Changes to the Management of Patients with AAA in the UK: Is NICE out of Touch with Worldwide Best Practice?

Mike Wyatt
Newcastle upon Tyne
Disclosure

Speaker name:
Michael Wyatt

I have the following potential conflicts of interest to report:

☐ Consulting
☐ Employment in industry
☐ Stockholder of a healthcare company
☐ Owner of a healthcare company
☐ Other(s)

☑ I do not have any potential conflict of interest
Abdominal aortic aneurysm: diagnosis and management

NICE guideline
Draft for consultation, May 2018


“Multidisciplinary committee looks at current clinical, cost effective and QoL evidence and develops their recommendations”

Currently out to consultation and final report will be published on 19th December 2018
Core principles of NICE’s work

• Based on the best evidence available
• Expert input
• Patient and carer involvement
• Independent advisory committees
• Genuine consultation
• Regular review
• Open and transparent process
• Social values and equality considerations
Stakeholders

- Politician
- Non Specialist Physician/s
- Specialist Physician/s
- Patients
- Carers
- Policy makers
- Societies
- Funders

Societies

Funders

INDUSTRY
Committee decision making

Clinical effectiveness

Cost-effectiveness

Extent of uncertainty

Social Value Judgements

Other health benefits

Innovation

Equality legislation

Recommendations

Clinical effectiveness

Cost-effectiveness

Extent of uncertainty

Social Value Judgements

Other health benefits

Innovation

Equality legislation

Recommendations
1.5  **Repairing unruptured aneurysms**

1.5.1  Consider aneurysm repair for people with an unruptured abdominal aortic aneurysm (AAA), if it is:

- symptomatic
- asymptomatic and 5.5 cm or larger
- asymptomatic, larger than 4.0 cm and has grown by more than 1 cm in 1 year.

1.5.2  For people with unruptured AAAs meeting the criteria in 1.5.1, offer open surgical repair unless there are anaesthetic or medical contraindications.

1.5.3  Do not offer endovascular repair (EVAR) to people with an unruptured infrarenal AAA if open surgical repair is suitable.
1.5.4 Do not offer EVAR to people with an unruptured infrarenal AAA if open surgical repair is unsuitable because of their anaesthetic and medical condition.

1.5.5 Do not offer complex EVAR to people with an unruptured AAA if open surgical repair is a suitable option, except as part of a randomised controlled trial comparing complex EVAR with open surgical repair.

1.5.6 Do not offer complex EVAR to people with an unruptured AAA if open surgical repair is unsuitable because of their anaesthetic and medical condition.
1.6 Reparing ruptured aneurysms

1.6.1 Consider endovascular repair (EVAR) or open surgical repair for people with a ruptured infrarenal abdominal aortic aneurysm (AAA). Be aware that:

- EVAR provides more benefit than open surgical repair for most people, especially for women and for men over the age of 70.
- open surgical repair is likely to provide a better balance of benefits and harms in men under the age of 70.

1.6.2 Consider open surgical repair for people with a ruptured complex AAA.

1.6.3 Do not offer complex EVAR to people with a ruptured AAA if open surgical repair is suitable, except as part of a randomised controlled trial comparing complex EVAR with open surgical repair.
Endovascular versus open repair of abdominal aortic aneurysm in 15-years’ follow-up of the UK endovascular aneurysm repair trial 1 (EVAR trial 1): a randomised controlled trial

Rajesh Patel, Michael J Sweeting, Janet T Powell, Roger M Greenhalgh, for the EVAR trial investigators*

Interpretation EVAR has an early survival benefit but an inferior late survival compared with open repair, which needs to be addressed by lifelong surveillance of EVAR and re-intervention if necessary.
EVAR 2 costs £450,000 per QALY (£30,000 – breakeven)

Every EVAR 2 patient denies 22-23 people a clinically and cost-effective treatment on the NHS.
**No-brainer**: no independent unbiased advisory committee could advise the NHS to purchase EVAR rather than OSR

1.5.3 Do not offer endovascular repair (EVAR) to people with an unruptured infrarenal AAA if open surgical repair is suitable.
In 21st century do we need to spend our money wisely!

Health Care Cost (1970-2016)

- Austria
- Canada
- Germany
- Switzerland
- United Kingdom
- United States

Percent of GDP

Year

US 18%

UK 8%?
Evidence Based Medicine

• Do you believe in Evidence Based Medicine?

• Do you think cost is important in determining treatment choices?
The Society for Vascular Surgery practice guidelines on the care of patients with an abdominal aortic aneurysm

Elliot L. Chaikof, MD, PhD,a Ronald L. Dalman, MD,b Mark K. Eskandari, MD,c Benjamin M. Jackson, MD,d W. Anthony Lee, MD,e M. Ashraf Mansour, MD,f Tara M. Mastracci, MD,g Matthew Mell, MD,b M. Hassan Murad, MD, MPH,h Louis L. Nguyen, MD, MBA, MPH,i Gustavo S. Oderich, MD,j Madhukar S. Patel, MD, MBA, ScM,a,k Marc L. Schermerhorn, MD, MPH,a and Benjamin W. Starnes, MD,l

Boston, Mass; Palo Alto, Calif; Chicago, Ill; Philadelphia, Pa; Boca Raton, Fla; Grand Rapids, Mich; London, United Kingdom; Rochester, Minn; and Seattle, Wash

Whereas cost-effectiveness results can vary among different populations of patients and health care systems and over time, the factors that influence cost and outcomes remain consistent. In a future of rising costs and constrained resources, cost-effectiveness analysis will provide a basis to guide health care policy that sustains health care coverage for all.
Effects if upheld

• Will UK be outliers if guidance is upheld? – Yes

• Is NICE out of touch? – Perhaps at present

• Is NICE wrong? – Probably not!

• Will the world follow? – Probably yes!
VS/BSIR/VASGBI Joint Statement

• OSR only or no intervention – unacceptable
• Validated tools for fitness assessment lacking
• Restricts primary Rx of AAA in UK
• Actively withdraws EVAR despite safety/effectiveness evidence existing
Conclusion

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Evidence based guideline

Best for patients at a cost effective threshold?

Huge areas of controversy