

3. Organisation of vascular services

Hospital workload >> Implications

These large scale studies do not mean that individual surgeons and hospitals performing small numbers of procedures cannot have excellent results. Nevertheless, it is of concern that so many hospitals are carrying out small numbers of procedures. Clinicians, Trust managers and purchasers should examine whether existing referral and work patterns are in the best interests of patients. The centralisation of such surgical services as cardiac surgery, neurosurgery and some cancer surgery is well established, as are networks for the management of cancer. The data from this study together with the published evidence suggest that serious consideration should be given to restricting elective open aortic aneurysm surgery to many fewer hospitals than are presently carrying out the procedure.

There will be an inevitable impact on the provision of emergency aortic surgery if elective surgery is restricted to fewer hospitals. Patients admitted to hospitals that have increased their aortic vascular workload will be treated by a surgical team that has the possibility of increasing its expertise. Patients admitted to a hospital that has faced a reduction in its vascular workload, or that now does no elective aortic cases at all, will be treated by a surgical team that only performs an occasional case. This is bound to lead to apprehension on the part of the patient and the surgical team, and may result in a worse outcome.

Screening programmes to identify asymptomatic aortic aneurysms before they rupture, and to offer elective surgery when appropriate, have been debated for some years. There appears now to be sufficient evidence to show that screening programmes for aortic aneurysm are beneficial^{9,10} and screening may be implemented. The National Screening Committee has stated that randomised controlled trials have demonstrated a reduction in mortality from ruptured abdominal aortic aneurysm and that a working group set up to appraise the policy implications will report by the end of 2005¹¹.

At present, some patients with a ruptured AAA present to hospitals that undertake very few or no emergency aneurysm repairs. Although the numbers of such patients would be reduced with the implementation of a screening programme, some patients will not be picked up by a screening programme and will continue to present with a ruptured AAA. Possible options are that a surgeon without any regular vascular experience may step into the breach to do the best they can; a vascular surgeon may travel from another hospital to operate in the admitting hospital (this solution will provide surgical expertise but the patient will not have access to anaesthetic, nursing and ICU expertise); or the patient may be transferred from the admitting hospital to a vascular unit in another hospital. Several recent publications explore the various models of care that are potentially available^{12,13,14}.

There is evidence that patients with a ruptured aortic aneurysm can be transferred safely for journeys of more than an hour by road or over 25 miles¹⁵. Some areas within the United Kingdom have already instituted schemes for the transfer of patients from a particular catchment area into a central vascular unit. It will be necessary to consider similar schemes whenever planning to withdraw vascular services from hospitals with small workloads.