Background and Purpose—The use of bare metal stents to treat symptomatic intracranial stenosis may be associated with significant restenosis rates. The advent of drug-eluting stents (DESs) in the coronary circulation has resulted in a reduction of restenosis rates. We report our technical success rate and short-term restenosis rates after stenting with DESs in the intracranial and extracranial circulation.

Methods—This study was a retrospective review of the period between April 1, 2004, and April 15, 2006, of 59 patients with 62 symptomatic intracranial or extracranial atherosclerotic lesions at 2 medical centers (University of Pittsburgh and Borgess Medical Center).

Results—The mean age of our cohort was 61±12 years. The location of the 62 lesions was as follows: extracranial vertebral artery 31 (50%), intracranial vertebral artery or basilar artery 18 (29%), extracranial internal carotid artery (ICA) near the petrous bone 5 (8%), and intracranial ICA 8 (13%). There were 2 (3%) periprocedural complications: 1 non—flow-limiting dissection and 1 disabling stroke. Fifty vessels were available for follow-up angiography or computed tomography angiography at a median time of 4.0±2 months. A total of 2 of 36 extracranial stents (7%) and 1 of 26 intracranial stents (5%) were found to have restenosis ≥50% at follow-up.

Conclusions—This report demonstrates that DES delivery in the intracranial and extracranial circulation is technically feasible. A small percentage of patients developed short-term in-stent restenosis. Longer-term follow-up is required in the setting of a prospective study to determine the late restenosis rates for DESs in comparison with bare metal stents. (Stroke. 2006;37:2562-2566.)

Key Words: angioplasty | intracranial stenosis | stenting | stents
A total of 59 patients underwent stenting of 62 vessels. The mean age for the cohort was 61 ± 12 years, with 42 patients (71%) found to have an infarct confirmed on magnetic resonance imaging or CT at the time of admission. Seventeen (29%) patients presented with TIAs referable to the vessel and who underwent stenting. Table 1 summarizes the demographic information for this cohort. The location of stent placement was as follows: extracranial vertebral artery 31 (50%), intracranial vertebral artery or basilar artery 18 (29%), extracranial internal carotid artery (ICA) near the petrous bone 5 (8%), and intracranial ICA 8 (13%). A Cypher stent was placed across 16 lesions (26%), whereas a Taxus stent was placed across 46 lesions (74%). Fifty-six of the 62 (90%) lesions treated had a stenosis ≥70%.

The success rate for delivery of a DES was 62 of 65 vessels (95%). The location of the 3 vessels with failed delivery of a DES was 2 intracranial ICAs and 1 intracranial vertebral artery; thus, the failure rate for delivery of an intracranial stent was 10% (3 of 29; Table 2). A bare metal stent was eventually successfully delivered to the intracranial vertebral artery lesion, but no stents were successfully navigated to the 2 intracranial ICA lesions. The mean stenosis before treatment was 83 ± 12%, with a reduction of stenosis to 12 ± 11% after the procedure in patients with successful stent delivery. Successful reduction of the stenosis to <50% occurred in 61 of 62 vessels (98%). The 1 patient with unsuccessful reduction of the stenosis to <50% had a heavily calcified intracranial carotid lesion (the Figure). During inflation of the balloon to deploy the stent, it was noted that the balloon did not fully expand, likely because of the underlying calcified plaque. The patient returned 4 months later with an acute stroke secondary to an occluded stent and was subsequently severely disabled as a result of the stroke. There were 2 periprocedural complications: 1 non–flow-limiting dissection was placed or to an intensive care unit when an intracranial stent was placed.

Follow-up conventional angiograms (n=41) or computed tomography (CT) angiograms (n=7) were available for 48 patients with 50 stents at 3 months or later. Eleven patients with 12 stents did not have follow-up studies owing to recent stent placement with follow-up not scheduled until a later time, patient refusal, or loss to follow-up. These follow-up studies were investigated for restenosis that was defined as a luminal narrowing of ≥50% in the target vessel. Clinical follow-up was available for these same 48 patients. Any new neurological event that patients might have experienced after the procedure was extracted from their clinical follow-up in the medical records.

Results

<table>
<thead>
<tr>
<th>Location of Stent</th>
<th>No. of Attempted Stents Placed</th>
<th>Stent Delivery Success, n (%)</th>
<th>Periprocedural Complications, n (%)</th>
<th>Stents Followed Up, n</th>
<th>No. Restenoses (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extracranial vertebral artery</td>
<td>31</td>
<td>31 (100)</td>
<td>0 (0)</td>
<td>27</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Intracranial vertebral artery/basilar artery</td>
<td>19</td>
<td>18 (95)</td>
<td>1 (6)</td>
<td>14</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Intracranial ICA</td>
<td>10</td>
<td>8 (80)</td>
<td>1 (13)</td>
<td>6</td>
<td>1 (17)</td>
</tr>
<tr>
<td>Extracranial ICA</td>
<td>5</td>
<td>5 (100)</td>
<td>0 (0)</td>
<td>3</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Any intracranial vessel</td>
<td>29</td>
<td>26 (90)</td>
<td>3 (12)</td>
<td>20</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Any extracranial vessel</td>
<td>36</td>
<td>36 (100)</td>
<td>0 (0)</td>
<td>30</td>
<td>2 (7)</td>
</tr>
</tbody>
</table>
A 63-year-old woman presented with left hemiparesis and was found to have scattered infarcts on diffusion-weighted imaging in the right hemisphere. The patient was referred for stenting of an intracranial ICA stenosis noted on magnetic resonance angiography (not shown). A, Lateral view shows a 60% calcified right ICA lacerum segment stenosis (solid black arrow). B, “Road map” image reveals crossing of a Taxus stent of the stenotic segment (dotted black arrow). C, After stent placement, the calcified region of the stenosis did not dilate, and the patient was left with a 60% stenosis of the segment (solid black arrow). D, The patient returned 4 months later with a National Institutes of Health Stroke Scale score of 16. She was found have a right carotid occlusion on angiography (solid black arrow). E, Selective right ICA injection shows extensive thrombus across the stent, along with deformation of the stent (black arrowheads) across the calcified lesion. Intra-arterial tissue plasminogen activator was infused and balloon angioplasty was attempted without success. The patient developed a large infarct in the right middle cerebral artery territory and was significantly disabled as a result.

Discussion

Our report demonstrates that DESs can be successfully placed in appropriately selected patients with intracranial and extracranial atherosclerotic lesions. The patients in this cohort were selected on the basis of the absence of excessive vascular tortuosity as assessed by the operators at both institutions. The 95% rate of delivery found in our experience does not reflect the deliverability of DESs in all patients with intracranial and extracranial atherosclerotic disease owing to this selection bias. In such cases, a different technique with balloon angioplasty or other modality may have been performed. We also found that the restenosis rate at a median follow-up of 4 months was 6% for the entire cohort.

There is limited experience as to the likelihood of developing DES toxicity to the cerebral arteries in humans because of short-term follow-up. A study on the placement of sirolimus-eluting stents in canine cerebral arteries did not reveal histological evidence of toxicity. This represents the largest experience to date with the use of DESs for these arteries. The compounds used on these stents, sirolimus and paclitaxel, have been shown to reduce the response of neointimal hyperplasia by blocking mitogen-induced smooth muscle proliferation. The literature on coronary stent placement has shown that these stents significantly reduce restenosis rates, thus reducing the need for revascularization. Longer-term follow-up at 2 years shows that the biological effects of the drug polymer persist toward suppressing neointimal hyperplasia. This effect may be dependent on whether the stent is a slow-release or a fast-release type.

Patients with symptomatic intracranial atherosclerotic disease had a 1-year risk of stroke in the ipsilateral territory of 11%. This risk nearly doubles to 19% in the first year if the target vessel has a stenosis ≥70%. In our series, 90% of patients had a stenosis ≥70% and were judged to be at high risk of a subsequent stroke if maintained on medical therapy. Prior studies had suggested that posterior circulation atherosclerosis was associated with a higher risk of stroke, but a recently published prospective study did not note differences in stroke rates by location. The natural history of symptomatic cervical and ostial vertebral artery stenosis is unknown. Patients with symptomatic internal carotid artery disease at the common carotid artery bifurcation have a 13% risk of a recurrent stroke at 1 year with medical therapy, which is similar to what was recently reported in symptomatic intracranial disease. Patients who underwent stenting procedures for extracranial vertebral artery disease in this series were considered only if they had bilateral vertebral artery disease or if 1 vertebral artery was occluded with poor contribution from the posterior communicating arteries. Although the natural history of symptomatic extracranial vertebral artery...
disease is unknown, we thought that these patients were at high risk of recurrent stroke even in placed on maximal medical therapy.

Other authors have used coronary stents to treat patients with symptoms as a result of extracranial vertebral artery stenosis and intracranial lesions. The main concern related to treating extracranial vertebral artery stenosis with stents has been the rate of restenosis, ranging from 10% to 40% in the literature, whereas periprocedural complication rates and vascular tortuosity have limited the wide use of intracranial stenting. Our report demonstrates that the restenosis rate was 6% at a median follow-up of 4 months in this cohort and 7% in patients treated for extracranial vertebral artery disease. Additionally, the periprocedural complication rates were relatively low at 3%, with 1 patient developing a disabling stroke after the procedure and 1 asymptomatic dissection. The WingSpan stent system (Boston Scientific) was studied as a treatment option for patients with symptomatic intracranial atherosclerosis. This study found that the stent could be delivered successfully in 44 of 45 patients (98%). The 6-month restenosis rate was found to be 7.5% with a 30-day ipsilateral stroke or death rate of 4.5%. The SSYLVIA trial considered stent placement in the intracranial or extracranial cerebrovasculature, and the 6-month restenosis rate was 32% overall and the periprocedural complication rate was 6.6%. Our results cannot be directly compared with either of these studies because of the shorter follow-up and the retrospective nature of the study, but it does provide short-term data.

Although there is justified enthusiasm for the use of DESs because of their lower restenosis rates, caution must be used, as delayed endothelialization may occur. It is unclear whether delaying the healing process results in reductions in longer-term rates of restenosis. In addition, although reports of arterial toxicity have not been noted in the intracranial and extracranial circulation, there have been reports of delayed hypersensitivity to the stents, causing thrombosis in the coronary circulation. As experience grows with the use of DESs in the intracranial and extracranial circulation, longer-term follow-up data will become available to answer these questions.

Another caution is the placement of a stent across a calcified lesion. In coronary vessels, rates of restenosis are significantly linked to plaque burden. Calcified lesions do not allow a stent to fully expand, and thus, it leaves a small lumen with a higher chance of causing restenosis. The patient whom we describe in the Figure unfortunately developed a subacute thrombosis at 4 months, and this event may be linked to poor stent expansion in the setting of high plaque burden from a calcified lesion. We have changed our practice since encountering this patient by attempting to predilate calcified lesions first. If the lesion does not reduce to <50%, then stent placement is not attempted.

There are limitations to this study because of its retrospective nature. The first is that longer-term follow-up is necessary to determine the restenosis rates for DESs. The second is that the rate of restenosis for bare metal stents in the cerebral circulation is not well established, and as such, a randomized, controlled study would be necessary to distinguish the differences in restenosis rates between bare metal stents and DESs. The third is that we did not attempt to place these stents in locations where it was deemed that excessive tortuosity would preclude successful delivery of the stent. This caveat introduced selection bias in our cohort, but nonetheless, the results show that these stents can be delivered and successfully deployed in select patients with a high degree of success. The fourth limitation is that 7 patients were followed up with CT angiography, which has not been validated against catheter angiography. Others have noted that CT angiography generally overestimates restenosis, and thus, it is unlikely that we underestimated the rates of restenosis in this study. Despite these limitations, this report shows that delivery of a DES to the extracranial and intracranial vessels is feasible with a high technical success rate and low complication rate. The rates of restenosis at short-term follow-up in this report are encouraging but require further investigation with longer-term follow-up.

Disclosures

None.

References


Safety, Feasibility, and Short-Term Follow-Up of Drug-Eluting Stent Placement in the Intracranial and Extracranial Circulation

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