Response to Letter Regarding Article, “Urgent Best Medical Therapy May Obviate the Need for Urgent Surgery in Patients With Symptomatic Carotid Stenosis”

We were delighted at the interest from Dr Naylor with regard to our study and appreciate his comments. We are in agreement as regards the need for minimizing delay from first neurological event to initiation of best medical therapy (BMT). That is why we concluded that our study adds to the data on the benefit of specialist transient ischemic attack clinics.1

In 2011, Salem et al2 reported an 11.9% neurological recurrence in 109 symptomatic carotid patients in the waiting time up to carotid endarterectomy (CEA). In this report, only 2 patients underwent CEA <48 hours after index event. Their BMT was aspirin and simvastatin in the waiting time to surgery, and all patients received 75 mg clopidogrel the night before surgery in addition to their regular aspirin.

Our aggressive BMT (loading doses aspirin and clopidogrel; aspirin, 75 mg; clopidogrel, 75 mg; and statin)3 was started promptly after emergency computed tomography in all patients with transient ischemic attack and ischemic stroke up to CEA. Median time to CEA was 26 days.

During the past 3 years, we have done 182 CEAs and have had only 1 patient who had restroke in waiting time from index event to surgery. This patient was a 78-year-old woman with severe hypertension and 70% ipsilateral stenosis who responded poorly to anti-hypertensive treatment at the time of restroke. After stabilizing her hypertension, she underwent surgery 1 week after the last attack without any complication. There was no ulceration in her carotid plaque.

Our patient population was comparable with other European and North American studies and not a low-risk population. Therefore, our study2 is noteworthy in the identification of a low rate of recurrent events despite a protracted interval between index event and CEA after initiation of aggressive dual antiplatelet and statin therapy. Although this regimen is not routinely recommended for secondary stroke prevention, it has been reported recently to be of benefit for short-term secondary prevention in a prospective randomized Chinese study of patients with acute stroke.3

Although natural history data (without urgent BMT) suggest a high rate of recurrent transient ischemic attack/stroke after carotid stenosis becomes symptomatic and support urgent CEA, the procedural risk in this period may be higher.4,5 The identification of appropriately aggressive bridge therapy to balance these competing risks is both necessary and important. Our study1 showed that urgent BMT in our region gives a remarkable benefit in reducing early neurological recurrent in CEA candidates and may obviate the need for urgent surgery. These results need to be tested and confirmed elsewhere.

The results of a randomized trial of aggressive medical therapy in patients with stroke and symptomatic carotid stenosis, such as the planned Carotid Revascularization Endarterectomy versus Stent Trial and European Carotid Stenosis Trial (CREST-2 and ECST-2), are eagerly awaited. Until then, I would continue to advocate starting our aggressive medical therapy and performing subacute CEA1 in neurologically stable patients.

Disclosures

None.

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