Type Two "Endoleak": Medical Jargon that Causes Significant Anxiety in Patients

Dear Sir,

We wish to propose a new term to describe a type 2 endoleak. In order to reduce the anxiety this word causes for patients we suggest the term ‘persistent collateral’ should be used. We and our educational supervisor would welcome the learned opinions of European vascular surgeons on this matter.

As final year medical students we often fall into the trap of absorbing medical lingo without fully appreciating the effects of such phrases on patients. During our recent clinical attachment in vascular surgery we gained an appreciation of how, following endovascular aortic aneurysm repair (EVAR), aneurysm sacs can still have a persistent inflow and be continuously pressurised; a phenomenon that is classified into four separate types (endoleak types 1–4).

As trainee clinicians, we automatically adopted these terms and appreciated the convenience of grouping such complications in a classified system. We found that generally this term was of appropriate use in patients who demonstrated an endoleak which warranted treatment. However, in patients with type 2 endoleaks, where perfusion of the aneurysm sac still occurs via collateral vessels, we observed that the word ‘leak’ tended to invoke significant anxiety amongst patients. This worry was then difficult to dissipate, especially when addressing concerns as to why they would not require further intervention. Whilst the current classification serves to satisfy clinical convenience, it does not help patients’ understanding of such phenomena. Therefore we suggest that it would be beneficial to change the nomenclature of a type 2 endoleak and after much contemplation, consider the term ‘a persistent collateral’ an adequate substitute. It not only avoids words which the patient will associate with adverse outcomes, but also sufficiently communicates the situation to other clinicians.

Yours sincerely,

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References

surveillance programme at Barts and The London NHS Trust. We have identified and extrapolated patients who have confirmed endoleaks on CTA but normal surveillance imaging using combined duplex ultrasonography and abdominal radiography. The patients with “missed” endoleaks have been reimaged using CEADUSS and in all ten patients recruited to our pilot study were found to have the endoleaks also detected with their CTA scanning. We have also found that the use of CEADUSS allows us to dynamically track the endoleaks to the responsible causative vessels or source to further provide vital information to help with reintervention planning.

CEADUSS is a very skilled imaging technique but has obvious benefits to both patients and the departmental financial budget. Do you believe there is a place for the inclusion of CEADUSS into you currently presented protocol? It could be used to replace a number of the CTA scans that your pathway requires when abnormal initial imaging detects sac size discrepancies. Another use of CEUS would be for the monitoring of patients known to possess “stable” endoleaks who often under certain protocols require more frequent surveillance imaging and thus risk exposure. We aim to present our results in the near future.

References


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Dear Editor,

We thank Dindyal, Fardon and Kyriakides for their comments on our work. We have shown that CTA can be avoided in the majority of patients as part of EVAR surveillance. Dindyal et al. have reported their pilot experience with contrast-enhanced ultrasound. We now also use contrast-enhanced ultrasound (CEUS) to investigate patients with endoleaks which are not definitively characterised at unenhanced Doppler ultrasound or arterial phase CT. The additional temporal information from CEUS is crucial in identifying endoleak type.

In the presence of endoleak with aneurysm expansion we still require CTA to ensure that endograft seal zones are adequate, which limits our potential replacement of CTA with CEUS. The experience of our first 20 CEUS was recently presented at the annual meeting of the British Society of Endovascular Therapy and is currently being prepared for submission for publication. We envisage an addition to our surveillance protocol to include CEUS.

Yours faithfully,
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