Several earlier studies have demonstrated that EVAR is associated with reduced mortality rates for the management of ruptured AAAs compared with open AAA repair [2, 3]. A recent meta-analysis showed that compared with open AAA repair, EVAR is associated with a significant 38% reduction in 30-day mortality [pooled odds ratio 0.624; 95% confidence interval (CI), 0.518–0.752; P < 0.0001], a shorter intensive care unit (pooled effect size estimate −0.70 days; 95% CI, −1.05 to −0.35 days; P < 0.0001) and hospital stay (pooled effect size estimate −0.33 days; 95% CI, −0.50 to −0.16 days; P = 0.0001), as well as a significant reduction in blood loss (pooled effect size estimate −1.88 l; 95% CI, −2.49 to −1.27 l; P < 0.0001) and procedure time (pooled effect size estimate −0.65 h; 95% CI, −0.95 to −0.36 h; P < 0.0001) for the management of acute (ruptured and symptomatic intact) AAAs [3]. Although it is probably a fact that EVAR should be preferred over open AAA repair for the management of ruptured AAAs, there are some practical difficulties. Firstly, not all hospitals may have the appropriate personnel for the performance of EVAR on a 24-h/day basis; the associated cost implications are substantial (if not prohibitive). In addition, each hospital should maintain an appropriate stock of materials required for emergency EVAR (e.g. catheters, stent grafts). Such an action also has considerable cost implications. This could be compensated for by having dedicated regional centers although this creates other problems, such as time required to reach the center and whether a specialist team could potentially handle more than one case within a certain time interval.

On the other hand, as the authors mention [1], not all patients presenting with ruptured AAAs will be hemodynamically stable to undergo a detailed CT-scan examination for the evaluation of the appropriateness of the AAA for EVAR. A large percentage of these patients reach the hospital in a state of hemodynamic instability [4]. For these patients, the option of EVAR is not an issue. Finally, a considerable percentage of ruptured AAAs will not be anatomically suitable for EVAR [2, 5]. EVAR should indeed be the first option in patients with ruptured (but hemodynamically stable) AAAs. However, it may be incorrect to support that offering EVAR as the primary treatment option for ruptured AAAs is achievable. The considerable costs associated with EVAR may render such a strategy incompatible with reality.

References