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The lived experience of abdominal aortic aneurysm (AAA): A qualitative systematic review

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Objective: To synthesise qualitative evidence on the lived experiences of screening, diagnosis, surveillance, and management among individuals with abdominal aortic aneurysm (AAA).
Data sources: AMED, CINAHL, Cochrane Library, Embase, PsycINFO, and PubMed were searched from inception to January 2025, supplemented by manual reference checks.
Review methods: Eligible studies reported primary qualitative data on the experiences of people living with AAA. Two reviewers independently screened titles, abstracts, and full texts, and assessed methodological quality using the Critical Appraisal Skills Programme (CASP) checklist. Data were synthesised using a best-fit framework approach with inductive thematic analysis. Reporting followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 statement.
Results: Fourteen studies involving 150 participants (predominantly men, aged 53–88 years) were included. AAA negatively affected quality of life across the care pathway. Surveillance was characterised by uncertainty and anxiety linked to the asymptomatic and unpredictable nature of the disease. Patients undergoing surgical repair expressed trust in healthcare providers but often lacked sufficient information to participate meaningfully in shared decision-making. Across care stages, individuals sought autonomy, control, and reassurance through ongoing follow-up and accessible information. Misconceptions about lifestyle factors such as exercise and smoking cessation were common, reflecting unmet patient education needs.
Conclusion: Current evidence highlights the profound psychological burden of AAA and the central role of patient education and patient-centred communication in supporting autonomy and empowerment. Improved information provision, shared decision-making, and attention to lived experiences may enhance quality of life throughout the AAA care pathway.
PROSPERO registration number: CRD42022312088

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Introduction

Abdominal aortic aneurysm (AAA) is defined as a pathological, permanent dilation of the abdominal aorta with a diameter ≥3 cm.[1] The condition is typically asymptomatic until rupture, which carries high mortality.[2,3] Advances in screening and surgical techniques have improved outcomes, yet AAA continues to present complex challenges for patients and healthcare systems.

While biomedical aspects of AAA are well described, less is known about the lived experiences of individuals navigating screening, surveillance, and treatment. Patients often face uncertainty about disease progression, struggle to interpret risk information, and may feel excluded from decisions about their care.[4] Enhancing patient information and shared decision-making is increasingly recognised as essential for high-quality, person-centred vascular care.

Qualitative perspectives are crucial for understanding quality of life (QoL) and for shaping services that address psychological, social, and cultural dimensions of care.[5,6] These perspectives also illuminate how factors such as age, socioeconomic position, health literacy, and healthcare provider-patient communication influence patient engagement and outcomes.[7]

To date, evidence remains fragmented. The most recent systematic review of patient experiences in AAA combined quan-

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titative and qualitative studies but included only three qualitative reports, most of which were more than a decade old.[8] Given the evolving nature of vascular services and changing patient expectations, an updated synthesis of qualitative evidence is needed.

The aim of this review was to synthesise qualitative studies exploring the lived experience of people with AAA, focusing on their perspectives of screening, diagnosis, surveillance, treatment, and recovery.

Methods

This review was conducted and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (see checklist in Supplementary File S1).[9] The protocol was prospectively registered with PROSPERO (CRD42022312088).

Search strategy

Systematic electronic searches were conducted in AMED (EBSCOhost), CINAHL (EBSCOhost), Cochrane Library, Embase, PsycINFO (ProQuest), and PubMed from inception to 18 January 2025. Search strategies were tailored to each database using controlled vocabulary (e.g. MeSH) and keywords relating to *abdominal aortic aneurysm* and *patient experience* (Supplementary File S2). Terms included "Aortic Aneurysm, Abdominal," "Quality of Life," "Patient Experience," "Lived Experience," and synonyms. No limits were applied for study design, year of publication, or participant age.

Eligibility criteria

Studies were eligible if they:

- Included adults with a diagnosis of AAA, or where AAA was the confirmed underlying condition.
- Reported primary qualitative data on lived experiences of screening, diagnosis, surveillance, treatment or recovery.
- Were published in English.
- Reported qualitative results separately when embedded in mixed methods designs.

Exclusion criteria were: survey-only or hypothetical data studies, conference abstracts, or studies without accessible full text.

Study selection

All search results were imported into Rayyan (Rayyan Systems Inc.)[10] and duplicates removed. Two reviewers (EO, CS) independently screened titles, abstracts, and full texts against eligibility criteria. Discrepancies were resolved through discussion.

Data extraction

The following data were extracted from each included study: first author, year, country, study design, sampling, data collection and analysis methods, participant characteristics (age, sex), setting, cultural context, and key findings.

Quality appraisal

Methodological quality was assessed independently by two reviewers using the Critical Appraisal Skills Programme (CASP) qualitative checklist.[11] All studies were retained regardless of appraisal outcome to ensure comprehensive synthesis, with appraisal used to contextualise confidence in the evidence.

Data synthesis

Data were synthesised using a best-fit framework synthesis approach.[12–15] An a priori framework reflecting anticipated stages of the AAA care pathway (screening, surveillance, pre- and post-operative experiences) was established through team discussion. Study findings were coded inductively into framework categories. Where data did not align, new themes were generated and integrated into the evolving framework. This process allowed accommodation of both anticipated and emergent insights.[14]

Themes were iteratively refined through discussion to ensure consistency and reflexivity, recognising that reviewer perspectives may have influenced interpretation. Findings are presented with illustrative participant quotations, mapped to stages of the care pathway (Tables 2–7), and visually represented in the final framework (Fig. 1).

Findings

Study selection

The database search yielded 964 records, of which 74 were removed as duplicates. After screening titles and abstracts, 867 records were excluded. Two articles could not be retrieved. Following full-text review, seven studies were excluded (three did not provide qualitative data on AAA experiences, four did not meet the eligibility criteria). Fourteen studies were included in the qualitative synthesis (Fig. 2).

Study characteristics

The 14 studies, published between 2009 and 2023, reported data from 150 participants.[4,6,16–27] While most participants were male (n = 112, 74.7%) with ages ranging from 53 to 88 years, two studies did not report participants' ages or sex.[16,20] Studies were conducted primarily in Sweden (n = 9), with three from the UK, one from the USA, and one from Denmark (Table 1). Interview settings varied (homes, hospitals, outpatient clinics, community facilities), though were not always reported.

Quality appraisal

Seven studies met all criteria (Supplementary File S3).[6,17,20,21,25,26,28] Common methodological limitations related to unclear reporting of researcher–participant relationships, insufficient detail on recruitment or analysis, and limited ethical discussion. Despite these issues, all studies were retained to maximise conceptual richness, with appraisal findings considered when interpreting results.

Lived experience of AAA

Using a best-fit framework synthesis, themes were identified and mapped to stages of the AAA care pathway: screening and diagnosis, surveillance and self-management, and pre- and post-operative experiences. Where studies did not provide explicit thematic frameworks, data were coded inductively and integrated into the analysis. Findings are supported with illustrative quotations (Tables 2–7 in Supplementary File S4) and visually represented in the conceptual framework (Fig. 3).

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Table 1
Data extraction & characteristics of included studies.

Study (year), country	Phenomenon of interest	Study design, sampling, data collection and analysis	Participants, age, gender	Setting	Geographical, cultural
Bertero, Carlsson, and Lundgren (2010),[18] Sweden	Patient experience one year after being informed of AAA diagnosis at screening.	One-year retrospective study, Purposive sampling, Interviews, Interpretative phenomenological method.	$n = 10$, 66 years, Male = 10; Female = 0.	Not stated.	Swedish
Brännström et al. (2009),[6] Sweden	Patient experience 5 years after being informed of AAA diagnosis at screening.	5-year follow-up case study, Purposive sampling, Interviews, Thematic analysis.	$n = 3$, 79–80 years, Male = 3; Female = 0	Participants' homes.	Swedish
Gunasekera et al. (2014) ,[16] United Kingdom	Recruitment strategies for future trials and patient experience of AAA.	Randomised controlled pilot study, Purposive sampling, Focus group session, Framework analysis.	$n = 6$, Age and gender were not specified in this sample.	Unclear.	British
Holmström et al. (2019),[17] Sweden	Views on AAA and smoking among male smokers with screening-detected AAA.	Descriptive with a qualitative approach, Purposeful sampling, Semi-structured interviews, Thematic analysis	$n = 16$ Median age (range): 67.5 (65–70) years. Male = 16; Female = 0	University hospital in mid-Sweden.	Swedish
Lecouturier et al. (2023) ,[19] United Kingdom	Patient experience of information provision and decision-making in treatment for AAA.	Qualitative exploratory approach, Purposive sampling, Semi-structured interviews, Framework analysis.	$n = 15$, Range: 56 – 85 years. Male = 14; Female = 1.	Telephone call and another location unspecified.	British
Letterstål et al. (2010),[4] Sweden	Patient experience of care pathway undergoing open surgery for AAA.	Exploratory descriptive design, Purposeful sampling, Narrative approach with a semi-structured interview guide, Qualitative content analysis.	$n = 10$, Age mean (range): 73.0 (55–83) years. Male = 6; Female = 4	Hospital and participants' homes.	Swedish
Mikkelsen et al. (2022),[20] Denmark	Patients' perspectives on living with AAA.	Action research, purposive sampling, interviews and questionnaires, inductive content analysis.	$n = 12$, Age and gender were not specified in this sample.	Patients' homes.	Danish
Nilsson et al. (2023),[21] Sweden	Patients' experience of an eHealth tool and tailored psychosocial support throughout the care trajectory of AAA repair.	Qualitative, purposive sampling, semi-structured interviews, qualitative content analysis with an inductive approach.	$n = 12$, Mean (range): 72 (53–86), Male = 9; Female: 3	Administrative hospital.	Swedish
Nieuwenhuijsen et al. (2009),[22] United States of America	A patient's and patient advocate's view of experience with rehabilitation and other healthcare services – an insider's point of view.	Convenient sampling. Case study	$n = 1$, Age: 88 years Male = 1; Female = 0	Intensive care at hospital, hospital for intensive respiratory treatment, and a nursing facility. Settings of interview – unclear.	American
Pettersson et al. (2022) ,[26] Sweden	Patients' perceptions and experiences of their body and bodily function in connection with open surgery of AAA.	Descriptive and explorative, purposive sampling, interviews, qualitative with hermeneutic approach.	$n = 12$ Age mean (range): 71 (57–79) years Male = 9; Female: 3	Vascular outpatient clinic at the hospital.	Swedish
Pettersson et al. (2010),[23] Sweden	Patient experience of diagnosis and treatment of AAA and state of recovery at month post-surgery.	Philosophical hermeneutics, Purposeful sampling (Recruited from a vascular surgery unit at a university hospital in Sweden).	$n = 20$, Age range: 59 – 84 years Male:16; Female: 4	Vascular surgery unit of university hospital	Swedish
Pettersson et al. (2013),[24] Sweden	Patient experience of living with knowledge of having AAA while receiving conservative treatment.	Exploratory and descriptive design, Selective sampling (selected from an outpatient clinic list of conservatively treated patients whose aneurysm had not been discovered by screening and who required monitoring, including radiography and regular visits to outpatient clinic.	$n = 10$ Mean age: 72.4 (Range = 63–82 years) Male = 8; female = 2	A private room at the vascular unit of the outpatient clinic.	Swedish
Pettersson et al. (2017),[25] Sweden	Experience of the screening process and diagnosis of AAA from invitation to one-year surveillance.	Qualitative explorative design with focus group interviews, Purposeful sampling Qualitative manifest and latent analysis.	$n = 11$ Age range: 65 – 66 years Male = 11; female = 0	A rented conference room external of hospital.	Swedish
Tocher (2013),[27] United Kingdom	Patients' expectations of postoperative pain when undergoing open surgical repair of AAA.	Mixed methods approach, Purposeful sampling	$n = 22$ Age: mean = 69 years; Range = 58–80 years, Male = 9; Female = 3	Unclear.	British

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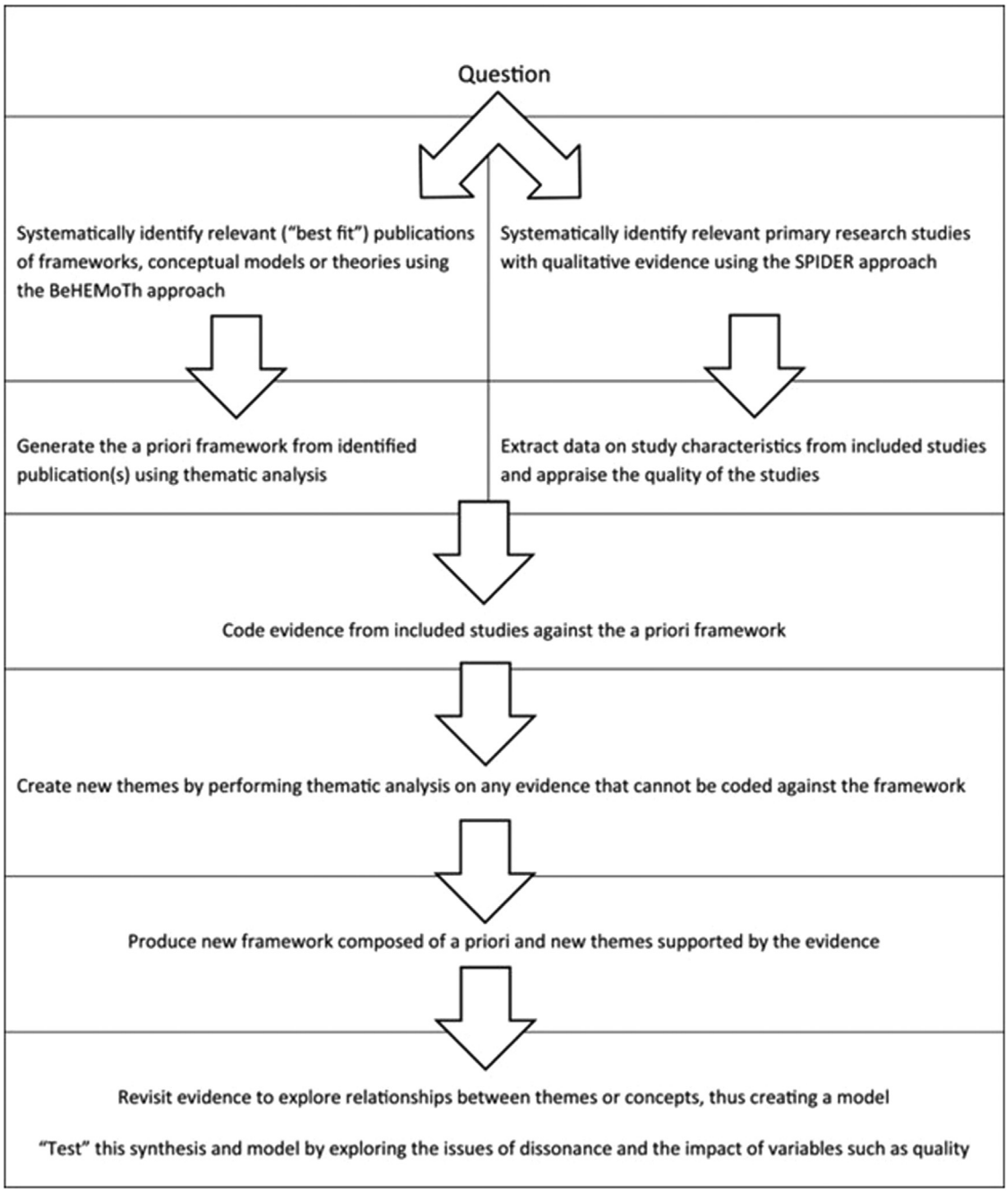


Fig. 1. Qualitative evidence synthesis using the "best fit" framework synthesis.

Screening and diagnosis

Diagnosis was often incidental, arising during investigations for unrelated conditions. The unexpected revelation of a life-threatening but symptomless disease generated shock, disbelief, and fear about the future. One participant recalled being "in the dark and wondering what would happen next".[16] For some, other co-morbidities muted the emotional impact, while for most, the invisible nature of AAA provoked hyper-awareness of bodily sensations and loss of trust in their own physical cues.

Information at diagnosis was typically brief or technical, centred on surgical risk rather than lived implications. Explanations using diagrams or analogies could reassure but rarely resolved confusion. This limited understanding constrained patients' participation in decisions. Many described clinicians leading choices about repair, with little time for reflection or family discussion. Earlier, clearer communication and written or digital materials were seen as essential for informed involvement.

Surveillance offered reassurance but also sustained anxiety. Stable imaging brought relief; evidence of growth re-ignited fear. Follow-up appointments often reopened worries patients had tried to suppress. Many preferred early surgery "while still fit and well", seeing it as regaining control over an uncertain future. When professional guidance was limited, patients sought information online or through acquaintances, which frequently amplified fear. Overall, the early phase of the AAA journey was characterised by emotional

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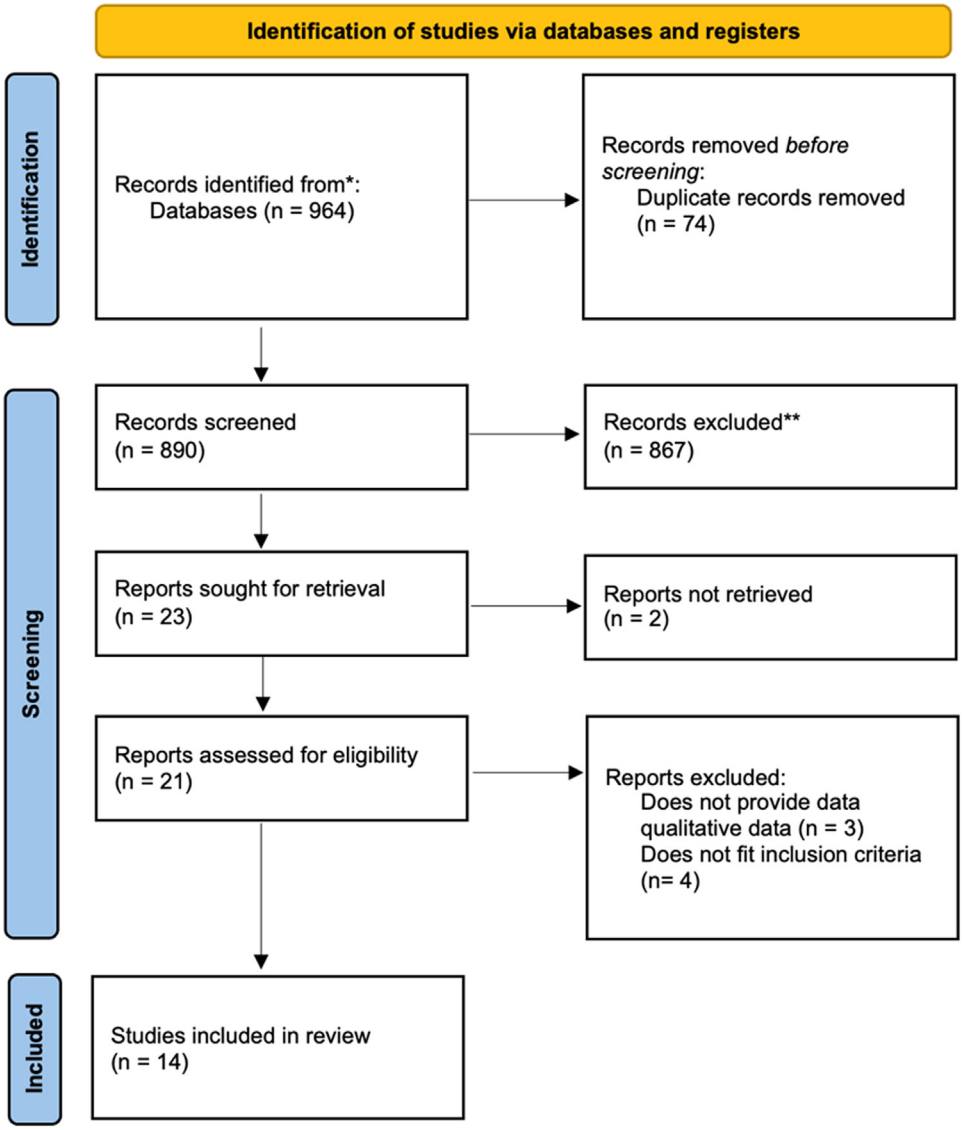


Fig. 2. PRISMA flow diagram for patients' experiences of living with abdominal aortic aneurysm.

upheaval, information gaps, and tension between dependence on clinicians and desire for agency.

Surveillance and self-management

Ongoing monitoring provided safety and structure but also constant reminder of living with "a ticking bomb".[23] Patients moved between reassurance and distress depending on scan results: stability signifying reprieve, growth signalling renewed threat. Some normalised the condition as part of ageing, choosing to "live in the present"[25]; others experienced surveillance as loss of independence, their lives punctuated by tests and reminders of vulnerability.

Relationships were shaped by this vigilance. Some withheld concerns to protect relatives; others found reassurance in shared coping. Trust in clinicians was central: honesty, continuity, and clear explanations reduced anxiety, while fragmented communication eroded confidence.

Self-management mirrored this interplay of trust, knowledge, and fear. Reactions to physical activity varied: some restricted movement to avoid rupture, others continued exercise to preserve normality. Supervised programmes with informed professionals provided reassurance. Misunderstandings about smoking were widespread, many doubted its link to AAA or felt unconvinced of the benefits of cessation.

Patients showed strong motivation to learn, but inconsistent timing and quality of information limited confidence. Some used digital resources to interpret scan results or lifestyle advice; when well-designed, these supported autonomy. Fears of rupture were reinforced by media and peer stories, whereas understanding slow growth as 'gaining more life years'[20] provided hope. Ultimately, surveillance demanded a balance between vigilance and normalcy, with coping strongly shaped by the clarity, accessibility, and empathy of clinical communication.

Pre-operative experience

The waiting period for surgery was dominated by anxiety and anticipation, an existence lived on "borrowed time".[23] Awareness of carrying a potentially fatal aneurysm heightened vigilance and sense of fragility. Despite receiving information, most felt ill-prepared; explanations were general, focused on procedure rather

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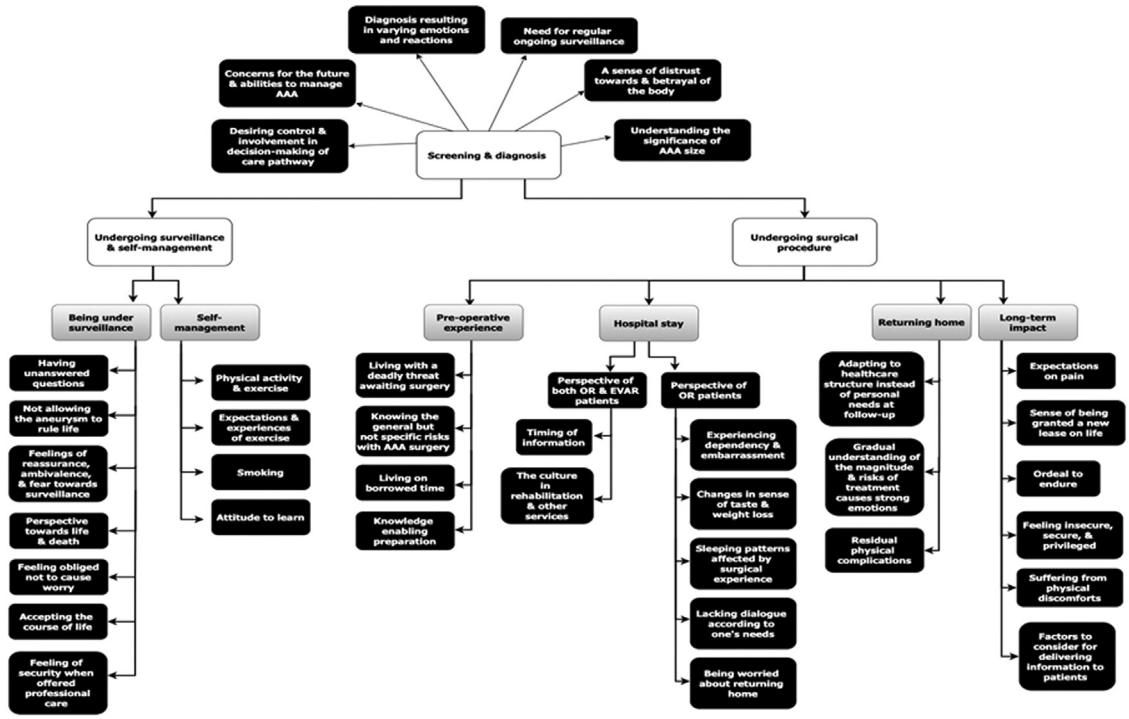


Fig. 3. The care pathway, stages, and themes of the lived experience of AAA.

than personal impact. Uncertainty persisted even after reassurance from clinicians or success stories from peers.

Patients described the emotional burden of "having a disease inside the body" and longing for it to be "repaired".[26] Surgery represented both salvation and surrender: a chance to regain control while handing it over to others. Many coped through distraction or 'keeping busy,' while others adopted a fatalistic trust in the surgical team. Waiting became a psychological negotiation between fear and faith, knowledge and ignorance, agency and dependence.

Post-operative experience

Recovery brought relief but also new challenges. During hospitalisation, patients valued staff competence and compassion but reported inconsistent pain control, rigid routines, and sleep disruption. Dependence on staff for basic care evoked embarrassment and underscored loss of control. Discharge planning was frequently inadequate, leaving patients uncertain about managing recovery at home.

At home, fatigue, appetite loss, altered taste, and emotional volatility were common. Many were unprepared for the duration and intensity of symptoms. Limited time during follow-up appointments discouraged questions, reinforcing passivity and isolation.

Long-term outcomes diverged by procedure. Open surgical repair (OSR) was associated with prolonged fatigue, pain, and slow return to normal life, sometimes leading to low mood or depressive symptoms. Endovascular repair (EVAR) was physically less demanding but accompanied by insecurity about graft durability and unclear follow-up results.

Despite these burdens, many described renewed gratitude and perspective, valuing relationships and health more deeply: a "new lease on life".[23] Surgery also altered body image: the repaired body was seen as restored yet fragile, prompting a desire to "feel whole again".[26]

Recovery was ultimately a process of negotiation between dependence and autonomy, fear and gratitude, fragility and resilience. While physical stability was restored, emotional and informational needs often remained unmet. Clear, compassionate communication and continuity of care were key to supporting adaptation and rebuilding trust in both the body and the healthcare system.

Summary of findings

Across the pathway, life with AAA was dominated by uncertainty, limited understanding, and a struggle for control. Trust in clinicians was strong but tempered by inconsistent communication and generic education. The synthesis highlights the psychological and informational dimensions of AAA care, underscoring the need for patient-centred communication, continuity, and tailored education to support autonomy and quality of life.

Discussion

The aim of this systematic review was to explore the lived experiences of people undergoing screening, surveillance, and management for AAA. The synthesis highlights the profound psychological and practical impact of AAA and identifies recurring challenges across the patient pathway.

A key cross-cutting theme was uncertainty. The asymptomatic and unpredictable nature of AAA left patients struggling to interpret their bodies, feeling betrayed by their physical state, and living with a persistent sense of fragility. This aligns with earlier work emphasising the difficulty of evaluating quality of life in asymptomatic aortic disease,[5] but our synthesis extends understanding by showing how this uncertainty permeates every stage of care, from diagnosis to long-term recovery.

Patients expressed a strong desire for autonomy and control yet reported limited opportunities to participate in shared decision-making. While surveillance offered reassurance, it also reinforced dependency on healthcare professionals and served as a constant reminder of illness. These findings echo previous studies showing ambivalence towards surveillance,[8] but add depth by reveal-

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ing how unanswered questions, inaccessible language, and professional jargon left patients unable to engage meaningfully in their care. The result was often a coping strategy of avoidance, an "out of sight, out of mind" approach,[18] to maintain normality.

Lifestyle behaviours, particularly physical activity (PA) and smoking cessation, were consistently shaped by misunderstanding and fear. In our synthesis, some individuals restricted activity due to concerns that exertion could precipitate rupture, while others expected exercise to reduce aneurysm size. Contemporary evidence indicates that moderate PA is generally safe for people with small AAAs and improves aerobic capacity and broader health outcomes[29]; community-based programmes in surveillance cohorts have increased peak VO_2 without excess adverse events, although exercise does not appear to shrink aneurysms or clearly slow growth rates.[30,31] Clear messaging should therefore emphasise what exercise does and does not do (e.g. cardiorespiratory fitness, function, mental health, and vascular risk reduction vs no direct "size-reduction" effect).

Similar patterns are well-described in peripheral arterial disease (PAD), where patients often interpret claudication pain as tissue damage, avoid walking because they fear harm, and struggle to link walking "dose" to benefits.[32] Qualitative syntheses and primary studies show confusion about safe exertion, competing lay theories of disease, and ambivalence toward behaviour change after revascularisation[12,33]; closely mirroring the fear-avoidance and unrealistic expectations identified in people with AAA. Behaviour-change approaches that normalise claudication symptoms, provide concrete progression targets, and explain the mechanism-of-benefit appear critical.

Smoking beliefs showed the same ambivalence. Despite robust evidence that smoking is among the strongest risk factors for both AAA and PAD, and that risk diminishes with sustained cessation,[34] patients frequently questioned the relevance of quitting or viewed smoking as stress-relieving, blunting motivation.[35] Counselling should pair unequivocal risk information with specific, time-bound gains from cessation and practical support.

These convergent findings across AAA, PAD and wider cardiovascular disease echo kinesiophobia literature in cardiac populations (post-MI, heart failure), where fear of provoking events and uncertainty about safe intensity drive inactivity.[36–38] Tailored education that explains mechanisms, sets graduated, supervised activity plans, and uses plain language may help reduce fear-avoidance and improve adherence.

For those undergoing surgery, experiences diverged by procedure type. OSR was associated with greater physical burden, prolonged fatigue, and ongoing disruption to daily life, while EVAR was less intrusive but generated uncertainty about graft durability and follow-up. Regardless of treatment, patients emphasised the need for timely, personalised information, delivered with compassion and sensitivity. Failures in dialogue, poorly timed communication, and a lack of preparation for home recovery were consistently reported. These findings reinforce the central role of patient-centred communication and echo the prerequisites for patient empowerment identified by Castro et al.[39]: dialogue, partnership, and knowledge-building.

Implications for nursing practice

The findings of this review have several direct implications for vascular nursing practice across the AAA care continuum. Nurses are uniquely positioned to address the psychological and informational needs that patients consistently reported as unmet, and to act as a bridge between patients' lived experience and the clinical management of their condition.

Patient education should be proactive, staged, and tailored to individual health literacy. Information delivered at diagnosis is frequently too brief, too technical, or poorly timed for patients to absorb meaningfully. Nurses can support comprehension by reinforcing key messages across multiple contacts, using plain language, diagrams, and written or digital materials to supplement verbal explanations. Particular attention should be paid to correcting common misconceptions about physical activity and smoking cessation, both of which were shaped by fear and misunderstanding in the reviewed studies.

Shared decision-making requires deliberate facilitation. Patients frequently reported feeling excluded from decisions about their care, deferring to clinical authority in the absence of sufficient information or structured opportunity for dialogue. Nurses should create space for patients to articulate their values, concerns, and preferences, and ensure that treatment decisions are not experienced as fait accompli. This is especially important in the preoperative period, when anxiety may limit receptiveness to information.

The psychosocial impact of AAA deserves routine assessment. Anxiety, fear of rupture, loss of autonomy, and disrupted identity were consistent features of patients' experience across all stages of the care pathway. Nursing assessments should incorporate psychological wellbeing alongside physical monitoring, with referral pathways to psychological support available where needed. Family members and carers also carry significant burden and should be included in conversations and educational opportunities wherever possible.

Post-operative and community follow-up should anticipate the challenges of recovery at home. Patients were frequently unprepared for the duration and intensity of fatigue, altered appetite, and emotional vulnerability following surgery. Discharge planning should include explicit, written information about expected recovery, guidance on when and how to seek help, and a clear point of contact. Follow-up appointments should be structured to allow adequate time for questions rather than focusing solely on physical parameters.

Signposting to peer support and reliable online resources can extend the reach of nursing support beyond clinical contacts. Patients who accessed credible information and peer experiences reported greater confidence and sense of control. Nurses can curate and recommend trustworthy resources, and where available, facilitate structured peer learning opportunities such as patient groups or post-operative information sessions.

Limitations and strengths

This review was limited to studies published in English, and most were conducted in Sweden. While this reflects a robust body of work within a single healthcare system, it may restrict generalisability to other cultural and organisational contexts. Additionally, by focusing on reported themes, some nuances unique to specific disease stages may not have been captured. Nonetheless, the consistency of patterns across studies strengthens confidence in the findings.

This review also has several notable strengths. The search was comprehensive, spanning six major databases from inception to January 2025, with no restrictions on year of publication, supplemented by manual reference checking to minimise the risk of missing relevant studies. Screening, data extraction, and quality appraisal were conducted independently by two reviewers, with discrepancies resolved through discussion, reducing the risk of bias in study selection and interpretation. Methodological quality was assessed using the well-validated CASP qualitative checklist, and the review was prospectively registered with PROSPERO and reported in accordance with PRISMA 2020 guidelines, ensuring transparency

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and reproducibility. The best-fit framework synthesis approach allowed both anticipated and emergent themes to be captured, providing a structured yet flexible analysis that reflects the breadth of patient experience across the full AAA care continuum. The inclusion of 14 studies representing 150 participants across multiple countries and healthcare systems strengthens the transferability of the findings.

Sex, gender, and representation

The included studies were conducted predominantly with male participants, reflecting the epidemiological reality that AAA disproportionately affects men, particularly those aged over 65 with a history of smoking. Across the 14 included studies, female participants were present in small numbers in at least seven studies, with a further two studies not reporting the sex of participants. None of the included studies explicitly examined how sex or gender shaped the lived experience of AAA, and no literature was identified that directly addresses this gap. This is a notable limitation given that women with AAA are known to carry higher operative risk, experience faster aneurysm growth rates, and present at older ages than men,[40] factors that may meaningfully influence their psychological and informational needs across the care continuum. The extent to which findings from this review generalise to women, or to individuals whose gender identity differs from biological sex as recorded in clinical notes, therefore remains uncertain. Future qualitative research should purposively recruit female and gender-diverse participants to explore whether the themes identified here, including uncertainty, fear-avoidance, and desire for autonomy, are experienced differently across sexes and genders, and to inform more inclusive, person-centred models of vascular care.

Future research

Future studies should examine how best to deliver tailored education on exercise, smoking cessation, and self-management, and explore the perspectives of families who play a key role in supporting patients. Research is also needed to address gaps in understanding of post-surgical experiences, particularly following EVAR, and to co-design interventions that prepare patients for recovery at home. Meta-ethnography may be an appropriate method for further synthesis, offering potential for novel insights into patient experiences.[41–43]

Conclusion

Living with AAA is characterised by persistent uncertainty, loss of autonomy, and unmet information needs. Across all stages of the care pathway, patients seek reassurance, control, and meaningful involvement in decisions. Improving patient education and tailoring communication to individual needs are central to supporting empowerment and enhancing quality of life. A patient-centred approach, grounded in dialogue, compassion, and continuity, should underpin future improvements to services provided throughout the AAA care continuum.

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Declaration of competing interest

The authors declare that they have no competing interests.

CRediT authorship contribution statement

Elizabeth Ong: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Ukachukwu Abaraogu:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Chris Seenan:** Writing – review & editing, Supervision, Project administration, Methodology, Formal analysis, Conceptualization.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jvn.2026.07.009.

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