INVITED COMMENTARY

Comments regarding ‘Structure of Delay in Carotid Surgery — An Observational Study’

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Recent guidelines recommend that carotid endarterectomy (CEA) in symptomatic patients should be performed within 14 days of onset of symptoms. However, there are concerns how this 2-week target could be achieved logistically in a busy vascular unit. The present study from Helsinki represents a first-class example of the practical problems behind offering an expedited CEA service. Our Finnish colleagues audited the delay in performing CEA in recently symptomatic patients during the period August 2007—September 2008 and documented the reasons for the delay. As such, the study gives a useful insight of what happens in the real world. So what are the lessons learned from this study? Only 11% of the patients had been operated within 2 weeks, an uncomfortable truth, whereas 10% had recurrence or progression of their symptoms during the delay from the first symptom to operation. CEA was more likely to be performed within the 2-week target if the patient had been an emergency referral to the on-call neurologist or the on-call vascular surgeon or if the patient himself presented to the emergency unit. Similarly, the total delay from the index symptom to CEA was significantly shorter 1) if the symptom was a minor or major stroke rather than a TIA or amaurosis fugax; 2) if the patient was referred to the (tertiary referral) hospital as an emergency patient rather than an elective one, 3) if the vascular surgeon was consulted during this first visit and 4) if the carotid imaging was performed urgently. Still, the longest component of the delay was surgery-related with a median of 25 days from seeing the vascular surgeon to the operation.

So what could be done to minimize such delays? To accomplish this, it would take more than a few enthusiastic vascular surgeons. It would require an orchestrated health policy change supported by hospital managers and health authorities. Local differences across regions or countries should be borne in mind, but raising public awareness about stroke would be a good first step. This is of paramount importance, because patients, as seen in the Finnish study, tend to ignore minor symptoms such as TIA or amaurosis fugax and not seek medical advice early enough. National stroke medicine, neurology and vascular surgical societies should also play a leading role in distributing the message of benefiting from rapid carotid intervention across the medical community. Creation of rapid access TIA clinics is another significant step forward. Proper initial assessment, initiation of “best medical therapy”, and imaging (with duplex ultrasound and brain CT or MR) during a single visit would confirm the diagnosis and identify those patients who would benefit from emergency referral to the vascular surgeon. The last (but not least) component of the delay is surgery-related, a major hurdle for the authors in the present study. Cancellation of non-urgent cases or utilisation of cancelled theatre sessions is one option, but this, alone, may not be enough and major reorganisation within the vascular unit itself may be necessary. Since the authors realising that only 11% of their patients were operated within 2 weeks, two additional weekly empty operation slots were added to shorten delay. Furthermore, access to

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emergency theatre during the holiday season had been provided as a means of operating some stable CEA cases. So, from the vascular surgeon’s point of view, the addition of new dedicated CEA slots may be a logical solution, but this is not without important logistical implications, such as financial issues, competition with other waiting list targets, availability of theatre and anaesthetic staff, to name a few. Finally, some of these theatre sessions may go unused if there is no appropriate candidate, but this could be minimised by offering the empty slot to another vascular or non-vascular case in short notice. Naturally, the latter requires flexibility by all parties involved.

In conclusion, this observational study documents the typical problems a vascular unit may face when attempting to minimise delays and introduce a rapid access CEA service. Such a study is the first step towards this direction, gives figures to support and plan changes and provides the ammunition vascular surgeons need to defend their case in front of health officials. Of course, the proposed changes should be monitored to see whether they have made any difference in delay and to close the audit loop. Efforts should be focused on raising public awareness, improving communication with other medical colleagues so that patients are referred with minimal delays and, finally, convincing managers about reorganising the service and providing extra operating time.

References

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