Letters to the Editor

Questions on the First Consensus Document of the ICCS-SPREAD Joint Committee on Carotid Artery Stenting

To the Editor:

We read with great interest the article on carotid artery stenting by the ICCS-SPREAD Joint Committee.1 Given the possible implications in interventional clinical practice for all those involved in the field, a few questions come to mind. In the first part of the report, focused on the indications to carotid artery stenting (CAS), it is acknowledged that scant available evidence would dictate a “team approach” to treatment. However, the simplicity of CAS, one of its major strengths, might be quickly lost when several physicians of different expertise, backgrounds, and (maybe) economic conflicts of interest are required to decide on each individual case. The consensus panel, however, also acknowledges that no scientific data support this model in an evidence-based medicine approach. Also, how would a team decide on a “high surgical risk patient” when, as again stated in the article, “the definition of high risk, however, is not evidence-based and is not universally shared”?2 Selection of symptomatic patients then remains a conundrum. In asymptomatic patients “the overall benefits of carotid endarterectomy (CEA) or stenting (CAS) over the best current medical treatments are still not conclusively established”;3 again, how do we decide by expert opinion when experts may very well each have personal biases without adequate scientific evidence? Last but not least, a lot can be said about proper training in carotid endovascular therapy. There must be a reason if, worldwide, CAS has been predominantly developed and implemented by interventional cardiologists. Could it be that when adequately experienced, after performing hundreds of coronary procedures every year, they might be best suited to overcome difficult anatomy (most have had their share of cannulation of left and right internal mammarys for years, that is pretty close to the common carotid . . . ), to use distal protection devices (initially developed for saphenous vein grafts), not to mention expertise in dealing with cardiac problems (not so uncommon in carotid disease) or endovascular complications. Does this affect the required numbers or is it inconsequential? The numbers required for maintaining competence appear a little too high for expert interventional cardiologists (or dedicated interventional radiologists). They are definitely too low for those vascular surgeons who see a lot of patients with carotid disease but still treat most of them (and probably rightly so2,4) with carotid endarterectomy. High rates of carotid endarterectomy have been associated with lower rates of appropriateness for both surgeons and hospitals.4 Paradoxically, in CAS it might just be in the patients’ best interest to be treated by physicians who perform a lot of endovascular procedures but not so many carotid stents. A real danger of inappropriate indications is emerging in clinical practice but also from scientific publications of large CAS series, characterized by a preponderance of asymptomatic patients. Consensus must be based on scientific evidence to be valid and convincing: the publication of the ICCS-SPREAD Committee document might be a little premature.

Disclosures

None.

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3. The SPACE Collaborative Group. 30 day results from the SPACE trial of stent-protected angioplasty versus carotid endarterectomy in symptomatic patients: a randomized non-inferiority trial. Lancet. 2006;368:1239–1247.

(Stroke. 2007;38:e54.)
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DOI: 10.1161/STROKEAHA.106.478313
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Stroke. 2007;38:e54; originally published online May 17, 2007;
doi: 10.1161/STROKEAHA.106.478313
Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the World Wide Web at:
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