Invited Commentary

Commentary on ‘Selection, Thirty Day Outcome and Costs for Short Stay Endovascular Aortic Aneurysm Repair (SEVAR)’

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One of the most consistent findings of all studies comparing open and endovascular repair (EVAR) of AAA has been that EVAR patients very seldom need postoperative intensive care and their overall hospital length of stay (LOS) is significantly reduced. These two elements are essential to offset for the high cost of EVAR devices and make the procedure economically competitive, especially in those with significant co-morbidities. In the past, the mean LOS for EVAR patients ranged between 2.5 and 2.8 days; however, there is a strong trend in the USA to discharge patients on the first postoperative day (POD). The rapidly increasing popularity of percutaneous EVAR (PEVAR) was expected to have an impact on LOS, but the reported difference was not statistically significant. Nevertheless, majority of uncomplicated PEVAR patients, particularly those who undergo procedure under local anaesthesia, do remarkably well and can be safely discharged home the same day.

The LOS is affected by multiple factors, which includes patient and procedure related (medical condition, functional and mental status, transportation, independent living, achieving good pain control and ambulation), physician related (setting criteria for discharge, communication with the patient) and finally system related. In the current study, Al-Zuhir and colleagues successfully addressed the patient- and procedure-related issues. In order to decrease LOS after EVAR, they have used a pathway developed for many other surgical procedures in the UK. Consequently, they were able to discharge 30% of patients on first POD and as the team has become more comfortable with the process this rate has increased to 45%. Authors used very conservative selection criteria for the SEVAR group. Excluding all diabetics, patients with body mass index (BMI) >35, and those with history of TIA/CVA (transient ischemic attack/cerebrovascular accident) within 12 months seems to be unnecessary, particularly if they have good functional capacity, optimised medical condition and independent living status.

In addition, adopting shorter hydration protocols for renal patients and performing adjunctive procedures such as coiling either as a separate outpatient procedure or simultaneously during the EVAR would increase the number of patients eligible for SEVAR. Interestingly, patients not selected for SEVAR had a mean LOS of 4 days which seems to be at least excessive, particularly if there was no complications related to the procedure. It may raise a question regarding the efficacy of the current system and the possible need for significant improvements, particularly if authors would attempt SEVAR for majority of their patients, which is a common practice in the USA.

The preoperative medical optimisation and assessment, transportation issues, setting patients’ expectations for estimated discharge as well as daily assessment of eligibility for discharge are routine components of admission in the US hospitals. Admission the day before elective surgery has been almost completely eliminated, as it is usually not reimbursed by private payers, and Centers for Medicare and Medicaid Services (CMS). This practice is also not allowed by Utilization Review Program in the Veterans Administration Healthcare System (VA). The VA which is often compared to European universal access health care systems underwent a massive transformation in the 90s. As a result, almost half of the hospital beds were eliminated and partially replaced by temporary lodging beds (‘Hoptel’). Case management and telephone-linked care became an integrated part of the overall care. Patients scheduled for elective surgery have mandatory outpatient evaluation by the anesthesia service, and arrangements for transportation to the hospital and upon discharge are made. Those coming from long distances and depending on VA transportation system are arranged to stay in the Hoptel. At the time of admission, discharge planning starts with the goal not only to send selective patients home early, but also to send all patients home as soon as they become medically stable, ambulates and home care arrangements are secured. These changes resulted in significant improvement in hospital LOS, which now is fully comparable to the private sector. We believe that reasons given by authors for not being able to discharge patients early imply that the system needs major changes to secure potential savings in the care of vascular patients.

References