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Keynote Lecture: The new **esvs** guidelines – what is new and what is different from the 2017 SVS AAA guidelines?

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Disclosure

Speaker name: **Anders Wanhainen**

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I do not have any potential conflict of interest



ESVS 2019 AAA Guidelines

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European Society for Vascular Surgery (ESVS) 2019 Clinical Practice Guidelines on the Management of Abdominal Aorto-iliac Artery Aneurysms

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ESVS 2019 AAA Guidelines

work process

- Initiated by ESVS GC in 2015
- 1st GWC meeting in Hamburg January 2016
- 2nd GWC meeting in Milano December 2016
- 3rd GWC meeting in Uppsala March 2017
- 1st draft July 2017
- 1st revision February 2018
- 2nd revision June 2018
- 3rd (final) revision August 2018
- E-published December 4 2018
- Printed version in EJVES January 2019



- **11 chapters**
- **835 references**
- **97 pages**
- **80,000 words**
- **125 recommendations**

What's ?

New topics:

- Quality control, resources, surgical volume, waiting time for surgery
- Juxtarenal AAA, isolated iliac aneurysms, mycotic AAA, inflammatory AAA, concomitant malignant disease, saccular AAA
- New treatment concepts; such as f-EVAR, ch-EVAR, EVAS and Endostaples
- The patient's perspective included for the first time in an ESVS guideline

Updated recommendations based on new data/evidence for already established topics:

- Medical treatment, screening, updated surveillance protocol for small AAAs and sub-aneurysms
- Threshold for elective repair, pre- and perioperative management
- EVAR first strategy for AAA repair, stratified less frequent follow-up regime after EVAR

Grading of recommendations

Classes of recommendations	Definition
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.
Class II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.
Class IIa	<i>Weight of evidence/opinion is in favour of usefulness/efficacy.</i>
Class IIb	<i>Usefulness/efficacy is less well established by evidence/opinion.</i>
Class III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.

Level of evidence A	Data derived from multiple randomized clinical trials or meta-analyses.
Level of evidence B	Data derived from a single randomized clinical trial or large non-randomized studies.
Level of evidence C	Consensus of opinion of the experts and/or small studies, retrospective studies, registries.

... is recommended

... should be considered

... may be considered

... is NOT recommended

7/125 (6%) recommendations
graded as **Class I**, **Level A**

Resources and availability

Recommendation 2	Class	Level
It is recommended that centres or networks of collaborating centres treating patients with abdominal aortic aneurysms can offer both endovascular and open aortic surgery at all times.	I	B

Surgical volume (caseload)

Recommendation 3	Class	Level
Abdominal aortic aneurysm repair should only be considered in centres with a minimum yearly caseload of 30 repairs.	IIa	C

Recommendation 4	Class	Level
Abdominal aortic aneurysm repair should not be performed in centres with a yearly case load <20.	III	B

Pathway for treatment

Recommendation 5	Class	Level
Once the intervention threshold has been reached, the waiting time for vascular surgical care is recommended to be kept at a minimum, with an eight-week pathway as a reasonable upper limit from referral to elective treatment of abdominal aortic aneurysms*	I	C

* A shorter timeframe should be considered for larger AAAs whilst a lengthier planning or work-up time may be justified for more complex aneurysms or comorbid patients.

Threshold for elective repair

Recommendation 22	Class	Level
In men, the threshold for considering elective abdominal aortic aneurysm repair is recommended to be ≥ 5.5 cm diameter.	I	A

Recommendation 23	Class	Level
In women with acceptable surgical risk the threshold for considering elective abdominal aortic aneurysm repair may be considered to be ≥ 5.0 cm diameter.	IIb	C

Surgical techniques

Recommendation 57	Class	Level
For newer generation of stent grafts based on existing platforms, such as low-profile devices, long-term follow-up and evaluation of the durability in prospective registries is recommended .	I	C

Recommendation 58	Class	Level
New techniques/concepts (such as endovascular aneurysm sealing with endobags) are not recommended in clinical practice and should only be used with caution, preferably within the framework of studies approved by research ethics committees, until adequately evaluated.	III	C

Surgical techniques

Elective repair

Recommendation 60	Class	Level
In patients with suitable anatomy and reasonable life expectancy, endovascular abdominal aortic aneurysm repair should be considered as the preferred treatment modality.	IIa	B

Recommendation 61	Class	Level
In patients with long life expectancy, open abdominal aortic aneurysm repair should be considered as the preferred treatment modality.	IIa	B

Recommendation 62	Class	Level
In patients with limited life expectancy, elective abdominal aortic aneurysm repair is not recommended .	III	B

Surgical techniques

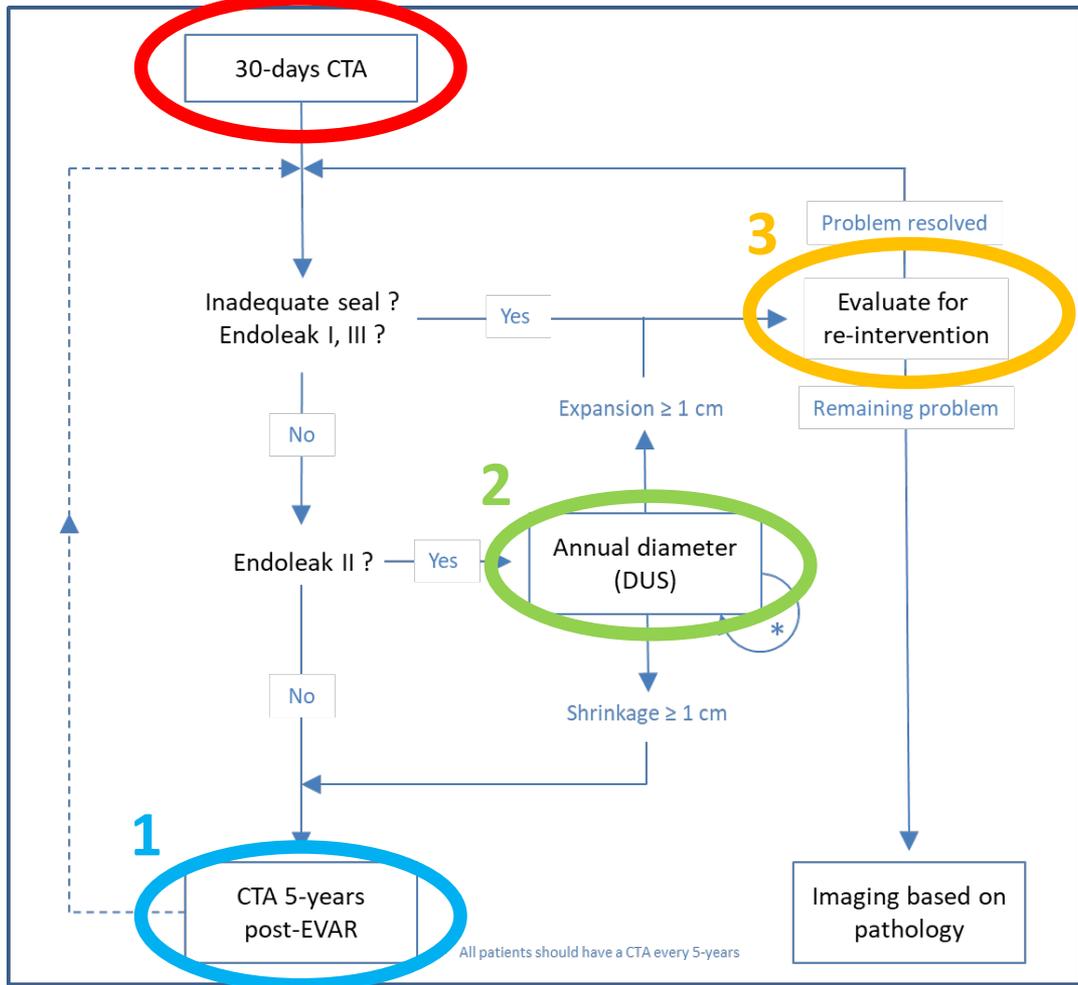
Rupture repair

Recommendation 74	Class I	Level
In patients with ruptured abdominal aortic aneurysm and suitable anatomy endovascular repair is recommended as a first option.	I	B

Recommendation 67	Class	Level
Local anaesthesia should be considered as the anaesthetic modality of choice for endovascular repair of ruptured abdominal aortic aneurysm whenever tolerated by the patient.	IIa	B

Follow-up after AAA repair

Recommendation 91	Class	Level
Early (within 30 days) postoperative follow-up after endovascular aortic repair including imaging of the stent graft to assess presence of endoleak, component overlap and sealing zone length is recommended .	I	B
Recommendation 92	Class	Level
Patients considered at low risk for endovascular aortic repair failure after their first postoperative computer tomography angiography, may be considered to be stratified to less frequent imaging follow-ups.	IIb	C



Juxtarenal AAA

Recommendation 93	Class	Level
In patients with juxtarenal abdominal aortic aneurysm and acceptable surgical risk, the minimum threshold for elective repair may be considered to be 5.5 cm diameter.	IIb	C
Recommendation 94	Class	Level
Centralization to specialized high volume centres that can offer both complex open and complex endovascular repair for treatment of juxtarenal abdominal aortic aneurysm is recommended .	I	C
Recommendation 95	Class	Level
In patients with juxtarenal abdominal aortic aneurysm open repair or complex endovascular repair should be considered based on patient status, anatomy, local routines, team experience and patient preference.	IIa	C

Juxtarenal AAA

Recommendation 96	Class	Level
In complex endovascular repair for JRAAA fenestrated stent grafts should be considered the preferred treatment option when feasible.	IIa	C
Recommendation 97	Class	Level
In complex EVAR for JRAAA using parallel graft techniques may be considered as an alternative technique in the emergency setting or when fenestrated stent grafts are not indicated or available, or as a bailout, ideally restricted to ≤ 2 chimneys.	IIb	C
Recommendation 98	Class	Level
In patients with JRAAA, new techniques/concepts, including Endovascular Aneurysm Seal, endostaples, and in situ laser fenestration, are not recommended as a first-line treatment, but should be limited to studies approved by research ethics committees, until adequately evaluated.	III	C

Ruptured juxtarenal AAA

Recommendation 99	Class	Level
In patients with ruptured juxta/pararenal abdominal aortic aneurysm open repair or complex endovascular repair (with physician modified fenestrated stent grafts, off-the-shelf branched stent graft, or parallel graft) may be considered based on patient status, anatomy, local routines, team experience and patient preference.	IIb	C

Iliac artery aneurysm

Recommendation 102	Class	Level
The threshold for elective repair of isolated iliac artery aneurysm (common iliac artery, internal iliac artery and external iliac artery, or combination thereof) may be considered at a minimum of 3.5 cm diameter.	IIb	C

Recommendation 103	Class	Level
In patients with iliac artery aneurysm endovascular repair may be considered as first line therapy.	IIb	B

Mycotic AAA

Recommendation 108	Class	Level
It is recommended to repair mycotic aneurysms irrespective of aneurysm size.	I	C
Recommendation 109	Class	Level
Surgical techniques in mycotic aneurysm repair should be considered based on patient status, local routines and team experience, with endovascular repair being an acceptable alternative to open repair.	IIa	C
Recommendation 110	Class	Level
Long-term postoperative antibiotic treatment (6-12 months or life-long) and surveillance should be considered after mycotic aneurysm repair.	IIa	C

Information for patients

patient's perspective

- Patient engagement improves the validity of clinical guidelines
- Lay review process;
 - Information for patients was drafted for each subchapter – plain English summary
 - Read and amended by a vascular nurse specialist and at least one layperson or patient
 - Finally reviewed by the Leicester patient focus group (PFG)
- Leicester PFG:
 - 8 men with small AAA under surveillance in Leicester (UK)
 - Previously attended a patient education on the clinical management of small AAA and the background to the ESVS guideline development process.

Information for patients

patient's perspective

- Resulted in clarity, consistency and simplicity in the presentation of facts and recommendations in the plain English summaries
 - What happens if I am diagnosed with an AAA?
 - If I have an AAA what is the risk of it bursting?
 - What happens if I have a small AAA and it gets bigger?
 - How is an operation to repair an AAA performed?
 - What are the main advantages and disadvantages of an open and an endovascular AAA repair?
 - What happens if I am not fit enough to have an operation to repair my AAA?
 - What happens if an AAA bursts?

→ **Development of Core Outcome Sets (COS)**



ESVS
guidelines
SUCKS!

#DUMB
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EVIDENCE

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OF
RESISTANCE

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