**VS/BSIR/VASGBI Joint Statement on Draft NICE AAA guidance**

In May 2018 the National Institute for Health and Care Excellence (NICE) released a draft for consultation of its updated guidelines for Abdominal Aortic Aneurysm (AAA) diagnosis and management. The Vascular Society of Great Britain and Ireland (VSGBI), the British Society of Interventional Radiologists (BSIR) and the Vascular Anaesthesia Society of Great Britain and Ireland (VASGBI) submitted responses to NICE as part of the Consultation process. A number of other important stakeholder organisations have also responded. After consideration of these responses, NICE is due to publish the final guideline in December 2018.

In our responses, we acknowledged the work of the NICE committee. We agree with, and support, some recommendations. For example, improving the detection and surveillance of small AAA’s, better medical care of AAA patients, and when rupture occurs, faster management and transfer of patients. More controversial are the recommendations in relation to the use of endovascular aneurysm repair (EVAR) versus open surgical repair (OSR) for AAA treatment, and the advice around post-EVAR surveillance. The use of EVAR in the elective repair of AAA’s is not recommended within the draft guidance, except for complex EVAR within a randomised clinical trial, and CT-based surveillance is mandated.

Adopting a medium to long term view, NICE justify these new recommendations on the basis of high EVAR maintenance costs and reduced durability, using only evidence from historic randomised trials of OSR versus EVAR. Vascular services have been transformed since these trials, and technology has advanced, in particular regarding imaging and hybrid theatres. The outcomes from aneurysm repair in the UK have improved dramatically over the last 10 years, and are now among the best in the World.

The members of all 3 Societies are concerned that commissioners for vascular surgery will take the published guidelines at face value and prevent many patients from receiving appropriate life-saving treatment that they would receive if residing in other areas of the Western World. They consider that the proposed NICE recommendations are overtly prescriptive, and clinically unworkable, leaving clinicians and patients without choice. The implementation of either OSR or no intervention is unacceptable from a patient’s perspective.

The assessment of “fitness” would be the primary factor determining whether a patient has elective OSR or no surgery. We are concerned that there appears to be an assumption that vascular anaesthetists would judge who will be “fit” for open repair, but validated tools for this are lacking and risk scores not recommended. There is always some degree of uncertainty about the fitness and life expectancy of AAA patients. Aortic surgeons are likely to be risk averse and the rate of aneurysm rupture would almost certainly increase.

The guidance restricts the primary treatment for AAA in the UK, and is the first ever NICE guidance to actively withdraw the predominant surgical treatment for a life-threatening condition, despite evidence of safety and effectiveness of this procedure, much of which has not been considered in developing the guidance.

The following recommendations take into consideration the broader evidence base, plus new guidance from the European Society of Vascular Surgery (ESVS) and the American Society of Vascular Surgery (SVS), which included international working groups of active AAA researchers and surgeons.

1. Patients should receive comprehensive information which they understand regarding the AAA treatment options, and be actively involved in the decision as to whether to operate and the mode of repair.
2. For fitter patients with good life expectancy open surgical repair (OSR) should be considered and offered to the patient as an option, though it should be recognised that EVAR may still be more appropriate in some with suitable anatomy.
3. For patients deemed very high risk or with clearly limited life expectancy, no intervention should be considered. Fitness and suitability for aneurysm repair should include input from an anaesthetist experienced in vascular anaesthesia, and MDT discussion.
4. In most patients with suitable anatomy and reasonable life expectancy, or who choose not to have OSR, EVAR should be considered as the preferred treatment modality.
5. Elective EVAR needs to be delivered in a cost-effective way. Short hospital stays, low re-admission rates, lower re-intervention rates. Close adherence to device IFU (Instructions For Use) is important to improve durability and reduce reintervention rates, and submission of cases to the NVR (National Vascular Registry) should be mandatory.
6. More data on complex EVAR is required. NHS England recommends that complex EVAR should only be performed in a small number of designated centres, in agreed circumstances. Designation of such centres should also require collection of longitudinal data to inform future practice, and/or consider formal Commissioning Through Evaluation.

These recommendations would provide a workable solution to rationalise AAA repair and facilitate implementation of any proposed guidelines. They will also assist in relation to other concerns raised in response to the NICE guideline such as the provision of EVAR for ruptured AAA, training, ITU/HDU and ward bed resources for OSR, clinical outcomes, and patient choice. There has been much discussion about the available evidence. The debate highlights the shortcomings of the evidence and further research is now an immediate and high priority.

The Joint Societies hope that the final NICE guidelines, due to be published in December, will acknowledge the concerns of their members, and present a set of recommendations that will support a safe and sustainable service for patients with aortic aneurysms.