
Shi Wu Wen, Marko Simunovic, J Ivan Williams, K Wayne Johnston, C David Naylor

Abstract

Objective – To determine, for abdominal aortic aneurysm surgery, whether a previously reported relationship between hospital case volume and mortality rate was observed in Ontario hospitals and to assess the potential impact of age on the mortality rate for elective surgery.

Design – Population based observational study using administrative data.

Setting – All Ontario hospitals where repair of abdominal aortic aneurysm as a primary procedure was performed during 1988–92.


Main outcomes – In-hospital death and length of in-hospital stay.

Results – The case fatality rate was 3.8% for unruptured abdominal aortic aneurysms and 40.0% for ruptured abdominal aortic aneurysms. For unruptured cases, after adjustment for patient and hospital covariates, each 10 case per year increase in hospital volume was related to a 6% reduction in relative odds of death (odds ratio (OR) 0.94, 95% confidence intervals 0.88, 0.99) and 0-29 days reduction (95% CI 0-22, 0-35) in postoperative in-hospital stay. Female sex (OR 1-53, 95% CI 1-08, 2-18) and transfer from another acute care hospital (OR 4-37, 95% CI 2-62, 7-29) were associated with increased case fatality rates among patients in the unruptured category. For ruptured cases, neither the case fatality rate nor postoperative in-hospital stay were significantly related to hospital volume. The case fatality rates increased linearly and substantially with advancing age both for unruptured and ruptured aneurysms, and the excess risk of postoperative death in ruptured as compared to unruptured aneurysms was substantially higher in older patients.

Conclusion – The relationship between hospital volume and mortality or morbidity was very modest and observed only for elective surgery. Case fatality rates in patients with ruptured abdominal aortic aneurysms remained 10 times higher than for patients with unruptured abdominal aortic aneurysms, despite improvements in overall mortality in comparison to previously published data. More effective detection of aneurysms, including elective repair for those once considered “high risk” older patients, might further reduce the toll from ruptured aortic aneurysms.

(J Epidemiol Community Health 1996;50:207–213)
Methods

DATA SOURCES, INCLUSION, AND EXCLUSION CRITERIA

In the province of Ontario, discharge abstracts for all acute care hospital separations (discharges, transfers or in-hospital deaths) are computerised by the Hospital Medical Records Institute (now the Canadian Institute for Health Information). Discharge summaries, operative notes, and pathology reports were coded by qualified technicians; diagnoses followed the International Classification of Diseases, 9th rev (ICD-9)\(^{26}\) and procedure coding followed the Canadian Classification (CC).\(^{25}\)

We included all Ontario residents admitted to an Ontario acute hospital with a principal diagnosis of unruptured (ICD-9 code 441-4) or ruptured (ICD-9 code 441-3) abdominal aortic aneurysm who underwent abdominal aortic aneurysm surgery with either replacement, anastomosis, or aorta-iliac-femoral bypass as the primary procedure (CC code 5034 or 5024 or 5125) from fiscal 1988 (01/04/1988) to fiscal 1992. For ruptured cases, an additional procedure code of laparotomy (CC code 661) was added to the inclusion criteria, because some of these patients died before completion of aneurysm surgery and were therefore recorded simply as laparotomy.

Patients were excluded if they underwent a secondary procedure involving any operations on the heart – for example coronary vessels, pericardium, valves, or septa (CC codes 47–49). Also excluded were patients with the following secondary diagnoses: dissecting aneurysm (ICD-9 code 4410) or thoracic aneurysm (ICD-9 codes 4411–4412); aneurysm of unspecified site, ruptured (ICD-9 code 4415); aortic aneurysm of unspecified site, without mention of rupture (ICD-9 code 4419); arterial embolism and thrombosis of abdominal (ICD-9 code 4440) or thoracic aorta (ICD-9 code 4441); congenital anomalies of aorta (ICD-9 code 7472) including coarctation (ICD-9 code 7471); or injury to abdominal aorta (ICD-9 code 9420).

The patient’s age, sex, occurrence of in-hospital death, main secondary diagnoses (co-existing diseases), whether transferred from another hospital, and LHS were abstracted from the database as needed. Analysis on LHS was restricted to non-fatal cases. We calculated the postoperative LHS by the difference between date of surgery and date of discharge. The postoperative LHS thus calculated was further validated by comparing its value with preoperative LHS and the entire LHS. If the sum of postoperative LHS and preoperative LHS was not equal to the entire LHS, the postoperative LHS was assigned as missing. One unruptured case and none of the ruptured cases was assigned a missing value on postoperative LHS by this rule. All postoperative LHSs that were equal to 15 days or less (27 days for unruptured and 51 days for ruptured aneurysms, respectively) were assigned the value of the 95th centile to limit the influence of a few patients with excessively long LHS. To mitigate the confounding effects on outcomes of diseases other than abdominal aortic aneurysms, a comorbidity index for each patient was calculated using a validated ICD-9-CM-based adaptation\(^{26}\) of a clinical system described by Charlson et al.\(^{27}\) Ontario discharge abstracts permit full calculation of this comorbidity index in nearly all cases.\(^{28}\) Information on hospital bed-size, and teaching status (presence or absence of house staff) was taken from the Canadian Hospital Directory, 1991–1992.\(^{31}\)

ANALYSIS

To consider the fundamental differences in the natural history of the disease and clinical management issues involved, the two categories of aneurysm (ruptured and unruptured) were analysed separately throughout. Yearly number of operations, number of hospitals performing the procedure, number of deaths, and mean postoperative LHS were determined first; hospital and patient characteristics for the overall five fiscal years were then determined for the two categories of aneurysm. Surgeon identifying codes in the discharge abstracts were inconsistent, hence volume-outcome relationships could only be examined by centre, not by surgeon.

CFR and mean postoperative LHS were first compared after grouping hospitals according to hospital volume for the entire five years: <50, 50–100, 101–200, and >200 cases for unruptured aneurysm, and <10, 10–20, 21–40, >40 cases for ruptured aneurysm. Corresponding annual volumes are readily determined by dividing by five. In choosing these cut off points, we aimed to create sufficient gradients in hospital volume groups, so that the volume effects could be assessed, while at the same time maintaining large enough sample sizes in each group for statistical stability. Sensitivity analyses were done to evaluate moving
Short-term outcomes in patients undergoing repair of abdominal aortic aneurysms

the five year volume cut off points for each category up or down by one case from the original cut off points, and the results were stable.

Stepwise multiple logistic regression analysis was used to examine the volume–mortality relationship, and stepwise multiple linear regression was used to examine the volume–postoperative LHS relationship at the individual patient level. Potential confounding factors included in the models were bed size and teaching status of the admitting hospital, patient’s sex and age, comorbidity index, and whether the patient had been transferred from another hospital. As the primary factor of interest, hospital volume was kept in the model regardless of significance; other factors were excluded at a threshold significance level of 0.10. Hospital volume, bed size, and teaching status were assigned to each patient according to the hospital to which he or she was admitted. Avoidable deaths for ruptured cases in low volume hospitals (using the 75th centile, or 40 cases per year as the cut off point) were also estimated by applying the ORs obtained from the multiple logistic regression model.

To frame the age specific CFR analysis, ruptured and unruptured abdominal aortic aneurysms were compared after dividing the patients into six groups according to their calendar age (<60, 60–64, 65–69, 70–74, 75–79, and ≥80 years, respectively). Again, cut off points reflected a balance between creation of gradients to examine age effects, while maintaining statistical stability. Sensitivity analyses evaluating the impact of moving cut points up or down one year showed no change in results or conclusions. To examine whether there was any age dependent differential excessive risk of postoperative deaths in ruptured aneurysms, age specific rate differences (CFR in ruptured aneurysms – CFR in unruptured aneurysms) and their 95% confidence intervals were estimated using the method described by Fleiss. Differences in numbers of deaths (number of deaths in ruptured aneurysms – number of deaths in unruptured aneurysms) were also calculated to describe the actual age specific differences in attributable deaths for the two types of aneurysms in the province of Ontario.

Ideally, all deaths occurring in aneurysm patients should be tallied in assessing the preventive value of elective surgery. However, in an analysis based on administrative data, we are unable to obtain information on deaths in aneurysm patients that occurred before surgery or after discharge from hospital. This limitation will be discussed later.

Several sensitivity analyses were performed. First, regression analyses were repeated after excluding patients admitted to extremely low volume hospitals (fewer than 10 cases for unruptured aneurysms, or fewer than five cases for ruptured aneurysms, respectively, for the entire five year period). Secondly, the analyses were repeated by including cases with a diagnosis of aneurysm of unspecified site, ruptured (ICD-9 code 4415) in the ruptured aneurysm category, and by including cases with a diagnosis of aortic aneurysm of unspecified site, without mention of rupture (ICD-9 code 4419) or arterial embolism and thrombosis of abdominal aorta (ICD-9 code 4440) in the unruptured category. Finally, to assess the impact of delayed discharge for administrative reasons on the results, the analyses for postoperative LHS were repeated by excluding those patients transferred to another acute or chronic care center.

Results

OVERALL PROFILE

During the five years, there were 5837 operations on patients with unruptured abdominal aortic aneurysms and 1288 operations for ruptured aneurysms in Ontario hospitals. Altogether 321 unruptured cases and 32 ruptured cases were excluded either because they were out-of-province residents, or their demographic data were missing. Twenty four unruptured cases and 53 ruptured cases were further excluded because of the co-existence of another aneurysm or other major procedures in the heart or thoracic cavity which might complicate the comparisons, leaving 5492 unruptured cases and 1203 ruptured cases for analysis. The overall CFR was 3.8% for unruptured and 40.0% for ruptured abdominal aortic aneurysms.

The annual number of operations rose moderately during the period analysed (table 1). Postoperative LHS decreased moderately both in ruptured and unruptured aneurysms, but no consistent temporal trend of CFR was observed for either category (table 1).

Patients with unruptured abdominal aortic aneurysms tended to be younger and were less likely than ruptured cases to be transferred from another hospital. On the other hand, there were no important differences in size or teaching status of the hospitals, sex ratio, or comorbidity index. As expected, both the CFR and postoperative LHS in non-fatal cases were substantially higher in ruptured than in unruptured abdominal aortic aneurysms (table 2).

HOSPITAL-LEVEL CROSS TABULATION

For the entire five years, the hospital volume for unruptured aneurysms ranged from 1 to 415, while that for ruptured aneurysms ranged from 1 to 64. There was a moderate decline in CFR with rising hospital volumes for both unruptured and ruptured abdominal aortic aneurysms (table 3) but this did not reach statistical significance. The volume–postoperative LHS relationship was weak and inconsistent in the crude comparison (table 3).

RESULTS OBTAINED FROM STEPWISE REGRESSION ANALYSIS

In the multivariate analyses, each 10 case per year increase in hospital volume was related to a 6% reduction in odds of death and a 0.29 day reduction in postoperative LHS in unruptured cases. On the other hand, there was no significant relationship between either CFR or
Table 1 Yearly statistics on repair of abdominal aortic aneurysms performed as primary procedures in Ontario hospitals, 1988-92

<table>
<thead>
<tr>
<th>Year</th>
<th>Unruptured aneurysm</th>
<th>Ruptured aneurysm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of operations</td>
<td>No of hospitals</td>
</tr>
<tr>
<td>1988</td>
<td>1022</td>
<td>60</td>
</tr>
<tr>
<td>1989</td>
<td>971</td>
<td>63</td>
</tr>
<tr>
<td>1990</td>
<td>1112</td>
<td>65</td>
</tr>
<tr>
<td>1991</td>
<td>1163</td>
<td>62</td>
</tr>
<tr>
<td>1992</td>
<td>1224</td>
<td>62</td>
</tr>
</tbody>
</table>

CFR = case fatality rate; LHS = length of hospital stay.

postoperative LHS and hospital volume in the ruptured cases. The CFR increased linearly with age both for unruptured and ruptured aneurysms: ORs for CFR for each 10 year age increase obtained from multiple logistic regression models were 1-75 (95% CI 1-52, 2-01) for ruptured abdominal aortic aneurysms and 2-10 (95% CI 1-74, 2-54) for unruptured aneurysms. Transfer from another hospital was associated with increased odds of death among unruptured cases (OR 4-37, 95% CI 2-62, 7-29) as was female sex (OR 1-53, 95% CI 1-08, 2-18). Comorbidity was also a predictor of outcomes (table 4).

Avoidable deaths for unruptured aneurysms in low volume hospitals

Approximately 40 deaths (8 deaths/year) in the low volume (<40 cases/year) hospitals might be avoidable if all of their surgery had been transferred to high volume hospitals (table 5).

### Table 2 Hospital and patient characteristics for abdominal aortic aneurysms in Ontario, 1988-92

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Unruptured aneurysm</th>
<th>Ruptured aneurysm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD) number of cases per year per hospital</td>
<td>15-6 (18-2)</td>
<td>3-1 (3-3)</td>
</tr>
<tr>
<td>Mean (SD) of bed size</td>
<td>236 (160)</td>
<td>225 (158)</td>
</tr>
<tr>
<td>Teaching hospital (%)</td>
<td>44-3</td>
<td>44-0</td>
</tr>
<tr>
<td>Female patients (%)</td>
<td>16-3</td>
<td>17-0</td>
</tr>
<tr>
<td>Patient's age (y):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;60 (%)</td>
<td>8-9</td>
<td>6-5</td>
</tr>
<tr>
<td>60-64 (%)</td>
<td>14-8</td>
<td>12-2</td>
</tr>
<tr>
<td>65-68 (%)</td>
<td>24-5</td>
<td>20-9</td>
</tr>
<tr>
<td>70-74 (%)</td>
<td>24-6</td>
<td>22-7</td>
</tr>
<tr>
<td>75-79 (%)</td>
<td>17-6</td>
<td>20-6</td>
</tr>
<tr>
<td>≥80 (%)</td>
<td>9-6</td>
<td>17-2</td>
</tr>
<tr>
<td>Comorbidity index:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 (%)</td>
<td>59-6</td>
<td>62-2</td>
</tr>
<tr>
<td>1 (%)</td>
<td>28-2</td>
<td>24-4</td>
</tr>
<tr>
<td>≥2 (%)</td>
<td>12-2</td>
<td>13-4</td>
</tr>
<tr>
<td>Transferred from another hospital (%)</td>
<td>4-1</td>
<td>26-4</td>
</tr>
<tr>
<td>In-hospital death (%)</td>
<td>3-8</td>
<td>40-0</td>
</tr>
<tr>
<td>Mean (SD) LHS</td>
<td>11-2 (5-1)</td>
<td>18-6 (12-6)</td>
</tr>
</tbody>
</table>

Aneurysm surgery volume, bed size, and teaching status were obtained from the HMRI database and published sources. Age, sex, comorbidity index, admission status, transferred from another hospital, death rates, and length of hospital stay (LHS) were determined for patients admitted to each hospital.

### Table 3 Distribution of in-hospital death rate of postoperative in-hospital stay by level of hospital-volume of abdominal aneurysm surgery in Ontario, 1988-92

<table>
<thead>
<tr>
<th>Volume level per y</th>
<th>Unruptured aneurysm</th>
<th>Ruptured aneurysm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;10</td>
<td>10-20</td>
</tr>
<tr>
<td>No hospitals</td>
<td>35</td>
<td>17</td>
</tr>
<tr>
<td>No patients</td>
<td>696</td>
<td>1179</td>
</tr>
<tr>
<td>CFR (%)</td>
<td>4-6</td>
<td>4-0</td>
</tr>
<tr>
<td>Mean (SD) LHS</td>
<td>11-6 (5-4)</td>
<td>11-2 (5-0)</td>
</tr>
</tbody>
</table>

CFR = case fatality rate; LHS = length of hospital stay.
Table 4 Adjusted odds ratios (95% confidence interval) for in-hospital death and adjusted linear regression coefficients for length of postoperative stay for patients undergoing abdominal aortic aneurysm surgery in Ontario, 1988–92

<table>
<thead>
<tr>
<th>Determinants</th>
<th>Unruptured aneurysm</th>
<th>Ruptured aneurysm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-hospital death (%)</td>
<td>Length of stay (d)</td>
</tr>
<tr>
<td>Aneurysm surgery volume &amp; 10 case increase for unruptured &amp; 2 case increase for ruptured</td>
<td>0.94 (0.88, 0.99)</td>
<td>0.29 (0.22, 0.35)</td>
</tr>
<tr>
<td>Bed size &amp; 30 bed increase</td>
<td>NS</td>
<td>0.11 (0.08, 0.13)</td>
</tr>
<tr>
<td>Teaching hospital &amp; yes; no = 1</td>
<td>NS</td>
<td>0.46 (0.14, 0.78)</td>
</tr>
<tr>
<td>Age &amp; 10 &amp; increase</td>
<td>2.10 (1.74, 2.54)</td>
<td>1.39 (1.23, 1.55)</td>
</tr>
<tr>
<td>Sex &amp; male = 0; female = 1</td>
<td>1.53 (1.08, 2.18)</td>
<td>0.47 (0.11, 0.83)</td>
</tr>
<tr>
<td>Comorbidity index &amp; 0; 1 = 1; 2 &amp; 2 = 2</td>
<td>2.12 (1.77, 2.53)</td>
<td>1.05 (0.87, 1.23)</td>
</tr>
<tr>
<td>Transferred from another hospital &amp; no = 0; yes = 1</td>
<td>4.37 (2.62, 7.29)</td>
<td>1.62 (0.92, 3.22)</td>
</tr>
</tbody>
</table>

NS: not significant; nos in brackets represent 95% confidence intervals.

excluded cases back to the sample (4.0% v 3.8% for unruptured cases and 40.9% v 40.0% for ruptured cases).

The CFR of 3.8% for unruptured aneurysm observed in our study sample reflects, at least partly, the continuous improvement in the treatment outcomes for this surgical procedure.\(^7^\) Another possible reason for the low mortality rate is a surgeon training effect. We estimate that more than 80% of abdominal aortic aneurysm patients were treated in Ontario hospitals with a trained vascular surgeon on staff. However, inconsistent identifying factors on the data for individual surgeons prevented us from exploring further the relationship between a surgeon’s training and outcomes.

Previous analyses showing an inverse volume and mortality relationship\(^8^\) have generated support for the view that stricter regionalisation of this procedure will lead to better treatment outcomes. We too found a volume-mortality relationship but it was modest. Similarly, there was a modest relationship between hospital volume and postoperative LHS in non-fatal cases, presumably caused, at least partly, by increased complication rates in low volume hospitals. As shown in table 5, in the unlikely event that all unruptured cases now treated in low volume hospitals were transferred to the high volume hospitals and achieved the same CFR as high volume hospitals, only 40 deaths for the entire five years (or 8 deaths per year) could be avoided. This is dramatically fewer than suggested in a similar analysis by Maerki et al\(^5\) using 1972 data; however, their series had a much higher overall mortality (resulting in a greater potential for saving). Hannan et al analysed more recent (1985–1987) New York State data separating unruptured aneurysms from ruptured aneurysms and, similar to our findings, showed an inverse relationship between hospital volume and CFR for unruptured aneurysm surgery but not for ruptured aneurysms.\(^7\) Hannan et al used a log transformation for hospital volume in their logistic regression analysis, which precludes a direct comparison between their study and the current one.

On balance, it seems reasonable to infer that as surgical skill and care has improved (reflected by a continuous decrease in overall CFR), the impact of hospital volume on mortality might have diminished. Moreover, there are many factors affecting surgical care, and hospital volume itself is only an indirect marker for surgical care. For example, as Pilcher et al have pointed out, surgeons in large volume hospitals who perform vascular surgery occasionally may not do as well as those who perform vascular surgery more frequently, and some smaller community hospitals with one or two well trained, busy vascular surgeons can produce results comparable to those in large centers.\(^9\) These observations, coupled with the limited volume-outcome relationship seen in this study, cast doubt on the policy of regionalisation of abdominal aortic aneurysm care focussing only on hospital volume. Unfortunately, the surgeon identifying codes in the hospital administrative data for Ontario are less reliable than procedure and diagnosis codes, and formal analysis is thereby precluded. However, an informal review of surgeon identifying codes in relation to volumes does suggest very substantial concentration of elective aneurysm surgery in the hands of one or two surgeons in small and medium sized hospitals – a factor that may help explain the weak volume-outcome relationships observed at the hospital level. Further analyses are needed that focus on individual surgical volume, surgical training, and the quality of postoperative care.

Any study drawing on administrative data necessarily suffers from a lack of clinical detail and is subject to vagaries in the coding of diagnoses and procedures. It seems unlikely that the observed excess CFR in women undergoing elective abdominal aortic aneurysm repair can be explained on this basis. However, sex did not significantly affect survival in an earlier Canadian registry study,\(^3\) and independent confirmation of this observation is needed. Unmeasured referral biases are a particular concern in volume–outcomes analyses.

Table 5 Avoidable deaths for unruptured abdominal aortic aneurysms in low-volume hospitals (using 40 cases/year as the cut-off point) if all patients underwent surgery in high volume hospitals, Ontario, 1988–92

<table>
<thead>
<tr>
<th>Volume range (per y)</th>
<th>&lt;10</th>
<th>10–20</th>
<th>21–40</th>
<th>&gt;40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median volume</td>
<td>3.6</td>
<td>15</td>
<td>27</td>
<td>65</td>
</tr>
<tr>
<td>Total no of deaths</td>
<td>32</td>
<td>47</td>
<td>64</td>
<td>67</td>
</tr>
<tr>
<td>% (95% CI) avoidable deaths*</td>
<td>36-0% (6%, 72%)</td>
<td>30-0% (5%, 60%)</td>
<td>23% (4%, 46%)</td>
<td>NA</td>
</tr>
<tr>
<td>No of avoidable deaths</td>
<td>12 (2, 23)</td>
<td>14 (2, 28)</td>
<td>15 (3, 29)</td>
<td>NA</td>
</tr>
</tbody>
</table>

NA: not applicable; *Estimated from the volume-mortality relationship in the multivariate model.
based on administrative data. For unruptured aneurysms, it does seem that more complicated and higher risk cases are preferentially referred to large centres, because after age and comorbidity adjustment, the inverse volume-mortality and volume-postoperative LHIS relationships became statistically significant. Indeed, as shown by our multivariable analysis, selection factors clearly operate not just through outpatient referrals, but through inter-institutional transfers of inpatients. The effects of these referral or selection biases are unlikely to be totally eliminated by adjustments for age, comorbidity, and transfer status, given the fact that administrative data lack clinical details about many relevant variables. As a result, the volume-outcome relationship in unruptured aneurysms might have been underestimated in our study. On the other hand, it seems likely, considering unadjusted data, that our findings of small effects are real. Earlier studies presented data only on crude comparisons, yet showed a dramatic effect of hospital volume on CFR. For example, Pilcher et al examined the CFR of abdominal aortic aneurysms in Vermont from 1970–1977, and found a 1.5 to 2.5 fold increase in CFR in low volume hospitals compared with high volume hospitals on crude comparisons. Only very dramatic shifts in referral patterns, such as low risk cases being referred to large centres in earlier years and high risk cases being referred to large centres in later years, would explain the large differences in unadjusted results observed in earlier studies when compared with the current one.

The results for ruptured aneurysms are difficult to interpret. Intuitively one would expect high volume centres with sophisticated intensive care units to achieve better outcomes with these critically ill patients. However, apart from age, there were no significant predictors of postoperative mortality. In any event, the emergency nature of this procedure makes regionalisation unrealistic in some parts of Canada where the distance between hospitals would put patients at risk from attempted transfer. Pilcher et al have suggested that resuscitation and selective transfer, as well as emergency operations in selected smaller hospitals, might be effective policies in the management of ruptured aneurysms. Although the overall CFR in our study sample was low, the rate in ruptured aneurysms remained 10 times higher than that in unruptured aneurysms. This emphasises the need for more effective detection of aneurysms with elective repair of the dilated aorta. Some authors have argued that with continuing improvement in postoperative mortality and morbidity rates, elective surgery should now be offered to patients at higher risk of postoperative death, including the elderly. Our results support this position, in that the absolute excess in numbers of postoperative deaths for ruptured compared with unruptured cases was highest in patients at advanced aged. Moreover, some hospitalised patients with ruptured aneurysms died before surgery was attempted. To assess the potential consequences of non-operative deaths on the results, we estimated the in-hospital mortality rates for ruptured aneurysms by diagnosis alone. The CFR increased substantially to 54.0% when non-operative deaths were tallied, underlining the potential advantages of elective surgery. We acknowledge that only short term postoperative mortality was examined and that some deaths related to elective aneurysm repair will occur after discharge but there is no reason for these to be greater among those surviving elective surgery than among those undergoing emergency surgery for rupture. Our inferences are also supported by the fact that for long term postoperative outcomes a Canadian registry study showed a strong relationship between short term post-operative mortality and long term postoperative mortality. Lastly, some deaths from rupture obviously occur before admission to hospital. This again emphasises the potential yields from elective surgery, especially in older patients who would be less likely to survive rupture and reach the operating room.

There are obviously many factors that affect the preventive value of elective surgery for aneurysms, such as the size of the aneurysm, expansion speed, likelihood of early death from competing causes, and average life expectancy. Adequate assessment of the cost effectiveness of elective surgery under various scenarios must therefore integrate these factors with decision analytic techniques. Nonetheless, our results strongly suggest that calendaryears per se should not be a reason to withhold elective abdominal aortic aneurysm repair from older patients.

This study was supported by the Institute for Clinical Evaluative Sciences in Ontario. Dr C D Naylor is a Career Scientist of the Ontario Ministry of Health. The authors would like to thank Ms Caitlin Davies for secretarial assistance and Mr Marc-Erick Theriault for computer programming support.

### Table 6 A comparison of age specific in-hospital case fatality rate differences (ruptured – unruptured) and differences in the actual number of postoperative deaths (ruptured – unruptured) for patients undergoing abdominal aortic aneurysm surgery

<table>
<thead>
<tr>
<th>Age (y)</th>
<th>Rate difference in (%)</th>
<th>Difference in no of deaths per year in Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;60</td>
<td>18.2 (8.7–27.7)</td>
<td>2</td>
</tr>
<tr>
<td>60–64</td>
<td>21.0 (13.7–28.2)</td>
<td>4</td>
</tr>
<tr>
<td>65–69</td>
<td>31.8 (25.7–38.0)</td>
<td>10</td>
</tr>
<tr>
<td>70–74</td>
<td>37.5 (31.4–43.6)</td>
<td>14</td>
</tr>
<tr>
<td>75–79</td>
<td>38.9 (32.3–45.6)</td>
<td>9</td>
</tr>
<tr>
<td>≥80</td>
<td>50.2 (42.8–57.7)</td>
<td>15</td>
</tr>
</tbody>
</table>

7 Hamann EL, Kalbhen H Jr, O’Donnell JF, Bernard HR, Shields EF, Lindsay ML, Yazici A. A longitudinal analysis...


S W Wen, M Simunovic, J I Williams, K W Johnston and C D Naylor

*J Epidemiol Community Health* 1996 50: 207-213
doi: 10.1136/jech.50.2.207

Updated information and services can be found at: [http://jech.bmj.com/content/50/2/207](http://jech.bmj.com/content/50/2/207)

### Email alerting service

**These include:**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

### Notes

To request permissions go to: [http://group.bmj.com/group/rights-licensing/permissions](http://group.bmj.com/group/rights-licensing/permissions)

To order reprints go to: [http://journals.bmj.com/cgi/reprintform](http://journals.bmj.com/cgi/reprintform)

To subscribe to BMJ go to: [http://group.bmj.com/subscribe/](http://group.bmj.com/subscribe/)