

EDITORIAL

Mapping the Workload Associated with Intact Abdominal Aortic Aneurysm

Epidemiology is the study of health related states or events (including disorders such as abdominal aortic aneurysm (AAA)), to find out how and why the disorder occurs in different groups of people. Given this definition, what does the paper from Swedvasc in this issue of the journal tell us about AAA?¹ It tells us that despite the excellent Swedish AAA screening programme,² aneurysm repairs are not increasing at the anticipated rate. Why not?

First, the structure of the population is changing, with more men and women living longer and at risk of developing an AAA, which is of course an age dependent disorder. However, this is offset by the decreasing population prevalence of smoking, which has been particularly marked in Sweden: the risk of developing an AAA is about five times higher in smokers than non-smokers. AAA is predominantly a disorder of those of White ethnicity, and Sweden, like many other European countries, has an increasingly diverse ethnic population, which might contribute to lowering the overall prevalence rate of AAA.

The Swedvasc data show how the increasing proportion of endovascular repairs has contributed to lowering the elective mortality rate and to safely extending elective aneurysm repair to an older age group, particularly the over 80s. The increasing number of repairs in this age group in Sweden parallels data from Australia, the UK, and elsewhere.^{3,4} However, since Swedvasc does not capture those patients not offered an intervention (deferred to conservative management) the epidemiology is far from complete: this is mentioned as a limitation of the current study. It remains possible that with an aging population, an increasing proportion of those with large aneurysms are consigned to conservative management. A recent meta-analysis suggests that 19% of men and 34% of women with large AAAs are not offered aneurysm repair, although the proportion may be lower in tertiary referral centres.⁵ These data are worrying, particularly for women and those who have been followed up for several years in a screening programme, and suggest that super-specialist centres expert in the management of these high risk patients might need to be developed. An increasing non-intervention rate might also explain why the rate of repairs for ruptured AAA remains relatively high, especially in women.

The current study from Swedvasc concludes that “this is the first time that a halt in intact AAA repair workload” has

been identified. This may not be a fair statement, since the re-interventions needed to support endovascular repair were not included: these actually have increased the workload. There is consensus from several studies that the re-intervention rate after endovascular repair is much higher than after open repair and remains this way for many years.^{6,7}

Therefore, to plan for the future AAA management workload in Sweden, considerable additional information is needed. Other European countries with different population structures and smoking habits and no screening programmes may have rather different future resource needs for the management of AAA.

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