Age and Outcomes After Carotid Stenting and Endarterectomy
The Carotid Revascularization Endarterectomy Versus Stenting Trial

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Background and Purpose—High stroke event rates among carotid artery stenting (CAS)-treated patients in the Carotid Revascularization Endarterectomy Versus Stenting Trial (CREST) lead-in registry generated an a priori hypothesis that age may modify the relative efficacy of CAS versus carotid endarterectomy (CEA). In the primary CREST report, we previously noted significant effect modification by age. Here we extend this investigation by examining the relative efficacy of the components of the primary end point, the treatment-specific impact of age, and contributors to the increasing risk in CAS-treated patients at older ages.

Methods—Among 2502 CREST patients with high-grade carotid stenosis, proportional hazards models were used to examine the impact of age on the CAS-to-CEA relative efficacy, and the impact of age on risk within CAS-treated and CEA-treated patients.

Results—Age acted as a treatment effect modifier for the primary end point (P interaction = 0.02), with the efficacy of CAS and CEA approximately equal at age 70 years. For CAS, risk for the primary end point increased with age (P < 0.0001) by 1.77 times (95% confidence interval, 1.38–2.28) per 10-year increment; however, there was no evidence of increased risk for CEA-treated patients (P = 0.27). Stroke events were the primary contributor to the overall effect modification (P interaction = 0.033), with equal risk at ≈64 years. The treatment-by-age interaction for CAS and CEA was not altered by symptomatic status (P = 0.96) or by sex (P = 0.45).

Conclusions—Outcomes after CAS versus CEA were related to patient age, attributable to increasing risk for stroke after CAS at older ages. Patient age should be an important consideration when choosing between the 2 procedures for treating carotid stenosis.

Clinical Trial Registration—URL: http://www.clinicaltrials.gov. Unique identifier: NCT00004732. (Stroke. 2011;42:3484-3490.)

Key Words: carotid artery • carotid endarterectomy • cerebrovascular disease • stents • vascular surgery

Patient age has been shown to influence the outcomes after carotid revascularization.1–6 The Carotid Revascularization Endarterectomy vs Stenting Trial (CREST) protocol was developed in 1997,7 when age and vascular anatomy8,9 were not yet recognized as predictors of complications of carotid artery stenting (CAS). To the contrary, it was postulated that CAS might be safer than carotid endarterectomy (CEA) in the elderly. However, during the conduct of the lead-in phase of the study, a high risk of stroke events was observed among the CAS-treated patients, and octogenarians were subsequently excluded from this portion of the trial (but were continued in the randomized phase to assess if equivalent risks were present for the CEA-treated patients).10 At this time (on the basis of lead-in data only and before unblinding of randomized data), the study investigators committed to the preplanned formal assessment of the impact of age on relative efficacy reported herein.

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Materials and Methods

Study Participants and Measurement
CREST is a randomized clinical trial assessing the relative efficacy of CAS versus CEA. The study enrolled 1321 symptomatic patients and 1181 asymptomatic patients. End points were adjudicated by committees blinded to treatment assignment. Details of the study are provided elsewhere.11–13 The protocol was approved by the Institutional/Ethics Review Board of all participating sites. All patients gave written informed consent.

Statistical Analysis
The focus of these analyses is to assess if the age of the patient influences the relative efficacy of CAS and CEA and, if so, what are the contributors of the effect modification. As such, the primary evaluation of efficacy was assessed on an intention-to-treat analysis using proportional hazards analysis to evaluate the potential of an age-by-treatment interaction after adjustment for symptomatic status and sex. The primary outcome of the trial was stroke, myocardial infarction (MI), or death during a periprocedural period (30 days), or ipsilateral stroke over a follow-up period extending 4 years from randomization to treatment within 30 days, or 36 days after randomization for those not receiving treatment within 30 days), or ipsilateral stroke over a follow-up period extending 4 years from randomization. Potential effect modification by age was analyzed assuming a linear effect of age (after confirming the linear assumption was reasonable). The stroke component was defined as any stroke during the periprocedural period and stroke ipsilateral to the study artery for the subsequent 4-year period. The MI component was defined as elevated enzymes plus either symptoms or electrocardiographic evidence of an event during the periprocedural period.

For both treatment groups in CREST, with increasing age older) to provide the reader details, including: (1) the number of events in this broad age range; (2) an assessment of the linearity of the primary analysis of age-by-treatment interaction; (3) event rates within age strata for each treatment for comparisons to other studies; and (4) crude estimates of CAS-to-CEA relative efficacy for these age strata.

We also assessed if any potential age-by-treatment effect modification was consistent by symptomatic status or sex by adding higher-order interaction terms to the model. Proportional hazards models were fit separately for those CAS-treated and CEA-treated patients to describe the age-related changes in risk within each treatment contributing to their relative CAS-to-CEA efficacy differences.

Finally, to identify potential causes underlying the age–treatment interaction, we conducted a mediation analysis14 to identify if the increased risk at older ages for CAS-treated patients was attributable to an increased prevalence of risk factors (hypertension, diabetes, or dyslipidemia), differences in the characteristics of the lesion (lesion length, eccentric lesions, ulcerated lesion, or percent stenosis), or differences in the procedure (fluoroscopy time or total procedure time) by entering these factors into the model and observing the change in the estimated hazard ratio associated with age. Characteristics of the lesion were determined by the local clinic. Anatomic characteristics such as aortic arch anatomy, vessel tortuosity, and calcification known to be associated with age and CAS complications were not available for analysis. The standard error of the mediation was estimated using bootstrap techniques.

Results
For both treatment groups in CREST, with increasing age participants were more likely to be female, white, and to have higher levels of systolic blood pressure and lower levels of diastolic blood pressure; however, they were less likely to have diabetes, dyslipidemia, or to be current smokers (Table 1). There were no significant differences between treatment groups for these factors in any age strata. Figure 1 shows the distribution of the ages for CAS and CEA.
Table 2 provides the observed number of MI, strokes, and primary end points within approximate tertiles of age strata for both the periprocedural period and for the 4-year outcome. Figure 2 provides the associated Kaplan-Meier estimates of the proportion of participants with a primary end point for each age–treatment strata, showing the similarity of time-to-event across age strata for CEA-treated patients, but the differences of time-to-event across age strata for CAS-treated patients. As previously reported for the primary end point at 4 years, there was evidence of a treatment-by-age interaction ($P_{H11005} = 0.02$). The CAS-to-CEA risk increased with advancing age, from 0.60 (95% confidence interval [CI], 0.31–1.18) for patients younger than 65 years to approximate equal risk for those aged 65 to 74 years (hazard ratio, 1.08; 95% CI, 0.65–1.78), and to 1.63 (95% CI, 0.99–2.69) for those aged 75 years and older. This increasing risk was associated with increasing event rates in the CAS-treated patients (3.9% in the youngest age strata, 6.3% in the middle, and 12.7% in the oldest), whereas risk was relatively stable in the CEA-treated patients (respective rates: 6.1% youngest, 6.8% middle, and 7.4% oldest). This increasing risk was driven by the stroke end point, with a higher ($P_{H11005} = 0.033$) CAS-to-CEA risk across age strata, with hazard ratios of 0.78 (95% CI, 0.37–1.62), 1.42 (95% CI, 0.78–2.60), and 2.15 (95% CI, 1.19–3.91). The increasing CAS-to-CEA risk at older ages is associated with increasing stroke event rates for those CAS-treated (3.9% in the youngest age strata, 6.3% in the middle, and 12.7% in the oldest), whereas risk was relatively stable in the CEA-treated patients (respective rates: 4.5% youngest, 4.6% middle, and 4.9% oldest). A similar pattern of effects (increasing CAS-to-CEA risk largely driven by increasing risk at older ages in the CAS-treated patients) was observed during the periprocedural period for both the composite and stroke end points; however, these trends failed to reach a level of statistical significance ($P_{H11005} > 0.1$). Contralateral strokes occurring during the periprocedural period were a component of the composite outcome and the stroke outcome, but contralateral strokes after the periprocedural period are not part of these outcomes. For the “all stroke” end point (including contralateral strokes occurring after the periprocedural period), the treatment differences across the age spectrums are diluted ($P_{H11005} = 0.19$) by the addition of the stroke events beyond the periprocedural period.

Although we urge caution in interpretation, Supplemental Table I (https://stroke.ahajournals.org) provides results similar to Table 2, stratified by symptomatic status. This Table requires stratification by both age and symptomatic status, and as such the small sample size in specific stratum could lead to misleading results. We have considered age-by-symptomatic status interactions and found none to be significant ($P_{H11022} > 0.1$), and differences between symptomatic and asymptomatic patients in the relationships of risk with age could have easily occurred by chance alone. However, these data are provided for comparisons with the results of other studies that do not include both asymptomatic and symptomatic patients.

The primary analysis for this report is shown in Figure 3. Figure 3A shows the CREST primary end point as a continuous function of age (identical Figure to that shown in primary study results article,11 all other Figures and analyses are novel to this article). The risk of the 2 procedures is approximately equal at age 70 years, with CAS showing superiority in younger patients, and there is an increasing benefit for CEA in older patients. The stroke component of the composite end point as a function of age is shown in Figure 3B. The steeper slope in this Figure implies a larger magnitude of effect modification by age on the occurrence of stroke ($P_{H11005} = 0.033$) than for occurrence of the primary end point. We note that unlike the composite outcome in which CAS-to-CEA risk approaches a significant advantage for CAS at younger ages, the wider CI the stroke end point implies the upper limit of the 95% CI bounds remains >1.0; however, the a priori focus of this article was on the trend of risk with differences in age (rather than differences at any specific age). The point of equal risk for CAS and CEA is at age 64 years, 6 years younger than for the primary end point. The wider 95% CI bounds imply greater uncertainty for the stroke outcome compared to the primary outcome. There was no evidence ($P_{H11005} = 0.35$) of effect modification by the MI component of the primary end point (Figure 3C).
For those treated with CAS, there was a 1.77-times increase in risk of primary end point event \((P<0.0001; 95\% \text{ CI}, 1.38–2.28)\) and a 1.76-times increase \((95\% \text{ CI}, 1.35–2.31)\) for stroke events with each 10-year difference in age. For those treated with CEA, there was no evidence of a difference in risk across the age spectrum for either the primary end point (hazard ratio, 1.16; 95\% CI, 0.89–1.50; \(P=0.27\)) or for stroke events (hazard ratio, 1.12; 95\% CI, 0.82–1.54; \(P=0.47\)). Introduction of higher-order interaction terms did not suggest that the age modification of treatment effect was influenced by either symptomatic status \((P=0.96)\) or by sex \((P=0.45)\). The sensitivity analysis using the alternative definition of MI, including 20 biomarker-only MI, showed a nonsignificant effect modification of age \((P=0.75)\).

**Mediation Analysis**

Mediation analysis was performed to assess factors potentially contributing to the age-related risk differences in the CAS treatment group (Table 3), but it was not performed for those randomized to CEA because of the lack of evidence for age-related changes for those randomized to CEA. There was no evidence that the effect of age in the CAS group was mediated by differences in the prevalence of hypertension, diabetes, or dyslipidemia, or by differences in observed lesion characteristics or procedure duration \((P>0.05)\). Although

**Figure 2.** Kaplan-Meier estimates of the proportion of study participants with a primary end point. CAS indicates carotid artery stenting; CEA, carotid endarterectomy.

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**Table 2. Number of Events and Event Rates by Age Category for Patients Treated With Carotid Artery Stenting and Carotid Endarectomy**

<table>
<thead>
<tr>
<th>CAS</th>
<th>Younger than 65</th>
<th>N = 525</th>
<th>CAS N of Events (Rate ± SE)</th>
<th>CEA N of Events (Rate ± SE)</th>
<th>Hazard Ratio (95% CI) (P)</th>
<th>Interaction (P^*)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary end point (any stroke, MI or death)</strong>&lt;br&gt;within periprocedural† period‡postprocedural (isolateral stroke)</td>
<td>Younger than 65</td>
<td>26 (5.0 ± 0.9)</td>
<td>21 (4.2 ± 0.9)</td>
<td>1.22 (0.68–2.18)</td>
<td>0.51</td>
<td>0.05</td>
</tr>
<tr>
<td>75 or older</td>
<td>30 (0.0 ± 1.6)</td>
<td>21 (5.9 ± 1.3)</td>
<td>1.49 (0.85–2.60)</td>
<td>0.16</td>
<td>0.08</td>
<td></td>
</tr>
<tr>
<td><strong>Stroke end point (any stroke within periprocedural)† period‡postprocedural (isolateral stroke)</strong></td>
<td>Younger than 65</td>
<td>9 (2.2 ± 0.7)</td>
<td>8 (2.1 ± 0.7)</td>
<td>1.10 (0.42–2.84)</td>
<td>0.85</td>
<td>0.32</td>
</tr>
<tr>
<td>75 or older</td>
<td>20 (3.8 ± 0.8)</td>
<td>10 (2.0 ± 0.6)</td>
<td>1.98 (0.93–4.23)</td>
<td>0.08</td>
<td>0.65</td>
<td></td>
</tr>
<tr>
<td><strong>All strokes (any stroke up to 4-y follow-up)</strong></td>
<td>Younger than 65</td>
<td>23 (6.9 ± 1.4)</td>
<td>11 (3.1 ± 0.9)</td>
<td>2.17 (1.06–4.45)</td>
<td>0.035</td>
<td>0.12</td>
</tr>
<tr>
<td>75 or older</td>
<td>26 (5.1 ± 1.0)</td>
<td>18 (4.6 ± 1.1)</td>
<td>1.42 (0.78–2.60)</td>
<td>0.25</td>
<td>0.65</td>
<td></td>
</tr>
<tr>
<td><strong>Death</strong></td>
<td>Younger than 65</td>
<td>4 (0.8 ± 0.4)</td>
<td>0 (0.0 ± 0.0)</td>
<td>NA††</td>
<td>NA††</td>
<td>0.50</td>
</tr>
<tr>
<td>75 or older</td>
<td>4 (1.2 ± 0.6)</td>
<td>2 (0.6 ± 0.4)</td>
<td>2.14* (0.39–11.68)</td>
<td>0.38</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td><strong>MI end point (periprocedural)†‡</strong></td>
<td>Younger than 65</td>
<td>1 (0.2 ± 0.2)</td>
<td>6 (1.6 ± 0.6)</td>
<td>0.16* (0.02–1.32)</td>
<td>0.09</td>
<td>0.35</td>
</tr>
<tr>
<td>75 or older</td>
<td>2 (0.6 ± 0.8)</td>
<td>3 (1.1 ± 0.9)</td>
<td>0.67* (0.26–1.72)</td>
<td>0.40</td>
<td>0.95</td>
<td></td>
</tr>
</tbody>
</table>

CAS indicates carotid artery stenting; CEA, carotid endarterectomy; CI, confidence interval; MI, myocardial infarction; NA, not available; SE, standard error.

*Univariate proportional hazards model used because of the small N of events.
†Periprocedural period was defined as the 30-day period after the procedure for all patients receiving treatment within 30 days of randomization, or day 36 for patients not receiving therapy within 30 days of randomization.
‡Event rates for MI end point was calculated as the proportion exposed patients experiencing the end point with SE calculated from the binominal distribution, whereas event rates for the stroke end point and primary end point were calculated using Kaplan-Meier survival function with SE calculated from the Greenwood formula.
§Hazard ratios for the primary end point and stroke end point and death end point were adjusted for symptomatic status and sex, but no adjustments were made in the MI end point because of a small N of events.

\(P\) was calculated from hazard ratio.

**Per protocol, \(P\) value was calculated with age as a continuous variable.
††Not available because of unreliable estimates.

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**Figure 2.** Kaplan-Meier estimates of the proportion of study participants with a primary end point. CAS indicates carotid artery stenting; CEA, carotid endarterectomy.
total fluoroscopy time was identified as a potential mediator ($P=0.046$), its effect was modest, only reducing the age hazard ratio from 1.68 to 1.62 for a 10-year difference in age.

**Discussion**

The current analysis indicates that the age-related differential efficacy observed in CREST is primarily attributable to the stroke component of the primary end point. In turn, the impact of the stroke component is largely driven by an increasing risk of stroke with increasing age among CAS-treated patients, but little change in the increasing risk of stroke with increasing age among CEA-treated patients.

The point of similarity for the risk of stroke for CAS and CEA is at 64 years, compared to 70 years for the risk of the primary end point. The occurrence of MI after either procedure did not differ with age, suggesting CAS results in fewer MI across the entire age spectrum. However, because there were fewer MI events ($N=42$) than stroke events ($N=122$), there was lesser power to detect effect modification for MI than stroke. There was no evidence that the age-by-treatment relationships differed by symptomatic status or sex.

Our observation of an age effect modification, originally reported in the primary results article, was subsequently confirmed by the meta-analysis of the Stent-Protected Angioplasty vs Carotid Endarterectomy (SPACE) trial, the Endarterectomy Versus Angioplasty in Patients with Symptomatic Severe Carotid Stenosis (EVA-3S) trial, and the International Carotid Stenting Study (ICSS). For patients 70 years and older, the risk of events in CAS-treated patients was approximately twice that for CEA-treated patients (hazard ratio, 2.04; 95% CI, 1.48–2.82). This differential age effect in the meta-analysis was also driven by stroke because MI was not a component of the primary end point for this meta-analysis. This meta-analysis showed no differences in risk for patients younger than age 70 (hazard ratio, 2.04; 95% CI, 1.48–2.82) and 70 years and older, the risk of events in CAS-treated patients was approximately twice that for CEA-treated patients (hazard ratio, 2.04; 95% CI, 1.48–2.82). This differential age effect in the meta-analysis was also driven by stroke because MI was not a component of the primary end point for this meta-analysis. This meta-analysis showed no differences in risk for patients younger than age 70 (hazard ratio, 2.04; 95% CI, 1.48–2.82), a finding not supported by our analysis in which younger CAS-treated patients were shown to be at lower risk. Separately, the SPACE investigators reported a risk of 0.54-times (95% CI,
increase in aortic arch and carotid artery tortuosity and predictor of stroke risk potentially related to the marked finding confirmed in the analyses reported herein. Observations (the observation leading to this preplanned analysis), a among the CAS-treated patients in the CREST lead-in registry, this position was challenged by the observation of high risk performance of CAS in younger individuals were unexpected. performance of CEA in older individuals and the superior compared to the more invasive CEA. Accordingly, the superior invasive CAS would be superior in older age groups consistent with reports from the lead-in series of CREST that did not incorporate anatomic exclusion criteria for CAS now thought to be important in elderly patients. None of the analyses included a detailed examination of the criteria for CAS now thought to be important in elderly patients. When CREST was designed, we anticipated that the less invasive CAS would be superior in older age groups compared to the more invasive CEA. Accordingly, the superior performance of CEA in older individuals and the superior performance of CAS in younger individuals were unexpected. This position was challenged by the observation of high risk among the CAS-treated patients in the CREST lead-in registry (the observation leading to this preplanned analysis), a finding confirmed in the analyses reported herein. Observational studies completed before CREST documented age as a predictor of stroke risk, potentially related to the marked increase in aortic arch and carotid artery tortuosity and calcification in the elderly. In CREST, characteristics of the carotid lesion such as the degree of stenosis, lesion length, eccentricity, and ulceration had no detectable effect on risk of CAS at older ages. However, the degrees of arterial tortuosity or lesion calcification were not available in the data set and could contribute to the increased CAS event rates in the elderly. We hypothesize that the risk of embolization during CAS is increased during navigation of tortuous extracranial arteries, particularly in patients with heavily calcified vessels and "extended" type II and III aortic arches. Consistent with this hypothesis, we observed that the elderly required longer fluoroscopy time for CAS. Adjustment for this factor partially mediated the magnitude of the increased risk at older ages. Of note, the higher event rates in the elderly were not associated with increase in cardiovascular risk factors, consistent with previous reports.

The interaction between patient selection, operator experience, and technology may be relevant to the age interaction in this analysis. Recent reports of CAS using updated patient selection criteria suggest that the age differential for CAS may be absent or blunted. These studies of CAS, also using new proximal protection devices designed to be less affected by arterial tortuosity, were notable for low event rates in the elderly. Further studies are required to confirm these findings.

Strengths of the CREST analysis include a large cohort of patients with a broad age distribution, inclusion of asymptomatic patients, and age results consistent with results from the CREST credentialing study and subsequent randomized trials. Limitations include smaller numbers of events than anticipated (because of better than expected safety for both CAS and CEA) and smaller proportions of patients at the tails of the age distribution, 161 (6.4%) aged 55 years and younger and 240 (9.6%) aged 80 years and older (Figure 1). Nonetheless, the finding that the interaction test was significant provides prima facie confirmation that there are sufficient

<table>
<thead>
<tr>
<th>Covariate</th>
<th>Potentially Mediating Impact of Age (Sample Size/N of Events)</th>
<th>Hazard Ratio for a 10-y Difference in Age After Adjustment for Gender and Symptomatic Status</th>
<th>Hazard Ratio for a 10-y Difference in Age After Further Adjustment for Covariate</th>
<th>Change in Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension (1259/85)</td>
<td>1.77 (1.38–2.27)</td>
<td>1.77 (1.37–2.27)</td>
<td>−0.0021±0.0078</td>
<td>0.79</td>
</tr>
<tr>
<td>Diabetes (1257/85)</td>
<td>1.77 (1.38–2.27)</td>
<td>1.79 (1.39–2.30)</td>
<td>0.0132±0.0153</td>
<td>0.39</td>
</tr>
<tr>
<td>Dyslipidemia (1254/85)</td>
<td>1.78 (1.38–2.28)</td>
<td>1.76 (1.37–2.26)</td>
<td>−0.0077±0.0139</td>
<td>0.58</td>
</tr>
<tr>
<td>Lesion length (mm) (1189/83)</td>
<td>1.73 (1.35–2.23)</td>
<td>1.68 (1.31–2.17)</td>
<td>−0.0286±0.0152</td>
<td>0.60</td>
</tr>
<tr>
<td>Eccentric lesion (1212/84)</td>
<td>1.75 (1.36–2.25)</td>
<td>1.75 (1.36–2.25)</td>
<td>0.0025±0.0094</td>
<td>0.79</td>
</tr>
<tr>
<td>Ulcerated lesion (1207/84)</td>
<td>1.75 (1.36–2.25)</td>
<td>1.73 (1.34–2.22)</td>
<td>−0.0127±0.0149</td>
<td>0.40</td>
</tr>
<tr>
<td>Procedural angiogram percent stenosis (1200/83)</td>
<td>1.73 (1.35–2.23)</td>
<td>1.73 (1.35–2.22)</td>
<td>−0.0001±0.0055</td>
<td>0.98</td>
</tr>
<tr>
<td>Fluoroscopy time (min) (1156/78)</td>
<td>1.68 (1.30–2.18)</td>
<td>1.62 (1.26–2.09)</td>
<td>−0.0370±0.0185</td>
<td>0.046</td>
</tr>
<tr>
<td>Total procedure time (min) (1210/83)</td>
<td>1.78 (1.38–2.30)</td>
<td>1.77 (1.37–2.27)</td>
<td>−0.0097±0.0123</td>
<td>0.43</td>
</tr>
</tbody>
</table>
numbers of individuals in the tails of the age distribution to describe the effect of age.

Conclusions
This prespecified analysis of the CREST trial demonstrates that the differential efficacy of CAS compared to CEA across the age spectrum is primarily attributable to stroke events. The pattern of lower relative risk in the CAS group at younger ages and higher relative risk at older ages is driven by increased risk for stroke at older ages for CAS. For CEA, the risk for stroke is relatively constant across the entire age spectrum. We conclude that patient age should be an important factor in selecting the treatment option for carotid stenosis. The anatomic factors that may contribute to these observations require further study.

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References
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The Carotid Revascularization Endarterectomy Versus Stenting Trial (CREST) 연구

Age and Outcomes After Carotid Stenting and Endarterectomy

The Carotid Revascularization Endarterectomy Versus Stenting Trial

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Key Words: carotid artery ■ carotid endarterectomy ■ cerebrovascular disease ■ stents ■ vascular surgery

배경과 목적: CREST (Carotid Revascularization Endarterectomy Versus Stenting Trial) 등록 초기에 경동맥 스텐트(carotid artery stenting, CAS) 치료를 받은 환자들에서의 높은 뇌졸중 발생률은 나이가 경동맥내막절제술(carotid endarterectomy, CEA)에 비해 CAS의 상대적 효과를 변화(modify)시킬 수 있을 것이라는 가설을 심혈적으로 제시하였다. CREST 일차 보고에서 서도 저자들은 나이에 따른 효과 변화에 주목하였다. 이 연구에서 저자들은 일차 종합검의 각 요소에 대한 상대적인 효과, 나이의 치료 특이적 영향 및 고령의 CAS 치료군에서의 위험을 높이는 기여 인자에 대하여 분석하였다.

방법: 고도의 경동맥 협착을 가진 2,502명의 CREST 환자를 대상으로 CAS 대 CEA의 상대적 효과에 대한 나이의 영향 및 CAS 치료군과 CEA 치료군에서의 위험에 대한 나이의 영향을 분석하기 위해 비례위험모형이 적용되었다.

결과: 나이는 일차 종합검에 대해 70세를 기준으로 치료 효과 변화 인자로 작용하였다 (P interaction=0.02). CAS의 경우 일차 종합검 발생 위험률은 나이가 많음에 따라 유의하게 증가하였다 (P=0.0001), 10세 증가할 때마다 1.77배 (95% CI, 1.38~2.28) 로 증가하였다. 그러나 CEA 환자에서 나이에 따른 위험을 증가하는 유의하지 않았다 (P=0.27). 뇌졸중 발생은 전체 효과 변화의 일차적 기여 인자였고 (P interaction=0.033), 64세를 기준으로 발생 위험은 유사하였다. CAS와 CEA에 대한 치료와 나이의 상호 작용은 중상 유무 (P=0.96)와 성별 (P=0.45)에 의해 변화되지 않았다.

결론: CEA에 대한 CAS의 효과는 환자의 나이와 연관되어 있으며, 고령에서는 CAS 치료 이후 뇌졸중 위험성이 증가하였다. 경 동맥 협착을 치료할 경우 두 가지 시술을 선택할 때마다 나이는 중요하게 고려되어야 할 요인이다.

환자의 나이는 경동맥 재건술 이후의 예후에 영향을 미칠 수 있는 것으로 보고되고 있다. 1-4 1997년 CREST (Carotid Revascularization Endarterectomy vs Stenting Trial) 프로토콜이 만들어질 당시 나이와 혈관 해부는 경동맥 스텐트(carotid artery stenting, CAS) 이후 혈증 발생의 예측 인자로 고려되지 않았다. 1 반대로 CAS는 고령에서 경동맥내막
Table 1. Description of Study Population by Treatment and Age Strata*

<table>
<thead>
<tr>
<th>Age Strata</th>
<th>CAS (n=404)</th>
<th>CEA (n=387)</th>
<th>CAS (n=525)</th>
<th>CEA (n=500)</th>
<th>CAS (n=333)</th>
<th>CEA (n=353)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger Than 65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male %</td>
<td>64.6</td>
<td>66.7</td>
<td>67.4</td>
<td>67.4</td>
<td>57.7</td>
<td>64.6</td>
</tr>
<tr>
<td>White %</td>
<td>90.6</td>
<td>92.8</td>
<td>93.1</td>
<td>92.8</td>
<td>95.2</td>
<td>95.5</td>
</tr>
<tr>
<td>Asymptomatic arteries %</td>
<td>43.8</td>
<td>41.6</td>
<td>53.1</td>
<td>53.0</td>
<td>41.4</td>
<td>45.6</td>
</tr>
<tr>
<td>Risk factor status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension %</td>
<td>81.4</td>
<td>84.4</td>
<td>88.7</td>
<td>87.9</td>
<td>86.4</td>
<td>85.2</td>
</tr>
<tr>
<td>Diabetes %</td>
<td>32.9</td>
<td>30.6</td>
<td>31.6</td>
<td>34.2</td>
<td>26.0</td>
<td>25.0</td>
</tr>
<tr>
<td>Dyslipidemia %</td>
<td>84.1</td>
<td>85.9</td>
<td>84.3</td>
<td>88.3</td>
<td>79.3</td>
<td>82.2</td>
</tr>
<tr>
<td>Current smoker %</td>
<td>46.3</td>
<td>47.9</td>
<td>22.3</td>
<td>21.0</td>
<td>8.6</td>
<td>9.0</td>
</tr>
<tr>
<td>Prior cardiovascular disease %</td>
<td>36.3</td>
<td>40.8</td>
<td>46.9</td>
<td>50.1</td>
<td>42.9</td>
<td>42.4</td>
</tr>
<tr>
<td>Previous coronary artery bypass %</td>
<td>15.9</td>
<td>18.2</td>
<td>22.3</td>
<td>24.7</td>
<td>21.1</td>
<td>20.8</td>
</tr>
<tr>
<td>Systolic blood pressure (mean±SD) mm Hg</td>
<td>137±20</td>
<td>138±20</td>
<td>142±20</td>
<td>141±21</td>
<td>147±20</td>
<td>145±20</td>
</tr>
<tr>
<td>Diastolic blood pressure (mean±SD) mm Hg</td>
<td>76±12</td>
<td>76±12</td>
<td>74±11</td>
<td>73±11</td>
<td>72±12</td>
<td>73±12</td>
</tr>
<tr>
<td>CTO measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate (&lt;70%)</td>
<td>11.1</td>
<td>12.4</td>
<td>13.3</td>
<td>17.6</td>
<td>15.0</td>
<td>13.9</td>
</tr>
<tr>
<td>Severe (≥70%)</td>
<td>88.9</td>
<td>87.6</td>
<td>86.7</td>
<td>82.4</td>
<td>85.0</td>
<td>86.1</td>
</tr>
<tr>
<td>Left carotid treated %</td>
<td>50.7</td>
<td>53.2</td>
<td>47.8</td>
<td>52.6</td>
<td>55.0</td>
<td>50.7</td>
</tr>
<tr>
<td>Contralateral occlusion %</td>
<td>3.4</td>
<td>4.7</td>
<td>4.9</td>
<td>3.3</td>
<td>3.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Median day from randomization to treatment</td>
<td>6.0</td>
<td>7.0</td>
<td>7.0</td>
<td>7.0</td>
<td>6.0</td>
<td>7.0</td>
</tr>
</tbody>
</table>

SD indicates standard deviation; CEA, carotid endarterectomy; CAS, carotid artery stenting.

*Sample sizes vary for specific characteristics (rows) because of missing data on specific items for a small number of patients.

대상과 방법

연구 참가자 및 측정

CREST는 CEA와 CAS의 상대적 효과를 평가하기 위한 무작위 임상시험이다. 이 연구는 증상성 환자 1,321명과 무증상성 환자 1,181명을 모집하였다. 조명점은 치료 할당에 대해 무작위된 의료진의 임상시험임을 둔 것으로 판단한 환자 중 총 2,502명을 모집하였다. 연구에 대한 상세한 설명은 이 전 논문에 포함되어 있다.[1, 2] 프로토콜은 모든 참여 기관의 임상시험 위원회에 의해 승인되었다.

동계 분석

이 연구의 핵심은 환자의 나이가 CEA와 CAS의 상대적 효과에 영향을 줄 수 있다는 것. 그렇다면 이러한 효과 변화의 기여 인자가 무엇인지를 평가하는 것이다. 따라서 효과의 일반적 평가의 합계의 증가와 유무 및 성별을 보정한 이후 나이와 치료의 상호작용 가능성을 평가하기 위해 범위 임상시험 분석을 이용한 치료-의도(intention-to-treat) 분석으로 시행되었다. 연구의 일차 결과 변수는 시술 전후(30일 이내에 치료를 받은 경우 시술 후 30일 이내, 30일 이내에 치료를 받지 않은 경우 무작위 배정 후 36일 이내)의 뇌졸중, 심근경색증(myocardial infarction) 및 사망, 또는 무작위 배정 후 4년까지 추적 관찰 기간 동안의 합병증 숭의 증과로 정의하였다. 나이와 임상적인 효과 변화는 나이의 상호 작용을 가정하여 분석하였다. 뇌졸중은 시술 전후의 모든 뇌졸중 및 이후 4년간 시술 동안에서 발생한 뇌졸중으로 정의하였다. 심근경색증은 시술 전후 기간 중 심근 호소처의 상승과 함께 중증이 있거나 시전은 동성 근처가 있는 경우로 정의하였다. 시술 전후 기간 중 사망이 물러 왔던 이로 이해할 수 있는 분석은 이루어지지 않았다.

모형적 접근은 복합 종합물, 뇌졸중 종합물 및 심근경색증 종합물을 예측하기 위한 비례위험모형에 상호작용항을 추가하여 분석하였다. 선형적으로 P<0.10의 변수들이 효과 변화와 관련되어 있는 것으로 간주하였다. 또한 (1) 낮은 연령대에서의 발생 사례 수, (2) 치료와 나이의 상호작용의 일자 분석에서의 신뢰성에 대한 평가, (3) 다른 연구와의 비교를 위해 각 시술에 따른 각 연령층에서의 사전 발생률, (4) 각 연령층에서의 CEA와 CAS의 상대적 효과에 대한 대략적 추정값 등을 제시하기 위해 각 연령층(65세 미만, 65~74세, 75세 이상) 내에서의 이
차 본석도 이루어졌다.
저자들은 또한 모형의 고위 상호작용을 추가하여 중상 여부 및 성별에 따라 치료와 나이의 상호작용에 일관성이 있는지 평가하였다. CAS와 CEA의 상대적 효과의 차이에 기여하는 나이에 따른 위험 변화를 치료군에 따라 보기 위해 CAS 치료군과 CEA 치료군으로 분리하여 비례위험모형을 적용하였다.

마지막으로 치료와 나이의 상호작용에 영향을 미치는 임체적 원인을 파악하기 위해 매개 변수를 수행하여 CAS 치료를 받은 환자들의 환자들에서 위험률 증가가 위험 인자의 증가(고혈압, 당뇨병 및 이상지질혈증(dyslipidemia), 병변의 특성의 차이(병변 깊이, 비등심성 병변, 궤양성 병변 및 혈착 정도), 또는 시술의 차이(나두 시청 및 혹은 중 시술 시간)에 기인한 것인지 알아보고자 이러한 요인들을 모형에 포함시키고 나아에 따른 추정 HR의 변화를 관찰하였다. 병변의 특성은 각 병변에서 결정하였다. 대등맥(short aortic arch) 비투, 혈관 비틀림, 나이와 연관된 석회화 정도, CAS 함께병증 등도 농도에 포함되지 않았다. 매개 변수의 표준오차는 부트스트랩(bootstrap) 기법을 이용하여 추정하였다.

결과
두 치료군 모두에서 나이 증가에 따라 여성과 백인이 많아지고 수축기 혈압은 높았으며 이완기 혈압은 낮은 경향을 보였으나 당뇨병, 이상지질혈중, 현재 흡연 여부는 감소하는 경향을 보였다(Table 1). 이런 연령층에서도 이러한 차이들에 대해 치료군간의 유의한 차이는 없었다. Figure 1에 CAS와 CEA 환자들의 연령 분포가 제시되어 있다.

Table 2에 내부적 3분의 연령층에 따른 시술 전후 기간 및 4년 경과 동안의 심근경색증, 뇌졸중 및 일차 종말점의 관측지가 제시되어 있다. Figure 2는 각 연령층에서 입자 종말점을 보인 환자의 분율의 Kaplan-Meier 추정값을 보여준다. CEA 치료군에서는 각 연령층간 사전 사전 발생이 유사하나, CAS 치료군에서는 각 연령층간 사전 사전 발생의 차이가 나타났다. 4년간 일차 종말점 발생에 대한 이전의 보고와 같이 치료와 나이의 유의한 상호작용이 확인되었다(P<0.02).

CEA 대비 CAS의 HR은 65세 미만군의 0.60 (95% CI, 0.31 ~1.18)에서 65~74세군의 유의한 HR (1.08; 95% CI, 0,65 ~ 1.78), 75세 이상군의 1.63 (95% CI, 0.99~2.69)으로 나이에 따라 증가하였다. 이러한 위험 증가는 상대적으로 안정적인 CEA 치료군에서의 위험률(95% 연령층 6.1%), 중간 연령층 6.8%, 고령층 7.4%)과는 달리 CAS 치료군에서의 사전 발생 증가(95% 연령층 3.9%, 중간 연령층 6.3%, 고령층 12.7%)와 연관되었다. 이러한 위험 증가는 뇌졸중 종말점에 의한 것으로 각 연령층에 걸친 CEA 대비 CAS의 HR은 각각 0.78 (95% CI, 0.37~1.62), 1.42 (95% CI, 0.78~2.60), 2.15 (95% CI, 1.19~3.91)였다(P=0.033). 고령에서 CEA 대비 위험 증가는 CAS 치료군에서의 뇌졸중 발생과 연관이 있었고(3.7%, 5.1%, 10.9%) CEA 치료군에서는 연관이 없었다(4.5%, 4.6%, 4.9%). 이와 유사한 경향의 효과가 시술 전후 기간 동안의 복합 종말점 및 뇌졸중 종말점에 대해서도 관찰되었으나 통계적 유의성은 없었다(P>0.1). 시술 전후 기간 동안 발생한 병변 반대측 뇌졸중의 경우 복합 및 뇌졸중 종말점의 요소로 포함되었으나, 시술 전후 기간 이후에 발생한 병변 반대측 뇌졸중은 이 종말점에 포함되지 않았다. 모든 뇌졸중 종말점(시술 전후 기간 이후에 발생한 병변 반대측 뇌졸중 포함)에 대한 연령층에 따른 치료 효과는 시술 전후 기간 이후에
Table 2. Number of Events and Event Rates by Age Category for Patients Treated With Carotid Artery Stenting and Carotid Endarterectomy

<table>
<thead>
<tr>
<th>CAS</th>
<th>CEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 65</td>
<td>Younger than 65</td>
</tr>
<tr>
<td>65–74</td>
<td>N = 404</td>
</tr>
<tr>
<td>75 or older</td>
<td>N = 515</td>
</tr>
</tbody>
</table>

Periprocedural Period††

<table>
<thead>
<tr>
<th>CAS N of Events</th>
<th>CEA N of Events</th>
<th>Hazard Ratio (95% CI)</th>
<th>Treatment by Age Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Rate = SE)</td>
<td>(Rate = SE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger than 65</td>
<td>10 (2.5 ± 0.8)</td>
<td>14 (3.1 ± 0.8)</td>
<td>0.69 (0.31–1.55)</td>
</tr>
<tr>
<td>65–74</td>
<td>26 (5.0 ± 0.9)</td>
<td>21 (4.2 ± 0.8)</td>
<td>1.22 (0.64–2.21)</td>
</tr>
<tr>
<td>75 or older</td>
<td>30 (9.0 ± 1.6)</td>
<td>21 (5.9 ± 1.3)</td>
<td>1.49 (0.95–2.30)</td>
</tr>
</tbody>
</table>

Stroke endpoint (any stroke, MI or death within periprocedural period: postprocedural (pulmonary stroke)

<table>
<thead>
<tr>
<th>CAS N of Events</th>
<th>CEA N of Events</th>
<th>Hazard Ratio (95% CI)</th>
<th>Treatment by Age Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Rate = SE)</td>
<td>(Rate = SE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger than 65</td>
<td>9 (2.2 ± 0.7)</td>
<td>8 (2.1 ± 0.7)</td>
<td>1.10 (0.43–2.84)</td>
</tr>
<tr>
<td>65–74</td>
<td>20 (3.8 ± 0.8)</td>
<td>10 (2.0 ± 0.6)</td>
<td>1.98 (0.93–4.23)</td>
</tr>
<tr>
<td>75 or older</td>
<td>23 (6.3 ± 1.4)</td>
<td>11 (2.3 ± 0.8)</td>
<td>2.17 (1.06–4.45)</td>
</tr>
</tbody>
</table>

All strokes (any stroke up to 4-year follow-up)

<table>
<thead>
<tr>
<th>CAS N of Events</th>
<th>CEA N of Events</th>
<th>Hazard Ratio (95% CI)</th>
<th>Treatment by Age Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Rate = SE)</td>
<td>(Rate = SE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger than 65</td>
<td>9 (2.2 ± 0.7)</td>
<td>8 (2.1 ± 0.7)</td>
<td>1.10 (0.43–2.84)</td>
</tr>
<tr>
<td>65–74</td>
<td>20 (3.8 ± 0.8)</td>
<td>10 (2.0 ± 0.6)</td>
<td>1.98 (0.93–4.23)</td>
</tr>
<tr>
<td>75 or older</td>
<td>23 (6.3 ± 1.4)</td>
<td>11 (2.3 ± 0.8)</td>
<td>2.17 (1.06–4.45)</td>
</tr>
</tbody>
</table>

Death

<table>
<thead>
<tr>
<th>CAS N of Events</th>
<th>CEA N of Events</th>
<th>Hazard Ratio (95% CI)</th>
<th>Treatment by Age Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Rate = SE)</td>
<td>(Rate = SE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger than 65</td>
<td>0 (0.0 ± 0.0)</td>
<td>1 (0.3 ± 0.3)</td>
<td>NA††</td>
</tr>
<tr>
<td>65–74</td>
<td>4 (0.8 ± 0.4)</td>
<td>0 (0.0 ± 0.0)</td>
<td>NA††</td>
</tr>
<tr>
<td>75 or older</td>
<td>4 (1.2 ± 0.6)</td>
<td>2 (0.5 ± 0.4)</td>
<td>2.14 (0.93–4.84)</td>
</tr>
</tbody>
</table>

MI end point (periprocedural MI)

<table>
<thead>
<tr>
<th>CAS N of Events</th>
<th>CEA N of Events</th>
<th>Hazard Ratio (95% CI)</th>
<th>Treatment by Age Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Rate = SE)</td>
<td>(Rate = SE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger than 65</td>
<td>1 (0.2 ± 0.2)</td>
<td>6 (1.5 ± 0.6)</td>
<td>0.16* (0.02–1.32)</td>
</tr>
<tr>
<td>65–74</td>
<td>7 (2.3 ± 0.7)</td>
<td>11 (2.3 ± 0.7)</td>
<td>0.47 (0.28–1.27)</td>
</tr>
<tr>
<td>75 or older</td>
<td>6 (1.7 ± 0.6)</td>
<td>11 (2.3 ± 0.7)</td>
<td>0.53* (0.20–1.42)</td>
</tr>
</tbody>
</table>

CAS indicates carotid artery stenting; CEA, carotid endarterectomy; C.I, confidence interval; MI, myocardial infarction; NA, not available; SE, standard error.
††Proportional hazards model used because of the small number of events.
†††Periprocedural period was defined as the 30-day period after the procedure for all patients receiving treatment within 30 days of randomization, or day 36 for patients not receiving therapy within 30 days of randomization.
‡‡‡Event rates for MI end point were calculated as the proportion exposed patients experiencing the end point with SE calculated from the binomial distribution, whereas event rates for the stroke end point and primary end point were calculated using Kaplan-Meier survival function with SE calculated from the Greenwood formula.
§§§HRs calculated for the primary end point and stroke end point and death end point were adjusted for symptomatic status and sex, but no adjustments were made in the MI end point because of a small number of events.
½ was calculated from hazard ratio.
*P was calculated with age and sex as a continuous variable.
†††Available because of unreliable estimates.

결과 해석에 매우 주의할 점이 많으나, Supplemental Table 1 (https://stroke.ahajournals.org)은 증상 유무에 따른 분 석에서도 Table 2와 유사한 결과를 보여준다. 이 표에서는 나 이와 증상 유무 모두에 따른 종합률이 필요하고 이에 인하여 특 정군에서의 표본 크기가 작아 잘못된 결과를 초래할 수 있다. 저자는 나이와 증상 유무에 따른 상호작용을 고려하였으나 유의성을 발견할 수 없었고(P>0.1), 나이와 위험률의 관계에 대한 무중상성 혹은 증상성 환자들 간의 차이는 우연에 의해 쉽게 발생할 수 있다. 그러나 이러한 결과는 무중상성 혹은 증상 성 환자들 모두를 포함하지 않는 다른 연구들의 결과와의 비교 를 위해 제공되었다.

이 연구의 일차 분석 결과는 Figure 3에 제시되어 있다. Figure 3A는 CREST 일차 중점에 대해 나이를 연속 변수로 함수화한 결과를 도식화한 것으로 연구 결과의 1차 보고 논문 의 그림과 동일하다. 두 시술의 위험률은 70세에서 유사하였
고, CAS는 젊은 환자들에서 우수한 효과를 보였고 나이가 많은 환자들에서는 CEA의 효과가 더 우월하였다. 나이중 종말점과 나이의 함수 관계는 Figure 3B에 제시되어 있다. 이 그림에서 가름기이 더 가파른 일차 종말점보다 나이중 발생에 대해 (P=0.033) 나이에 의한 효과 변환의 정도가 더 크다는 것을 알 수 있다. 젊은 환자들에서는 CAS가 유의한 장점은 보인다는 복합 종말점에 대한 결과이지만, 나이중 종말점의 경우 CI의 폭이 큰 것은 95% CI의 상한이 1.0보다 크다는 것을 시사한다. 그러나 원래의 본 연구의 핵심은 나이 차이에 따른 위험률의 경험을 보고한 것이며, 특정 연령에서의 위험률의 차이를 보기 위한 것이 아니다. CEA와 CAS의 나이중 발생 위험률의 유사한 사례로, 일차 종말점의 경우보다 6년 더 낮게 나타났다. 95% CI의 폭이 넓다는 것은 일차 종말점에 비해 나이중 종말점의 경우 불확실성이 더 크다는 것을 시사한다. 일차 종말점 중 심근경색증에 대해 나이에 의한 효과 변화는 없는 것으로 나타났다 (P=0.35, Figure 3C).

CAS 치료를 받은 환자는 나이가 10세 많아질수록 일차 종말점의 위험률은 1.77배 (P<0.0001; 95% CI, 1.38~2.28) 일이증의 위험률은 1.76배 증가하였다 (95% CI, 1.35~2.31). CEA 치료를 받은 환자들 간의 경우 일차 종말점(HR, 1.16; 95% CI, 0.89~1.50; P=0.27) 비교중(HR, 1.12; 95% CI, 0.82~1.54; P=0.47)의 위험률은 나이에 따라 차이를 보이지 않았다. 고위 위험작용을 추가하여 분석한 결과, 나이에 의해 모든 치료의 효과의 변화는 증상 유무 (P=0.96) 혹은 성별 (P=0.45)에 영향을 받지 않았다. 기존 심근경색증의 생존에 대한 20간의 생존표준에서 양성인 심근경색증까지 포함시킨 만간도 분석에서 나이에 의한 효과 변화는 유의하지 않았다 (P=0.75).
매개 분석

CAS 치료군에서 나이와 연관된 위험률의 차이에 잠재적으로 기여하는 요인을 평가하기 위한 매개 분석이 이루어졌으나 (Table 3), CEA 치료군에 대해서는 나이와 연관된 위험률의 차이가 유의하지 않아 이러한 분석이 수행되지 않았다. CAS 치료군에서의 나이의 효과는 고혈압, 당뇨병, 이상질환증, 혹은 관측된 병명의 특정 또는 시술 시간의 차이에 의해 매개된다는 근거는 없었다(P=0.09). 총 뇌졸중 발생이 10년의 생존율이 0.046이 잠재적 매개 요인으로 확인되었으나, 나이 10세 증가당 HR이 1.68에서 1.62로 소폭 감소하여 그 효과는 미미하였다.

고찰

본 분석 결과는 CREST 연구에서 관찰된 나이와 연관된 효과의 차이가 장기 중대점 중 주로 뇌졸중에 의한 것임을 보여 준다. 따라서 바꾸어 말하면 뇌졸중의 영향은 CAS 치료군에서 나이가 많아지면서 뇌졸중의 위험이 증가하지만 CEA 치료군에서는 나이에 따른 뇌졸중 위험 변화가 거의 없는 것에 주로 기인 한다.

CAS 치료군과 CEA 치료군에서 뇌졸중 위험이 유사한 시점은 64세였고, 일차 중대점의 경우에는 약 70세였다. 두 군에서 나이에 따른 심근경색증 발생은 차이가 없어, CAS의 경우 모든 연령대에서 심근경색증 발생이 더 적은 것을 시사한다. 그러나 뇌졸중 발생(122건)에 비해 심근경색증 발생(42건)이 더 적어 뇌졸중보다 심근경색증에 대한 효과 변화를 확인하기 위한 점은 아직은 미흡하다. 증상 유무 혹은 성별에 따른 치료와 나이의 상호작용 관계의 변화는 유의하지 않았다.

일차 결과 논문에 제시되었던 나이에 의한 효과의 변화는 이어 Stent–Protected Angioplasty vs Carotid Endarterectomy (SPACE) 연구, Endarterectomy Versus Angioplasty in Patients with Symptomatic Severe Carotid Stenosis (EVA–3S) 연구, International Carotid Stenting Study (ICSS)를 이용한 메타분석에서도 확인되었다. 70세 이상의 환자들에서는 CAS 치료군에서 사전 발생의 위험률은 CEA 치료 받은 환자들에 비해 약 2배 정도였다(HR, 2.04; 95% CI, 1.48~2.82). 이 메타분석에서 일차 중대점의 요소로 심근 경색증은 제외되었으므로, 나이에 의한 효과는 역시 뇌졸중에 의한 것으로 해석된다. 이 메타분석에서 70세 미만의 환자들 의 위험률은 차이가 없었다(0.11; 95% CI, 0.73~1.71), 젊은 CAS 치료군에서 위험률이 낮았던 본 분석 결과에 차이가 있다. SPACE 연구진들은 별도로 68세 미만에서 CEA 대비 CAS의 위험률은 0.54배(95% CI, 0.28~1.03)로 적었으며, 68세 이상에서는 CAS가 1.80배(95% CI, 0.96~3.40)의 위험률이 증가하는 것으로 보고하였다. 이러한 나이에 의한 효과는 CREST 초기 자료, Carotid Acculink/Accunet Post–Approval Trial to Uncover Unanticipated or Rare Events (CAP-
TURE) and ICSS results are consistent with previous studies.57,58

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Sources of Funding

Disclosures

References