VSQIP VASCULAR SERVICES QUALITY IMPROVEMENT PROGRAMME

National Vascular Registry

AAA Repair

Patient Details

Patient Consent* $_0$☐ No $_1$☐ Yes $_2$☐ Not Required

Date consent recorded ____ /____ /_____ (DD/MM/YYYY)

NHS number* _____

Date of birth* ____ /____ /_____ (DD/MM/YYYY)

Sex* $_1$☐ Male $_2$☐ Female

Last name _____

First name _____

Postcode* _____

If patient not consented:
Do not record NHS number, name(s) or postcode.
If consent not required:
Ignore consent date.

Admission Details

Admission date* ____ /____ /_____ (DD/MM/YYYY)

Mode of admission* $_1$☐ Elective $_2$☐ Non-elective

Hospital code* *Pre-populated drop down menu on NVR audit site*

Local ID* _____

Procedure type **Abdominal Aortic Aneurysm Repair**

Pre-operative: Pathway

Elective

Indication for intervention*

- $_0$☐ ≥5.5 screen detected aneurysm (NAAASP)
- $_1$☐ ≥5.5 screen detected aneurysm (non NAAASP)
- $_2$☐ ≥5.5 lesion non-screen detected aneurysm
- $_3$☐ Symptomatic
- $_4$☐ Rapid growth
- $_5$☐ Other threshold
- $_6$☐ Iliac aneurysm

Non-elective

Prior contact*

- $_0$☐ Not known
- $_1$☐ Yes, on surveillance
- $_2$☐ Yes, not for elective repair
- $_3$☐ Yes, on waiting list or booked for surgery

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AAA Threshold (date of first scan where threshold was reached) ____ /____ /_____ (DD/MM/YYYY) CT/MR angio assessment date ____ /____ /_____ (DD/MM/YYYY) MDT discussion date ____ /____ /_____ (DD/MM/YYYY)	*…continued from previous page*

Anaesthetic Assessment *(for Elective Pathway only)*

Date of Anaesthetic review ____ /____ /_____ (DD/MM/YYYY)

Consultant vasc anaesthetist review*

0☐ No 1☐ Yes

Fitness measurement used*

Please select as many options as applicable

0☐ None
1☐ CPET
6☐ Incremental shuttle walk test/6 minute walk test
4☐ Non-invasive cardiac stress test
5☐ Transthoracic echocardiogram

Investigation after preop anaesthetic assessment*

Please select as many options as possible

1☐ No additional investigation /intervention
2☐ Referral to another specialty
4☐ Optimisation/change in drug therapy
5☐ Coronary angiogram

For both Elective and Non-elective pathways

Patient weight* _____ in Kg

Patient height* _____ in cm

Indications

AAA/Aortic Diameter* _____ in mm

Previous Aortic op*

0☐ No
1☐ Open repair
2☐ Endovascular repair
3☐ AAA repair – type unknown
4☐ Both open and endovascular repair

Risk Scoring

Comorbidities* Please select as many options as applicable.

- 0☐ None
- 1☐ Diabetes
- 2☐ Hypertension
- 3☐ Chronic lung disease
- 4☐ Ischaemic heart disease
- 5☐ Chronic heart failure
- 6☐ Chronic renal disease
- 7☐ Stroke
- 8☐ Active/managed cancer
- 9☐ Lower limb arterial disease

Smoking status*

- 1☐ Current or stopped within 2 months
- 2☐ Ex-smoker
- 3☐ Never smoked

White cell count* _____ ($x10^9$/l)

Sodium* _____ (mmol/l)

Potassium* _____ (mmol/l)

Creatinine* _____ (µmol/l)

Albumin _____ (g/l)

Haemoglobin* _____ (dg/l)

Non Elective Admission – *Additional items*

Highest pulse pre-op _____

Lowest systolic BP pre-op_____

Abnormal ECG*

- 0☐ Normal
- 1☐ Abnormal

ASA Grade*

- 1☐ 1 – Normal
- 2☐ 2 – Mild disease
- 3☐ 3 – Severe, not life-threatening
- 4☐ 4 – Severe, life-threatening
- 5☐ 5 – Moribund patient

Pre-operative medication*

- 0☐ None
- 8☐ Single anti-platelet
- 9☐ Dual anti-platelet
- 2☐ Statin
- 3☐ Beta blocker
- 4☐ ACE inhibitor / ARB s
- 7☐ Oral anti-coagulant

Peri-operative medication*

- 1☐ None
- 2☐ Antibiotic prophylaxis
- 3☐ DVT prophylaxis

Has the patient had COVID-19 within the last 2 months?

- 1☐ No
- 2☐ Yes

COVID-19 Vaccine?

- 1☐ No
- 2☐ Yes, 1 dose
- 3☐ Yes, 2 doses
- 4☐ Yes, 3+ doses

Patient's frailty score

- 1☐ Not frail (well or managing well, routinely walking)
- 2☐ Mild frailty (evident slowing such as difficulty walking outside)
- 3☐ Moderate frailty (need help with some personal care or keeping house)
- 4☐ Severe frailty (completely dependent for personal care)

Procedure: AAA Repair

Date/Time start* ____ /____ /_____ (DD/MM/YYYY); ____ : ____ (HH:MM)

Aortic status*
- 1☐ Asymptomatic
- 2☐ Symptomatic unruptured
- 3☐ Ruptured
- 4☐ Aortic transection
- 5☐ Acute dissection
- 6☐ Chronic dissection

Type of repair*
- 1☐ Open
- 2☐ EVAR
- 3☐ Complex EVAR
- 4☐ Revision Open
- 5☐ Revision EVAR *(See relevant sections below)*
- 6☐ EVAS *(See relevant sections below)*

OPCS code of procedure 1* _____

OPCS code of procedure 2 _____

OPCS code of procedure 3 _____

All options will be available on NVR audit site via drop down menus.

Neck angle*
- 1☐ 0 to 60 degrees
- 2☐ 60 to 75 degrees
- 3☐ 75 to 90 degrees
- 4☐ More than 90 degrees

Neck diameter* _____ in mm

Neck length* _____ in mm

Open

AAA Clamp site*
- 1☐ Infra-renal
- 6☐ Trans-renal
- 2☐ Supra-renal
- 3☐ Supra-mesenteric
- 4☐ Supra-coeliac
- 5☐ Thoracic aorta

AAA Graft*
- 1☐ Tube
- 5☐ Bifurcated
- 6☐ Any groin incision

EVAR & EVAS

EVAR exclusion*
- 0☐ No
- 1☐ Yes primarily
- 2☐ Yes after adjunctive procedures

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Complex EVAR – *Additional items*

Type of complex EVAR*
- 1☐ FEVAR
- 2☐ BEVAR
- 3☐ TEVAR
- 4☐ Iliac branched graft
- 5☐ Composite graft
- 6☐ Chimney/periscope/snorkel

Note: If complex EVAR is 3=TEVAR, then the following questions won't appear on the screen: iliac branch, neck angle, neck length, extended into external iliac artery, common iliac artery diameter

Iliac branch*

0☐ No 1☐ Right 2☐ Left 3☐ Bilateral

Extended External Iliac Artery (EIA)*
0☐ No
1☐ Right
2☐ Left
3☐ Bilateral

Common Iliac Artery* (CIA) diameter (larger one)_____ in mm

EVAS – *Additional items*

Type of EVAS device*
1☐ Standard
2☐ Chimney/periscope/snorkel

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Endoleak

Endoleak type*
0☐ No endoleak
1☐ Type 1
2☐ Type 2
3☐ Type 3
4☐ Type 4
5☐ Unclassified

If NO endoleak ignore the next 2 items.

Endoleak intervention 0☐ No 1☐ Yes
Success 0☐ No 1☐ Yes

Operator

Vascular specialist 1* _____
Vascular specialist 2 _____
Vascular specialist 3 _____
Vascular specialist 4 _____

Anaesthetist 1* _____
Anaesthetist 2 _____

Devices

Device section (please add each device component). The device barcode can also be scanned directly into the NVR IT system.

Manufacturer _____ Batch/Lot Number _____
Product Number _____ Was this device used on IFU? 0☐ No 1☐ Yes
GTIN _____

Manufacturer _____ Batch/Lot Number _____
Product Number _____ Was this device used on IFU? 0☐ No 1☐ Yes
GTIN _____

Peri-operative Anaesthetic Details

Anaesthetic type* *Please select as many options as applicable*
7☐ Local infiltration
8☐ Plexus/compartment block
9☐ Neuraxial block (spinal/epidural)
3☐ General anaesthetic

Direct arterial monitoring 0☐ No 1☐ Yes

Intraoperative cardiac output monitoring	0☐ No	1☐ Yes
Postoperative coagulopathy	0☐ No	1☐ Yes
Core temperature ≥ 36 °C at end of procedure	0☐ No	1☐ Yes
Patient reported severe pain within 1 hour of surgery	0☐ No	1☐ Yes

Post Operative

Destination after surgery*

1☐ Ward
2☐ Level 2 (HDU/PACU)
4☐ Level 3 (ICU)
5☐ Died in theatre

Note: If Died in theatre is selected, the remaining questions in the post-operative section will not show

Critical care stay* _____ (Number of days)

Return to theatre within admission* 0☐ No 1☐ Yes

Readmission to a higher level of care* 0☐ No 1☐ Yes

Postoperative complications*

Please select as many options as applicable.

0☐ None
1☐ Cardiac (MI / NSTEMI / heart failure)
2☐ Respiratory
3☐ Cerebral (stroke)
4☐ Renal failure
5☐ Haemorrhage
6☐ Limb ischaemia
7☐ Paraplegia
8☐ Ischaemic bowel
13☐ Post-operative confusion
14☐ Major GI complication
15☐ Surgical site infection
17☐ Other

Discharge

Discharge status – Alive on discharge* 0☐ No 1☐ Yes

Date discharged/died* ____ /____ /_____ (DD/MM/YYYY)

Discharge destination*

1☐ Usual place of residence
2☐ Rehabilitation
3☐ Other hospital
4☐ Intermediate care (e.g. nursing or care home)

Please also complete the COVID-19 dataset, which can be found on our website.

Was the management of this patient affected by COVID-19?*

0☐ No
1☐ Yes

Patient does not have to be COVID-19 positive for this to apply, as their planned care may have been changed due to COVID-19 without a positive diagnosis.

Follow Up

Readmission to hospital within 30 days* 0☐ No 1☐ Yes

Was the readmission for vascular reasons? * 0☐ No 1☐ Yes

Did the patient die within 30 days of the procedure? * 0☐ No 1☐ Yes

Reason for NO follow up

1☐ Died prior to planned follow-up after discharge
2☐ Moved out of area
3☐ Did not attend
4☐ Other

Date clinic appointment attended ____ /____ /_____ (DD/MM/YYYY) *(Only if follow up occurred)*

If you have any queries please contact us on 020 7869 6621 and nvr@rcseng.ac.uk