Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Public consultation on the draft health technology assessment of abdominal aortic aneurysm (AAA) screening for men: Statement of outcomes

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About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services** — Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.

- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

Table of contents

1 Introduction

Following submissions received by the National Screening Advisory Committee (NSAC) for new population-based screening programmes, NSAC requested that HIQA undertake a health technology assessment (HTA) of population-based screening for abdominal aortic aneurysm (AAA or 'Triple A') for men in Ireland. As outlined in the HTA protocol, multiple engagement strategies, including convening an expert advisory group (EAG), and a public consultation, were employed to ensure that all relevant and important issues from the perspectives of multiple stakeholders were considered during the conduct of the HTA. The draft HTA report was made available for public consultation over a six-week period in May and June 2025.[1]

Public consultation is a structured process whereby a draft document is made available, and stakeholders are invited to provide feedback on the draft document within a specified timeframe. The overall aim of the public consultation on the draft HTA was to give stakeholders not directly involved in the HTA process an opportunity to provide feedback and, based on the feedback received, to expand coverage of material requiring further clarification.

The feedback received during the public consultation and HIQA's responses to the issues raised, including any changes incorporated into the final draft as a result, are summarised below.

2 Methods

The consultation process was undertaken in line with HIQA guidelines for stakeholder engagement.[2] The draft HTA report and associated draft plain language summary were published on the HIQA website for a six-week period, from 1 May to 12 June 2025.[1] The consultation webpage provided access to the draft HTA report, the draft plain language summary, a press release, and information on how to participate in the consultation. To ensure wide accessibility, feedback was accepted through multiple channels including an online survey hosted by Qualtrics, and a feedback form available for download, which could be returned by email or post.

2.1 Consultation feedback form

The consultation feedback form comprised two free-text fields to facilitate flexibility in the responses. These related to:

- general or specific feedback on the draft report, and
- the clarity or presentation of the draft report.

A copy of the downloadable feedback form is provided in Appendix A.

2.2 Dissemination

Materials for the press and social media were developed highlighting the key findings of the draft HTA. At the start of the consultation period, a press release was distributed to a range of media outlets. Announcements about the public consultation were also shared on social media platforms, including LinkedIn, X (formerly Twitter), Bluesky, Threads, Instagram and Facebook. Regular reminders were posted on these platforms to support continued engagement. Tailored content was shared on key dates during the consultation period including:

- World No Tobacco Day (31st May)
- Men's Health Week (9th to 15th June).

Targeted email invitations, inviting the submission of feedback, were sent to key stakeholders and stakeholder groups who are likely to be affected by the proposed introduction of an AAA screening programme for men. These included relevant stakeholder groups within the Health Service Executive (HSE), organisations that represent patients or the public, and professional bodies.

2.3 Synthesis

Following closure of the online survey, all responses were exported to Excel. Responses submitted via email or post were subsequently combined with the online responses. Each submission was assigned a unique identifier.

Submissions were considered incomplete if questions relating to the draft report were left blank. These submissions were excluded from the results (Section 3). In cases where a question was skipped by the respondent, it was assumed that the respondent had no feedback in relation to that question. Submissions were categorised according to whether they were submitted by members of the public or stakeholder organisations.

Topics within individual submissions were coded by a single researcher. Topics were then grouped into broader themes. Individual topics and grouped themes were reviewed by a second coder to ensure fidelity to the original data.

Feedback was presented in tabular format, alongside responses and actions relating to the feedback. Where necessary, responses were amended to ensure anonymity and to correct for grammatical and/or typographical errors.

3 Results

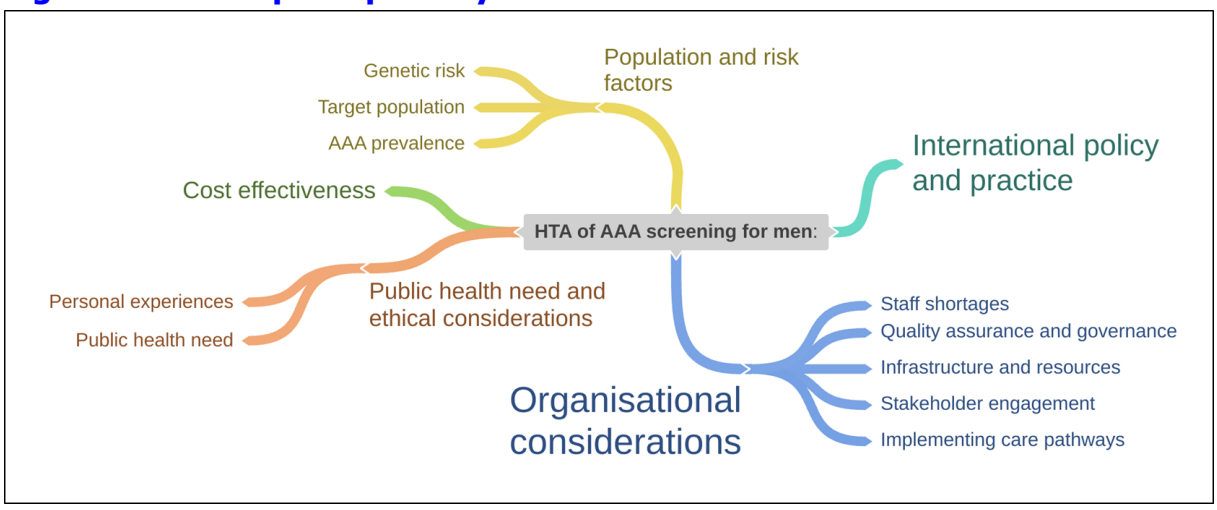
Overall, 17 unique submissions were received by email or through the online survey, including five complete submissions. Two of the five submissions were received by email or post, and three were submitted through the online survey. No responses were submitted on behalf of stakeholder groups or organisations.

3.1 Summary of feedback

All submissions expressed strong support for the introduction of AAA screening for men. However, some concerns were raised regarding the relevance of a population-based approach in the context of a changing clinical landscape, and the feasibility of screening in the Irish context given resource constraints.

Key themes across the five submissions are presented in Figure 3.1. All submissions made reference to organisational considerations, for example, the need for clear and adequately-resourced care pathways, the absence of a national vascular database, the value of stakeholder engagement in service design and delivery, and or the importance of robust quality assurance processes. Other common topics included AAA prevalence, international policy and practice, and the cost effectiveness of screening.

Figure 3.1 Concept map of key themes



Concept map created using Coggle. Themes are represented by major nodes, with related topics shown as smaller branches.

Two submissions described personal experiences involving a friend or relative with an AAA. These submissions highlighted the unpredictable nature of detection in the absence of screening, and the devastating impact that AAA rupture can have on friends, families and communities:

"Personally, I have known of two men who have had a AAA in the community recently one discovered accidently, the other sadly died, both smokers."

"Delays in establishing a screening program risk continued preventable deaths, including those similar to the tragic loss of my father… Families of those who have lost loved ones to undiagnosed AAAs are often unaware that screening could have saved lives… The failure to implement screening sooner has already cost lives—[my father's] included—and it is time for this to change."

3.2 Feedback on the clarity and presentation of the report

No feedback was received on the clarity or presentation of the report.

3.3 Feedback on the content of the report

HIQA's responses to the individual submissions on the content of the report are outlined in Table 3.1.

Table 3.1 Comments on report content

	Submission	Response	Action
1	Section 5.3.5 – Transferability Assessment **Subject: Recommendation for Risk-Stratified AAA Screening Model in Ireland** This submission responds to the draft Health Technology Assessment (HTA) on AAA screening in Ireland, with a particular focus on Section 5.3.5 Transferability Assessment. It highlights the limitations of applying outdated, non-localised cost-effectiveness models and advocates for a formal AAA screening programme in Ireland based on dynamic, risk-stratified criteria rather than age alone. Given the declining prevalence of AAA in the general population, the continued use of historic, age-based screening thresholds may reduce cost-effectiveness and clinical utility. A modern screening approach must align with current epidemiology, contemporary guidelines such as the 2024 ESVS recommendations, and international best practices that prioritise targeted screening for high-risk subpopulations. Notably the European Society for Vascular Surgery (ESVS) revised their AAA guidelines from 2019 in 2024 and documented a very clear shift towards stratified screening. **Key Points** 1. Limitations of Age-Only Screening Models The current HTA proposal largely rests on the assumption that a once-off screening for men aged ≥65 years remains cost-effective,	**Conclusions regarding the cost effectiveness of screening for AAA** The available international evidence suggests that population-based AAA screening in men is cost effective. However, as noted in this submission, the decline in AAA prevalence has been captured to a limited extent in economic evaluations published to date. The inputs and assumptions underpinning existing cost utility analyses (CUA) may not reflect the current clinical context in Ireland, characterised by declining AAA prevalence, an increase in the use of imaging studies as part of usual care, and improvements in cardiovascular risk factor management. These caveats are highlighted in the key points of Chapter 5. It is likely that the direction of the benefit-harm balance, at present, still favours screening despite changes in the clinical landscape over time. However, the long-term cost effectiveness of a population-based screening programme is uncertain. Based on the totality of the evidence presented in the HTA, targeted screening approaches are becoming increasingly relevant. However, at present, the evidence base for organised targeted screening is limited. Of note, the scope of this assessment was focused on population-based screening for men, in line with the request received from NSAC. This is outlined in Chapter 1, section 1.1.1 of the HTA. **Transferability assessment and targeted AAA screening**	Transplant recipients included as a high-risk group in Chapter 7, section 7.3.2. Uncertainty regarding the long-term cost effectiveness of population-based AAA screening, and the potential need to move towards a targeted screening approach, have been reflected in HIQA's Advice to NSAC.

Submission	Response	Action
citing older studies (e.g., MASS 2009) based on higher historical AAA prevalence. However, this assumption no longer holds due to: • Significantly reduced smoking rates and improved cardiovascular risk control. • Declining AAA prevalence, as documented in Sweden (4.9% in the 1990s to 1.7% by the 2010s) and likely mirrored in Ireland. • AAA prevalence for today's older male population is likely more closely resembling historic female populations, for whom screening was deemed not cost-effective. 2. Risk-Based Screening Enhances Diagnostic Yield and Cost-Effectiveness Evidence supports integrating additional risk factors into screening eligibility, including: • Smoking history (most significant modifiable risk; up to 6-fold increased AAA risk). • Hypertension and atherosclerotic disease. • Family history of AAA (particularly first-degree relatives). • Peripheral aneurysms or history of organ transplantation. Adopting these risk factors aligns with the 2024 ESVS Guidelines, which recommend screening based on local high-risk profiles and explicitly move away from population-wide age thresholds. 3. Inadequate Transferability Analysis in HTA Section 5.3.5 fails to reflect updated prevalence or simulate risk-based screening scenarios. It therefore fails to consider a modelling strategy of a stratified population.	Chapter 5 presents a structured assessment of the relevance of international cost-effectiveness literature to the Irish context, using the ISPOR questionnaire.[3] This tool served as a framework to guide identification of key transferability considerations, including AAA prevalence and the cost components considered in existing economic evaluations. Studies investigating the cost effectiveness of targeted screening were not formally considered as part of the transferability assessment as these studies did not meet the inclusion criteria of the systematic review (see Chapter 5, Table 5.1). While the scope of the HTA was limited to consideration of population-based AAA screening for men, three studies were identified that evaluated the cost effectiveness of targeted screening.[4-6] These studies are discussed in Chapter 5, section 5.4. In these studies, targeted screening referred to screening of siblings or patients already managed within cardiology or vascular services, as opposed to structured invitation to screening based on risk factors; targeted screening was not intended to replace population-based screening, but rather to augment existing approaches. The studies are therefore of limited relevance to the context of this HTA. No high-quality studies comparing the cost effectiveness of alternative screening strategies were identified. A CUA is underway in the UK, comparing the cost effectiveness of targeted screening with the existing population-based approach, and is expected to be completed in 2026.[7] As noted in the submission, the 2024 European Society for Vascular Surgery (ESVS) guidelines recommend screening in high-risk populations.[8] The guidelines do not explicitly	

Submission	Response	Action
4. Policy and Clinical Implications for Ireland Without national guidance, current AAA screening remains informal, unaudited, and inequitable. The current NCPS (National Care Plan for Vascular Surgery) model lacks clear implementation pathways and does not reflect the shift in international recommendations. A risk-stratified screening strategy would: - Maximise diagnostic yield by focusing on high-risk individuals. - Reduce unnecessary imaging and resource use in low-risk groups. - Improve public health equity through structured access. - Better align with Wilson and Jungner criteria by ensuring the right population is screened. **Recommendations** I would like to advocate for HIQA to revise its current HTA position and consider the following: 1. Implement a national AAA screening programme using stratified criteria: - Screen men aged ≥65 only if one or more risk factors are present (smoking history, hypertension, atherosclerosis). - Include targeted early screening (e.g., from age 50) for individuals with a first-degree relative with AAA. - Extend eligibility to organ transplant recipients and those with peripheral aneurysms. 2. Develop clear screening pathways and clinician guidance, supported by the HSE and relevant surgical and general practice bodies, ensuring equitable and consistent practice. Relevant stakeholders should include trainees in on the Higher Specialty	recommend against population-based screening; high-risk groups should be determined at a local level with consideration to factors such as AAA prevalence, life expectancy and healthcare system factors. In Ireland, implementation of organised targeted screening would be challenging due to the absence of a centralised database with risk factor data to facilitate identification of all members of the eligible population. As discussed in Chapter 4, section 4.3.3, there is currently no well-defined or widely-accepted approach to implementing organised targeted AAA screening. Opportunistic targeted AAA screening programmes in the US and France are based on smoking status and family history of AAA. However, such an approach would not be expected to identify all cases that would be detected with population-based screening.[9] While targeted screening is becoming increasingly relevant, its implementation in the Irish context would depend on significant improvements in ICT infrastructure, and further work to define the optimal set of risk factors. As noted in Chapter 9, section 9.2.8, if the prevalence of AAA continues to decline, and clinically validated risk factors that can readily identify the population at greatest risk of AAA are defined, a targeted screening approach may be appropriate. **HTA conclusions** Consistent with the recommendations outlined in this submission, significant investment in clinical workforce capacity, in particular clinical radiology and vascular surgery services,	

	Submission	Response	Action
	Training Programme in Vascular Surgery to ensure their voice is represented. 3. Commission new prevalence studies to validate current Irish AAA risk profiles and inform future cost-effectiveness modelling. 4. Invest in education and infrastructure to support referral and follow-up in at-risk populations. **Conclusion** Ireland stands at a critical juncture. Adopting an outdated, age-only AAA screening model risks poor yield, wasteful resource allocation, and missed diagnoses in true high-risk groups. A formal screening programme guided by risk stratification, not age alone, offers the best path forward. It is time to act decisively and implement a modern, evidence-aligned approach that reflects the needs of the Irish population.	would be required to support implementation of an AAA screening programme. If a decision is made to implement AAA screening for men, continued engagement with key stakeholders would be important to ensure that the implementation plan reflects all relevant perspectives. Up-to-date estimates of AAA prevalence would facilitate informed decision-making regarding the optimal approach to delivery of an AAA screening programme in the Irish context.	
2	The draft discusses how the prevalence of people developing AAA's has reduced in Ireland, due to people stopping smoking, I would be genuinely interested in obtaining where this reference has been obtained from, there also needs to be more of a mention on family history as genetics can play a significant role in particular the genes CDKN2BAS (also known as ANRIL), DAB2IP, and LRP1 have been identified as contributing to the genetic risk for AAAs. It's significant to also understand that Ireland does not have a National vascular database for reporting AAA's. Personally, I have known of two men who have had an AAA in the community recently one discovered accidently, the other sadly died, both smokers. I understand from the research previously conducted, Ireland had a greater incidence	As outlined in Chapter 2, the decline in AAA prevalence internationally over time is well supported by evidence from national AAA screening programmes, including Sweden and the UK (see Chapter 2, sections 2.6.1 and 2.9.1).[10, 11] No evidence was identified to suggest that the prevalence of AAA in Ireland is higher when compared with other developed countries. However, as highlighted in the submission, in the absence of up-to-date epidemiological data, the prevalence of AAA in men in Ireland is subject to uncertainty. Epidemiological evidence from the UK is likely applicable to Ireland with consideration to the strength of the association between smoking and AAA, and similarities in smoking rates (see Chapter 2, section 2.3.1).	Additional information on the role of genetics and family history in AAA development has been added to Chapter 2, section 2.3.1.

	Submission	Response	Action
	reported of men over aged 65 years developing a AAA in comparison to other developed countries. However as discussed it is difficult to assess whether Ireland has the largest unreported deaths caused by an undiagnosed AAA.	The possibility of underreporting of AAA-related mortality also cannot be eliminated due to the potential for misclassification of the cause of death in individuals with multimorbidity. This is a recognised limitation of mortality data reporting for AAA and similar conditions, where death is unexpected, occurs in the context of multimorbidity, and often in the absence of post-mortem examination. Robust data collection mechanisms to support accurate estimation of AAA prevalence in the Irish context are needed. The need for a national vascular database to support monitoring of patient outcomes, epidemiological trends, and healthcare system planning, is a key finding of the HTA. Additional information on the role of genetics and family history on AAA development has been added to Chapter 2, section 2.3.1. It is noted that in international practice, genetic markers are not currently applied in the context of screening to identify individuals at increased risk of AAA.	
3	Feedback on HIQA's Draft Health Technology Assessment (HTA) on Abdominal Aortic Aneurysm (AAA) Screening in Ireland **1. Urgency of Implementation and Public Health Need** The draft HTA acknowledges the life-threatening nature of AAA and the benefits of screening in reducing mortality. However, the assessment does not sufficiently highlight the critical need for swift implementation. Delays in establishing a screening program risk continued preventable deaths, including those similar to the tragic loss of my father. Given that AAA often progresses undetected until	**1. Urgency of Implementation and Public Health Need** AAA rupture is a time-critical medical emergency with a high mortality rate (approximately 80%, see Chapter 2, section 2.4.3). In the absence of screening, due to its asymptomatic nature, AAA is typically detected during imaging for other indications. However, as described in Chapter 9, section 9.2.2, incidental diagnosis as a primary method of case detection is unreliable.	The psychological impact of AAA rupture has been added to Chapter 8, section 8.3.1.

Submission	Response	Action
rupture, it is imperative that screening be prioritized as an immediate public health intervention rather than merely a consideration. Recommendation: Establish an expedited timeline for program rollout, ensuring screening availability within the next year. Lessons from the UK's National Health Service (NHS) AAA screening program should be used to inform rapid implementation. **2. Expansion of Target Population Beyond Men Aged 65** The draft HTA restricts screening to men aged 65, relying primarily on historical prevalence data. This limitation excludes high-risk groups, particularly individuals with family history, smokers, and those with cardiovascular conditions. The assessment does not sufficiently examine alternative screening models that could improve accessibility for these higher-risk individuals. Recommendation: Introduce a tiered screening approach that prioritizes men over 65 while incorporating additional risk-based screening (e.g., men with a family history of AAA, smokers, individuals with hypertension). Consider voluntary screening for women with strong risk factors, given emerging evidence of AAA prevalence among post-menopausal women. **3. Ethical Considerations and Patient Impact** The report discusses ethical concerns, but fails to amplify the personal and societal consequences of inaction. Families of those who have lost loved ones to undiagnosed AAAs are often unaware that screening could have saved lives. The absence of public	Decision-making in the context of screening is inherently complex, requiring careful consideration of multiple factors, as set out in established screening criteria.[12] The typically asymptomatic nature of AAA, the high mortality rate associated with AAA rupture, the availability of an accurate test with good acceptability, and the availability of an effective treatment, mean that AAA is a suitable candidate for screening. However, the changing clinical landscape (characterised by declining AAA prevalence, improved cardiovascular risk factor management and increasing use of diagnostic imaging as part of usual care) and current capacity constraints within the Irish healthcare system must be carefully considered. **2. Expansion of Target Population Beyond Men Aged 65** In international practice, target populations for screening have been selected based on the epidemiological literature, which shows an increase in AAA-related mortality from approximately age 65 onwards. Men older than age 65 years have not been systematically invited to AAA screening programmes internationally. No evidence was identified as part of this HTA to support a change from current international practice. The scope of this HTA was limited to consideration of population-based screening for men; alternative screening strategies, such as opportunistic or targeted screening, or screening women for AAA, were beyond the scope of this assessment. However, some information on these aspects is outlined in Chapters 2 and 4 to clearly articulate the rationale behind the project scope. As outlined in Chapter 2, section 2.11,	Additional information on self-referral criteria has been added to Chapter 7, section 7.3.2.

Submission	Response	Action
awareness campaigns and education initiatives in the assessment limits its impact. Recommendation: Ensure patient voices—including those affected by preventable AAA-related deaths—are incorporated into the consultation process. Advocate for a national awareness campaign informing the public and healthcare professionals about screening's lifesaving potential. **4. Resource Allocation and Infrastructure Readiness** While the draft HTA details cost considerations, it does not sufficiently outline a clear implementation plan or how Ireland's healthcare infrastructure can be rapidly adapted for screening. The assessment should provide firm commitments on ultrasound availability, workforce readiness, and referral pathways to ensure timely intervention. Recommendation: Outline a concrete action plan detailing infrastructure upgrades, training programs for ultrasound technicians, and referral efficiencies. Engage with vascular surgeons to optimize post-screening care pathways, preventing treatment delays that could increase mortality risk. Final Call for Action AAA screening is not a matter of policy convenience but of life-saving necessity. The failure to implement screening sooner has already cost lives—[my father's] included—and it is time for this to change. The recommendations above urge HIQA and policymakers to take decisive, expedited action to ensure no more families experience the loss that could have been prevented.	the evidence base for screening among women is limited. At present, no European country currently has a population-based or organised targeted AAA screening programme for women. Given evidence of declining AAA prevalence and the potential implications of this on the benefit-harm balance for population-based screening, the clinical effectiveness of targeted screening was considered in Chapter 4, section 4.3.3. As outlined by the World Health Organization (WHO), a formal screening programme requires systematic identification and invitation of the target population.[13] At present, organised targeted AAA screening is not in place in any European country. In Ireland, clinical risk factor data are collected through the HSE Chronic Disease Management (CDM) Programme for those with selected chronic conditions who also hold a medical or GP visit card (see Chapter 8, section 8.3.4). The absence of robust risk factor data to facilitate identification of all members of the eligible population means that, at present, organised targeted screening is unlikely to be feasible. In light of these challenges, the assessment considers the potential for additional populations to self-refer to the programme, including high-risk groups or men older than 65 years at the time of implementation (see Chapter 7, section 7.3.2). **3. Ethical Considerations and Patient Impact** Additional information on the devastating impact that AAA rupture can have on families, friends and communities has been added to Chapter 8 (Ethical, patient and social considerations).	

Submission		Response	Action
		Consistent with existing national screening programmes, if a decision is made to implement AAA screening for men, the implementation plan would include a public awareness campaign (see Chapter 7, section 7.6.2). Existing public health campaigns, such as Men's Health Week, could also be leveraged to increase awareness, as described in Chapter 8 (section 8.3.2). **4. Resource Allocation and Infrastructure** HTA involves the assessment of health technologies in a structured and transparent framework, with a focus on the information needs of policy-makers. The scope of a HTA does not extend to the implementation of health technologies into healthcare systems. If screening were to be recommended by the National Screening Advisory Committee (NSAC) and if the Minister for Health were to approve this recommendation, an implementation plan would then be developed. However, the HTA sets out important factors that could inform the development of an implementation plan, if a decision were made to implement AAA screening. As described in Chapters 7 and 9, a decision to implement screening should be preceded by a capacity-building phase, with a particular emphasis on development of clinical workforce capacity and data reporting mechanisms. This will also be reflected in the Advice to NSAC.	
4	The draft assessment is very thorough however there needs to be an exploration amongst the radiological and vascular team in order to help make AAA screening efficient.	An Expert Advisory Group (EAG) was convened to support this assessment, including representation from the National Clinical Programmes for Surgery and the Faculty of Radiologists and Radiation Oncologists. Members of the EAG highlighted significant resource deficits in vascular surgery and clinical	The importance of stakeholder engagement has been

	Submission	Response	Action
	One of the issues within the draft is the cost-effectiveness of the screening. There are many studies completed within the EU and internationally that support the implementation of AAA screening more recently Czech Republic and Denmark have begun a screening programs for men aged 65.	radiology, which may represent barriers to implementation. If a decision is made to implement AAA screening for men, further engagement with key stakeholders during pre-implementation and implementation would be critical. As noted in the submission, there have been recent changes in the AAA screening landscape internationally. Since publication of the draft report, an ongoing pilot screening programme in Hungary was identified. This additional information has been included in the final report.	considered in the key findings and advice to NSAC.
5	Just to highlight that a robust ultrasound quality assurance program is vital to this screening programme. This was mentioned in the report and the HTA allowed for 1 WTE senior physicist for ~ 52 ultrasound scanners (assuming 1 x scanner in each of the 2 screening sites per county). As non-ionising radiation (e.g. ultrasound, lasers, MRI) is not regulated in this country, there is a shortage of trained physics staff in these areas as the emphasis on Medical Physics roles is ionising radiation. It may be very difficult to find someone with the appropriate experience and expertise for this role. We are all too aware of the detriment of screening programmes (cervical) when they results are incorrect so ensuring that the ultrasound equipment is performing to correct specifications is essential. I am happy to see that this has been considered for this AAA programme and would love to see a push from HIQA to regulate non-ionising radiation. A recent IAPM (Irish Association of Physicists	The survey of ultrasound quality assurance processes under current practice referenced in this submission indicates a need to develop and standardise processes for quality assurance of ultrasound equipment nationally.[14] For the purposes of the budget impact analysis, it was assumed that 14 portable ultrasound scanners would be purchased (one per screening technician), and moved between screening locations (estimated to be 52 locations). The feasibility of such an approach would be dependent on the availability of ultrasound equipment meeting the required technical specifications. In the event that suitable portable ultrasound systems could not be identified, an increased quantity of ultrasound scanners would be required. Engagement with medical physics experts during the equipment commissioning and evaluation processes would be important. It is noted that a shortage of medical physicists in Ireland may present challenges in this regard.	The assumed number of ultrasound scanners required has been clarified in Chapter 6, section 6.2.7. The findings of the *National Survey on Ultrasound Quality Assurance* have been noted in

Submission	Response	Action
in Medicine) survey to hospitals in Ireland showed that only 40% of respondents have an ultrasound quality assurance programme in place. All of these hospitals have ultrasound machines in use for diagnostic radiology!	In January 2019, the European Union Basic Safety Standards for the Protection Against Dangers from Medical Exposure to Ionising Radiation (Euratom) were initially transposed into Irish law under SI 256. These regulations named HIQA as the competent authority for medical exposure to ionising radiation. At present, medical exposure to non-ionising radiation lies outside HIQA's legislative remit.	Chapter 7, section 7.3.4. Section 7.5.3 has been updated to note the shortage of trained medical physicists in Ireland.

Key: CDM – Chronic Disease Management; CUA – cost utility analysis; EAG – Expert Advisory Group; ESVS - European Society for Vascular Surgery; EU – European Union; HSE – Health Service Executive; ICT - Information and Communication Technology; ISPOR - International Society for Pharmacoeconomics and Outcomes Research; MRI – magnetic resonance imaging; NSAC – National Screening Advisory Committee; UK – United Kingdom; WHO – World Health Organization; WTE – whole time equivalent.

3.4 Changes to the report arising from the consultation process

The following changes were made to the draft report in response to comments and feedback received through the consultation process:

- Chapter 2 (Epidemiology), section 2.3.1, has been updated to include additional information on the role of genetics and family history in AAA development.
- Chapter 6 (Budget impact analysis), section 6.2.7, has been updated to clarify the assumed number of ultrasound scanners required.
- Chapter 7 (Organisational considerations):
    - section 7.3.2, has been updated to include additional considerations regarding self-referral criteria.
    - section 7.3.4, has been updated to include the findings of the National Survey on Ultrasound Quality Assurance.
    - section 7.5.3, has been updated to highlight the shortage of trained medical physicists in Ireland.
- A new section has been added to Chapter 8 (Ethical, patient and social considerations), section 8.3.1, highlighting the psychological impacts of AAA rupture resulting in unexpected death on friends, families and communities.

While not all submissions necessitated changes to the report, all submissions were carefully considered by the evaluation team in the preparation of HIQA's Advice to NSAC and will be submitted to NSAC for their review prior to decision-making.

3.5 Post-consultation outcomes

Following revision of the HTA report to take into account the feedback received, the key findings and Advice to NSAC were developed, and are presented in the final version.

Following approval by the Board of HIQA, the revised HTA report including HIQA's advice to NSAC and this statement of outcomes report were submitted to NSAC for consideration in October 2025.

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Appendix A: Copy of the consultation feedback form

Health Technology Assessment of abdominal aortic aneurysm (AAA or 'triple A') screening for men in Ireland

Public Consultation feedback form

The Health Information and Quality Authority (HIQA) is holding a six-week public consultation to give people an opportunity to provide feedback on the health technology assessment of abdominal aortic aneurysm (AAA or 'triple A') screening for men in Ireland.

Your views are important to us. HIQA will carefully assess all feedback received and incorporate it into the report, where appropriate.

The final assessment and a statement of outcomes report (a summary of the consultation responses) will be published on HIQA's website once the HTA has been completed.

The closing date for the public consultation is 5 pm on Thursday, 12 June 2025.

How to provide feedback:

- If you are commenting in a personal capacity, there is no need to provide your name or any other personal information.
- If you are commenting on behalf of an organisation, please combine all feedback from your organisation into one submission form. We will request a name and contact number for a designated representative from your organisation in case we need to clarify your feedback.
- If your feedback contains any commercially sensitive or confidential information, please highlight this at the time of submission, so it can be excluded from the summary of feedback that will be published by HIQA.
- Please spell out any abbreviations that you use.

You can **email** the completed form to consultation@hiqa.ie

OR

Print the consultation feedback form and **post** the completed form to:

Health Information and Quality Authority
Public consultation on HTA of AAA screening for men
Dublin Regional Office
George's Court,
George's Lane,
Smithfield,
Dublin 7,
D07 E98Y

Data protection and Freedom of Information

HIQA will only collect personal information, such as the names of individuals who provided feedback or any other personal details during this consultation, for the purposes of seeking clarification on your feedback, if necessary. No personal information will be included in the stakeholder consultation document that will be published by HIQA.

Any response you provide will be held securely and anonymised. Information provided in your response, for example, an anecdote or statement about an experience, may be included in the statement of outcomes that will be published by HIQA at the end of the HTA process. However, information will be provided in a manner which protects the privacy of respondents. All personal information will be deleted once no longer needed, in line with HIQA's record retention policy.

For further information on how HIQA uses personal information, please see our Privacy Notice available here. If you have any concerns regarding your personal information, please contact HIQA's Data Protection Officer at dpo@hiqa.ie.

Please note that HIQA is subject to the Freedom of Information (FOI) Act and the statutory Code of Practice in relation to FOI. We cannot give you an assurance that confidentiality can be maintained in all circumstances due to the requirements of the FOI Act.

☐ **I agree to take part in the public consultation**

1. About you

1.1 Are you providing feedback as:

☐ an individual

☐ on behalf of an organisation

1.2 If answer is 'on behalf of an organisation', please give the name of the organisation:

If applicable, for clarification purposes, please provide your name, your role in the above organisation and your contact details:

2. Your feedback on the draft health technology assessment

2.1 Please provide any general or specific feedback you have on the draft assessment. Where applicable, please specify the section to which you are referring.

2.2 Please outline any issues with the clarity or presentation of the draft report. In your response, where applicable, please specify the section to which you are referring.

Thank you for taking the time to share your feedback with us

Please ensure that you return your completed form to us either by email or post, to reach us by Thursday, **12 June 2025**.

If you have any questions, please contact the evaluation team at consultation@hiqa.ie or by phone at (021) 240 9300.

Published by the Health Information and Quality Authority (HIQA).

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