
To the Editor:

We commend the authors for the first well-reported systematic review of the outcomes of carotid revascularization in patients with postradiotherapy carotid stenosis.1 We agree that surgical revascularization and carotid artery stenting can both be performed safely in postradiotherapy carotid stenosis and, based on recent randomized controlled trials,2 are no less safe than in nonirradiated patients. We therefore agree that these patients need not be considered a “high-risk” group for surgical revascularization.

However, there are some important limitations to the article that we would like to highlight. It should be made clearer that this is a study comparing not just carotid endarterectomy, but open surgical revascularization with carotid artery stenting, because in several of these case series, surgical procedures other than endarterectomy have been undertaken, namely interposition grafts and bypass grafts.3

The authors’ pooled data do not demonstrate a significant difference in cerebrovascular event rate at 30 days. However, several key articles have been omitted from the analysis that may have made a difference to this finding. For example, White et al4 performed 119 procedures in patients with postradiotherapy carotid stenosis, which resulted in 5 strokes within 30 days. This would have increased the number of strokes reported after carotid artery stenting by 50%.

In addition, because the purpose of carotid revascularization is to prevent stroke and death, a primary outcome of stroke alone or a composite end point of stroke or death should also be reported, as recommended by the Society for Vascular Surgery.5

Finally, a key limitation of the article is the pooling of data from symptomatic and asymptomatic individuals. The safety of a 30-day cerebrovascular event rate of 3.5% to 3.9% in a mixed group of symptomatic and asymptomatic individuals is difficult to interpret. As Carotid Revascularization Endarterectomy Versus Stenting Trial (CREST) demonstrates, the 30-day stroke and death rate in symptomatic patients was more than double that observed in asymptomatic patients.2 Reporting of outcomes by symptomatic status is therefore essential given that the safety of intervention in these subgroups may be different.

Disclosures

None.

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