Commentary

iMedPub Journals
www.imedpub.com

Journal of Vascular and Endovascular Therapy

2019
Vol.4 No.1:3

Abdominal Aortic Aneurysm: The Hard Battle between What Should be Done and What can be Done

Oscar Ojeda*

Department of Vascular Surgery, Eugenio Espejo Hospital, Ecuador

***Corresponding author:** Oscar Ojeda, Department of Vascular Surgery, Eugenio Espejo Hospital, Ecuador, Tel: 593998594736; E-mail: oscarle1942@gmail.com

Received date: January 20, 2019; **Accepted date:** February 07, 2019; **Published date:** February 14, 2019

Citation: Ojeda O (2019) Abdominal Aortic Aneurysm: The Hard Battle between What Should be Done and What can be Done. J Vasc Endovasc Therapy Vol.4 No.1:03

Commentary

A patient with abdominal aortic aneurysm arrives at the medical office. You review your exams and imaging studies and conclude that he is a candidate for endovascular aneurysm repair (EVAR). However, you do not have an endograft in the hospital and get it takes a period of time between 3 and 6 months, with no guarantee that you will be able to acquire it at the end.

That is the reality in our public health system. I cannot offer the best because the budget is limited. We do open surgery with good results. In out-patient consult I always explain to the patient that we can do EVAR or open surgery but the first one has an important economic and logistic limitation. There is no limitation in ability to do it; we are well trained to offer these modern treatments.

For the colleagues of the first world who read this, it will surely seem absurd and laughable, but it is our reality. The public health system in my country has many difficulties in the economic and administrative issues. The theory of buying "the cheapest" is very common in the authorities. They do not care what is best for the patient but what is the cheapest for the institution. That's why they buy dacron prostheses for open surgery but do not buy endografts, because the endografts cost ten times more, however, there is no analysis or studies. They do not realize that a patient with open surgery stays several days in ICU and then goes to hospitalization and that this represents more expensive than that patient with EVAR who stay a day of ICU and one or two days of hospitalization and then goes home. What cost more? What was the best for the patient?

This daily struggle tires us and diminishes our self-esteem. You cannot offer the best to the patient and I do not say it for criticizing open surgery that remains very important, valid and the fundamental axis of the training of a vascular surgeon. I say this because there are other less invasive alternatives that cannot be done for administrative and financial reasons. Why does not that vision of cost benefit exist in some medical supplies? Until when the vascular surgeons of the public health system must wait to do the best?

The difficult is that it is not only the economic problem, there is also slow and retrograde bureaucracy in the public procurement system and what I mentioned before, little or no vision of what is more costly in the long term.

With all this in your mind, you have to go back to reality and talk to the patient and their families, and explain that we only do open surgery. There is no other alternative. If you wait for the purchase of an endograft, the aneurysm breaks and the whole story is different. We operate, often successful surgery, the patient can survive, you are happy and the hero. Nobody but you and your colleagues know that it is the best that the patient could have received. It is our idiosyncrasy. The eternal fight between what must be done and what can be done. Who loses? The authorities remain the same, doctors lose the possibility of doing a modern procedure and continue to train us, but the patient loses. In this long chain of errors and mistakes, the patient can lose his life or be left with an important morbidity. But for the authorities it seems that this is not important as long as everything is within the annual budget.