

EDITORIAL

SCREENING FOR ABDOMINAL AORTIC ANEURYSMS: IS IT WORTHY?

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Because abdominal aortic aneurysms (AAA) are an asymptomatic, but potentially fatal disease, efforts have been made around the world to establish programs of early detection.

Much has been written for and against screening programs for AAA. The argument most used supporting those programs is, obviously, the fact that elective and preventive surgical repair carries a mortality risk varying from 2% to 10%, much lower than the 50% mortality associated with surgery for ruptured aneurysms. It is known that rupture is usually the first clinical manifestation of an AAA. The cases against are: most aneurysms do not require surgical intervention (only the large ones, hence the cost-effectiveness of screening is doubtful);

aneurysms prevail in an age group close to average life expectancy, thus many patients will die from other causes; and detection of a small aneurysm does not mean a life threatening situation, but may cause psychological stress.

In this issue, Bonamigo and Siqueira present the results of a screening for AAA in three different population samples in Porto Alegre, Brazil. The prevalence found is slightly lesser than that found in samples of the North American and European population. Knowing that AAA is dependant on genetics and on the presence of atherosclerosis, one can expect different prevalences in different populations, depending on the racial and alimentary factors. Thus, to know the preva-

lence in a given population is of utmost importance in public health.

The discussion about the usefulness of such programs shall consider two different situations: one is the *permanent* and *continuous* screening of a given population, and other is the performance of *one* study to know the prevalence in a specific geographic group. Certainly, the decision to promote a permanent program to screen AAA in the whole population of a given country shall be made on the basis of cost-effectiveness. But the conduction of *one* screening in each geographical region shall be enforced, since the knowledge of the prevalence can orient future public health policies and, more than that, provides information to

individuals about the risk of the disease. Data from literature cannot be used worldwide, for the disease depends on ethnic and ambient factors.

When the cost of screening is covered by governments, priority

has to be decided depending on the total budget for health care, and on the need for screening other diseases.

On an individual basis, however, we must state that each person has the right to know what

kind of disease may eventually afflict him, what the odds are, and to decide whether to be screened or not, at his own expenses.

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