A retrospective study of 228 consecutive carotid endarterectomies was conducted to determine the operative stroke and mortality rate in two 600-bed community hospitals. The combined stroke-mortality rate for the series was 21.1% (48 of 228). Eleven endarterectomies were performed for asymptomatic bruits and the combined stroke-mortality rate was 18.2% (2 of 11). Fifty-seven endarterectomies were performed for transient ischemic attack(s) in the symptomatic carotid artery distribution and the combined stroke-mortality rate was 21.1% (12 of 57). Seventy-one endarterectomies performed following a mild-moderate stroke in the symptomatic artery distribution and the combined stroke-mortality rate was 21.1% (15 of 71). Twelve endarterectomies were performed following a severe stroke in the symptomatic carotid artery distribution and the combined stroke-mortality rate was 41.7% (5 of 12). There was no trend toward more or less operative strokes or deaths from 1970 to 1976.

The similarity of results among the eleven board-certified neurological and vascular surgeons who performed the 228 endarterectomies suggests that the operative stroke and mortality rates for carotid endarterectomy reported here are likely to be representative of those in many other community hospitals in this country in the 1970s.

Recent years a considerable amount of information has accumulated regarding the relationship between extracranial carotid artery disease and cerebral and/or retinal infarction. The use of angiography and carotid terectomy has become widespread in the treatment of patients. Carotid endarterectomy is frequently being performed as prophylaxis against stroke in patients with asymptomatic bruits. A large number of selected and uncontrolled, and prospective and retrospective studies have been published, and the results in terms of operative stroke rate and death rate have been highly variable. Among the 24 institutions involved in the Study of Extracranial Arterial Occlusion, the operative mortality rate alone varied from less than 2% to 0 to 2% range, especially for selected patients with transient ischemic attacks and asymptomatic bruits, and investigators now imply that we can expect exceedingly low complication rates for carotid endarterectomy.1-13 Others have pointed out the high variability in the operative complication rates from various series and the need to look at individual results rather than pooled results.14 This view is the need for physicians to be informed of results of medical and surgical therapy in their own medical community. There may be some reluctance for investigators to report less than optimal results.

The purpose of this communication is to report a retrospective study of all carotid endarterectomies performed over a six and one-half year period in one community. The charts were reviewed in detail by the authors and the data reported are derived from the best information available for study. Each patient was assigned a preoperative diagnosis of asymptomatic carotid bruit, transient ischemic attack, stroke or "other" (see table 1). A transient ischemic attack was defined as an episode of neurological dysfunction attributed to cerebral ischemia in either carotid artery distribution (retinal or hemispheric) of less than 24 hours duration. Transient neurologic symptoms attributable to ischemia in the posterior circulation, or ill-defined neurological symptoms, were categorized as "other." A stroke was defined as a residual neurological deficit in either cerebral hemisphere that persisted for longer than 24 hours. The neurological deficit was designated as severe if the patient was non-ambulatory as a result of hemiparesis or profoundly non-communicative as a result of dysphasia. All other persistent neurological deficits were designated mild or moderate. All strokes following operation occurred within seven days of operation and most occurred within the first 24 hours. All operative deaths occurred within seven days or the patient suffered a massive stroke that progressed to death within one to three weeks.

There was no uniformity in the preoperative angiographic procedure performed, with visualization ranging from a single extracranial carotid artery to the complete demonstration of the aortic arch, the extracranial vessels and the intracranial circulation. A useful comparison between angiographic findings and operative results could not be made.

Nine board-certified general surgeons (vascular surgeons) and two board-certified neurological surgeons performed the operations.

Results

The operative stroke rate for the series was 14.5% (33/228) and the mortality rate was 6.6% (15/228) giving a combined stroke-mortality rate of 21.1% (48/228) (see table 1). No patients were counted twice, i.e., in both the stroke group and the death group. Four vascular surgeons had no operative complications, but together they performed only 11 (4.8%) of the endarterectomies. There were no statistically significant differences in the stroke and death rates among the different surgeons (see table 2).
TABLE 1  
Operative Stroke and Mortality Rate for the 228 Carotid Endarterectomies

<table>
<thead>
<tr>
<th>Year Operated</th>
<th>Total Number</th>
<th>Stroke</th>
<th>Death</th>
<th>Stroke + Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970 (6½ yr.)</td>
<td>28</td>
<td>4</td>
<td>2</td>
<td>6 (28) 21.4%</td>
</tr>
<tr>
<td>1975</td>
<td>59</td>
<td>10</td>
<td>3</td>
<td>13 (59) 20.0%</td>
</tr>
<tr>
<td>1974</td>
<td>26</td>
<td>5</td>
<td>1</td>
<td>6 (26) 23.1%</td>
</tr>
<tr>
<td>1973</td>
<td>35</td>
<td>4</td>
<td>3</td>
<td>7 (35) 20.0%</td>
</tr>
<tr>
<td>1972</td>
<td>25</td>
<td>5</td>
<td>1</td>
<td>6 (25) 24.0%</td>
</tr>
<tr>
<td>1971</td>
<td>36</td>
<td>3</td>
<td>2</td>
<td>5 (36) 13.9%</td>
</tr>
<tr>
<td>1970</td>
<td>19</td>
<td>2</td>
<td>3</td>
<td>5 (19) 26.3%</td>
</tr>
</tbody>
</table>

There is no significant difference in the operative stroke-death rate for the seven individual surgeons (x² = 4.2, df = 6).

Eleven endarterectomies were performed for asymptomatic carotid bruits. The stroke rate was 18.2% (2/11); the mortality rate was 0%; the combined stroke + mortality rate was 18.2%.

Fifty-seven endarterectomies were performed for transient ischemic attack(s) in the symptomatic carotid artery distribution. The stroke rate was 14.0% (8/57); the mortality rate was 7.0% (4/57); the combined stroke + mortality rate was 21.1% (12/57).

Seventy-one endarterectomies were performed following a mild-moderate stroke in the appropriate carotid artery distribution. The stroke rate was 5.6% (4/71); the combined stroke + mortality rate was 21.1% (15/71).

Twelve endarterectomies were performed following a severe stroke in the appropriate carotid artery distribution. The mortality rate was 41.1% (5/12). A stroke rate for this group could not be assessed because all patients already had severe hemispheric deficits preoperatively. No contralateral hemisphere strokes occurred without progressing to death. If these 12 severe stroke patients are excluded from the study on the grounds that they were inappropriately operated on, the death rate for the overall series is 4.6% and the combined stroke + mortality rate is 19.9%.

Of the 15 patients who died, 12 clinically had an obvious stroke or were comatose within the first postoperative day and the remainder suffered neurological deterioration between postoperative day one and day eight. All patients then progressed to death by the 28th postoperative day. Since much of the mortality in patients with cerebral vascular disease is cardiac in origin, it is important to note that the operative deaths in this series clinically appeared to result from cerebral ischemic injury. However, it was not possible to rule out with certainty such factors as intraoperative or postoperative hypotension or hypertension or unrecognized myocardial infarction.

There is no significant difference in operative complication rates from 1970 to 1976 (x² = 2.4, df = 6).
It was not always possible to determine with certainty the severity of the operative strokes. However, the best estimate is that 11 of 33 were "transient" (but persisting longer than 24 hours) or mild, and 22 of 33 were moderate or severe. Two patients in the severe group were decerebrate.

There was no trend toward more or less operative strokes or deaths from 1970 to 1976 (see table 3). There was also no change in the indications for endarterectomy between 1970 and 1976 (see fig. 1).

The mean age of patients in the complicated and uncomplicated groups was the same (see table 4). There was no relationship between the operative complication rate and the use of an intra-operative carotid artery shunt (see table 5).

It was only possible in 75% of the patients to determine the time interval from the last vascular episode to operation. The combined stroke-mortality rate was 28.2% (11/39) for those patients operated within seven days and this is somewhat higher than the rate for those operated later (see table 6). However, a substantially higher percentage of the earlier operated patients were operated on for severe strokes and thus the higher complication rate was expected.

The most active surgeon performed an average of 0.97 endarterectomies per month (76 operations in 78 months).

**Discussion**

This study's finding of a 41.7% operative mortality for the severe stroke group confirms several published reports regarding the high operative mortality in these patients. When the operative mortality for this group is compared to the mortality in an unoperated control group, the inadvisability of performing carotid endarterectomies in these patients is evident.

Studies of the natural history of untreated transient ischemic attacks suggest that approximately 15-35% of patients will go on to have a stroke in the next three to five years, though one series reported a stroke incidence of 51%. This group of patients is generally considered to be the optimal group for carotid endarterectomy if an operable lesion is found in the symptomatic carotid artery. The enthusiasm for operating on these patients stems from the reports indicating that an operative stroke-mortality rate in the range of 0 to 5% can be expected. Even though extensive long-term follow-up data is not yet available, one can certainly justify surgical therapy if an operative risk this low provides any improvement over the natural stroke-mortality rate. The 21.1% operative stroke-mortality rate for this optimal group, in this series, makes it more difficult to recommend carotid endarterectomy for these patients. Additionally, the beneficial effects of anticoagulant treatment for cerebral ischemia must be considered in outlining a management plan.

The place for carotid endarterectomy in the management of patients with asymptomatic carotid bruits is controversial even when the operative complication rate is very low as reported by some authors. Until there is clear evidence that these bruits indicate a substantial risk of impending stroke, it is difficult to recommend prophylactic surgery in the face of an operative stroke rate of 18.2% in this series.

A number of factors can be considered in explaining the high variability in the stroke-mortality rates reported in various carotid endarterectomy series. Patient selection in terms of clinical presentation (i.e., completed stroke, transient ischemic attacks, asymptomatic bruit, etc.) is considered by many authors to be important. However, there is little difference in the operative stroke-mortality rate for these different groups in this series, except for the very high complication rate seen in the severe stroke group. The patient's age at the time of operation might also be expected to influence the complication rate. However, this was not observed in this series. While we expected that the operative complication rate might diminish with experience over time, we saw no diminution in the operative stroke-mortality rate between 1970 and 1976. It may be significant that the most active surgeon performed an average of only one endarterectomy per month.

**Table 5 Relationship Between Operative Complication Rate and Shunt Usage**

<table>
<thead>
<tr>
<th></th>
<th>Shunt</th>
<th>No Shunt</th>
<th>Indeterminate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Complication</td>
<td>127 (127/180 = 70.6%)</td>
<td>38 (38/180 = 21.1%)</td>
<td>15</td>
<td>180</td>
</tr>
<tr>
<td>Stroke</td>
<td>23 (23/33 = 69.7%)</td>
<td>3 (3/33 = 9.1%)</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Death</td>
<td>9 (9/15 = 60%)</td>
<td>4 (4/15 = 26.7%)</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>159 (159/228 = 69.7%)</td>
<td>45 (45/228 = 19.7%)</td>
<td>24 (24/228 = 10.5%)</td>
<td>228</td>
</tr>
</tbody>
</table>
The data available were not adequate to assess the relationship between the rate of operative complications and the presence of diabetes mellitus, hypertension or heart disease. No attempt was made to correlate electroencephalographic findings with operative outcome.

Only rarely was there intraoperative measurement or monitoring of the electroencephalogram, the cerebral blood flow or the arterial stump pressure. No attempt was made to correlate the type of anesthesia, the regulation of blood pressure or the state of anticoagulation with operative outcome.

One or more of these preoperative, intraoperative or postoperative factors may be influential in the operative outcome.

The similarity of results among the eleven board-certified neurological and vascular surgeons who performed the 228 endarterectomies suggests that the operative stroke and neurological and vascular surgeons who performed the 228 endarterectomies for asymptomatic carotid endarterectomy — complications and preoperative assessment of risk. Mayo Clin Proc 50: 301-306, 1975


References


Stroke and mortality rate in carotid endarterectomy: 228 consecutive operations.
J D Easton and D G Sherman

Stroke. 1977;8:565-568
doi: 10.1161/01.STR.8.5.565

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://stroke.ahajournals.org/content/8/5/565

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Stroke can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Stroke is online at:
http://stroke.ahajournals.org/subscriptions/