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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-

← For prescribing information see page 753

tively repairing only aneurysms that grow to a predetermined size (usually 6 cm), grow rapidly or become symptomatic."[4]

Although there is general agreement on the need for repair of aneurysms 6 cm in diameter or greater[4] the management of smaller aneurysm remains controversial. Factors such as the type of aneurysm (fusiform or saccular), the operative risk and personal preference will influence the decision about surgery and should be discussed with a vascular expert. Several studies comparing immediate surgery with "selective surgery" are currently in the planning stage in the United States, Canada and Britain. When the results are available proponents of aggressive and conservative surgical treatment will be able to reach agreement on the basis of evidence rather than conviction.

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References

1. Cronenwett JL, Murphy TF, Zelenock GB et al: Actuarial analysis of variables associated with rupture of small abdominal aortic aneurysms. *Surgery* 1985; 98: 472-483
2. Taylor LM Jr, Porter TM: Basic data related to clinical decision-making in abdominal aortic aneurysms. *Ann Vasc Surg* 1986; 1: 502-503
3. Nevitt MP, Ballard DJ, Hallet JW: Prognosis of abdominal aortic aneurysms. *N Engl J Med* 1989; 321: 1009-1014
4. Lederle FA: Management of small aortic aneurysms. *Ann Intern Med* 1990; 113: 731-732
5. Johannsson G, Nydahl S, Olofsson P et al: Survival in patients with abdominal aortic aneurysm: comparison between operative and nonoperative management. *Eur J Vasc Surg* 1990; 4: 497-502
6. Cole CW: Highlights of an international workshop on abdominal aortic aneurysms. *Can Med Assoc J* 1989; 141: 393-395
7. Greenhalgh RM: Prognosis of abdominal aortic aneurysm [E]. *BMJ* 1990; 301: 136
8. Bernstein EF, Chan EL: Abdominal aortic aneurysm in high-risk patients: outcome of selective management based on size and expansion rate. *Ann Surg* 1984; 200: 255-263

Canadian medicare: view from Utopia

The sarcastic and undeservedly smug response of the *CMAJ* editor to Mr. David Woods' letter (*Can Med Assoc J* 1991; 145: 1198) is a symptom of the malaise affecting Canadians and their health care system. With perspicuity Woods articulates the essence of the growing Canadian health care problem not from a self-perceived utopia, as the editor cynically suggests, but from the clear perspective gained with distance, the passage of time and an intimate knowledge of the system's functioning.

The attitude expressed by the editor generally reflects that of Canadian politicians and is reminiscent of the anti-American propaganda promulgated by now-defunct communist governments in eastern Europe and the former Soviet Union. Even as their leaky ships were sinking, the leaders of those so-called egalitarian societies castigated the philosophy of a free-market economy, claiming that elitism deprived the underclass of what rightfully belonged to it. Unfortunately, they learned the hard way that competition and economic incentive together drive a successful and thriving society that, with a sense of social justice, will be able to provide for those who are economically deprived. Canadians must realize that their health care system too is a leaky ship, doomed to sink like the socialist orders it resembles. They must realize that a society can provide adequate care without providing the same care. They and the editor must realize that there is no medical utopia. I did not understand Woods to say that the US system was perfect or even the best but, rather, that unless dismantled and resurrected in a viable form the Canadian health care system will die.

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The editorial comment on Mr. Woods' letter implied that people who become ill in Utopia (i.e., the United States) will not receive adequate medical care; this is incorrect. I would have expected editorial comment in *CMAJ* to rise above the "holier-than-thou" anti-American attitudes of so many Canadians. The sarcasm of that comment is unwarranted.

Although 35 million Americans are estimated to be without health care benefits, and a large number of these qualify under Medicaid, there are over 200 million Americans who have health insurance and for whom adequate, in fact excellent and timely, medical care is available. As a Quebec physician who immigrated to the United States several years ago I can confirm that although this is surely not Utopia most people receive health care administered in a fashion far surpassing that provided by the overburdened, overcrowded, overworked and overused medical system in Canada.

With the continuing stresses on the Canadian system, which are rapidly exposing its inadequacies, one can expect an increased flow of patients to the United States for treatment, much as the goods and services tax is driving Canadians to dramatically increase cross-border shopping.

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[The editor responds:]

I agree with Drs. Munro and