Regarding Article “Treating Arteries Instead of Risk Factors: A Paradigm Change in Management of Atherosclerosis”

To the Editor:

We read with great interest the intriguing article by Spence et al published in the June issue of Stroke.1 The authors performed serial carotid total plaque area measurements by ultrasound in 4378 patients between the years 1997 and 2007 in the setting of cardiovascular prevention clinics. Before the Year 2003, patients were treated according to the consensus guidelines. Then plaque progression was recorded approximately in half of the patients and plaque regression in approximately one fourth of them. After that year, a more intensive therapy was introduced for patients with plaque progression. With its application, the proportion of patients with plaque progression was reduced by half and those with plaque regression markedly increased. The authors have pointed out that these preliminary results should be validated in a randomized clinical trial.

This observational clinical study has certain limitations. The patient population is heterogeneous. Some subjects are eligible for primary and others for secondary stroke prevention. No data are given on the incidence of vascular event rates, stroke, myocardial infarction, and death, during the course of the more intensive medical therapy. Another recent publication has reported that in asymptomatic patients with carotid stenosis, vascular events have markedly declined with this more intensive therapy.2 The frequency of the side effects from this medical therapy. Another recent publication has reported that in asymptomatic patients with carotid stenosis, vascular events have markedly declined with this more intensive therapy.2 The frequency of the side effects from this medical therapy, which includes 80 mg atorvastatin or 40 mg rosuvastatin, has not been mentioned. A randomized, double-blind, placebo-controlled trial on secondary stroke prevention has found that 80 mg atorvastatin per day increases the incidence of hemorrhagic stroke.3 The side effects with higher-dose rosuvastatin are also more prevalent. In addition, a significant increase in risk of diabetes with rosuvastatin therapy has been reported.4 As far as antihypertensive medication is concerned, randomized, double-blind, longitudinal trials have found that dihydralazine calcium channel blockers also slow down carotid atherosclerosis progression and may slightly decrease the risk of cardiovascular events.5,6

Despite the limitations of this study, it clearly shows that carotid total plaque area measurements could be a useful method for evaluating different antiatherosclerotic treatment strategies and for following up the course of carotid atherosclerosis.

Disclosures

None.

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