Asymptomatic Carotid Stenosis (ACS) up to 80% Is Benign: What about Those Stenoses over 85% - Especially When Associated with a Contralateral Occlusion: Which ACS Patients Should Be Treated Invasively and How?
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What we “know”
- Carotid plaque causes strokes
- Strokes are more common the greater the degree of stenosis but still relatively uncommon
- “Optimal” medical management can reduce the incidence of stroke
- Optimal or “Best Medical Therapy” (BMT) has improved
- The results of CEA have improved

What we don’t Know
- Who will actually have a stroke?
- What constitutes BMT?
  - New antiplatelet agents
  - New lipid lowering drugs and guidelines
  - New BP guidelines
- What really should the stroke rate be for CEA?
  - 1%-3%-6%?
Best Medical Therapy vs Best CEA

Faculty Advocating for Collaborative and Thoughtful Carotid Artery TreatmentS (FACTCATS)

Predictors of ACS leading to Stroke
- Degree of stenosis
- Rate of progression
- Microemboli detection on TCD
- Silent Embolic infarcts on CCT or MRI
- Reduced cerebral blood flow Reserve
- Intraplaque hemorrhage using MRI
- Unstable carotid plaque on ultrasound
- Contralateral stenosis
- History of contralateral stroke/TIA
- Age
- Gender
- Lipid lowering medications
- Calcification

Notable
- In every study showing the predictive value of a potential risk factor or group of risk factors for stroke
- More patients with that risk factor had a stroke
- BUT MOST DID NOT!
For patients with baseline stenosis 70% to 99% 8-year cumulative ipsilateral cerebral ischemic stroke rate
- Without progression (n = 349) -12%
- With progression (n = 77) - 21%

BUT
- The average annual stroke rates were only 1.5% and 2.6%, respectively
- Only nine (30%) of the 30 strokes occurred in the progression group

For medical and surgical consultation, refer to the following:

“Predictions and clinical significance of progression or regression of asymptomatic carotid stenosis.”

[Link to the original article]