Five percent to 15% of patients with carotid territory transient ischemic attacks or cerebral infarctions have complete occlusion of the internal carotid artery.\textsuperscript{1,2} Their risk of recurrent stroke during the next 2 years while on medical therapy is 5% to 9% per year for all stroke and 2% to 8% per year for ipsilateral ischemic stroke.\textsuperscript{3-6} Debate on the best means to prevent recurrence has centered on whether embolic or hemodynamic mechanisms are most important. In the late 1970s and early 1980s, embolism of atherothrombotic material from the persisting proximal stump of the occluded internal carotid artery through external carotid artery collaterals was put forward as the most common cause for recurrent cerebral ischemic events.\textsuperscript{7,8} At this same time, extracranial-intracranial (EC-IC) bypass was increasingly used to prevent recurrent stroke by improving the hemodynamic status of the cerebral circulation distal to the occluded vessel.\textsuperscript{9,10} From 1977 to 1985, an international, multicenter, randomized trial was conducted to determine the efficacy of EC-IC bypass for the prevention of subsequent stroke. Among 808 randomized patients with symptomatic carotid occlusion, no benefit of surgery was demonstrated.\textsuperscript{11} Some concluded that the reason for the negative results was that the majority of strokes were because of emboli, whereas others criticized the trial for failing to identify patients with hemodynamic cerebral ischemia because of poor collateral circulation for whom surgical revascularization would be of benefit.\textsuperscript{12,13} However, the pattern of arteriographic collaterals failed to identify a subgroup who benefitted from surgery.\textsuperscript{14}

At the time of the EC-IC Bypass Study, there was no reliable method for assessing the hemodynamic effects of carotid artery occlusion on cerebral circulation. Although direct measurements of arterial-jugular venous oxygen differences had demonstrated that reductions in whole-brain cerebral blood flow (CBF) by induced systemic hypotension led to an increase in cerebral oxygen extraction fraction (OEF), jugular sampling was not useful for assessing the hemodynamic effects of unilateral carotid occlusion.\textsuperscript{15,16}

OEF = \frac{CMRO_2}{CBF \times CaO_2}

where CMRO\textsubscript{2} is cerebral metabolic rate of oxygen, CBF is cerebral blood flow, and CaO\textsubscript{2} is arterial oxygen content.

OEF reflects the balance between oxygen use (CMRO\textsubscript{2}) and oxygen delivery (CBF\times CaO\textsubscript{2}). Normal OEF is 30% to 40%. When whole-brain CBF decreases, OEF increases as much as 2-fold. The invention of positron emission tomography (PET) in the early 1980s made it possible to measure regional cerebral OEF in vivo. Because of the close coupling between regional flow and metabolism in the resting brain, OEF is normally uniform (Figure 1).\textsuperscript{17-19} In 1981, Baron et al\textsuperscript{20} described a patient with carotid artery occlusion and focally increased OEF in the ipsilateral cerebral hemisphere. They proposed the term misery perfusion to describe this condition.

At Washington University in the early 1980s, we began to study patients with carotid artery occlusion using PET measurements of OEF to assess the hemodynamic status of the cerebral circulation in the ipsilateral middle cerebral artery (MCA) territory. In some, OEF in the MCA territory distal to the occlusion was normal, indicating collateral circulation maintained the normal balance between oxygen delivery and metabolism. In others, a regional increase in OEF indicated poor collateral circulation with chronically reduced CBF relative to CMRO\textsubscript{2} (Figure 1).\textsuperscript{21}

From 1992 to 1997, we performed the St Louis Carotid Occlusion Study to determine whether increased OEF in the cerebral hemisphere distal to symptomatic carotid artery occlusion was an independent predictor of the subsequent stroke in medically treated patients.\textsuperscript{5} Major eligibility criteria were (1) occlusion of 1 or both common or internal carotid arteries; and (2) transient ischemic neurological deficits (including transient monocular blindness) or mild to moderate stroke in the appropriate carotid artery territory. Just before PET, each subject underwent neurological evaluation and assessment of the baseline risk factors.

Quantitative regional OEF was measured by PET.\textsuperscript{22} When technical difficulties precluded collection of the arterial time-activity curves necessary to determine quantitative OEF, the ratio image of the counts in the unprocessed images of O\textsubscript{15}O and H\textsubscript{2}\textsuperscript{18}O was substituted. The left/right MCA OEF ratio was calculated from noninfarcted tissue. Ratios from 18 normal control subjects defined the normal range for OEF. A separate normal range for count-based O\textsubscript{15}O/H\textsubscript{2}\textsuperscript{18}O ratio images was determined. No information regarding the PET results was
Figure 1. Positron emission tomographic scans of cerebral blood flow (CBF), cerebral metabolic rate of oxygen (CMRO2), and cerebral oxygen extraction fraction (OEF) in a normal subject (top row), a patient with carotid artery occlusion and normal OEF (second row), and a patient with carotid occlusion and high OEF before (third row) and after (bottom row) extracranial-intracranial (EC-IC) bypass surgery.

Table 1. Stroke Rates in the St Louis Carotid Occlusion Study

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OEF indicates oxygen extraction fraction. Reprinted from Grubb et al2 with permission of the publisher. Copyright ©1998, the American Medical Association.
60 days postoperatively. Subsequent follow-up visits were at 3-month intervals after randomization until 24 months or the end of the trial.

The primary end point for all who were assigned to surgery and received surgery was the combination of (1) all stroke and death from surgery through 30 days postsurgery and (2) ipsilateral ischemic stroke <2 years of randomization. The primary end point in the nonsurgical group and for those assigned to surgery who did not receive surgery was the combination of (1) all stroke and death from randomization to randomization plus 30 days and (2) ipsilateral ischemic stroke <2 years of randomization. Ipsilateral ischemic stroke was defined as the clinical diagnosis of a focal neurological deficit because of cerebral ischemia clinically localizable within the territory of the symptomatic occluded internal carotid artery that lasted >24 hours. Final determination of stroke end points was by a 3-person, blinded adjudication committee.

COSS was stopped by the Data, Safety, and Monitoring Board based on a futility analysis of 139 patients who had completed 2-year follow-up; 195 total participants had been randomized, 97 to the surgical group and 98 to the nonsurgical group. Comparison of 24 baseline variables produced 1 difference at the $P < 0.05$ level as expected, in systolic blood pressure. At last follow-up visit, risk factor control was similar in both groups.

Follow-up for the primary end point was 99% complete. All primary end points were ipsilateral ischemic strokes, 20 in each group. For the intention-to-treat analysis of the primary end point, 2-year rates were 0.210 for the surgical group and 0.227 for the nonsurgical group ($P = 0.78$; Figure 3A). COSS was designed with 90% power to detect 16% absolute risk reduction. The final results excluded with >95% confidence a benefit for surgery this large.

There was no significant benefit for surgery on any of the COSS secondary outcome measures. The Randomized Evaluation of Carotid Occlusion and Neurocognition (RECON) trial performed on a subset of COSS patients showed no difference in 2-year cognitive change between the surgical and nonsurgical groups ($P = 0.9$). The number of subjects enrolled in RECON met the prestudy power calculation for detecting a large effect size of a difference of 0.8 SD in composite cognitive change score between treatment arms. The 95% CI was $-0.5$ to 0.5 SD, the limits of a moderate effect size. It is possible that greater numbers of patients may have demonstrated a small or moderate superiority of 1 treatment arm or the other, although with the point estimate near zero this would have been unlikely.

COSS was designed with a 2-year end point. Trials of medically treated symptomatic large artery atherosclerosis have shown a major decrease in stroke rate after 2 years. In the EC-IC Bypass Study, the stroke rate at 2 years was 20%, but at 4 years the stroke rate had only increased by an additional 6%. In the carotid endarterectomy trials, the stroke rate at 2 years for 70% to 99% stenosis was 20% but increased only by an additional 4% by year 4. Data reported by Persoon et al from 117 patients with symptomatic internal carotid artery occlusion show a recurrent ischemic stroke rate of 12% at 2 years, increasing to only 14% by 4 years. Continuing COSS for an additional 3 years with a 1% to 3% per year rate of stroke in the nonsurgical group would not have resulted in a statistically significant benefit for surgery, even if no additional strokes occurred in the surgical group.

A subsequent subgroup analysis of 36 subjects in St Louis Carotid Occlusion Study who met the clinical eligibility criteria for COSS confirmed the superiority of the count-based OEF ratio method to determine eligibility. The risk of ipsilateral ischemic stroke was higher in the surgical group than in the nonsurgical group ($P = 0.04$). The Kaplan–Meier curves for ipsilateral ischemic stroke from the St Louis Carotid Occlusion Study are shown in Figure 2.

![Figure 2. Kaplan–Meier cumulative occurrence curves for ipsilateral ischemic stroke from the St Louis Carotid Occlusion Study. OEF indicates oxygen extraction fraction. Reprinted from Grubb et al with permission of the publisher. Copyright ©1998, the American Medical Association.](http://stroke.ahajournals.org/Downloaded from)

Table 2. Two-Year Kaplan–Meier Ipsilateral Stroke Rates From Studies Measuring OEF in Patients With Cerebrovascular Disease

<table>
<thead>
<tr>
<th></th>
<th>High OEF (n)</th>
<th>Normal OEF (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grubb et al</td>
<td>0.265 (39)</td>
<td>0.053 (42)</td>
</tr>
<tr>
<td>Yamauchi et al</td>
<td>0.714 (7)</td>
<td>0.061 (33)</td>
</tr>
<tr>
<td>Hokari et al</td>
<td>0.375 (9)</td>
<td>0.000 (11)</td>
</tr>
<tr>
<td>Powers et al</td>
<td>0.223 (98)</td>
<td></td>
</tr>
<tr>
<td>Yamauchi et al</td>
<td>0.25 (16)</td>
<td>0.03 (114)</td>
</tr>
</tbody>
</table>

OEF indicates oxygen extraction fraction.
stroke in patients who met the COSS ratio criteria (7/18; 39%) was virtually identical to those with quantitative OEF threshold of \( \geq 50\% \) (4/10; 40%), but the COSS ratio method identified more patients (7/9) who would go on to develop a stroke than the absolute OEF criteria (4/9).34

In the COSS surgical group, 30-day graft patency was 98%, and patency at last follow-up was 96%. Mean OEF ratio improved from 1.258 to 1.109. Of 20 strokes in the surgical group, 14 occurred in the 30-day postoperative period. This perioperative stroke rate of 15% was not significantly different from the international EC-IC Bypass Trial.11 Twelve of these postoperative strokes occurred <2 days of surgery. Eliminating these 12 strokes, the subsequent stroke rate in the remainder of the surgical group was 0.09, significantly less than the nonsurgical group \( (P=0.02; \text{Figure 3B}) \).

COSS demonstrated the importance of cerebral hemodynamics in the treatment of carotid occlusion. The pathophysiological hypothesis was correct. Surgical improvement of hemodynamics by EC-IC bypass reduced stroke risk. However, the cure was as bad as the disease. The perioperative stroke rate was sufficiently high to nullify any benefit. Extensive post hoc analyses failed to define any patient, procedural, or surgeon characteristic that predicted who would have a perioperative stroke.35

COSS demonstrated that EC-IC bypass provides no benefit compared with medical management for stroke prevention in patients with symptomatic carotid artery occlusion, even on those with increased OEF. However, disagreement existed whether strict blood pressure control was the best for these patients or if higher blood pressures were needed to preserve cerebral perfusion and prevent subsequent stroke.1,36 To address this issue, we analyzed data from the nonsurgical group of COSS.37

Of 98 nonsurgical participants, 91 were included in the analysis: 3 had no postrandomization blood pressures recorded, and 4 had ipsilateral ischemic strokes before the first
blood pressure recording at the 30- to 35-day follow-up visit. We compared the occurrence of ipsilateral ischemic stroke in the 41 subjects with mean blood pressures during follow-up who met the COSS target ≤130/85 mm Hg to the remaining 50 subjects with higher blood pressures. We used only the blood pressures recorded before the stroke occurred for those who experienced an end point ipsilateral ischemic stroke. For all others, we used all recorded blood pressure measurements. The groups were well-matched for baseline characteristics and medical management during follow-up except for the time from entry event to randomization, which was not a significant predictor of subsequent stroke in these 91 patients (P=0.32).

Of 16 ipsilateral ischemic strokes <2 years of randomization, 3 occurred in the 41 subjects with mean follow-up blood pressure of ≤130/85 mm Hg compared with 13 in the remaining 50 subjects with mean follow-up blood pressures >130/85 mm Hg (hazard ratio, 3.74; 95% CI, 1.07–13.15; P=0.027; Figure 4) The 2-year Kaplan–Meier estimated rates were 0.082 and 0.304, respectively. In the subgroup of 52 subjects who were always taking at least 1 antihypertensive drug at every follow-up visit, there were 2 strokes in 23 patients in the ≤130/85 mm Hg group and 10 strokes in 32 subjects in the >130/85 mm Hg group (hazard ratio, 3.78; 95% CI, 0.83–17.30; P=0.065, log-rank). The hazard ratio of 3.78 for this always-treated subgroup was essentially identical to that of 3.74 for the primary analysis. There was no evidence of a J-curve.38

This was not a randomized trial of different targets for blood pressure control. Nevertheless, this study provided class III evidence by American Academy of Neurology criteria that control of hypertension ≤130/85 mm Hg is associated with a reduced risk of subsequent ipsilateral ischemic stroke in patients with recently symptomatic carotid occlusion and hemodynamic cerebral ischemia (increased OEF).37 COSS patients with increased OEF represent the most extreme case of cerebral hemodynamic compromise. Nevertheless, lower blood pressures were associated with reduced, not increased, stroke risk. This was not simply because of the lower blood pressure group not being hypertensive to begin with because the hazard ratio was the same for the subgroup always treated with antihypertensive drugs as for the entire cohort.

This series of studies has demonstrated that the hemodynamic status of the cerebral circulation distal to an occluded carotid artery is the most important predictor of subsequent stroke. Patients with the worst hemodynamic compromise (increased OEF) have a 2-year stroke risk of 20% to 25%. Surgical improvement of hemodynamics by EC-IC bypass does reduce stroke risk, but the perioperative stroke rate is sufficiently high to nullify this benefit. Counterintuitively, best medical management for these patients includes strict blood pressure control.

The results of these studies also reinforce the need for empirical data. Conclusions about therapeutic efficacy based on presumed mechanisms for stroke and for stroke therapies have too often proven to be wrong. Research into the pathophysiology of stroke and the biological effects of different treatments can provide the rationale for clinical trials but cannot substitute for the empirical data in choosing individual patient therapy.

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Disclosures
None.

References


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경동맥 영역의 일과성허혈발작 또는 뇌경색을 가진 환자의 5~15%는 내경동맥완전폐색을 가지고 있다. 내과적 치료에도 불구하고 증상 발생 후 2년 동안 뇌졸중의 재발 위험은 모든 뇌졸중에 대해 연간 5~9%, 동측의 허혈뇌졸중에 대해 2~8% 정도이다. 내경동맥 완전폐색 지역 내의 혈관물질 저유지를 추적할 수 있던 뇌졸중의 재발 위험에 대한 논란은 주로 색전 기전 또는 혈류학적 기전이 중요하다고 하여 집중되어 왔다. 1970년대 후반에서 1980년대 초반에는 폐색된 내경동맥의 근위부에 남아있는 용역물질이 외경동맥의 측부순환을 통하여 색전뇌경색을 일으키는 것이 재발성 뇌졸중의 가장 중요한 요인으로 제기되었다. 이와 비슷한 시기에 폐색된 혈관 원위부 뇌순환의 혈류역학적 상태를 개선하여 뇌졸중 재발을 예방하기 위한 방법으로 두개내외우회로조성술(extracranial–intracranial bypass, EC-IC bypass)의 시행이 점차 증가되었다. 1977년부터 1985년까지 재발성 뇌졸중 예방에 있어 EC-IC bypass가 효과적이었지만, 다수의 연구가 수행되었다. 무작위배정된 808명의 증상성 경동맥폐색을 가진 환자에서 수술 치료의 효과가 입증되지 못하였다. 일부 사람들은 효과가 없는 이유가 뇌졸중의 대부분이 색전 때문인 것으로 결론 지었고 다른 사람들은 이 연구가 측부순환의 불량하여 수술적 혈관재형성이 도움될 수 있는 혈류학적 허혈 환자를 선별하지 못하였기 때문이라고 비판하였다. 그러나 동맥조영상 측부순환의 패턴을 분석해 보았을 때에도 수술이 이득이 되었음을 시사하였다. 1992년부터 1997년까지 본 저자들은 경동맥폐색에서의 혈류학적 효과를 평가하는 데에는 유용하지 않았다. OEF는 다음과 같다:

\[
OF = \frac{CMRO_2}{CBF \times CaO_2}
\]

CMRO는 뇌산소대사율(cerebral metabolic rate of oxygen), CBF는 뇌혈류(cerebral blood flow), CaO는 동맥 내 산소의 양(arterial oxygen content)입니다.

The primary end point was ischemic stroke defined clinically as a neurological deficit of presumed ischemic cerebral origin lasting more than 24 hours.

Secondary end points were ipsilateral ischemic cerebral infarction and death. Patients with subsequent cerebrovascular events were arranged. All living patients were followed up for the first year and thereafter at 6-monthly intervals. Symptoms suggesting a stroke and death were documented by the COSS neurosurgeon. Otherwise, all patients were followed up in a similar manner to the original COSS study.

### Table 1. Stroke Rates in the St Louis Carotid Occlusion Study

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OEF indicates oxygen extraction fraction. Reprinted from Grubb et al with permission of the publisher. Copyright ©1998, the American Medical Association.
발생한 반구 증상을 가진 환자들의 대상으로 BC–IC 우두부혈이 2년 이내 동측 혈류에 휘행하는 발생을 감소시킬 수 있는지를 평가하는 연구였고, 이 연구는 2002년부터 2010년까지 미국과 캐나다에서 49개의 임상센터 및 18개의 PET 센터에서 수행되었다. PET 검사의 선정기준은 반대편 대비 동측의 count-based OEF 비율이 1,130보다 큰 경우로 정의하였다. 동맥네 카테터혈관조영술로 1) 증상성 내경동맥폐색 및 2) 문합에 적합한 두개 내/외의 혈관이 있음을 확인하는 것도 요구되었다. 수술군에서 수술 전후의 혈류장 치료는 COSS 신경외과의사들에 의하여 결정이 되었다. 다른 경우에서는 모든 환자들이 의사들이 원하는 혈류장 치료가 유지되었다. 위험인자 조절을 위한 목표로 혈압은 130/85 mmHg, 저밀도 콜레스테롤 100 mg/dL, 증상성방의 경우 150 mg/dL, 당화혈소백은 7%이었다. 일차 진료로 진단 혹은 직접적인 급언 프로그램 참여를 결정하였다. 처음의 추적관찰은 무작위배정 후 30~35일이었다. 모든 수술
환자군에서 수술 30~60일 이후에 PET 검사가 이루어졌다. 무작
위배정 후 배 3개월 간격으로 24개월까지 혹은 연구 종료까지 추적관찰을 하였다.

수술군에 배정되어 수술을 시행 받은 모든 환자들에서의 일차 종점은 (1) 수술 후 30일까지 모든 뇌졸중 및 사망의 합 및 (2) 무작위배정 후 2년 이내 동측에 발생한 혈류에 휘행하는 발생을 감소시킬 수 있는지를 평가하는 연구였다. 이 연구는 2002년부터 2010년까지 미국과 캐나다에서 49개의 임상센터 및 18개의 PET 센터에서 수행되었다. PET 검사의 선정기준은 반대편 대비 동측의 count-based OEF 비율이 1,130보다 큰 경우로 정의하였다. 동맥네 카테터혈관조영술로 1) 증상성 내경동맥폐색 및 2) 문합에 적합한 두개 내/외의 혈관이 있음을 확인하는 것도 요구되었다. 수술군에서 수술 전후의 혈류장 치료는 COSS 신경외과의사들에 의하여 결정이 되었다. 다른 경우에서는 모든 환자들에게 의사들이 원하는 혈류장 치료가 유지되었다. 위험인자 조절을 위한 목표로 혈압은 130/85 mmHg, 저밀도 콜레스테롤 100 mg/dL, 증상성방의 경우 150 mg/dL, 당화혈소백은 7%이었다. 일차 진료로 진단 혹은 직접적인 급언 프로그램 참여를 결정하였다. 처음의 추적관찰은 무작위배정 후 30~35일이었다. 모든 수술

OEF indicates oxygen extraction fraction.

<table>
<thead>
<tr>
<th>Table 2. Two-Year Kaplan–Meier Ipsilateral Stroke Rates From Studies Measuring OEF in Patients With Cerebrovascular Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>High OEF (n)</td>
</tr>
<tr>
<td>Grubb et al(^1)</td>
</tr>
<tr>
<td>Yamauchi et al(^25)</td>
</tr>
<tr>
<td>Hokari et al(^27)</td>
</tr>
<tr>
<td>Powers et al(^29)</td>
</tr>
<tr>
<td>Yamauchi et al(^28)</td>
</tr>
</tbody>
</table>

OEF indicates oxygen extraction fraction.
중의 발생이 전혀 없다고 가정하여도 수술의 유의한 효과는 보이지 않는다. 뇌졸중 발생을 1~3%로 가정하고 수술군에서 추가적인 뇌졸중을 보였다. COSS 연구를 3년 이상 연장하여 비수술군에서의 추가자들을 조사한 Persoon 등인 발생은 4%에 그쳤다.

발생률은 20%였으나, 4년 동안의 추적관찰 결과 뇌졸중의 추가적인 뇌졸중 발생률은 6% 증가하는데 그쳤다. 경우 2년 동안의 뇌졸중의 발생률은 20%였으나 4년째까지 추가적인 뇌졸중 발생률은 6% 증가하는데 그쳤다. COSS는 2년간의 종점 분석하기 위해 계획되었다. 증상성 대혈관증후군 환자를 대상으로 치료한 연구에서 2년 후 뇌졸중의 발생이 대폭 감소함을 보였고, EC-IC Bypass Study의 경우 2년 동안의 뇌졸중의 발생률은 20%였으나 4년째까지 추가적인 뇌졸중 발생률은 6% 증가하였다. 정동맥내막절제술 연구에서는 70~90%의 혈착을 가진 환자들에서 2년간 뇌졸중의 발생률은 20%였으나, 4년 동안의 추적관찰 결과 뇌졸중의 추가적인 발생은 4%에 그쳤다. 증상성 내경동맥폐색에 가진 117명의 환자를 조사한 Persoon 등이 보고에 의하면 2년간의 재발성 휴혈뇌졸중 발생률은 12%였으며, 4년 동안에는 14%로 소폭의 증가를 보였다. COSS 연구를 3년 이상 연장하여 비수술군에서의 추가적인 뇌졸중 발생을 1~3%로 가정하고 수술군에서 추가적인 뇌졸중의 발생이 전혀 없다고 가정하여도 수술의 유연한 효과는 보이지 않았을 것이다. St Louis Carotid Occlusion Study에서 COSS의 선정기준을 만족하는 36명의 환자들의 추가 분석에서 선정 조건을 만족한 count-based OEF ratio의 우수성을 확인하였다.

COSS 소상품기준에 맞는 환자들의 동측 뇌졸중 발생 위험이 (7/18: 39%)은 정량적 OEF 영역 기준인 50% 이상을 가진 환자들의 위험도 (4/10: 40%)와 거의 동일하였다. 그러나 COSS ratio 방법은 절대적 OEF 기준 (4/9)보다 뇌졸중 발생위험이 있는 환자들을 더 많이 (7/9) 확인할 수 있었다. COSS 수술군에서 수술혈관의 개통성은 98%였고, 마지막 추적관찰에서 96%였다. 평균 OEF ratio는 1,258에서 1,109로 개선되었다. 수술군의 20례 뇌졸중 중에서 14례는 수술 후 30일 이내에 발생하였다. 이러한 수술 전후의 뇌졸중 발생률은 15%로 EC-IC Bypass Trial의 결과와 유의한 차이가 없었다. 수술 후 뇌졸중 중 12례는 수술 3일 이내에 발생하였다. 이 12례의 뇌졸중의 위치는 뇌의 전반부에 분포하였다. 수술 부위로 짧은 시간 내에서 발생하였다. 0.08로 비교하였을 때 유의하게 낮은 뇌졸중 발생률을 보였다 (P=0.02; Figure 3B).

Figure 4. Kaplan–Meier cumulative occurrence curves for ipsilateral ischemic stroke for 91 patients from the nonsurgical group of the Carotid Occlusion Surgery Study (COSS) comparing the 41 subjects with mean blood pressures (BPs) during follow-up who met the COSS target ≤130/85 mm Hg to the remaining 50 patients with higher BPs. Reprinted from Powers et al. with permission of the publisher. Copyright ©2014, Wolters Kluwer Health.
역시 질병만큼이나 나빴다. 수술 전후의 뇌졸중의 발생이 많아 치료 효과를 상쇄하였다. 다각적인 사후분석에서도 수술 전후의 뇌졸중 위험 증가를 예측할 수 있는 환자의 특성, 시술 관련 및 집도 의사의 특성을 파악하는데 실패하였다. 35

COSS 연구는 증상성 경동맥폐색을 가진 환자들, 심지어는 OEF가 증가되어 있는 환자들에서 EC-IC 우회술이 내과적인 치료와 비교하여 뇌졸중의 예방에 효과가 없음을 보여주었다. 그러나 이러한 환자들에서 억제할 전후의 뇌졸중 위험 증가를 예측할 수 있는 환자의 특성, 시술관련 및 집도 의사의 특성은 실패하였다. 1,36

이러한 문제들을 다루기 위해 저자들은 COSS 연구의 비수술군 자료를 분석하였다. 37 98명의 비수술군 환자들 중에서 91명이 분석에 포함되었다. 3명은 무작위배정 후 혈압 기록이 없었고, 4명은 30~35일 추적관찰에서의 혈압 측정이 전사의 허혈뇌졸중이 확인되어 분석에서 제외되었다. COSS의 목표혈압인 130/85 이하로 조절된 41명과 혈압이 높았던 50명에서의 동측 허혈뇌졸중 발생을 비교하였다. 연구의 중점은 동측 허혈뇌졸중을 경험한 환자들의 경우에는 뇌졸중 발생 전에 기록된 혈압만을 사용하였다. 다른 환자들에서는 평균 혈압을 사용하였다. 연구의 시작에서부터 무작위배정까지의 기간을 제외하고 추적관찰 기간 동안 기본적인 특징 및 내과적 치료에 대해 두 군에서 차이가 없었고, 연구 등록 후 무작위배정까지 시간에 차이가 있었다. 2년간 Kaplan-Meier 추정 발생률은 각각 0.082 및 0.304였다. 매 추적 방문시에 적어도 1개 이상의 항고혈압제를 항상 복용하고 있었던 52명의 환자들로 분석을 한 유의한 예측인자는 아니었다 (P=0.32).

무작위배정 2년 이내에 발생한 16례 동측 허혈뇌졸중 중, 3례는 평균 추적 혈압이 135/85 mmHg 이하인 41명의 환자들에서 발생하였고, 나머지 13례는 평균 추적 혈압이 135/85 mmHg를 초과한 50명의 환자들 중에서 발생하였다(위험도, 3.74; 95% CI, 1.07~13.15; P=0.027, Figure 4). 2년 간의 Kaplan–Meier 추정 발생률은 각각 0.082 및 0.304였다. 매 추적 방문시에 적어도 1개 이상의 항고혈압제를 항상 복용하고 있었던 52명의 환자들로 분석을 한 유의한 예측인자는 아니었다 (P=0.32). 이와 같이 항상 고혈압을 조절하였던 하위 그룹에서의 뇌졸중 발생 위험도 3.78이 incubate; 95% CI, 0.83~17.30; P=0.065, log–rank). 이와 같이 항상 고혈압을 조절하였던 하위 그룹에서의 뇌졸중 발생 위험도 3.78은 임상적에서 얻은 3.74와 상당히 동일한 수치였다. J 커브 효과에 대한 증거는 없었다.38

이 연구는 혈압조절에서 목표치가 다른 무작위 연구는 아니었다. 그럼에도 불구하고 이 연구는 증상성 경동맥폐색과 혈류역학적 뇌혈액량 증가를 일으키기 위해 혈압을 130/85 mmHg 이상으로 조절해야 한다는 American Academy of Neurology 기준의 class III의 근거를 제공한다. OEF가 증가된 COSS 환자들은 뇌 혈류역학적 악화의 가장 극단적인 경우를 대표한다. 그럼에도 불구하고 혈압을 낮추는 것은 뇌졸중의 위험을 감소시키거나 증가시키지 않는 것과 연관된다. 항상 항고혈압제를 투여받았던 하위그룹에서의 위 혈압도 전체 코호트와 동일하기 때문에 이것은 단순히 처음부터 혈압이 낮아 항고혈압제를 복용할 필요가 없는 집단 때문인 것은 아니다.

이러한 일련의 연구 결과들은 폐색 경동맥의 원위부 뇌혈액량의 혈류역학적 상태가 차후 뇌졸중의 발생에 있어 가장 중요한 예측인자를 증명해주고 있다. 혈류역학적 악화가 큰 OEF가 증가된 환자의 2년간 뇌졸중의 위험이 20~25%이다. EC-IC 우회 수술을 통한 혈류역학적 개선은 뇌졸중 위험을 감소시키지만, 수술 전후의 뇌졸중의 발생 위험이 이러한 이득을 무효화하기로 충분히 크다. 이와는 다르게 이러한 환자들에게 최신의 내과적 치료는 억제할 수 있는 경우를 포함한다.

이러한 연구 결과들은 또한 수차례의 적절한 치료를 더 강조하고 있다. 뇌졸중과 뇌졸중 치료에 대한 단면의 것과 같이 여겨질 수 있던 기전에 기반한 치료의 효과가 너무 자주 잘못된 결론에 도달하는 경우가 많다. 뇌졸중의 병태생리 및 다양한 치료의 생물학적 효과에 대한 연구들은 임상실험에 대한 다양한 이유를 제공할 수는 있으나 개별적인 환자들의 치료를 선택하는데 있어 실증적인 데이터를 대체할 수는 없다.

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Disclosures

None.

References


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