

INVITED COMMENTARY

## Does quality of life really matter in a screening programme?

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All screening programmes have the potential to affect quality of life (QoL) adversely. Whereas this is overt if a man dies after elective intervention for a large screen detected AAA, the effect of being in surveillance for many years is less well described. Anecdotally, people in any surveillance programme will tell you that most of the time, they don't think about their condition, but they dread each surveillance scan, and the potential news it might bring.

The authors of this paper on QoL of people with screen detected AAA had a difficult task to create a coherent narrative review of a number of very different studies done over a 20 year interval.<sup>1</sup> They have been honest about the difficulties, and have considered and reasonable conclusions.

Their conclusions fit the general consensus that the offer of screening causes a small dip in QoL, which returns to normal after a negative initial scan. A positive initial scan causes a continued dip in QoL because of being in surveillance. The dip is small, and partly due to lower physical QoL scores in these subjects, who all have associated arterial disease.<sup>2</sup> It is less clear what the effect of being in surveillance long term would be.

This is important, partly as a reminder that AAA screening and surveillance can have negative consequences to individuals that clinicians think they are helping. But also, the present means to assess interventions such as screening involve cost effectiveness analysis, where the cost of each quality adjusted life year is assessed. Small changes in QoL over many years can make a big difference to this calculation and significantly reduce the effectiveness of an intervention, thus rendering it not cost effective.<sup>3</sup> This could be most relevant for men with a sub-aneurysmal aorta at age

65 (2.6–2.9 cm) who do not currently qualify for surveillance scans in the UK. Building a case for routine surveillance for these men, who may require monitoring for 15–20 years before they develop a large AAA, requires that adverse changes in long-term QoL do not offset any reduction in AAA related death that results from surveillance.

In the UK, it has been agreed to include QoL measurement as part of the routine process of AAA screening and surveillance. This will allow prospective assessment of changes in QoL from the initial screening intervention and being in surveillance. Data will be collected online, and in England linked to data from the bespoke IT system AAA SMaRT.

Small changes in QoL may seem trivial in comparison to life and death decisions about large AAAs, but understanding how screening affects individuals is fundamental to planning and funding this, and all other screening programmes.

### REFERENCES

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DOI of original article: <https://doi.org/10.1016/j.ejvs.2018.10.012>

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<https://doi.org/10.1016/j.ejvs.2018.11.017>