Regarding “Pilot testing of a decision support tool for patients with abdominal aortic aneurysms”

We have read with interest the article by Berman et al. reporting the evaluation of a decision support tool for patients with an abdominal aortic aneurysm (AAA). This article is of particular importance because AAA patient preferences should be taken into account when weighing a patient’s risk of aneurysm rupture against the risk of surgical complications. In current clinical practice, however, patient preferences are insufficiently explored. The content of the developed tool was based on a national survey of vascular surgeons and the input of postoperative AAA patients. A health literacy expert was involved as well.

Two years ago, we developed a decision aid for newly diagnosed AAA patients in the Netherlands. In addition to the input of vascular surgeons and AAA patients, we followed the International Patient Decision Aids Standards criteria, which provide an international consensus-based framework for high-quality decision aids. We also included input from patients who did not consent to surgery, because their ideas about what information should be included in a decision aid may well differ from patients who have undergone aneurysm repair.

In the study by Berman et al., 12 surgical candidates with an AAA reported the decision support tool to be feasible. Before and after tool measurements showed increased patient knowledge and decreased decisional conflict. From our point of view, it would be interesting to monitor final treatment decisions as well. Providing comprehensive information, such as in decision aids, may reassure unnecessary surgical treatment.

The issues mentioned here are currently being addressed in our ongoing randomized clinical trial on the effectiveness of a decision aid to enhance shared decision making by patients with AAA patients. Final results are expected to be published in 2012.

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REFERENCES


Regarding “Late outcomes following open and endovascular repair of blunt thoracic aortic injury”

I applaud Patel and colleagues for an informative and well-written article on late outcomes associated with repair of blunt thoracic aortic injury. However, the evaluation of late mortality—the stated primary end point of the trial—is notably missing for each treatment group. Instead, the results of both treatment groups are presented collectively in Fig 1, A. This data presentation is confusing because: (1) mean follow-up was nearly 10 years with open surgical repair vs only 3 years with endovascular repair and, (2) open surgical repair patients comprised 83% (90 of 109) of the entire cohort. These factors strongly influence the overall survival estimate (especially with longer follow-up) to approximate that of open surgical repair. Despite the small number of patients treated with endovascular repair in this study (n = 19), it would be of great interest to see the long-term survival rate in this group reported separately.

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REFERENCE

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Reply

We appreciate Dr Miller’s comments regarding our work on late outcomes after repair of traumatic aortic injury. We agree that in the analysis of the entire cohort, the weight of the open descending thoracic aortic repair (DTAR) group will statistically influence late survival of the cohort for the reasons he stated. The type of repair was not associated with the primary endpoint of late mortality rate (DTAR 15.6% vs thoracic endovascular aneurysm repair [TEVAR] 10.5%; P = .73). The Kaplan-Meier curves stratified by type of repair are shown below (Fig) and confirm that there is no time dependency of this mortality rate. The curves have been truncated at 48 months beyond which the standard error rises above 10%.

Fig. Late survival after open and endovascular repair for blunt thoracic aortic injury.
REFERENCE
