SUPPLEMENTARY DIGITAL MATERIAL 1

Supplementary Table I.—Statements and answers provided in the three rounds.

Statement		I Round					II Round					III Round		
		Strongly agree	Partially agree	Neither agree nor disagree	Partially disagree	Strongly disagree	Strongly agree	Partially agree	Neither agree nor disagree	Partially disagree	Strongly disagree	Agree	Neither agree nor disagree	Disagree
1	Performing an EVAR outside the IFU affects short-term outcome	8%	54%	14%	21%	3%	5%	57%	12%	23%	3%	25%	48%	27%
2	Performing an EVAR outside the IFU affects mid/long-term outcome	36%	50%	6%	7%	1%	40%	49%	7%	3%	1%	**71%**	25%	4%
3	Performing an EVAR outside the IFU results in a worse outcome in terms of AAA Related Reintervention	37%	52%	4%	6%	1%	43%	44%	8%	4%	1%	**74%**	23%	3%
4	Performing an EVAR outside the IFU results in a worse outcome in terms of AAA Related Mortality	10%	51%	16%	19%	4%	13%	50%	15%	19%	3%	37%	44%	19%
5	EVAR outside the IFU is a procedure that should always be avoided in elective settings	14%	35%	10%	33%	8%	9%	36%	8%	36%	11%	17%	34%	49%
6	EVAR outside the IFU as an elective procedure should be avoided even in subjects not eligible for open surgery	9%	20%	10%	38%	23%	5%	21%	8%	42%	24%	14%	22%	64%
7	EVAR outside the IFU should be avoided regardless patient's age	5%	22%	13%	39%	21%	3%	24%	12%	39%	22%	6%	30%	64%
8	The proximal aortic neck is an important criterion for evaluating the	**79%**	19%	1%	1%	0%	-	-	-	-	-	-	-	-

	feasibility of an EVAR procedure outside the IFU													
9	The aortic bifurcation is an important criterion for evaluating the feasibility of an EVAR procedure outside the IFU	34%	44%	9%	11%	2%	28%	42%	14%	13%	3%	58%	26%	16%
10	The iliac landing zone is an important criterion for evaluating the feasibility of an EVAR procedure outside the IFU	32%	44%	10%	11%	3%	35%	39%	8%	16%	2%	63%	24%	13%
11	The presence of adequate access vessels is an important criterion for evaluating the feasibility of an EVAR procedure outside the IFU	40%	35%	9%	13%	3%	43%	39%	6%	10%	2%	61%	24%	15%
12	An EVAR procedure can be performed in the presence of a proximal aortic neck <15 mm in length	57%	35%	2%	5%	1%	58%	38%	2%	2%	0%	**92%**	7%	1%
13	An EVAR procedure can be performed in the presence of a proximal aortic neck <10 mm in length	18%	46%	9%	21%	6%	20%	45%	7%	20%	8%	55%	23%	22%
14	An EVAR procedure can be performed in the presence of a proximal aortic neck <5 mm in length	3%	16%	6%	22%	53%	4%	16%	6%	19%	55%	13%	17%	**70%**
15	An EVAR procedure can be performed in the presence of a proximal aortic <15 mm in length and an angulation >60°	19%	43%	14%	17%	7%	16%	50%	7%	20%	7%	60%	23%	17%

16	An EVAR procedure can be performed in the presence of a proximal aortic neck diameter >30 mm	13%	45%	6%	28%	8%	12%	43%	9%	26%	10%	35%	35%	30%
17	An EVAR procedure can be performed in the presence of an aortic bifurcation diameter <18 mm	28%	53%	4%	14%	1%	12%	43%	9%	26%	10%	60%	29%	11%
18	Proposing to a patient an EVAR procedure outside the IFU makes the informed consent process more complex (*e.g.* the need to spend more time informing the patient and/or providing him/her with more details regarding risks and benefits).	50%	26%	8%	13%	3%	44%	33%	10%	11%	2%	**70%**	21%	9%
19	Given the inconsistency between what is stated in the guidelines and the results of clinical practice, performing an EVAR procedure outside the IFU requires the physician to give the patient only the information that he or she believes the subject can understand.	16%	19%	9%	29%	27%	16%	23%	10%	26%	25%	37%	24%	39%
20	Given the inconsistency between what is stated in the guidelines and the results of clinical practice, performing an EVAR procedure outside the IFU requires the	59%	28%	4%	5%	4%	60%	25%	5%	7%	3%	**82%**	15%	3%

	physician to give the patient the information about the procedure relevant to the patient in order to decide.													
21	Given the inconsistency between what is stated in the guidelines and the results of clinical practice, performing an EVAR procedure outside the IFU requires the physician to give the patient all available information regarding the procedure and its risks/benefits.	**79%**	14%	3%	3%	1%	-	-	-	-	-	-	-	-
22	Performing an EVAR procedure outside the IFU also requires a preliminary assessment of preferences and clinical and non-clinical outcomes relevant to the patient (e.g. postoperative discomfort, time needed to return to daily activities, need of support after discharge, etc.).	50%	30%	11%	6%	3%	48%	31%	10%	7%	4%	66%	22%	12%
23	An EVAR procedure outside the IFU can only be considered after the physician has presented the patient with the best treatment option.	**70%**	22%	5%	2%	1%	-	-	-	-	-	-	-	-

24	An EVAR procedure outside the IFU can only be considered after the physician has presented the patient with the intervention options that he or she considers to be the safest and most effective.	62%	25%	6%	6%	1%	**70%**	19%	7%	3%	1%	-	-	-
25	An EVAR procedure outside the IFU can only be considered after the physician has presented the patient with all available intervention (and non-intervention) options.	**79%**	16%	2%	2%	1%	-	-	-	-	-	-	-	-
26	Even if the physician thinks that performing an EVAR outside the IFU is the most appropriate procedure for a particular patient, he or she must directly and actively involve the patient in the clinical decision-making process.	69%	23%	2%	4%	2%	64%	27%	2%	5%	2%	**75%**	18%	7%