website is merely a list of endorsements or warnings from treated patients writing about their treatment experiences. While it may provide some sense of community to rosacea sufferers, the information it provides is the worst of any of the sites reviewed. It fails to give even the most basic medical information about rosacea and rhinophyma, and relies on hearsay and personal testimonies for its content.*

Endovascular aneurysm repair (EVAR) for abdominal aortic aneurysm (AAA)

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Abdominal aortic aneurysms (AAAs) are common in the industrialised world, causing 2% of all male deaths over 55 years of age, with a male to female ratio of 4:1. Risk factors are essentially those of atherosclerosis (tobacco use, hypertension, male sex and a family history of AAA). Rarer causes of aneurysms include infection, trauma, arteritis and connective tissue disorders such as Marfan's and Ehlers-Danlos syndrome.

Treatment has traditionally been surgical, performed for over 50 years via laparotomy, by clamping the aorta above and below the aneurysm, and anastomosing a tubular inlay graft to the normal calibre artery above and below the aneurysm, thus excluding it from the circulation. Operative mortality of this procedure in the emergency setting is in excess of 50%. Mortality is greater than 99% in the event of peri-operative cardiac arrest. Mortality associated with elective AAA repair is just under 5%.

Juan Carlos Parodi pioneered the endovascular approach to infrarenal aneurysm exclusion in Argentina, publishing a series of five patients (deemed anaesthetically unfit for open surgery) whom he had successfully treated via a femoral endovascular approach in 1991. Perhaps due to the wide familiarity and acceptance of the open operation, its conceptual simplicity and on-going role, the technique of EVAR met initial resistance; however, during the intervening 15 years, significant advances have been made.

An endoluminal approach to exclude aortic aneurysms is now becoming increasingly common in the UK, predicated upon the two-thirds' reduction in 30-day mortality compared to open repair. Patients are increasingly aware of the technique and the widely publicised EVAR 1 Trial demonstrating the decreased 30-day mortality (from 4.7% with the open technique to 1.7% using EVAR).

<http://www.evartrials.org/summary.htm>

The official Trial website contains a useful patient introduction with simple illustrations as well as a brief results summary of the

EVAR 1 and 2 multicentre randomised controlled trials. The key result showed reduced 30-day mortality of EVAR for those fit for open surgery (EVAR 1) from 4.7% to 1.7%. Conversely, 30-day mortality for EVAR in those patients considered unfit for open surgery (EVAR 2 trial) was 9%, with no long-term survival advantage or increased quality of life. These peri-operative deaths were, however, largely cardiac, cerebrovascular, pulmonary and renal rather than aneurysm-related and, at the time of the Trial risk-factor optimisation (aggressive control of hypertension, use of aspirin and statins) was poor in this cohort of patients. The site is useful for patients and practitioners having to decide between the two approaches.****

<http://www.evtoday.com/AAA/2004%20Files/Update%20on%20the%20EUROSTAR%20Registry.html>

This site has an extremely useful review of the EUROSTAR (EUROpean collaborators on Stent/graft Techniques for aortic Aneurysm Repair) registry; an open-ended audit of clinical outcome, collating data from over 6000 patients who have undergone EVAR for infrarenal AAA, at 110 participating centres since 1997. Aneurysms are subdivided by diameter into groups: A = 4.5–5.4 cm; B = 5.5–6.4 cm; and C = 6.5 cm. Larger aneurysms (C) were found in an older population group with higher renal, cardiac and pulmonary co-morbidity; they were also associated with larger infrarenal neck diameters and more tortuous arterial trees making placement of stents more technically challenging. Perhaps unsurprisingly, these largest aneurysms, when treated with earliest stent types, had significantly poorer long-term outcome, with an exponential rise in the rate of aneurysm-related death reaching 12% at 6 years. These were chiefly associated with a tendency for distal migration (causing type 1 endo-leak) and material fracture (causing type 3 endo-leak), problems that have been substantially overcome by the newer generation of devices. Type II endo-leaks (from aortic side branches communicating with the excluded aneurysmal sack) by contrast, were found to have no significant adverse effect provided they were not associated with increasing sac size (which is usually the case). Despite these early difficulties with larger aneurysms, the EUROSTAR registry shows excellent results for smaller aneurysms, with 0.002 aneurysm-related deaths per patient year in group A and an overall freedom from aneurysm-related death in the entire study cohort of 97% at 4 years. The site is tremendously useful for practitioners having to advise patients on the relative merits of EVAR and open repair.****

<http://www.medterms.com/script/main/art.asp?articlekey=38676>

This on-line medical dictionary has a useful entry pitched for layperson or patient introduction. Keywords prompt further explanatory texts (similar to Wikipedia), though these are not always very helpful. This site quotes reasonable figures for 30-day mortality of 4–12% for elective open AAA repair which 'decreases by 2/3 but with a higher rate of re-operation using EVAR.***

****CONSIDER BUYING SHARES ****TELL YOUR FRIENDS
***MAY BE USEFUL **LOOK IF YOU'VE GOT NOTHING TO DO
*BEST AVOIDED

SELECTED INTERNET VIEWING

http://www.pennhealth.com/int_rad/health_info/aaa.html

The patient information website of the Hospital of the University of Pennsylvania gives a good patient introduction to AAA anatomy as well as aetiology; the pros and cons of open and endovascular techniques are also frankly discussed. The site was clearly written by interventional radiologists and predictably pitches in favour of percutaneous EVAR performed by interventionalists. Some good CT images before and after procedure make it a useful patient resource.***

<http://www.or-live.com/memorialhermann/1386/event/rnh.cfm>*****

<http://meet.synaps-stream.com/video.php?chapter=4&video=0>***

<http://www.or-live.com/robertwoodjohnson/1219/>***

Several full-length filmed procedures may be viewed on line, usually in 'RealPlayer' format. These include offerings from 'or-live.com' (in this instance an hour-long archived webcast of infra-renal AAA EVAR, originally performed live in May 2005 at the Memorial Hermann Cardiovascular Institute in Texas) and another presented by 'MEET' (Multidisciplinary European Endovascular Therapy). The definition of the feed is slightly variable and can be a little shaky, with intermittent pauses to download data, depending on PC specification, but overall the format is very useful with simultaneous discussion and slide presentation. A great deal of information is thus related and an excellent overall conception of the procedure is gained. An excellent site for patients and practitioners alike.*****

<http://www.nwlh.nhs.uk/documents/patientleaflets/endovascular.pdf>

http://www.heatherwoodandwexham.nhs.uk/patient_info/information_leaflets/Y0131.pdf

Examples of NHS patient information leaflets available on the web include Northwick Park (NW London), which has a well-established EVAR service and Heatherwood & Wrexham Hospital (Ascot), which commenced EVAR in January 2007. The two documents show a slightly different approach with greater description given by NWLH. Heatherwood's leaflet is available as 'tape, large-print and translated versions' and its main statement of (reduced) risk reads: 'there is less strain put on your heart and the risk of you dying during the operation is reduced to 2%, three times less than for an open repair, which is 6–7%'. The Northwick Park leaflet gives no firm figures or risk of death but a more extensive list of secondary complications (renal impairment, endo-leak, femoral pseudo-aneurysm, etc.). Synthesis of the two approaches would yield an excellent template leaflet.***

<http://www.cardiomems.com/content.asp?display=medical>

This website's highlight is its nice animated sequence demonstrating the EVAR technique. It contains little patient information, however, as it is essentially a commercial site dedicated to selling their patented remote 'wireless' manometer, which is left within the excluded aneurysmal sack during endovascular repair to aid diagnosis of endo-leak. This is the major complication of EVAR responsible for its high re-intervention rate.**

http://www.malehealth.co.uk/userpage1.cfm?item_id=2000

This website gives UK-specific information on incidence and a clear and simple idea of the anatomy and aetiology of AAAs. Studies and figures are quoted appropriately and the case is made for both screening and EVAR.***

<http://www.answers.com/topic/abdominal-aortic-aneurysm>

(reproduces the Wikipedia webpage)

http://en.wikipedia.org/wiki/Abdominal_aortic_aneurysm

An interesting historical background of open aneurysmal surgery is related, as is detailed information on pathology. Active keywords are used to link to further explanatory texts and illustrations are reproduced from *Gray's Anatomy*. Unfortunately, little information is devoted to treatment and a bald statement of 'no survival advantage' is almost all that is said regarding EVAR.**

Spinal injury

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Patient orientated

Spinal Injuries Association

<http://www.spinal.co.uk>

This site was set-up in 1974 and continues to be run by victims of spinal cord injury. Its primary aim is to offer information and support to others with spinal injuries. It is a well-presented and clearly laid out site that leads the viewer easily around its content. There is an extremely useful glossary of medical terminology for the layperson and a question and answer section that covers the main immediate questions one would have. The site is user-friendly and has comprehensive links to all the other major spinal injury associations. Overall, this site is thorough and informative and provides a valuable resource and support network to those with spinal injury and their families.****

Spinal Injury Network

<http://www.spinal-injury.net/spinal-cord-injury.htm>

An individual following a cervical cord injury established this site in 1994. The initial impression is of a busy site with large amounts of information. Although very wordy, it does offer good quality descriptions with the occasional diagram that is helpful to the reader. There is a useful question and answer section but the links to other sites are not available as yet. In summary this is an exhaustive site that covers all aspects of spinal cord injury. It could be of use to medical staff wanting the basics regarding spinal injuries.***