Local Symptoms and Recanalization in Spontaneous Carotid Artery Dissection

To the Editor:

We congratulate Nedeltchev and coworkers for their meritorious report on recanalization of spontaneous internal carotid artery dissection. The strengths of this work are a fairly large patient population compared with most previous reports and the repeated ultrasound examinations of the vasculature at 1, 3, 6, and 12 months. Recanalization always occurred within 6 months, but not later. We, having similar experience, currently repeat vascular imaging only at 6 months.

Nedeltchev et al discuss that they did not detect any beneficial effect of complete recanalization and refer to 2 articles that do not directly support their view; of these, one is a small study on 60 cervical artery dissection patients treated with anticoagulants and the second is a review in Spanish that discusses the merits of thrombolysis in acute ischemic stroke. In patients with carotid artery dissection, ischemic stroke may occur either by artery-to-artery embolism or by hemodynamic mechanisms. The risk for embolism is substantially reduced with timely anticoagulation, and prevention of hemodynamic infarction may not require complete recanalization, but modest recanalization may establish enough blood flow. Although most of their patients may have had late recanalization, still it would be interesting to see if different levels of recanalization correlate with clinical outcome. We recently showed that patients in whom complete recanalization occurred within 6 months from symptom onset returned to work more often.

Nedeltchev et al state in their “Results” that presentation with local symptoms only that were associated with a high rate of complete recanalization. However, several typographic errors in Table 3 obscure this finding, and the patient numbers used for statistical analysis may be erroneous. Surprisingly, migraine was found in 30 patients, a figure much lower than expected. On the other hand, we fully agree with the authors on the use of Rankin 0 to 1 as a favorable outcome. A patient with a Rankin score of 2 will be independent in daily life but will not return to his or her work. Patients with carotid artery dissection are mostly young to middle-aged adults and working ability after carotid artery dissection is critical for most of them.

Regarding the risks and benefits of anticoagulation and antiplatelet therapies and for many other unanswered questions in the carotid artery dissection field, multicenter collaborations with large numbers of patients such as the Cervical Artery Dissection in Ischemic Stroke Patients (CADISP) network are needed instead of overinterpreting results from small patient series.

Disclosures

None.

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