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Controversy over aneurysm surgery

I read the conclusions in "Periodic health examination, 1991 update: 5. Screening for abdominal aortic aneurysm" (*Can Med Assoc J* 1991; 145: 783–789), by the Canadian Task Force on the Periodic Health Examination, with some dismay. The article is excellent in general and covers the topic of aortic aneurysm very well until the conclusions.

Those of us who do vascular surgery have been fighting the "magic 5 cm" dogma for some years now. The conclusion in this article would set vascular surgery back more than 10 years. I see no reason why surgery should be deferred until the aneurysm inevitably reaches 5 cm in diameter in an otherwise healthy person. The mere presence of an aneurysm is an indication for surgery. I believe that a patient with any aneurysm should be referred to someone who has the knowledge and expertise to determine whether surgery is indicated or to appropriately follow the patient up.

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[The principal author responds:]

Dr. Stiles' opinion is not shared by most vascular surgeons. Numerous studies indicate that the risk of aneurysmal rupture is related to size. Aneurysms smaller than 5 cm in diameter are unlikely to rupture. In a retrospective study 67 patients were found to have aneurysms with a mean diameter of 3.9 cm but to have been considered too unwell for surgery; the annual rate of rupture was 6%.[1] Asymptomatic aneurysms less than 5 cm in diameter have a rupture rate of 4.1% yearly according to Taylor and Porter.[2] A community-based retrospective study determined that no aneurysm less than 3.5 cm in diameter had ruptured after 8 years, and of aneurysms between 3.5 and 4.9 cm in diameter 5% had ruptured after 9 years.[3]

The low rate of rupture of aneurysms less than 5 cm in diameter must be balanced against a death rate for elective surgery in the range of 4.5% to 6.5%.[4] When late complications from aneurysm surgery are taken into account the total aneurysm-related death rate for patients undergoing elective resection is 6% to 9%.[4] Preliminary data suggest that patients with asymptomatic aneurysms less than 5 cm in diameter do not benefit from elective repair.[5]

I agree with Stiles that "a patient with any aneurysm should be referred to someone who has the knowledge and expertise to determine whether surgery is indicated or to appropriately follow the patient up"; however, current recommendations tend to support the "magic 5 cm dogma." Cole,[6] reporting on an international workshop on abdominal aortic aneurysms, held in January 1989, stated that "reconstruction is generally recommended when the size reaches 5 cm or more." In an editorial in the *British Medical Journal* Greenhalgh[7] stated that "most British surgeons favour surgery for asymptomatic aneurysm over 5.5 cm. . . . All favour observation of aortic swellings of up to 4 cm." In the United States "current recommendations are to offer elective surgery to patients with aneurysms greater than 5 cm in diameter if no medical contraindications exist, and to follow patients with smaller aneurysms with serial ultrasonography of the aorta."[8]

The low chance of survival after aneurysmal rupture has led many surgeons to advocate elective surgery for all aneurysms over 4 cm in diameter in "good surgical candidates with reasonable life expectancy."[4] Nevertheless, until this has been shown to improve survival rates the "selective surgery" approach appears to offer comparable and possibly increased total survival time; this involves observing "small aneurysms at intervals of 3 to 6 months with ultrasound and selec-

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