Royal Cornwall Hospitals
NHS Trust

# Elective Abdominal Aortic Aneurysm Standard Operating Procedure

## V1.0

## July 2024

## Summary

This Standard Operating Procedure (SOP) describes the management pathway of patients presenting to the Royal Cornwall Hospital with unruptured abdominal aortic aneurysms requiring consideration of surgery.

The pathway covers the management of patients not undergoing surgical repair, surgical repair provided locally and transfer to tertiary centres for complex aortic surgery. This SOP is based on standards set by Vascular Society of Great Britain and Ireland (VSGBI), National Institute for Health and Care Excellence (NICE) and NHS Abdominal Aortic Aneurysm Screening Programme (NAAASP).

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

# 1. Introduction

1.1. An aortic aneurysm is a localised swelling of the aorta – the main blood vessel transporting blood from the heart. If the swelling is confined to the aorta in the abdomen it is referred to as an abdominal aortic aneurysm (AAA). Aneurysms occur elsewhere and the management of these aneurysms is covered in other SOPs.

1.2. Rationale for treatment: The risk of untreated AAA is rupture (bursting). Patients with ruptured AAA who do not undergo surgery have a 100% mortality. Survival for patients with ruptured AAA who undergo emergency surgery is approximately 50%. If they are repaired prior to rupture the mortality rate is below 5%. The Provision of Vascular Services 2021 (POVS 21) document states that vascular units providing AAA care need to ensure a mortality rate of under 6% (ideally under 3.5%). In addition, the re-admission rate should be under 15%.

1.3. Small abdominal aortic aneurysms are at low risk of rupture, but they tend to grow at a slow rate (3 to 4 mm per year). As they grow beyond 5.5 cm in diameter the risk of rupture increases exponentially. The yearly risk of rupture at 5.5cm is approx.1% but at 7cm this increases to approx. 30%.

1.4. Because the risk of rupture is higher than the risk of death from surgery when the AAA reaches 5.5cm, patients are entered onto the AAA treatment pathway at the point at which the AAA measures 5.5cm. The management of AAAs greater than 5.5 cm is tailored to the patient's health and fitness, and the shape of the aneurysm. This is often based on complex decision making and requires a multidisciplinary approach.

1.5. There are two principle approaches to repairing an AAA: Open or endovascular (EVAR).

1.5.1. Open surgery involves an abdominal incision (laparotomy), clamping of the blood supply and replacement of the aneurysmal section with a plastic tube or graft. Following this procedure patients require ITU and often at least a week recovery in hospital. Once the repair is complete and they have recovered, they require little follow up care and are often discharged after one year. This surgery can be used to repair any aneurysm shape or size but is often not suitable for frail sick patients with AAA. This is often based on complex decision making and requires a multidisciplinary approach. Because of the risk and complexity of AAA surgery, many open AAA operations are performed by two Consultant Vascular Surgeons.

1.5.2. Endovascular Aneurysm Repair (EVAR) is a comparatively newer technique. It is performed in collaboration with Interventional Radiologists (IR) in a specialised theatre (Theatre 14 Trelawney). Through small incisions in the groin an expandible metal, covered, stent is passed up into the swollen section of the aorta to prevent further swelling. This procedure is often better tolerated by patients and is therefore occasionally offered to more frail or sick patients. It is not as durable as conventional open surgery and at least 30% patients have an AAA that is anatomically unsuitable for EVAR. In addition, a significant proportion of patients require further treatment in and around the stent over the years following the initial operation. Because of the complexity of the decision making for EVAR

operations, a multidisciplinary approach is essential and recommended by POVS 21.

1.6. The decision to perform open or EVAR repair is complex. **The scientific data and recommendations from national and international bodies is not consistent.** The reasons for the technique used will be based on anatomical suitability, physiological suitability and patient preference, after shared decision making and fully informed consent following robust discussion in MDT. Surgeon preference is recognised as important but should not be allowed to over-ride the above points. If a patient decides to opt for treatment with which the lead consultant disagrees, the care of that patient may be transferred to an alternative Vascular Surgeon.

1.7. Referral sources: Patients with AAA at 5.5cm or greater may present via the National Abdominal Aortic Aneurysm Screening Programme (NAAASP), from RCHT surveillance or as incidental findings picked up during other investigations.

1.8. There are stringent time constraints set out for the care of AAA in England, described in POVS 21. 85% of patients at threshold should be referred within one day. Assessment for AAA repair should be complete for 90% of patients within 2 weeks and 80% of patients should have their treatment completed by 8 weeks.

1.9. Abbreviations

- AAA – Abdominal aortic aneurysm.
- CPET – Cardiopulmonary exercise testing.
- CTa – Computed tomographic angiography.
- DVLA – Driver and Vehicle Licensing Agency.
- ECG – Electrocardiogram.
- EPOC – Elective perioperative care.
- EVAR – Endovascular aneurysm repair.
- FBC – Full blood count.
- IR – Interventional radiology.
- ITU – Intensive care unit.
- LFT – Liver function tests.
- MDT – Multidisciplinary team.
- NAAASP – National Abdominal Aortic Aneurysm Screening Programme.
- NICE – National Institute for Health Care Excellence.
- NVR – National vascular registry.
- POA – Pre-operative assessment.

- POVS 21 – Provision of Vascular Services 2021.
- QA – Quality assurance.
- UEC – Urea, electrolytes and creatinine.
- USS – Ultrasound scan.
- VACP – Vascular advanced care practitioner.
- VSGBI – Vascular Society of Great Britain and Ireland.

# 2. Purpose of this Standard Operating Procedure

2.1. From the above it is clear that the time constraints set out by the Vascular Society of Great Britain and Ireland, described in the POVS 21 document require a clear and efficient pathway for patients presenting with threshold AAAs.

2.2. The purpose of this SOP is to outline the management of patients with AAA. It is envisaged that a clear pathway will provide accurately measurable assessment of performance against Nationally agreed standards.

2.3. The management of patients with subthreshold AAA and ruptured AAA is described in separate SOPs.

# 3. Ownership and Responsibilities

3.1. The responsibility for this pathway remains with the Departmental Leads for Vascular Surgery, Interventional Radiology and Vascular Anaesthesia.

3.2. Because of the nature of aortic aneurysm presentation, patient physiology and treatment options it is expected that there will be variations in practice, however all stakeholders (Consultant Vascular Surgeons and Vascular Interventional Radiologists and Anaesthetists) will agree to adhere to the pathway as described or justify variances in practice at regular QA meetings.

3.3. Provision of appropriate imaging will be the responsibility of the Imaging Directorate. Patients referred on from NAAASP with threshold AAA will become the responsibility of RCHT.

3.4. All cases undergoing surgery (open or EVAR) will be recorded on the National Vascular Registry (NVR) and this is the responsibility of the VACP.

3.5. All patients undergoing any type of aortic surgery will require formal anaesthetic assessment (CPET where possible) and it is the responsibility of the Vascular Anaesthetists to oversee the investigations and present them to the MDT.

3.6. MDT is considered the crux of the elective AAA service, and all stakeholders are expected to attend or be appropriately represented. The outcome of the MDT discussion will be clearly recorded at the time of the discussion – to the agreement of all present and this information will be the basis of the discussions with the patient about treatment and consent.

3.7. AAA cases not undergoing surgery will likewise be recorded at MDT and the outcome communicated to the patient's GP by a member of the vascular team. These patients will normally be seen face to face to discuss the MDT outcome.

## 3.8. Role of the Vascular Surgeons

3.8.1. Because of the time restraint placed on the pathway for elective AAA treatment (see section 1.7) all possible measures will be taken to ensure delays in the pathway are minimised. This means that to run a smooth and efficient pathway the Vascular Surgery Consultants agree to a degree of shared care to prevent undue delays in the assessment and treatment pathway.

3.8.2. NAAASP referred with AAA will be allocated to a Consultant Vascular Surgeon at the time of referral (preferably within 24 hours of referral). The consultant taking the referral will normally be the consultant on call. Where an appropriate outpatient appointment (within 2 weeks) is not available, an appointment in the Vascular Hot Clinic will be offered. In this circumstance the patient will be assessed by the attending the VACP and then by the on-call consultant vascular surgeon. Best medical therapy should be started as soon as possible. This should include aspirin, statin, blood pressure control and diabetic optimisation. Urgent referral to specialist medical groups or back to the GP should be undertaken, if necessary. Alcohol and smoking cessation advice are of paramount importance and should be addressed at every step of the pathway. Advice to increase physical activity to include daily brisk walking should be given at this stage to improve aerobic capacity, in preparation for surgery.

3.8.3. Patients will be seen face to face to assess general fitness for surgery and the patient's attitude to surgery. Up to date RCHT information sheets will be available. If the patient agrees to consider surgery the consultant will start the process of patient assessment: A CTa will be booked and an anaesthetic assessment requested. On the initial clinic appointment bloods will be drawn for FBC, UEC, LFT, clotting. An ECG will be requested.

3.8.4. When CPET and CTa are available the patient will be presented to the MDT for discussion of treatment options. It is the responsibility of the Vascular Surgeon overseeing the patient's care to ensure that the patient is booked and the appropriate investigations are available.

3.8.5. Occasionally a patient will be clearly unfit for surgery or may refuse. In this circumstance the Vascular Surgeon will present what information is available to the MDT and the result will be recorded on Maxims and when indicated, to NAAASP.

3.8.6. In the event that a patient is not considered fit for surgical AAA repair, the MDT will discuss the probable suitability of the patient for emergency in the event of rupture. This outcome should be documented in Maxims and communicated to the patients GP. Patients not suitable for repair but who wish to continue to drive, will continue to be scanned and informed of their AAA size by letter.

3.8.7. All patients with AAA over 6.5cm should refer themselves to DVLA and cease driving until successfully treated. The MDT outcome will include advice on this as necessary.

## 3.9. Role of the Vascular Anaesthetists

3.9.1. The Vascular Anaesthetists will perform an assessment to include if possible, a Cardiopulmonary Exercise Test (CPET). They will talk to the patient about the possible procedures, bearing in mind the plan for any particular type of surgery is not yet confirmed. CPET and POA outcomes should be reported in a standard format. **All** AAA patients will undergo a transthoracic echocardiogram as part of the preoperative assessment.

3.9.2. The Vascular MDT will be attended by a vascular anaethetist to provide an opinion on the patient's suitability for surgery based on CPET, cardiac echo and clinical judgement, and this opinion uploaded to the MDT prior to the meeting. This role will be job planned for one of the vascular anaesthesia group. Adequate time should be allowed for preparation and planning for this meeting. The patient list for the MDT should be available at least 24hrs before the meeting. Where it is decided that a patient will require further preop investigation or optimisation, a careful risk-benefit discussion between surgery and anaesthesia will be necessary. Second opinion should be sought from within both groups to aid this process.

3.9.3. This assessment and opinion will be recorded on the MDT outcome and form part of the overall assessment of the patient's suitability for the treatment planned.

3.9.4. Ad-hoc pre-assessment for urgent inpatient AAA will be performed by one of the vascular anaesthesia group, if available.

3.9.5. AAA list coverage will only be undertaken by an anaesthetist with appropriate experience in vascular anaesthesia.

3.9.6. Anaesthesia will contribute data to AAA NVR when required.

## 3.10. Role of the Interventional Radiologists

3.10.1. All patients with threshold AAA detected by USS will require CTa unless considered not fit or suitable for aortic surgery.

3.10.2. Requests for CTa will be made via Maxims and the duty Vascular Interventional Radiologist informed who will undertake to vet the request as soon as possible. They or a colleague will report the scans in a timely fashion and ensure a summary report is available for the next MDT. This may be the summary of the report filed on Maxims.

3.10.3. The MDT will ideally be attended by at least two Interventional Radiologists to enable full discussion of treatment options based on radiological findings.

### 3.11. **Role of the Vascular Advanced Clinical Practitioners**

3.11.1. Maintain a database of all threshold AAAs.

3.11.2. Ensure booked investigations and results of tests are recorded and acted on.

3.11.3. Ensure all patients on the pathway are discussed as soon as the CPET and CTa are available for MDT.

3.11.4. Record and oversee presentation of complications.

3.11.5. Submit NVR data.

### 3.12. **Role of the MDT Coordinator**

3.12.1. The MDT Co-ordinator will receive the names and details of all patients referred with AAA. They will ensure patients are given timely Consultant Appointments and ensure Anaesthetic reviews (with CPET) and Radiology report summaries are complete and available to upload to the MDT Document by at least 1500hrs on the day prior to the MDT (Usually 1500hrs on Thursday).

3.12.2. The coordinator will publish the AAA MDT list at 1530hrs on the day before the meeting.

3.12.3. The coordinator will take outcome decisions dictated in the meeting. These minutes will contain action points arising from the discussion of each patient. The coordinator will distribute outcomes from each patient discussed and monitor the responses to ensure adherence to the time constraints of the pathway.

3.12.4. The AAA MDT document is attached to this document.

### 3.13. **Role of the Management**

3.13.1. Managerial responsibility for this SOP lies with Vascular Surgery.

3.13.2. Ongoing professional development of junior staff and Allied Care Professionals lies with the relevant specialty lead.

3.13.3. Management will support twice yearly Q+A meetings to ensure all outcomes are adequately discussed and documented.

3.13.4. Management are responsible for the provision sufficient equipment and resources as to facilitate the service.

## 4. Standards and Practice

### 4.1. **Treatment**

Following full discussion of relevant radiology and the anaesthetic opinion, a decision about treatment will be agreed and documented in the Vascular Multidisciplinary Meeting. The following four outcomes are possible:

4.1.1. Open Surgery – Theatre to be booked by theatre booking staff immediately on receipt of MDT outcome. ITU bed to be requested. When required, second surgeon to be identified and notified at time of booking case.

4.1.2. Standard EVAR – Theatre to be booked by theatre booking staff immediately on receipt of MDT outcome. This involves negotiation with radiology staff. EPOC bed to be booked.

4.1.3. Complex EVAR – If MDT decide that tertiary referral is required, it is the responsibility of the Surgeon caring for the patient (or a colleague if necessary) to make a timely referral to an appropriate tertiary referral centre. The close working relationship with the Vascular Team in North Bristol NHS Trust is noted. Images will require to be made available for review and this must be arranged contemporaneously with the referral (vascular secretary). Occasionally images require review by graft manufacturing companies and in the event the transfer of images will be arranged by the IR.

4.1.4. Conservative non-surgical treatment – Described above (section 3.8.5,6,7). Patients not undergoing surgery will have a face-to-face meeting with a consultant vascular surgeon when MDT deems this appropriate.

4.1.5. Jehovah's Witness patients will require full pre-operative discussion of risks of AAA repair. Cell salvage blood is available for all AAA patients.

4.2. **Standards**

4.2.1. This pathway is based on standards set by NICE (NICE _NG 156 Abdominal Aortic Aneurysm Diagnosis and Management, 2020) and NAAASP (Standards and Outcome Measures for the NHS AAA Screening Program, 2020).

4.2.2. Timeline for patients on the pathway to be monitored by VACP and MDT coordinator.

4.2.3. Monthly audit of surgical activity and complications to be presented at vascular surgery Department Governance Meeting. Twice yearly AAA QA meeting.

4.2.4. NAAASP – report as indicated by NAAASP guidelines.

4.2.5. NVR – Data for each case uploaded to NVR following discussion with lead surgeon. Disagreements to be discussed and resolved in Department Governance Meeting. We don't currently discuss before uploading data to remain impartial.

# 5. Dissemination and Implementation

5.1. This document will be shared by email to the teams supporting the care of elective threshold AAA patients. The document will also be discussed at the Vascular Surgery, Anaesthetics, and Interventional Radiology monthly governance meeting. Any revisions and version updates will be similarly communicated.

5.2. Most of the above SOP and pathway is currently in place. Early audit and simple observation should identify what is required to implement parts of the pathway to streamline the care of AAA patients.

# 6. Monitoring compliance and effectiveness

| Information Category | Detail of process and methodology for monitoring compliance |
|---|---|
| **Element to be monitored** | Time to treatment of AAA arising from NAAASP.<br>Time to treatment for non-NAAASP patients.<br>Proportion of AAA patients turned down for surgery.<br>Complications for open AAA surgery.<br>Number of referrals to tertiary centre. |
| **Lead** | Mr Harvey Chant, Consultant Vascular Surgeon. |
| **Tool** | Hospital audit systems.<br>NAAASP reporting.<br>NVR. |
| **Frequency** | Six months for 12-24 months.<br>One year thereafter if no concerns. |
| **Reporting arrangements** | Vascular Team members.<br>Service Leads.<br>Service Manager.<br>Care Group Leadership Team. |
| **Acting on recommendations and Lead(s)** | Actions will be determined by the service Leads, Vascular Governance lead and/or Service Manager.<br>Required actions will be identified and completed within 3 month timeframe unless dependent upon external resources/investment.<br>Clinical leads will oversee/address any clinical concerns including DATIX/Harm reviews. Service lead will oversee/address any operational concerns. Nursing line manager will oversee/address any educational/training needs/concerns. |
| **Change in practice and lessons to be shared** | System and practice changes will be shared through existing governance processes including monthly meetings and care group newsletters.<br>Required changes to practice will be identified and actioned within three months. A lead member of the team will be identified to take each change forward where appropriate as suggested above. Lessons will be shared with all the relevant stakeholders. |

# 7. Updating and Review

7.1. The AAA pathway will continue to run as described, with 6 monthly reviews in joint Morbidity and Mortality meetings.

7.2. This document should be reviewed every three years or earlier if revised.

# 8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

8.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

# Appendix 1. Governance Information

| Information Category | Detailed Information |
|---|---|
| **Document Title:** | Elective Abdominal Aortic Aneurysm Standard Operating Procedure V1.0 |
| **This document replaces (exact title of previous version):** | New Document |
| **Date Issued/Approved:** | May 2024 |
| **Date Valid From:** | July 2024 |
| **Date Valid To:** | July 2027 |
| **Author/Owner:** | Mr Harvey Chant, Consultant Vascular Surgeon. |
| **Contact details:** | 01872 252197 |
| **Brief summary of contents:** | Standard operating procedure for management of elective, unruptured abdominal aortic aneurysms. |
| **Suggested Keywords:** | Aneurysm, elective, vascular. |
| **Target Audience:** | **RCHT:** Yes<br>**CFT:** No<br>**CIOS ICB:** No |
| **Executive Director responsible for Policy:** | Chief Medical Officer. |
| **Approval route for consultation and ratification:** | Vascular Department Governance Meeting, GSC Care Group Board, Clinical Effectiveness Group, Information Governance Group. |
| **Manager confirming approval processes:** | Ian McGowan. |
| **Name of Governance Lead confirming consultation and ratification:** | Suzanne Atkinson. |
| **Links to key external standards:** | National Standards: NICE, POVS 21, GIRFT. |
| **Related Documents:** | Abdominal Aortic Aneurysm (AAA) Screening Policy |
| **Training Need Identified:** | Yes – only to be carried out by trained consultants. |

| Information Category | Detailed Information |
|---|---|
| **Publication Location (refer to Policy on Policies – Approvals and Ratification):** | Internet and Intranet. |
| **Document Library Folder/Sub Folder:** | Clinical/Vascular. |

**Version Control Table**

| Date | Version Number | Summary of Changes | Changes Made by |
|---|---|---|---|
| 14 May 2024 | V1.0 | Initial issue | Mr Harvey Chant Consultant Vascular Surgeon |

**All or part of this document can be released under the Freedom of Information Act 2000.**

**All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.**

**This document is only valid on the day of printing.**

**Controlled Document.**

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# Appendix 2. Equality Impact Assessment

## Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

| Information Category | Detailed Information |
|---|---|
| **Name of the strategy/policy/proposal/service function to be assessed:** | Elective Abdominal Aortic Aneurysm Standard Operating Procedure V1.0 |
| **Department and Service Area:** | Vascular/ General Surgery and Cancer Services |
| **Is this a new or existing document?** | New |
| **Name of individual completing EIA** (Should be completed by an individual with a good understanding of the Service/Policy): | Mr Harvey Chant, Consultant Vascular Surgeon |
| **Contact details:** | 01872 252197 |

| Information Category | Detailed Information |
|---|---|
| **1. Policy Aim - Who is the Policy aimed at?** (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed) | All RCHT and Primary Care staff involved in the management of elective abdominal aortic aneurysm. |
| **2. Policy Objectives** | Standardise care pathway and ensure compliance with National standards for care and reporting. |
| **3. Policy Intended Outcomes** | Maintain acceptable management timeline for AAA as indicated by national guidelines. |
| **4. How will you measure each outcome?** | National Vascular Registry yearly audit of diagnosis to treatment times, morbidity and mortality, and patient numbers. |
| **5. Who is intended to benefit from the policy?** | Patients under care of Royal Cornwall Hospital Vascular Service. |

| Information Category | Detailed Information |
|---|---|
| **6a. Who did you consult with?**<br>(Please select Yes or No for each category) | • Workforce: Yes<br>• Patients/visitors: No<br>• Local groups/system partners: Yes<br>• External organisations: Yes<br>• Other: No |
| **6b. Please list the individuals/groups who have been consulted about this policy.** | **Please record specific names of individuals/groups:**<br>Vascular Surgeons, Vascular radiologists, Vascular Anaesthetists, National Aneurysm Screening Program, North West Regional Vascular Service, Royal Preston Hospital, Lancashire. |
| **6c. What was the outcome of the consultation?** | Approved. |
| **6d. Have you used any of the following to assist your assessment?** | **National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:**<br>National guidelines summarised in the Provision of Vascular Services 2021 Document, NAAASP management pathway/guideline, NICE. |

**7. The Impact**

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

| Protected Characteristic | (Yes or No) | Rationale |
|---|---|---|
| **Age** | No | AAA tends to present in later life. |
| **Sex** (male or female) | No | Males statistically more likely to suffer AAA. |
| **Gender reassignment** (Transgender, non-binary, gender fluid etc.) | No | Patients undergoing or have undergone gender re-assignment are treated regardless of gender characteristics. |
| **Race** | No | As above. |
| **Disability** (e.g. physical or cognitive impairment, mental health, long term conditions etc.) | No | Disability is not a characteristic that would change approach to AAA treatment. All patients on this pathway are treated equally in terms of their suitability or not, for AAA treatment. |

| Protected Characteristic | (Yes or No) | Rationale |
|---|---|---|
| **Religion or belief** | No | Religious belief is not an important aspect of AAA treatment EXCEPT in the case of Jehovah's Witness patients; in this case blood transfusion will be discussed prior to surgery, in time to ensure alternative arrangements, if available, are put in place. |
| **Marriage and civil partnership** | No | AAA care is not affected by marriage of civil partnership status of patient. |
| **Pregnancy and maternity** | No | In the highly unlikely event of a pregnant patient presenting with and AAA, treatment will be delayed until after parturition. |
| **Sexual orientation** (e.g. gay, straight, bisexual, lesbian etc.) | No | Sexual orientation does not affect the management of AAA. |

**A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.**

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Mr Harvey Chant, Consultant Vascular Surgeon.

**If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:**
Section 2. Full Equality Analysis

# Appendix 3. Aneurysm MDT Form

## ANEURYSM MDT

**Date:**

| Vascular Surgeons | Interventional Radiology | Anaesthetics |
|---|---|---|
| | | |

### Patient 1

| Patient Name: | Date of Birth: | RCHT CRN: |
|---|---|---|
| Consultant: | | |
| NAAASP? Y/N | | For discussion in absence of referrer? Y/N |

| **Reason for Referral – including question for MDT** |
|---|
| This to be filled out by referring team member |
| **Co-Morbidities/Past Medical History/Medications** |
| This to be filled out by referring team member |
| **Previous MDT Management Plan (if applicable)** |
| This to be filled out by referring team member |

| | | |
|---|---|---|
| **Imaging Review:** | | |
| Comments on suitability for EVAR/FEVAR/other significant pathology and findings of potential surgical significance | | This could be filled out and submitted to MDT Co-ordinator prior to MDT. Alternatively dictated to MDT Co-ordinator at time of MDT. |
| **MDT Anaesthetist:** | | |
| Comments from anaesthetics regarding suitability for anaesthesia. Interpretation of CPET/ECHO etc<br>This could be filled out and submitted to MDT Co-ordinator prior to MDT. Alternatively dictated to MDT Co-ordinator at time of MDT. | | |
| **Management Plan:** | | |
| Dictated in meeting with all members agreeing to management plan and options. When there is disagreement this is documented and support for all options clarified. The operating surgeon/IR 'on the day' has final say in cases where MDT decision is equivocal. | | |
| **Actions:** Clear simple instructions that can be interpreted by any qualified practitioner | | **To be actioned by:** Team member responsible for action |