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Aaa surveillance guidelines

Background: The GUIDELINES of the US Preventive Services Task Force (USPSTF) are the most widely used screening criteria for abdominal aorta aneurysms (AAA). However, when the USPSTF criteria are applied retrospectively to a group of patients who have undergone AAA treatment, there are many patients who do not meet any of the AAA screening criteria. The More Sensitive Guidelines of the Society for Vascular Surgery (SVS) expand screening criteria for AAA in the hope of capturing the majority of those individuals who may undergo treatment for their AAA before submitting with the AAA rupture. We seek to determine the number of patients who would be identified as having AAA screening criteria under the USPSTF and SVS criteria in a cohort of patients who underwent treatment for AAA. Methods: We evaluate demographic, comorbidity, and perioperative complications data for all patients undergoing endovascular and open AAA repair in the Vascular Quality Initiative. Patients who meet each of the screening criteria have been identified. Clinical factors and demographic variables have been collected. Results: We found that 55,197 patients undergoing AAA repairs were under the Vessel Quality Initiative, including 44,602 patients who underwent endovascular aneurysm (EVAR) repairs and 10,595 patients undergoing open-label repair. Of these, the USPTF guidelines would identify less than a third of patients (32% EVAR and 33% open repair). The implementation of the SVS guidelines increases the number of verification criteria by 6% and 12% for EVAR and open repair cohorts respectively. Finally, the adoption of the extended SVS guidelines (including weak recommendations) would identify an additional 34% of patients receiving EVAR and 21% of open-ended AAA patients. The use of the extended criteria would result in 27% of patients undergoing EVAR and 33% of patients undergoing open-air AAA repairs who would not meet the screening criteria. In patients who did not meet the criteria, 52% were under 65 years old, had heavy smoked smoke. Of all those who did not meet the screening criteria, ruptured AAA were twice as prevalent as those who met the screening criteria (8.5% vs. 4.4%; $\leq .0001$). Conclusions: Extending established USPSTF screening guidelines to include advanced SVS criteria could potentially double the number of patients identified with AAA. Smokers under the age of 65 and elderly patients aged 70 and over without being smokers represent two groups with AAA and potentially twice the risk of rupture. Keywords: Abdominal aortic aneurysm; sv; Check; 2014 and 2014, 200,000 people in the U.S. were diagnosed with abdominal aortic aneurysm (AAA), an expansion of artery in the abdomen. AAA rupture is the 15th leading cause of death in the country (~ 4,500 cases/year/year. over 55 years of age. AAAs occur in up to 13 percent of men and 6 percent of women over the age of 65. Since the mortality associated with the elective repair of the aneurysm is drastically lower than after the repair of a ruptured AAA, the emphasis should be on early detection and repair before the onset of rupture. Death from AAA is preventable with early detection and appropriate, timely treatment. When to refer to the Society for Vascular Surgery (SVS) has created disease-specific guidelines to help in the care of patients at risk of being diagnosed with AAA. Screening for AAA in specific patient populations has been found to improve disease mortality and can be performed without the risk of patients using duplex ultrasound. SVS recommends one-time screening for all patients ≥ 65 yo with a history of tobacco use, as well as first-degree relatives of AAA patients, regardless of tobacco history. Any expansion of the aorta ≥ 1.5 times its reference

diameter is considered an aneurysm. We recommend referral to a vascular surgeon during the diagnosis of each AAA. Specific features that may require repair include: secular morphology, size > 5cm in women, size > 5.5cm in men, or whatever symptoms such as back or abdominal pain or embolisms to the lower extremities that can be attributed to AAA. Why refer to vascular vascular surgery is the only discipline among the American Council of Medical Specialties, which has specific training requirements for studying natural history, medical treatment, minimally invasive repair and traditional surgical repair options for your patients. The vascular surgeon may be your partner to help you and your patients get the most comprehensive treatment for their vascular disease, as well as treatment that is best for them. Early referral and cooperation with a vascular surgeon can lead to better outcomes for each patient. AAA: Useful evidence-based guidance is recommended to check appropriate groups of physicians who are at increased risk and monitor established AAA; ultrasound is the preferred imaging tool. We recommend using ultrasound whenever possible as the preferred form of imaging for aneurysm chest of drawers and observation. Level of recommendation 1 (Strong) Quality of evidence A (high) We assume that the maximum aneurysm diameter obtained from the CT image should be based on the outer wall of the outer wall perpendicular to the path of the aorta. Recommendation level Declaration of good practice Quality of evidence Unin limited Who should be checked for AAA? We recommend one-time ultrasound screening for AAAs in men or women 65 to 75 years of age with a history of tobacco use. Recommendation level 1 (Strong) Quality of evidence (high) We offer ultrasound screening for AAA in first-degree relatives of patients who are present with AAA. Screening should be carried out in first-time relatives between 65 and 75 years of age or those over 75 years of age and in good health. Recommendation Level 2 (Weak) Quality Of Evidence C (Low) We offer one-time ultrasound screening for AAAs in men or women over the age of 75 with a history of tobacco and in otherwise good health who have not previously received an ultrasound examination. Recommendation level 2 (Weak) Quality of evidence C (Low) If the initial ultrasound screening identifies aortic diameter >2.5 cm, but <3cm, we offer re-hiding after 10 years. Recommendation level 2 (Weak) Quality of evidence C (Low) How often should supervision be carried out? Recommendations based on AAA diameter: We offer imaging at 3-year intervals for AAA patients between 3.0 and 3.9 cm. Recommendation level 2 (Weak) Quality of evidence C (low) We assume imaging at 12-month intervals for patients with AAA from 4.0 to 4.9 cm in diameter. Recommendation level 2 (Weak) Quality of evidence C (low) We assume imaging at 6-month intervals for patients with AAA between 5.0 and 5.4 cm in diameter. Recommendation Level 2 (Weak) Quality of Evidence C (Low) We recommend CT image for patients who think they have symptomatic AAA (abdominal or back pain with known AAA, risk factors for AAA, etc.). We recommend CT scans to evaluate patients who believe they have AAA who have recently appeared in the early abdomen or back pain, especially in the presence of a pulp-strong epigastric mass or significant risk factors for AAA. Recommendation level 1 (Strong) Quality of evidence B (Moderate) Referral recommendations and possible AAA fixes: We offer referral to a vascular surgeon during the initial diagnosis of aortic aneurysm. Level recommendation Declaration of good practice Quality of evidence Unlimited Recommend repair for the patient who presents with AAA and abdominal or back pain that is likely to be due to an aneurysm. Recommendation level 1 (Strong) Quality of evidence C (Low) We recommend selective repair for the patient at low or acceptable surgical risk with fusiform AAA, which is ≥5.5 cm. Level of recommendation 1 (Strong) Quality of evidence A (high) We assume elective repair for the patient, which presents with a sacular aneurysm. Recommendation level 2 (Weak) Quality of evidence C (low) We offer repair in women with AAA between 5.0 cm and 5.4 cm in maximum diameter. Recommendation level 2 (Weak) Recommendations for smoking cessation and medical therapy in patients with AAA: We recommend smoking cessation to reduce the risk of AAA growth and rupture. Level of Recommendation 1 (Strong) Quality of Evidence B (moderate) We suggest not applying statins, doxycycline, roxythromycin, ACE inhibitors, or angiotensin receptor blockers for the sole purpose of reducing the risk of enlargement and of AAA. Level of 2 (Weak) Quality of Evidence B (Low) We suggest not applying beta blocker therapy for the sole purpose of reducing the risk of expansion and rupture of AAA. Recommendation level 1 (Strong) Quality of Evidence B (moderate) Additional recommendations for beta blocker therapy for patients with AAA: We offer continuation of beta blocker therapy during the perioperative period if it is part of an established medical regimen. Level of Recommendation 2 (Weak) Quality of Evidence B (moderate) If the decision is made to start beta blocker therapy (due to the presence of numerous risk factors, such as ischemic heart disease, renal failure, and diabetes), We suggest starting well before surgery to give sufficient time to assess safety and tolerability. Recommendation level 2 (Weak) Quality of evidence B (moderate) Recommendations for endovascular and open repair to optimize patient outcomes: We suggest that elective EVAR is performed in centers with a volume of at least 10 EVAR cases each year and documented perioperative mortality and osr conversion rate of 2% or less. Recommendation level 2 (Weak) Quality of evidence C (Low) We assume that elective ERC is carried out in centres with a volume of at least 10 EVAR cases each year and documented perioperative mortality and osr conversion rate of 2% or less. Recommendation Level 2 (Weak) Quality of Evidence C (Low) Shared Decision-making with patients and referral providers: We suggest informing high-risk patients about their VQI mortality risk in order to make an informed decision to proceed with an aneurysm repair. Recommendation level 2 (Weak) Quality of evidence C (Low) Quality of evidence B (moderate) In patients with a small aneurysm (4.0 cm to 5.4 cm), who will require chemotherapy, radiation therapy, or solid organ transplantation, We offer a common approach decision-making for treatment decisions. Recommendation level 2 (Weak) Quality of Evidence C (Low) Recommendations for follow-up after Open Surgical AAA Repair and EVAR: Longitudinal care is important for all vascular patients, especially after EVAR (Endvascular Aneurysm Repair) After EVAR: We recommend baseline imaging in the first month after EVAR with contrast amplification CT and color duplex ultrasound. In the absence of an endolac or expansion of a bag, the images should be repeated within 12 months, using contrast-enhanced CT or color duplex ultrasound. Recommendation level 1 (Strong) Quality of evidence B (moderate) If type II endoleak is observed 1 month after EVAR, we offer postoperative monitoring with contrast enhanced CT and color duplex ultrasound of 6 months. Recommendation level 2 (Weak) Quality of evidence B (moderate) If neither AAA enlargement is observed 1 year after EVAR, we color duplex ultrasound when when or CT image, if ultrasound is not possible, for annual observation. Recommendation level 2 (Weak) Quality of evidence C (low) If type II endoleak is associated with an aneurysm sac that shrinks or stable in size, we offer color duplex ultrasound for prolonged observation at 6-month intervals for 24 months and then annually therein. Recommendation level 2 (Weak) Quality of evidence B (low) If a new endoleak is detected, we offer an assessment for endolyc type I or iii type of endolyc. Recommendation level 2 (Weak) Quality of evidence C (Low) We assume an uncontative CT image of the entire aorta at 5-year intervals after an open repair or EVAR. Recommendation level 2 (Weak) Quality of evidence C (Low) After open repair: We recommend that monitoring patients after recovery of the aneurysm include a thorough examination of the pulse of the lower extremities or ABI. Level of recommendation 1 (Strong) Quality of evidence B (moderate) We recommend a quick assessment of possible occlusion of the limb in graft, if patients develop emerging lower limb claudication, ischemia, or reduction of ABI after aneurysm repair. Level recommendation 1 (Strong) Quality of evidence A (high) Source: Society for Vascular Surgery Guidelines for the practice of treating patients with abdominal aortic aneurysm Eliot L. Dr. Chaikoff, Dr. Ronald L. Dolman, Dr. Mark K. Escandari, MD, Benjamin M. Jackson, MD, W. Anthony Lee, MD, M. Ashraf Manour, MD, Tara M. Mastracci, MD, Matthew Mel, MD, MD. Hassan Murad, MD, MPH, Louis L. Nguyen, MD, MBA, MPH, Gustavo S. Oderich, MD, Madhukar S. Patel, MD, MBA, SCM, Mark L. Schermerhorn, MPH, IMF, Benjamin W. Zvez, MD J Vasc Surg 2018; 67(1):2-77.

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