied treatment. That would give us a better impression of any potential risk aversion. We currently collect no data on these patients, and it is impossible to prove a high quality of service without an understanding of the entire picture. Patients with aortic aneurysms are a very good example. We know very little about what happens to patients in the UK who are denied intervention, but we do know that there is significant geographical variation in the "turn down" rates.

I also believe that we need better long-term outcome collection either within our National Vascular Registry or with easier and more robust cross-linking between that registry and other national data sets, especially the mortality records.

To what degree might the practice of early discharge for low-risk patients offset the higher costs associated with endovascular aneurysm repair compared to surgery, therefore negating the rationale of defaulting to surgery due to the cost differences?

There are a number of key factors that could reduce the overall expenditure on endovascular therapy. First, the potential to reduce the length of stay, in many cases to a single-day stay, would be a great cost benefit. However, this must not be at the "expense" of higher readmission rates,

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which would offset any potential savings. Careful pathways and infrastructure to ensure a safe and efficient short-stay service would be required.

Second, stent costs need to be consistent, with transparent pricing across hospitals and between companies. GIRFT is looking at this in detail in England.

The third factor is reducing reintervention rates and, by definition, rationalizing surveillance. I strongly believe that ultrasound should be the primary mode of aneurysm surveillance, rather than CT, and that in patients treated "on instructions for use [IFU]" with favorable anatomy, we could reduce the amount of surveillance required. Perhaps we need to start thinking outside of the box and look at combining a screening program with postoperative ultrasound surveillance in the community. This would be a much cheaper way of providing the service but would need some research for proof of concept.

Finally, stricter adherence to IFU is also key here, as we know that it will reduce reintervention and therefore reduce overall cost. This is something that I have stressed should be within any revised NICE guidelines.

Currently, what precautions do you employ to protect patients undergoing thoracic endovascular aneurysm repair from neurologic injury due to cerebral emboli?

At the moment, this is all rather nonscientific. We rely on loading the patient with antiplatelet agents, plus intraoperative heparin. I think one of the most important factors that I stress, particularly to my trainees, is minimal manipulation of wires and devices in the arch. Thankfully, we see very few major strokes in our practice. However, we should not underestimate the effect of minor embolic events and long-term cognitive function.

There is good work being done by Dr. Tilo Kölbel in Hamburg, Germany, looking at the way devices are prepared prior to implantation, including the use of carbon dioxide to flush the delivery devices to reduce air embolization. There are also a number of groups studying the use of cerebral protection devices, but these add to the expense and complexity of the case, so we need to understand which subgroup of patients may derive the most benefit from their use.

Can you tell us how you developed your center's endovascular program to include complex procedures and how you accomplished your goals in this role?

We have worked very hard as a team to build this practice. One of the key elements has been to demonstrate good outcomes despite high complexity and risk. We do this through a combination of a strong track record in publications and transparency of data on activity and outcomes in our National Vascular Registry, for which we have 100% data acquisition for aortic practice.

We have an open-door policy and will take patients any time, day or night, however complex the problem. Close subsequent communication with referring centers is then important. We have also developed a very close working relationship with our cardiology and cardiac surgical colleagues, sharing multidisciplinary team processes, joint management structures within the hospital, and a cardiovascular intensive care unit.

As Clinical Director of the Regional Aortic Aneurysm Screening Programme, what do you think can be done to achieve better outreach to at-risk patients?

The poorest attendance rates are among those patients who are most at risk. The link between deprivation and poor health, including smoking-related disease, is well proven. In the 10 years that we have been providing a screening service, the most deprived areas have always had lower attendance rates than those with the least deprivation. Targeted health education and awareness programs are vital. There is still very little knowledge or understanding of what aortic aneurysms are, even among other health care professionals.

As a screening program (based on the assumption that endovascular therapies will remain available), aneurysm screening works at all levels. It is cost-effective, relatively easy to run, and the established ultrasound method is very accurate. This may all change if endovascular therapy is either limited or denied. If that occurs, I think the benefit of this program will need careful thought. There is no point in detecting a condition that may prove to be fatal if we find ourselves unable to treat a large proportion of the patients. That would ultimately create more harm than benefit.

If you had not chosen to be a physician, what other career path might have interested you?

I always wanted to be a pilot. My godfather was a spitfire squadron leader in World War II and then a test pilot for most of his life. He was a hugely inspirational figure, and as a child, it seemed to me to be the most glamorous of careers. I have taken lessons for fixed-wing aircraft and helicopters but never quite got to the point of obtaining a license. I guess it's not too late if the NICE guidelines do leave me looking for other options! ■

Ian M. Loftus, MD, FRCS
Professor of Vascular Surgery
St George's Vascular Institute
St George's Healthcare NHS Trust
London, United Kingdom
ian.loftus@stgeorges.nhs.uk
Disclosures: Speaker fees from Gore & Associates; consultant to Medtronic (fees paid to charity).