Original Contributions

Measuring Carotid Stenosis
Time for a Reappraisal

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Background and Purpose: Data from recent multicenter carotid endarterectomy trials have questioned the validity and reliability of Doppler ultrasound in the assessment of carotid stenosis.

Methods: We prospectively analyzed 45 patients undergoing carotid angiography to compare the North American Symptomatic Carotid Endarterectomy Trial (NASCET) and European Carotid Surgery Trial (ECST) methods of measuring carotid stenosis with those of direct visualization (“eyeballing”) and duplex ultrasound. Linear NASCET and ECST measurements were also converted into area using the \( \pi r^2 \) function and termed “squared NASCET” (N²) and “squared ECST” (E²). In 15 of 45 patients undergoing carotid endarterectomy, the carotid plaque was removed intact, sectioned, and photographed for computer measurement of cross-sectional area. Comparison of this “gold standard” was then made to each method of measurement.

Results: Comparison between duplex and the various angiographic measurement techniques revealed significant differences between NASCET and duplex (P<.0001), ECST and duplex (P<.01), and E² and duplex (P<.01) but not between N², eyeballing, and carotid duplex methods. Even the NASCET and ECST methods themselves differed significantly (P<.006). When comparison was made with computerized planimetric measurements of the carotid plaque, there were significant differences for both NASCET (P<.0007) and ECST (P<.0007). Correlation was demonstrated only between planimetry and N², E², and duplex.

Conclusions: NASCET and ECST angiographic methods of measurement consistently underestimate the “true” anatomic stenosis. As such, they represent only “indexes” of carotid stenosis severity. Duplex provides a more accurate measurement of carotid stenosis. (Stroke. 1993;24:1292-1296.)

Key Words • angiography • carotid artery diseases • ultrasonics

Two recently published multicenter studies have firmly established carotid endarterectomy as the best prophylaxis against stroke in cases of high-grade carotid atherosclerosis: the North American Symptomatic Carotid Endarterectomy Trial (NASCET)¹ and the European Carotid Surgery Trial (ECST).² The results of similar trials in asymptomatic patients have been published,³,⁴ and one other large study is in progress.⁵

To minimize the risks associated with carotid angiography, many trialists used Doppler ultrasound methods to screen for the presence and severity of carotid stenosis. In general, the reported accuracy of noninvasive ultrasound methods has been disappointing, often with wide divergence from results of the apparent “gold standard” of angiography. As a result, some authors suggest that ultrasound methods are so unreliable that they are a “dubious presurgical strategy” and should be used only for the diagnosis of minor degrees of carotid stenosis.⁶,⁷ Promulgation of such opinions will undermine confidence in ultrasound data, may cause some to abandon the use of carotid ultrasound technology, and could in effect deny patients access to a valuable and cost-effective diagnostic aid.

Angiographic stenoses with 70% to 80% diameter reduction as measured by NASCET and ECST techniques often have pinpoint lumens at surgery (>90% stenosis). This suggests that both these linear methods of measurement consistently underestimate the “true” anatomic stenosis. The aim of this study, therefore, was to evaluate more closely the apparent discrepancies between carotid angiographic imaging and ultrasound and to compare them with the findings at carotid endarterectomy.

Subjects and Methods

We prospectively compared carotid angiographic findings with those of color-flow duplex sonography (duplex) in patients undergoing carotid endarterectomy from June 1992 to March 1993. All patients had previous transient ischemic attacks or minor stroke. Angiography was performed by the intra-arterial digital subtraction technique via the femoral route using selective catheterization of the extracranial arteries. Biplanar images were obtained for each internal carotid artery (ICA). Measurements of ICA diameter reduction were performed by use of the linear-based methods of NASCET⁸ and ECST² (Fig 1) and by direct visualization.
Carotid reduction of symptomatic artery; diagrams showing methods used by the North American Symptomatic Carotid Endarterectomy Trial (A) and the European Carotid Surgery Trial (B) for estimating diameter reduction of the internal carotid artery (ica) on angiography. The linear formula is $1 - (d/n) \times 100$, where $d$ is the diameter of the residual lumen at angiography and $n$ is an estimation of the normal vessel diameter. ica indicates the external carotid artery; cca, the common carotid artery.

(“eyeballing”) by an independent neuroradiologist. All measurements were assessed in a blind manner.

To test the difference between linear and area methods of measuring carotid stenosis, we calculated the area luminal reduction from the linear NASCET and ECST formulas using the $\pi r^2$ function as outlined in Fig 2. The derived equations were then termed “squared NASCET” ($N^2$) and “squared ECST” ($E^2$).

Color-flow duplex sonography of the carotid arteries was performed on a Diasonics Spectra (Diasonics Inc, Milpitas, Calif) using a 7.5-MHz transducer. The highest peak systolic velocity in the stenotic area was documented in each case. Evaluation of the degree of stenosis was based on previously published criteria9,10 as well as the conversion curve from linear index to area stenosis (Fig 3). This was performed without knowledge of the angiographic findings. In a subgroup of these patients in whom carotid endarterectomy was performed, the plaque was carefully dissected out intact and immediately placed in saline. Plaques that fragmented during surgery were discarded. The plaque was photographed both longitudinally and end-on, placed in formalin followed by decalcification, and photographed again. It was then sectioned manually in approximately 2-mm sections, placed on paper with a 1-mm calibration, and rephotographed (Fig 4).

The carotid bulb was identified, and the section with the narrowest lumen was selected. Planimetric tracings were taken of these, including the millimeter calibration for references. A computerized program SIGMA SCAN (Jandel Scientific, Corte Madera, Calif) was then used to calculate cross-sectional areas of both carotid bulb and the residual lumen. Percent area stenosis was calculated as $1 - (S/S_n) \times 100$, where $S$ represents the area of the residual lumen and $S_n$ represents the area of the bulb (Fig 2).

To assess the possible influence of plaque shrinkage, measurements of the specimen were made before and after laboratory processing. Processing produced uniform shrinkage of the whole specimen by $13 \pm 1.5\%$ which is consistent with previous studies,11 so that the degree of stenosis was not affected.

Statistical analysis consisted of $t$ tests and regression analyses to compare groups.

Results

We evaluated 45 consecutive patients undergoing carotid endarterectomy. When we compared the various linear (NASCET and ECST), eyeballing, and area ($N^2$ and $E^2$) methods of angiographic evaluation to carotid ultrasound data, we found significant differences in all, except for $N^2$ and eyeballing methods (Table 1). Furthermore, when NASCET was compared with ECST, there was also a significant discrepancy ($P<.006$). There were also striking discrepancies when the regression lines were compared (Fig 5). For instance, a NASCET linear stenosis of 55% equaled approximately 70% on ECST, 78% on $N^2$, and 88% on $E^2$. Conversely, a duplex stenosis of 80% corresponded to 80% on $N^2$.

With these discrepancies established, however, the question remains as to which is correct. That is, which method most accurately reflects the anatomic stenosis seen at surgery? We then compared mean ICA stenoses measured by ultrasound and each of the angiographic methods with planimetric measurements taken on the 15 carotid plaques that had been removed intact and evaluated without knowledge of the angiographic or ultrasound findings. NASCET and ECST methods consistently underestimated the planimetric measurements of the surgical specimens, whereas duplex, $N^2$, and $E^2$ did not differ significantly (Table 2).
Discussion

Our data indicate that NASCET and ECST methods of angiographic measurement of carotid stenosis differ significantly and that both consistently underestimate the actual "anatomic" stenosis. This reflects the shortcomings of estimating area reduction of the ICA lumen (often asymmetric) by a single linear measurement from angiography. In other words, although mathematically related, what is measured on angiography is not what is seen when looking at the carotid pathology.

The NASCET and ECST "stenoses" in fact represent indexes of severity, and whether they reflect anatomic reality might well be considered irrelevant: the clinical guidelines for carotid surgery have already been established. But it would be equally unrealistic to believe that the world will uniformly adopt either of these two methods of angiographic evaluation, whether it is believed they represent true anatomic stenosis or not. Moreover, the claim that one must read an angiogram and institute management according to the methods and results of one or other of the endarterectomy trials does not do justice to the individual patient. For instance, an 80% ECST stenosis is equivalent to 50% by NASCET 12; yet, although they are anatomically the same, they will be managed differently. Our data show that the NASCET method is less accurate than the ECST method, but at least it removes the guesswork in predicting the position of the carotid bulb. Only by being aware of the limitations of each technique in predicting the true reduction in lumen diameter can one make an informed decision as to whether a patient warrants operative intervention for a symptomatic carotid stenosis.

There are several problems with the NASCET method. Principally, it depends on finding the first "normal" segment of distal ICA, decided by subjective evaluation of the observer. Also, since the carotid bulb is normally larger than the more distal ICA, minor degrees of stenosis result in a paradoxical "negative" stenosis. For example, an artery with a residual (stenosed) lumen of 5 mm and a normal distal ICA diameter of 4 mm using the NASCET method yields a stenosis of 1 - (5/4) × 100 = -25%.

This study was limited to analysis of severe carotid stenosis only. In this group, inspection of the linear versus area correlation curve (Fig 3) indicates that there

<table>
<thead>
<tr>
<th>Method</th>
<th>Stenosis (%)</th>
<th>Difference from duplex (%)</th>
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<tbody>
<tr>
<td>NASCET</td>
<td>63±18</td>
<td>0.0001</td>
</tr>
<tr>
<td>ECST</td>
<td>73±16</td>
<td>0.01</td>
</tr>
<tr>
<td>Eyeballing</td>
<td>76±19</td>
<td>NS</td>
</tr>
<tr>
<td>E²</td>
<td>82±17</td>
<td>NS</td>
</tr>
<tr>
<td>E²</td>
<td>90±12</td>
<td>0.01</td>
</tr>
</tbody>
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NASCET, North American Symptomatic Carotid Endarterectomy Trial (linear method); ECST, European Carotid Surgery Trial (linear method); E², squared NASCET (area method); E², squared ECST (area method); NS, not significant. Values are mean±SD for stenosis.
is little change in area for larger changes in diameter. Toward lesser grades of stenosis, correlation between linear and area parameters becomes increasingly discrepant. Although we did not have the opportunity to document lesser degrees of stenosis, it is clearly even less likely that NASCET, ECST, and squared derivations will correlate with plaque planimetry.

The ECST method relies on a “guesstimate” of the presumed outline of the carotid bulb, but bulb size is variable and sometimes almost insignificant. This may explain the slightly wider discrepancies between $E^2$ and $N^2$ data since, by virtue of its subjectivity, the margin of potential error is greater with the ECST technique. It is less surprising that duplex methods of estimating carotid stenosis showed no significant differences from surgically removed specimens, since the blood flow velocity in the stenosed artery is dependent on area cross section, not on the symmetry of the lumen. Thus, when area stenosis is used, ultrasound continues to be consistent, even in light of Doppler criteria based on diameter stenosis. Data from the $N^2$ and $E^2$ methods are also closer to the actual anatomic stenosis because they represent an expression of area, not linear stenosis. By use of these simple measurements derived from existing data in the NASCET and ECST studies, the carotid stenosis is easily calculated and represents values closer to reality.

It is also reassuring that the time-honored technique of eyeballing (direct visual estimation) was closer to duplex results than either NASCET or ECST methods, since this method is used most widely throughout the world.

These observations are not academic but have critical implications in clinical practice. As Bousser indicated, the NASCET method underestimates carotid stenosis compared with the ECST method, so that a NASCET stenosis of 0% equals an ECST stenosis of 57%. Hence, the NASCET study conclusions, in reality, are based on patients with more stenosed carotid lesions. From our data, the NASCET surgical threshold of 70% diameter reduction actually represents 91% area stenosis, whereas the ECST threshold of 70% is equal to 80% area stenosis. The “moderate” (30% to 70%) NASCET group at present being enrolled actually represents area stenoses ranging from 54% to 91%. Indeed, some patients who are at present being randomized to the medical arm of this study will actually have more than 70% ECST stenosis, which is above the recommended threshold for surgery. As attempts are made to evaluate lower and lower degrees of carotid stenosis, the paradoxical NASCET negative stenoses already alluded to will make accurate assessment impossible.

Discrepancies between duplex ultrasound and angiography have been previously documented, but our data indicate that duplex is more, not less, accurate than either of the NASCET and ECST methods. The apparent discrepancies, in fact, represent the correlation between linear and area functions.

It has been suggested that the discrepancy between angiography and ultrasound methods reflects the unevenness of the ultrasound technique. Duplex technology is operator and interpreter dependent, but so is angiography. The NASCET or ECST criteria cannot be applied unless a clear biplanar angio graphic image of the stenotic area is obtained. Furthermore, because these angiographic formulas were not established using a comparison to a gold standard, one cannot then evaluate performance of duplex in carotid atherosclerosis measured by NASCET and ECST methods. It is essential in studies of this kind to have internal validation of Doppler criteria with quality assessment to provide reliable and consistent results. This should include standardization of equipment, uniform sonographic criteria, and validation of all involved ultrasound laboratories before enrollment into the study.
In conclusion, our data indicate that NASCET and ECST linear methods significantly underestimate the degree of underlying carotid stenosis and are actually less accurate than duplex ultrasound. These inaccuracies in measurement of high-grade carotid atherosclerosis can be easily corrected by using area (πr²) instead of linear derivations. Duplex ultrasound remains the easiest, least expensive, safest, and most accurate screening test for evaluating carotid stenosis.

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