

Decreased Cerebral Perfusion in Carotid Artery Stenosis, Carotid Angioplasty and Its Effects on Cerebral Circulation

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1. Introduction

Cervical carotid artery stenosis frequently causes ischemia by embolic phenomena, but stenosis can also induce ischemia via a reduction in blood flow. Cerebral perfusion failure can be caused by reductions in blood flow arising from a stenosis or an occlusive vascular lesion (Bokkers et al., 2008; Wilkinson et al., 2003).

Two major mechanisms are involved in cerebral ischemia (Mohr et al., 1997). Cerebral perfusion failure may occur as the result of flow reduction mediated by stenosis or occlusive vascular damage such as that arising from atheroma plaques that affect the carotid bulb. Perfusion failure affects the distal territories, and it is known as a watershed infarction. The second mechanism of cerebral ischemia is artery-to-artery embolism, which is considered to be the main cause of ischemia associated with plaques in the larger arteries. There are thrombosis in situ and embolic infarctions associated with these plaques, which usually involve the occlusion of intracranial distal vessels.

Ischemia is the physiological term indicating a blood flow that is insufficient for the normal functioning of cells, whereas infarction is the pathological term denoting permanent tissue damage caused by ischemia (Jensen et al., 2005). Classically, atherosclerotic infarctions, particularly those in major arteries, are caused by the formation of thrombosis at the atheroma plaque site or from an embolism that originates from the same plaque. The most common location of plaques in the cerebrovascular circulation is at the carotid bifurcation involving the distal common carotid artery and the first 2 cm of the internal carotid artery.

Treatment options for atherosclerotic carotid artery stenosis include drug therapy and surgical treatment (Mas et al., 2006; NASCET, 1991; Ringleb et al., 2006; Yadav et al., 2004). Clinical treatment includes antiplatelet aggregation agents and statins, along with the control of risk factors such as arterial hypertension, dyslipidemia, hyperglycemia and tobacco use (Bates et al., 2007). Two relevant studies comparing clinical and surgical treatments showed a significant reduction of cerebral infarction risk in the group of patients selected for surgical intervention. In the NASCET (North American Symptomatic Carotid Endarterectomy Trial) study, the stroke risk was significantly reduced by surgery (9% in the surgical group versus 26% in the clinical treatment group) (NASCET, 1991). In another

classic trial with asymptomatic patients, the prognosis also improved with surgical treatment (4.8% versus 10.6% with drug treatment) (ACAS Trial investigators, 1995).

Endovascular surgical treatment consists of carotid angioplasty and stenting (CAS), a procedure in which the stenosis is approached through a natural passage inside the vessels themselves. In this technique, a flexible guidewire and catheter are inserted into the arterial system through a peripheral puncture site. The guidewire and catheter are then directed to the site of the stenosis, where the stent and the balloon open the narrowing.

CAS was designed as a less invasive method to treat carotid artery stenosis, and the Carotid Revascularization Endarterectomy Versus Stenting Trial (CREST) showed that angioplasty was as effective as endarterectomy for the prevention of stroke (Bates et al., 2007; Caldas, 2006; Chaturvedi & Yadav, 2006; Gurm et al., 2008; Menon & Stafinski, 2006). CAS is also advantageous because it most often uses a local anesthetic, maintains a constant blood flow to the brain and allows an earlier hospital discharge (Menon & Stafinski, 2006).

Initially, the “status” of cerebral perfusion in patients with carotid artery stenosis, or the changes that occur after angioplasty, was not well known. Research suggesting that the modification of cerebral blood flow following angioplasty possibly induces cerebral reperfusion syndrome (Fukuda et al., 2007) is relatively recent. The course of other diseases can be potentially altered after carotid angioplasty.

Recent publications show cognitive dysfunction in some patients with carotid artery stenosis (Takaiwa et al., 2009; Takaiwa et al., 2006; Turk et al., 2008). Takaiwa et al. observed cognitive improvement in elderly patients after CAS (Takaiwa et al., 2009).

2. Cerebral ischemia and carotid artery stenosis

Carotid artery stenosis is present in 7% of men and 5% of women aged 65 years or older (O'Leary et al., 1992). Severe carotid artery stenosis is a leading cause of cerebral infarction and transitory ischemic attack. The estimated risk of ipsilateral carotid artery infarction in a 5-year period is 4% in the population without carotid artery stenosis, 18% in asymptomatic patients with stenosis of over 75% and 27% in symptomatic patients with stenosis of over 75% (Inzitari et al., 2000).

3. Poor cerebral perfusion in carotid artery stenosis

Cerebral infarction resulting from hypotension, which is the result of cerebral blood flow that is insufficient to comply with metabolic demands, represents about 0.7 to 3.2% of cerebral infarctions. The terms “border-zone” and “watershed” are used synonymously to describe this condition in everyday clinical practice. The appearance of these infarcts varies but can include wedge-shaped lesions with their base on the surface of the cortex, exhibiting a border-zone irrigation topography. There may be a string-of-pearls presentation of the infarcts where there are three or more lesions in the deep white matter within the centrum semiovale, with a linear orientation parallel to the lateral ventricle. These ischemic lesions are identified on magnetic resonance imaging (MRI) studies (Ogata et al., 2005) and on CT scan (Del Sette et al., 2010). This appearance can be unilateral when there is ipsilateral carotid artery stenosis or bilateral when there is a severe and global hemodynamic event or bilateral arterial stenosis (Hamilton, 2005). Regarding pathology, infarctions arising from

hypotension occur in border zones and result in encephalomalacia and ulegyria (Hamilton, 2005).

The etiology of infarctions in watershed areas is varied and includes global cerebral injury resulting from perfusion or oxygenation disorders such as prolonged severe hypotension, cardiac arrest with resuscitation, asphyxia and carbon monoxide inhalation. Carotid artery stenosis or occlusion is another etiology that predisposes subjects to border-zone infarctions during episodes of hemodynamic compromise, often with rosary-like patterns. Carotid artery disease infarctions can occur in the cortical and watershed areas as well (Krogias et al., 2010; Momjian-Mayor & Baron, 2005). Although embolisms can occur in the border zones, they are difficult to identify with precision by imaging (Hamilton, 2005; Marks, 2002; Yamada et al., 2010).

In addition to Perfusion-Weighted Imaging (PWI) by MRI, brain perfusion can be evaluated by several techniques including parenchymography, perfusion by helicoidal tomography, perfusion by multislice tomography, transcranial Doppler, intracarotid xenon injection and MRI volume flow quantification analysis. Transcranial doppler studies have the advantage of being non-invasive, but the technique is usually limited to an analysis of a single vessel, usually the middle cerebral artery ipsilateral to the carotid artery stenosis. Doppler studies can also be impaired by cardiac arrhythmias, which make the recorded velocity on the spectral trace unreliable (Kleiser & Widder, 1992; Niesen et al., 2004). Perfusion by tomography has attained a level of technical refinement; however, its application is still restricted to small slices or only one slice per examination (Jongen et al., 2010; Roberts et al., 2000; Waaijer et al., 2007). Evaluation by intracarotid xenon has been limited to research (Bando et al., 2001).

3.1 Digital subtraction angiography

Parenchymography, as described by Theron et al., is an innovative and simple method to evaluate cerebral perfusion. The research on parenchymography included an analysis by angiography with modified windowing to allow the preferential study of the brain blood supply (Theron et al., 1996). Angiography has the capacity to directly assess the degree of carotid artery stenosis and, with the addition of parenchymography, the hemodynamic effects between the brain and its blood supply (Theron et al., 1996).

During the angiographic study of many of our patients, we observed (Figure 1 A) a poor opacification of the anterior and middle cerebral arteries when ipsilateral severe cervical carotid artery stenosis was present.

3.2 Cerebral perfusion by MRI (PWI)

Although perfusion evaluation by MRI is semi-quantitative, its advantages are that MRI is a non-invasive method of evaluating cerebral blood flow that is available in most large centers, avoids ionizing radiation and retains good spatial resolution and good correlation with SPECT (Single-photon emission computed tomography) (Bokkers et al., 2008; Martin, A. J. et al., 2005; Rasmussen et al., 2010; Rohl et al., 2001; Tavares et al., 2010; Van Laar et al., 2007).

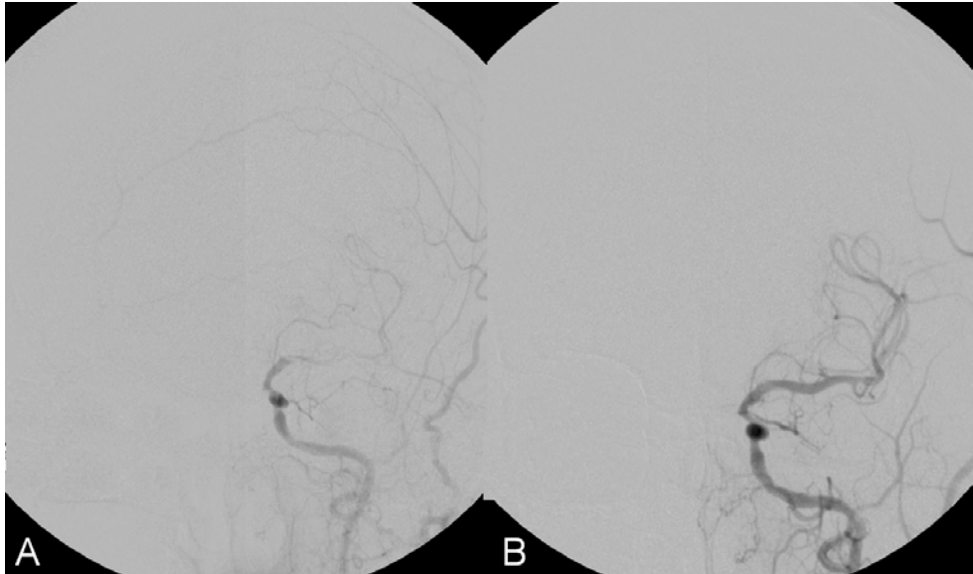


Fig. 1. A 61-year-old patient with severe left cervical carotid artery stenosis. Angiography of the left carotid artery in PA position before angioplasty with stenting shows the slight opacification of the middle cerebral artery (A). Angiography of the left carotid artery in PA after angioplasty with stenting shows the normal opacification of the left middle cerebral artery (B).

A recent study of PWI by MRI in patients with carotid artery stenosis investigated the relative values of cerebral blood volume (CBV), mean transit time (MTT) and time to peak (TTP). A reduction in the CBV and a time-to-peak delay in the middle cerebral artery territory ipsilateral to the cervical carotid artery stenosis were noted (Tavares et al., 2010). The intracranial blood supply was shown to be compromised by a timing delay (increase in the TTP) of the contrast peak in the territory fed by the middle cerebral artery ipsilateral to the cervical carotid artery stenosis. There was less signal loss (negative wave) in the area analyzed (reduction in CBV), which indicated a lower regional blood volume in the middle cerebral artery territory (Tavares et al., 2010).

The TTP delays in the middle cerebral artery ipsilateral to the cervical stenosis compared with the contralateral territory have also been observed by Gauvrit et al. (2004).

Teng et al. showed that analysis of the TTP is a valuable tool for the assessment of the hemodynamic changes in carotid artery stenosis that correlates well with the mean transit time (MTT) parameter (Teng et al., 2001).

An earlier study of cerebral perfusion in patients with carotid artery stenosis showed MTT prolongation ipsilateral to the carotid artery stenosis and stated that this finding was due to hemodynamic compensation between the cerebral hemispheres (Bozzao et al., 2002).

Even when the perfusion damage is limited, the timing parameters (TTP and MTT) are delayed, but these ischemic alterations are not sufficiently significant to be detected by

diffusion MRI. Delayed perfusion parameters indicate infarction risk, whereas alterations in diffusion indicate an already-established lesion.

4. Modification of the cerebral flow after carotid angioplasty with stenting

4.1 Digital subtraction angiography

The analysis of cerebral perfusion by parenchymography has revealed an improvement in cerebral hemodynamic flow achieved by carotid angioplasty (Theron 1996). We observed restored intradural artery opacification (Figure 1 B) and a significant improvement in parenchymography results following CAS.

4.2 PWI

Several authors observed cerebral blood flow modifications after angioplasty (Bozzao et al., 2002; Martin, A. J. et al., 2005; Van Laar et al., 2007; van Laar et al., 2006)

A recent publication by our team that assessed patients with carotid artery stenosis used PWI by MRI to show that there was a discrete increase in rCBV ($p=0.940$) and important reductions in dMTT ($p<0.001$) resulting from the reduction in MTT at the site of the angioplasty.

However, during the evaluation before CAS, we observed a delay in the TTP in the middle cerebral artery (MCA) territory ipsilateral to the carotid stenosis when compared to the contralateral artery. After CAS, there was a remarkable reduction in dTTP ($p=0.019$) and the TTP was earlier at the site of the stent than in the contralateral territory (Tavares et al., 2010).

Timing parameters such as the MTT proved to be the most sensitive and the most reproducible in measuring cerebral hemodynamic alterations (Soinne et al., 2003; Waaijer et al., 2007; Wintermark et al., 2006).

The variations in relative CBV, MTT and TTP are illustrated in Figure 2, where patient improvement is shown through the imaging parameters of PWI by MRI after CAS (Figure 2).

Laar et al. found an increase in cerebral blood flow (CBF) on the side of carotid stenosis, after treatment of the stenosis with CAS or EAC; this increased rate of CBF became similar value to the CBF of the control group (Van Laar et al., 2007).

In our study, we observed an increase in CBV in the cerebral territory ipsilateral to the CAS as well as in the contralateral territory (Tavares et al., 2010). Other authors have documented this same phenomenon in the intracranial territory on the healthy side (Hino et al., 2005; Ko et al., 2005). The treatment of the carotid artery stenosis cannot explain this phenomenon based solely on hemodynamics (Ko et al., 2005). Other unknown factors must play an important role in the perfusion modifications before and after the treatment of carotid artery stenosis. This increased flow in the contralateral hemisphere may occur via collateral circulation through the anterior communicating artery (Tavares et al., 2010) or from the leptomeningeal anastomosis (Matsubara et al., 2009).

Thus, the benefits and eventual risks resulting from an increase in cerebral blood flow may occur in both the ipsilateral and contralateral hemispheres during the treatment of carotid artery stenosis.

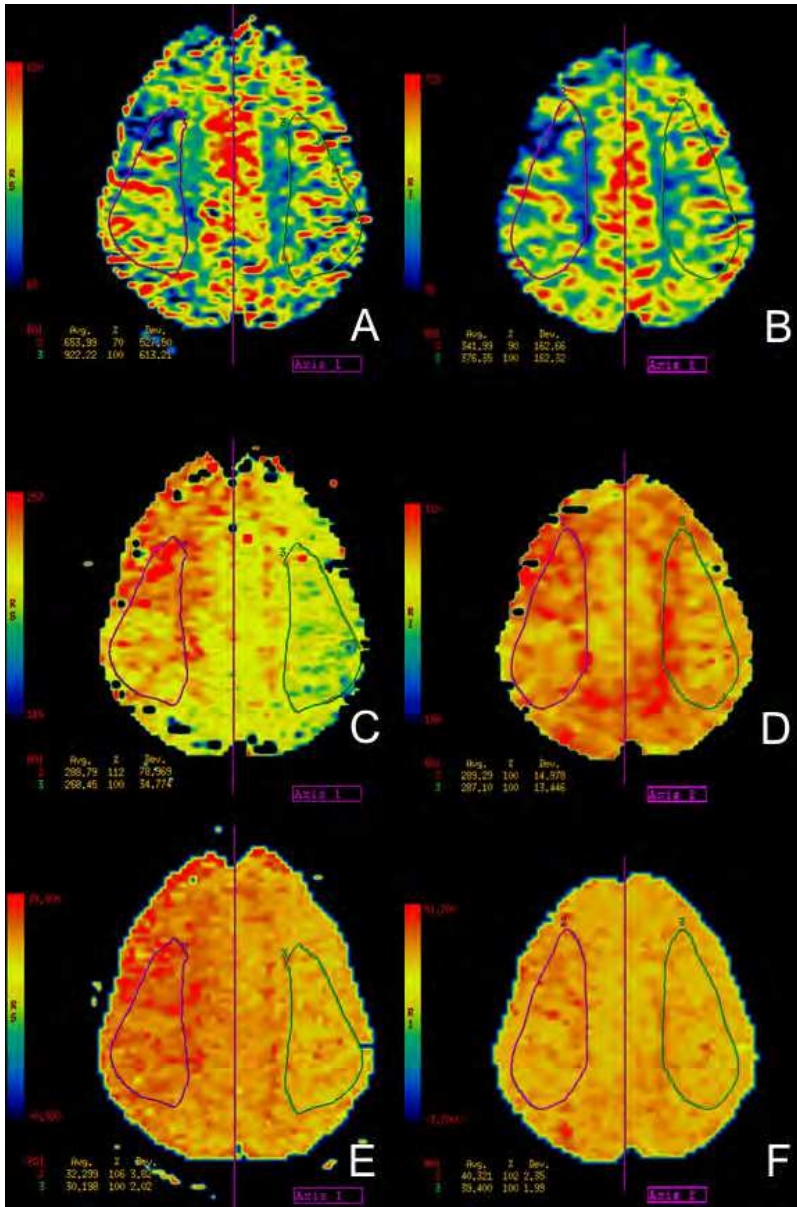


Fig. 2. A 56-year-old patient with severe right cervical carotid artery stenosis evaluated by digital angiography (not shown). Perfusion by MRI was performed in a section above the lateral ventricles. Before carotid angioplasty, the cerebral blood volume (CBV) of the right ACM territory was reduced by 30% compared with the contralateral (A), the mean transit time (MTT) was delayed by 12% (C) and the time to peak (TTP) was delayed by 6% (E). In the same axial plane after CAS, perfusion studies show improved parameters: the right side CBV

became less reduced (10%) compared with the contralateral (**B**), there was no difference in the MTT compared with the left side (**D**) and the TTP delay was lessened to 2% (**F**).

The improvement in cerebral perfusion after CAS, as documented by imaging technologies (Ko et al., 2005; Martin, A. J. et al., 2005; Tavares et al., 2010; Van Laar et al., 2007), has also been documented through questionnaires for dementia that show clinical improvement in scores after CAS (Moftakhar et al., 2005; Takaiwa et al., 2009; Turk et al., 2008).

According to Takaiwa, patients with carotid artery stenosis who scored below average on the questionnaire prior to carotid angioplasty and endarterectomy showed an improvement in cognitive function after the procedures (Takaiwa et al., 2009). Scores were decreased temporarily at 1 week after carotid endarterectomy (CEA), but not after CAS (Takaiwa et al., 2009).

Moftakhar concluded that the improvement in the perfusion parameters shown by MRI is predictive of cognitive improvement after angioplasty (Moftakhar et al., 2005).

These data together suggest that CAS not only prevents stroke but also improves cognitive function (Takaiwa et al., 2009).

In addition to carotid angioplasty, intracranial angioplasty is also associated with perfusion improvement as shown by MRI (Bendok et al., 2010).

According to Takaiwa, rapid improvement in cognitive function occurs following CAS (Takaiwa et al., 2009). Some studies, however, showed a worsening of cognitive function following CEA, which may be associated with hypoperfusion during the cross-clamping of the internal carotid artery (Costin et al., 2002; Heyer et al., 1998; Takaiwa et al., 2009).

Endarterectomy may interrupt the cerebral blood flow at several moments during the procedure, and it certainly does so during the construction of the bypass. However, the treatment of carotid artery stenosis by CAS with cerebral protection filters does not interrupt the cerebral blood flow, which avoids momentary deficits in cerebral perfusion.

Complex self-regulatory mechanisms may be set in motion by severe stenosis and may include microcirculatory vasodilatation or a direct response from the central nervous system. Therefore, it is theoretically possible that the microcirculatory condition that results from long-standing severe proximal stenosis might excite a state of microcirculatory vasodilatation after CAS, causing some blood volume reduction in the ipsilateral territory. This tends to occur during a reduction in the MTT. The equation $CBF=CBV/MTT$ expresses the flow equilibrium (Kluytmans et al., 1998).

5. The risks of the immediate increase in cerebral perfusion following carotid angioplasty

5.1.1 Reperfusion syndrome

Because CAS induces changes in cerebral perfusion, it has the inherent although low risk of complications related to increased cerebral blood flow such as reperfusion syndrome (Matsubara et al., 2009; Morrish et al., 2000; Tavares et al., 2010) and even fatal hemorrhagic complications (Hartmann et al., 2004; Morrish et al., 2000). Patients who receive endarterectomies are exposed to similar risks (Bodenant et al., 2010).

Signal alteration, especially as seen with FLAIR sequence imaging, has been reported and is located in the spaces of the cortical convolutions that occur unilaterally after CAS. This finding may be related to modifications in perfusion that are clinically difficult to correlate (Martin, A. J. et al., 2005; Michel et al., 2001; Wilkinson et al., 2003).

Through MRI studies before and after conventional angioplasty with stenting, we observed hypersignal areas in the subarachnoid space of some of our patients in the FLAIR sequence after CAS. These areas showed gadolinium enhancement in the T1-weighted sequence and did not show signs of ischemia or neurological symptoms upon diffusion (Figure 3).

Wilkinson et al. called this finding "unilateral leptomeningeal enhancement" (Wilkinson et al., 2003). Although they stated that there was no definite cause, it is possible that there is an increase in flow to the territory of the MCA ipsilateral to the stent, and this greater flow might contribute to the leptomeningeal enhancement, especially because the enhancement occurred in the areas fed by the MCA that experienced transit time reductions (Wilkinson et al., 2003). Martin et al. showed similar images ipsilateral to the CAS in the liquor space of the ipsilateral cerebral sulcus in the watershed area (Martin, A. J. et al., 2005).

This asymmetric appearance is not fully understood and may be related to factors such as the leakage of the contrast agent or the possible alteration of the partial pressure of oxygen following treatment (Braga et al., 2003; Michel et al., 2001).

Patients who showed a signal increase on FLAIR in the subarachnoid space ipsilateral to the CAS experienced isolated symptoms (headache, transitory neurological deficit or mental confusion) in the series of Grunwald et al. (2009) These authors also reported that the signal increase on FLAIR is temporary and disappears within 3 to 5 days.

Thurley et al. (2009) described a similar unilateral leptomeningeal enhancement in a patient exhibiting headache, vomiting, seizure and hypertension after endarterectomy.

We believe that the finding described by Grunwald et al. (2009) and Thurley et al. (2009) may be related to a clinical syndrome of hyperperfusion that is not complicated by intracranial hemorrhage. Our patients with leptomeningeal enhancement after CAS (Figure 3) did not exhibit the classical symptoms of cerebral hyperperfusion, such as transitory focal deficit, unilateral migraine and seizures.

Nevertheless, we believe that areas with chronic ischemia have increased perfusion after CAS and that there is some degree of poor hematoencephalic barrier regulation. This notion is grounded on the pattern of dural/sulcal enhancement in border zones.

However, because of the reduction in the timing parameters of perfusion following CAS (Tavares et al., 2010) without a reduction in CBV, cerebral hyperflow with possible complications such as hyperperfusion syndrome can theoretically exist (Ko et al., 2005; Niesen et al., 2004; Wilkinson et al., 2003). This concept follows the equation of hemodynamic equilibrium, where cerebral blood flow is proportional to CBV and inversely proportional to the timing parameter MTT (Kluytmans et al., 1998; Waaijer et al., 2007; Wilkinson et al., 2003).

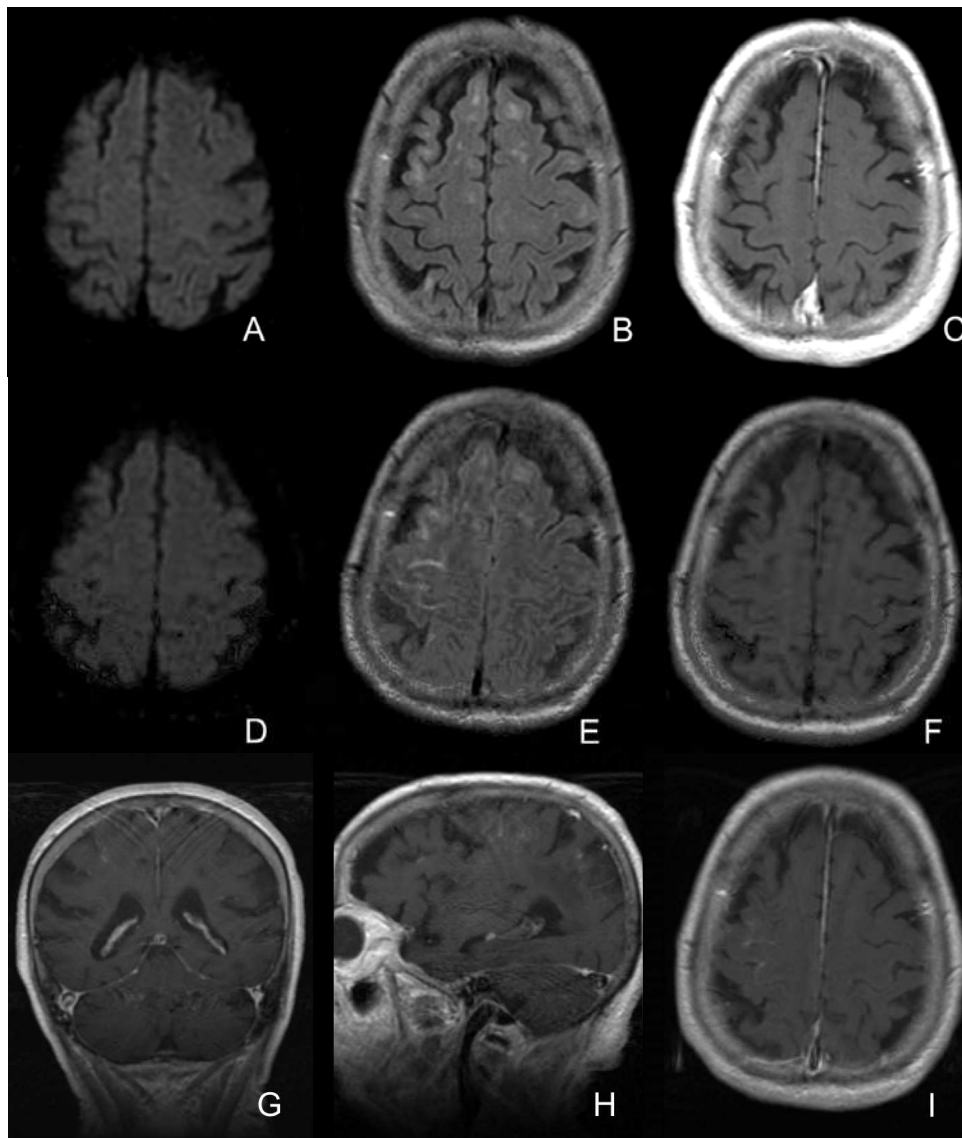


Fig. 3. An 87-year-old patient with right carotid artery stenosis. MRI in diffusion sequence before CAS: DWI (A), FLAIR (B) and T1 with gadolinium (C). Conventional angioplasty of the carotid artery was performed (not shown), and the patient was asymptomatic after endovascular treatment. A new MRI study was performed 12 hours after CAS (D,E,F,G,H,I): note the hypersignal in the central and precentral sulcus of the FLAIR sequence (E) without expression in DWI (D) or T1 without gadolinium (F). T1 sequences with coronal (G), sagittal (H) and axial (I) contrast after CAS: enhancement in the sulcal (pial) space in the right posterior frontal area.

5.1.2 Carotid stenting without postdilatation

Some authors hold that cerebral circulation is somehow altered when there is severe carotid artery stenosis by a “plegic vasodilatation” induced by chronic ischemia (Abou-Chebl et al., 2004; Hartmann et al., 2004; Matsubara et al., 2009).

The study of CBF by intracarotid xenon injection or photon emission tomography showed that patients with a two-fold increase in CBF after endarterectomy were at a greater risk of developing hyperperfusion syndrome (Bando et al., 2001; Henderson et al., 2001).

According to Hirooka et al. (2008), cerebral hyperperfusion after CEA is defined as a 100% increase in CBF in PWI by MRI.

Hosoda et al. based on SPECT data obtained before and after CEA, noted that the abrupt restoration of cerebral perfusion pressure immediately after the surgical correction of a tight carotid stenosis could not be quickly compensated for by vasoconstriction (Hosoda et al., 2001). However, the arterioles presumably contracted to normal size over the long term, thus reducing the CBV.

Matsubara et al. (2009) postulated that after the treatment of carotid stenosis, if the vascular walls of the arterioles were damaged and permeability increased, cerebral edema and convulsions could occur.

Furthermore, rapidly increased CBF and CBV (Matsubara et al., 2009) and a reduction in MTT by CAS (Tavares et al., 2010) and CEA may be risk factors for reperfusion syndrome after the treatment of carotid stenosis (Fukuda et al., 2007).

The technique of CAS has not been standardized, and there are technical variations among different institutions and neurointerventionists. The CAS technique that we call conventional has already been described in the literature (Caldas, 2006; Tavares et al., 2010). Briefly, the procedure is performed in an angiography suite and includes transfemoral access under local anesthesia, sedation and full heparinization (70 U/kg). All patients receive double anti-aggregation agents 5 days before CAS. The activated coagulation time (ACT) is not routinely checked. We initially establish access up to the common carotid artery with a 6F wired sheath or 8F guiding catheter. Next, a cerebral protection system is delicately placed in the internal carotid artery distal to the stenosis. We usually use filter protection because it affords intraprocedural safety against emboli without flow interruption. Most often, the protection filter is advanced without predilatation. Balloon dilatation before stenting is only employed when the filter or the stent cannot pass by the stenosis. Next, a self-expandable stent is advanced over the filter guide and released so as to cover the atheroma plaque. At this point, the stent is able to perform the partial or the subtotal opening of most stenoses and to reduce the friction of the blood flow against the plaque. Thus, the stent protects against emboli. The next step is to utilize balloon angioplasty within the stent to mold and widen the internal diameter of the stent or to continue to reduce the size of the residual stenosis to less than 30%.

Despite the lack of clear standards, we believe that the consensus is to achieve a post-stenting stenosis of less than 30%. The CREST study, which compared CAS and endarterectomy, required a final stenosis of less than 30% at the end of each procedure.

The CAS variation that we employ is a simplification of the technique described above, and it does not employ any pre-stenting or post-stenting balloons. By not fully opening the stent at the procedure, we seek to avoid the instantaneous increase of carotid flux that occurs during conventional angioplasty.

Because carotid angioplasty is most often indicated to avoid atheroembolic ischemic events rather than to correct hemodynamic effects, there is no need for complete stent expansion immediately during angioplasty (Bussiere et al., 2008). The restoration of a normal lumen diameter should be considered a secondary goal.

To avoid an abrupt increase in cerebral perfusion as well as the risks of reperfusion syndrome with its serious complications, we started a case series in which the release of the self-expandable stent was performed without the use of the balloon to completely open the stent (Figure 4). In this group, intra-stent angioplasty (post-dilatation balloon) was used only when the residual stenosis post-stenting did not change compared with the degree of stenosis before the stent placement; intra-stent angioplasty was also used when the residual stenosis was greater than 30%. The force of a self-expanding stent alone can dilate severely stenosed carotid (Lownie et al., 2005), and as the dilation is gradual, it may function protectively against hemorrhagic reperfusion (Maynar et al., 2007).

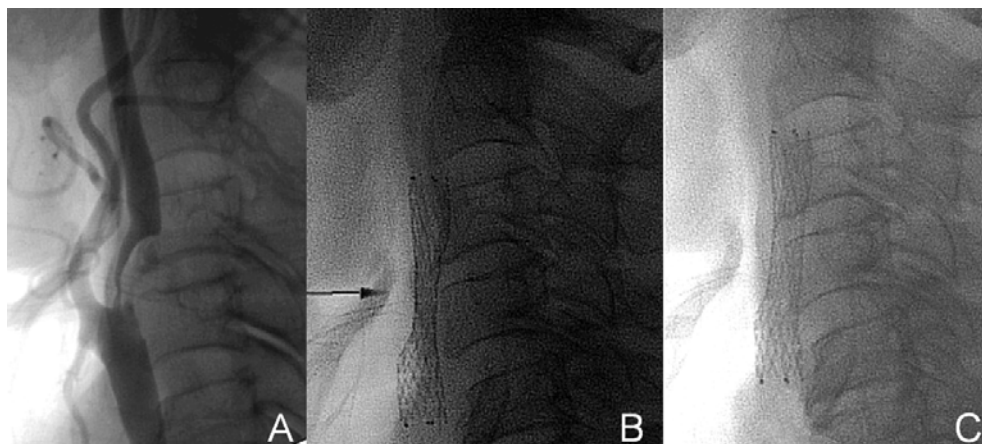


Fig. 4. A 78-year-old patient with severe aortic valve insufficiency and chronic obstructive pulmonary disease who exhibited an episode of amaurosis fugax of the right eye. Angiography showed severe (80%) right internal carotid artery stenosis (A). A 7 X 40 mm self-expandable stent (arrow) (Protégé®, eV3 Inc., Plymouth, Minnesota, USA) for stenting without balloon angioplasty; the immediate result after placement of the stent showed a small residual stenosis of about 30% (b). Lateral radiography 1 month later (C) showed complete expansion of the stent.

In a manner similar to that employed by Baldi et al. (2011), our group followed patients after the placement of the self-expandable stent with cervical radiographic studies at 3, 6 and 12 months. These studies showed a tendency for the stents to completely open. Baldi et al. showed an average reduction of stenosis from 82% to 30% immediately after stenting. In follow-up, however, 14.8% of the patients exhibited restenosis (Baldi et al., 2011).

In the patients who received CAS without balloon inflation, we also noticed the absence of intraprocedural bradycardia and hypotension induced by the compression of the balloon on the carotid baroreceptors. This effect was also observed by Rebellino et al. (Rebellino et al., 2010). This factor may contribute to shorter hospitalizations and increased periprocedural safety.

Each step of an angioplasty procedure includes the risk of thromboembolic events. The procedure with the highest risk of embolism is balloon angioplasty (Martin, J. B. et al., 2001; Men et al., 2002; Vitek et al., 2000). The use of the simplified technique (without balloon dilatation) may reduce such periprocedural risks and improve the clinical results (Jin et al., 2010; Men et al., 2002). The simplified technique may work especially well in cases with soft plaques that can easily rupture and form a large number of emboli.

We consider accentuated calcification, as shown by ultrasound or other imaging methods before angioplasty, to be a relative contraindication for the angioplasty without balloon that we used in our case series.

Other technical variations of CAS have been described in the literature. Maynar et al. (2007) published a series of 100 cases where neither the protection system nor balloon angioplasty was used. They demonstrated an average reduction of stenosis from 79% to 21% immediately after stent release, and in some cases, there was an almost complete opening of the stent. In most cases, however, the stent opening occurred gradually over time with an average final stenosis of 15% at the 6-month radiographic evaluation (Maynar et al., 2007).

Bussière published the results of a series of endovascular treatments of carotid stenosis in which 79% of the patients received a stent-only procedure (Bussiere et al., 2008). The risk of intra-stent restenosis (mostly asymptomatic) was higher than in conventional angioplasty, and residual stenosis below 30% occurred in only 25% of the cases at the end of the procedure. Bussière stated that plaques with circumferential calcification or very severe stenosis (>90%) must be treated with conventional CAS (with postdilatation).

Jin et al. used a 3-to-5-mm balloon after placement of the protection system (Jin et al., 2010). They used predilatation balloons with diameters similar to the luminal caliber of the internal carotid artery distal to the stenosis. After the placement of the stent, the arterial lumen exhibited minimal residual stenosis in about 70% of cases, which indicates that the use of the postdilatation balloon was unnecessary. We find the technique described by Jin et al. (2010) to be inadequate because we believe that the stent has a stabilizing action on the plaque that reduces embolic phenomena. Because the balloon has the potential to induce plaque rupture, it seems contradictory to use the balloon before stenting.

None of the protection systems now in use can perfectly prevent the occurrence of embolism. Emboli have been detected by diffusion MRI when using most of the protection systems described in the literature (Angelini et al., 2002; du Mesnil de Rochemont et al., 2006; Kastrup et al., 2008; Maleux et al., 2006; Muller-Hulsbeck et al., 2003; Schnaudigel et al., 2008; Vos et al., 2005; Yamada et al., 2010).

Indeed, other risk factors for reperfusion syndrome that might be involved include hypertension, severe carotid stenosis (>90%), severe stenosis of the contralateral carotid artery and recent cerebral ischemic or infarction events. The use of anticoagulants and antiplatelet agents may also play a role in this syndrome (Abou-Chebl et al., 2004).

Thus, new studies are required to establish whether or not CAS without postdilatation is a positive factor in clinical results.

5.2.1 The association of carotid stenosis with cerebral aneurysms

Cerebral aneurysms are incidentally found in 5% of adults by autopsy (McCormick & Schochet, 1976). The development of neuroimaging techniques has allowed to increasingly detect unruptured aneurysms in vivo. The overall risk of hemorrhage from incidental aneurysms was initially described as 1% per year by the ISUIA study (ISUIA, 1998). The incidence of unruptured, intracranial aneurysms that are present along with carotid artery stenosis is 3 to 5% (Suh et al., 2011). In most cases, this association involves unruptured aneurysms (Navaneethan et al., 2006). Some risk factors, such as hypertension and tobacco use, influence the development of both carotid artery stenosis and cerebral aneurysms (NASCET Trial Investigators, 1991; Wiebers et al., 2003).

Endarterectomy and conventional carotid artery angioplasty can induce an abrupt increase in cerebral perfusion. Additionally, any angioplasty technique that employs antiplatelet agents and heparin makes subsequent use of surgical correction by craniotomy and clipping immediately after CAS impossible. A further complication is that patients with carotid artery stenosis are usually greater than 50 years of age and frequently exhibit hypertension and diabetes, which are complicating factors in craniotomy and clipping according to the results of the ISUIA trial and other studies (Chen et al., 2004; Cowan et al., 2007; Wiebers et al., 2003; Xu et al., 2011).

Some studies have reported on the stability of small unruptured aneurysms after stenting or endarterectomy (Ladowski et al., 1984; Stern et al., 1979; Suh et al., 2011). These studies, however, do not describe with any uniformity the dimensions of the aneurysms (some studies describe aneurysms as large as 4 mm or 7 mm) or the treatments employed to control hypertension and to achieve hemodynamic stability; furthermore, the periods of observation are short. These studies have a relatively small sample size and include only a single center (Kang et al., 2007; Suh et al., 2011). Because only 3 to 5% of the patients have both lesions (Kappelle et al., 2000; Suh et al., 2011), 2,000 to 3,334 cases must be included to reach the statistically significant number of approximately 100 cases in which patients have both carotid artery stenosis and a cerebral aneurysm.

Stern et al. (1979) reported on one case of a fatal rupture of a cerebral aneurysm after EAC. They suggested that the risk of subarachnoid hemorrhage during endarterectomy might be increased in patients with aneurysms (Stern et al., 1979).

The analysis of the NASCET trial data (1991) by Kapelle et al. (2000) identified one case of a fatal subarachnoid hemorrhage that occurred 6 days after endarterectomy among 25 patients, which, according to the authors, increased the risk of rupture to 4% in this population (Kappelle et al., 2000).

Al-Mubarak et al. (2001) reported on the case of one patient with 90% symptomatic right carotid artery stenosis who developed a massive and fatal intracerebral and subarachnoid hemorrhage (arising from the left sylvian fissure) that occurred immediately after CAS. In this case, there was an occlusion of the left carotid artery.

Cheung et al. (2003) reported a case of a fatal subarachnoid hemorrhage after endarterectomy. The patient had two 4-mm ipsilateral intracranial aneurysms. The authors reported, however, that the autopsy failed to identify areas of rupture in these aneurysms.

Hartmann et al. (2004) reported a case of a fatal subarachnoid hemorrhage after the treatment of carotid artery stenosis. Their report did not include the complete angiography of the four main cerebral arteries. However, we believe that CAS increases the cerebral blood flow in the treated territory and in the other intracranial territories via the polygon collateral circulation. Hartmann et al. (2004) further reported that necropsy could not definitively rule out saccular aneurysms.

Riphagen et al. reported a case of one patient with an occlusion of the left carotid artery and symptomatic stenosis of the right carotid artery that was treated with endarterectomy. This patient developed a 6-mm aneurysm in the anterior communicating artery 10 days after endarterectomy with subarachnoid and intraventricular hemorrhage. The patient underwent a craniotomy and clipping (Riphagen & Bernsen, 2009). The annual risk of rupture from incidental aneurysms smaller than 7 mm in the anterior circulation is close to 0% in the ISUIA 2003 study (Wiebers et al., 2003). The case described by Riphagen et al. thus represents a negative shift in the natural course of this type of aneurysm.

Although hypertension is a classic factor that contributes to the rupture of cerebral aneurysms (Obray et al., 2003; Vlak et al., 2011), there is no consensus concerning the effects of CAS on the course of unruptured intracranial aneurysms. However, intracranial hemorrhages are associated with high morbidity and high mortality during the treatment of carotid artery stenosis (Cheung et al., 2003; Hartmann et al., 2004). We therefore conclude that there should be no delay in the treatment of cerebral aneurysms in hypertensive patients during the treatment of carotid stenosis. Theoretically, conditions such as hypertension and increased cerebral blood flow may contribute to the rupture of aneurysms. Other factors inherent to CAS can also worsen the course of hemorrhage, such as the use of antiplatelet agents and the non-reversal of heparin after the CAS.

Badrudin et al. (2010) suggested that intracranial aneurysms might be partially protected by the reduced flow and pressure in the intracranial arteries when there is carotid artery stenosis (Badrudin et al., 2010). Another author suggested that the intentional partial occlusion of the carotid artery might protect cerebral aneurysms, and a reduction of intracranial aneurysms has been observed (Cronqvist et al., 1964)

5.2.2 Minimally invasive treatments for carotid stenosis and cerebral aneurysm

Because of the potential risk for aneurysm rupture after carotid revascularization surgery (endarterectomy or stenting) arising from the increase in cerebral blood flow (Hartmann et al., 2004; Suh et al., 2011) and because there is a minimally invasive and safe technique for endovascular treatment (coiling) of cerebral aneurysms (Cowan et al., 2007; Higashida et al., 2007; Molyneux et al., 2009; Raja et al., 2008; Spelle & Pierot, 2008; van Rooij et al., 2006; van Rooij & Sluzewski, 2006), we believe that patients must be immediately protected by performing embolization (coiling) consecutively after CAS.

In patients for whom carotid artery stenosis is initially diagnosed and further investigation reveals an incidental aneurysm, the treatment of the aneurysm is based upon its rupture

risk, which is calculated by the diameter and localization of the aneurysm and the age of each patient (Wiebers et al., 2003). However, most neuroradiology interventionists believe that aneurysms that are 3 mm or larger must be treated by coiling when it can be safely performed (Fang 2009). The decision to treat aneurysms is also based on the geometry of the lesion (including the neck-dome ratio) and on the availability of experienced specialists in interventionist neuroradiology.

In patients where a cerebral aneurysm was initially diagnosed and further investigation revealed asymptomatic severe carotid stenosis, the ACAS trial showed that treatment of asymptomatic carotid stenosis is beneficial (ACAS Trial investigators, 1995).

We prefer to treat these patients during a single procedure. We treat the carotid artery stenosis before the cerebral aneurysm to avoid the crossing of the stenosis by the endovascular materials that are necessary for the treatment of the aneurysm and that cause the iatrogenic embolism of parts of the cervical plaque (Figure 5). In such patients, we use antiplatelet agents by the oral route (or nasogastric tube) just one hour before angioplasty (clopidogrel 300 mg and aspirin 300 mg). We employ intravenous heparin to maintain an ACT between 200 and 300 seconds.

We perform the angioplasty with a closed-cell stent, since access of catheters to the intracranial carotid seems to us easier. We do not routinely use a post-dilatation balloon (intra-stent before removing the embolic protection device) because we want to limit the increase of the blood flow towards the intracranial territory. However, if the arterial lumen is too small for catheters up to 6F (3 mm) to pass, we perform a stent dilatation with a 4- or 5-mm balloon. After completion of the angioplasty, a 6F guide catheter is placed in the common carotid artery below the stent followed by a microcatheter and micro-guide that are carefully advanced through the stent and into the internal carotid artery distal to the stent. The microcatheter and micro-guide are then advanced up to the aneurysm, and coiling is performed according to the conventional embolization technique. Alternatively, the guide catheter can be carefully advanced over the microcatheter through the stent to the internal carotid distal to the stent. In cases where we employed CAS immediately followed by coiling, the aneurysm was on the same side as the carotid stenosis.

Aneurysms located outside of the circulation subjected to CAS also received increased blood flow after CAS, probably via the Willis polygon (Tavares et al., 2010). Theoretically, then, these aneurysms have an increased risk of rupture and can also be treated by CAS and coiling together.

Navaneethan et al. (2006) reported a case of bilateral carotid stenosis and a 25-mm aneurysm in the left middle cerebral artery. They performed an angioplasty of the left carotid artery and coiling in one single procedure. They believe that craniotomy and clipping of the aneurysm may reduce the cerebral blood flow and thus worsen the eventual hypoflow resulting from the concomitant carotid artery stenosis (Navaneethan et al., 2006).

Iwata et al. reported the case of a patient with 60% asymptomatic stenosis of the left cervical carotid artery with a 6-mm unruptured aneurysm in the ipsilateral intracranial carotid artery. They treated the aneurysm first by coiling, and 1 month later, they performed the CAS (Iwata 2008). A disadvantage of this approach to treatment arises from the potential risks due to the general anesthesia required for the cooling of the patient to reduce the

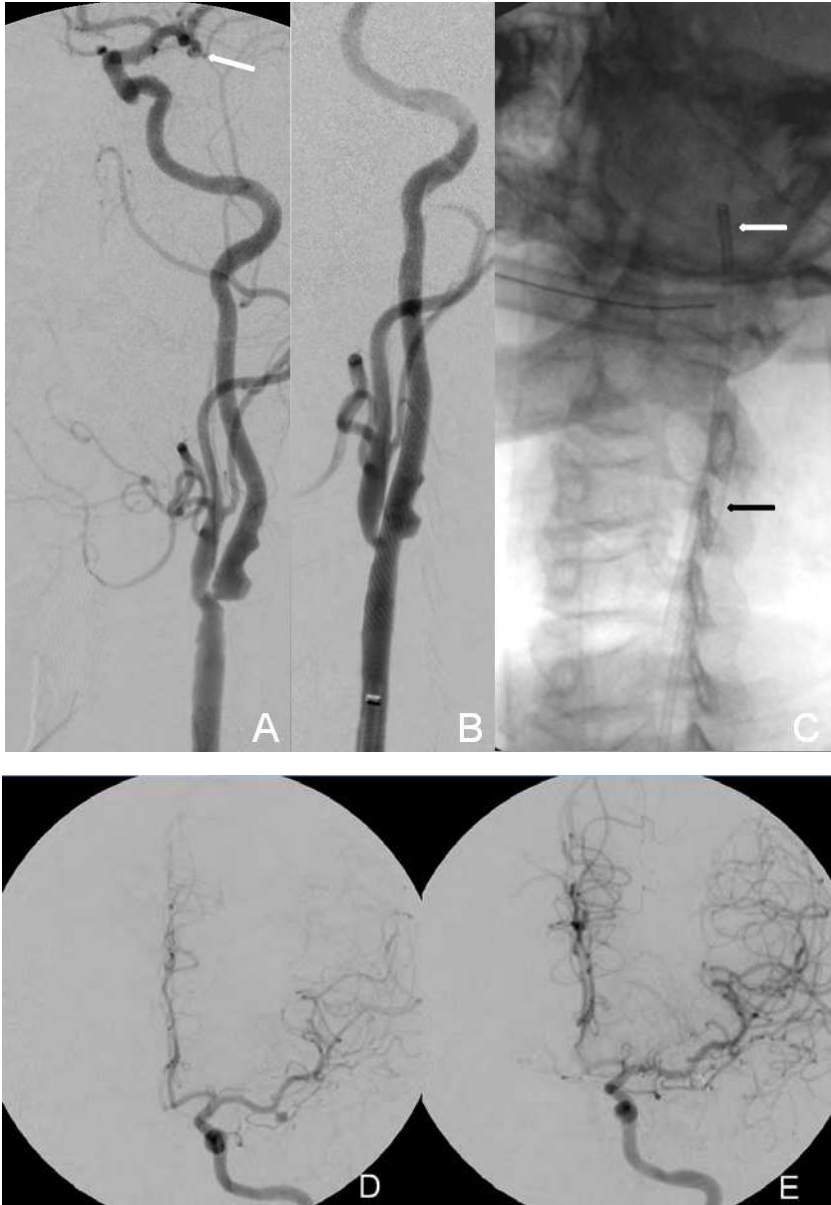


Fig. 5. A 52-year-old patient with a family history of deaths (brother and mother) from subarachnoid hemorrhage presented with an unruptured saccular aneurysm with a narrow neck in the left middle cerebral artery and severe ipsilateral cervical carotid artery stenosis. Left oblique incidence angiography showed (A) severe (70%) left cervical carotid artery stenosis by plaque with ulcers and an aneurysm in the same intracranial territory (arrow). Treatment with a self-expandable stent under anesthetic sedation employing a 6F sheath

resulted in the satisfactory opening of the stenosis (B). During the same procedure, the patient was subjected to general anesthesia, and a 6F guide catheter (white arrow) was advanced through the stent (black arrow, C) to the petrous segment of the carotid artery. Full embolization of the aneurysm was completed (F).

cerebral blood flow (Kappelle et al., 2000; Ladowski et al., 1984). This approach to treatment decreases the stenotic lumen generated by the atheroma plaque during embolization because of the passage of embolization materials through the stenosis, which can hinder the cerebral blood flow. We further note that during coiling, the patient was unnecessarily exposed to the risk of embolism because of the crossing of embolization materials over the cervical atheroma plaque. The authors employed antiplatelet agents, but the additional use of statins might afford higher protection.

The risk of hematoma in the inguinal area of coiling is avoided by use the puncture of the femoral artery for CAS. The single femoral approach is safe, and it decreases the risks inherent to each separate procedure.

The technique we described above has some limitations. The use of antiplatelet agents in carotid stenting might increase the risk if accidental rupture of the aneurysm occurs during coiling. Because the treatment of the carotid artery stenosis is performed first, a sudden increase in cerebral perfusion might theoretically increase the risk of aneurysm rupture; therefore, special efforts are required to diminish the interval between CAS and cooling. For these reasons, we believe that CAS and coiling should be performed exclusively by experienced neuroradiologists. A further risk of the combined CAS and coiling technique is the increase in exposure to ionizing radiation and contrast. However, experienced physicians are agile and employ less contrast, thus reducing the exposure to radiation and the risk of kidney damage.

Finally, in addition to aneurysms, angiographically hidden micro MAVs may theoretically cause intracranial hemorrhages for unknown reasons (Berker et al., 2003; Cheung et al., 2003; Hartmann et al., 2004) after treatment of the carotid artery stenosis. These patients may benefit from the treatment of carotid stenosis without the angioplasty balloon to prevent intracranial hemorrhages.

6. Conclusion

Although angioplasty was initially designed as a minimally invasive therapeutic approach to prevent ischemic events, several reports mention its ability to restore cerebral perfusion (Tavares et al., 2010).

The endovascular technique for the treatment of carotid artery stenosis is still being developed. Stent placement without post-dilatation by balloon allows the gradual dilatation of the stenosis and may reduce the risk of reperfusion syndrome and possibly also reduce the embolic load to the protection system. Confirmation of this hypothesis requires further studies.

Although the relationship with the possible rupture of aneurysms after treatment of carotid stenosis is not clear, it seems safe to us to suggest that cases with simultaneous carotid stenosis and cerebral aneurysm should be treated by endovascular techniques (CAS and

coiling) in a single procedure to avoid the increase in cerebral flow, which is a risk factor for aneurysm bleeding. Again, further studies are required to confirm this hypothesis.

7. Acronyms

ACT - achieve activated clotting time

CAS - carotid angioplasty and stenting

CBF- regional cerebral blood flow

CBV - regional cerebral blood volume

CEA - carotid endarterectomy

Coiling – endovascular treatment of cerebral aneurysms

CREST - Carotid Revascularization Endarterectomy Versus Stenting Trial

DWI - Diffusion -Weighted Imaging

FLAIR - Fluid Attenuated Inversion Recovery

MCA - middle cerebral artery

MRI – magnetic resonance imaging

MTT - regional mean transit time

NASCET - North American Symptomatic Carotid Endarterectomy Trial

PWI - perfusion weighted images or cerebral perfusion by MRI

PWI - Perfusion-Weighted Imaging

SPECT - Single-photon emission computed tomography

TTP- regional time to peak

8. References

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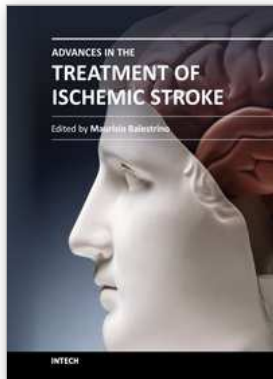
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In recent years research on ischemic stroke has developed powerful therapeutic tools. The novel frontiers of stem cells therapy and of hypothermia have been explored, and novel brain repair mechanisms have been discovered. Limits to intravenous thrombolysis have been advanced and powerful endovascular tools have been put at the clinicians' disposal. Surgical decompression in malignant stroke has significantly improved the prognosis of this often fatal condition. This book includes contributions from scientists active in this innovative research. Stroke physicians, students, nurses and technicians will hopefully use it as a tool of continuing medical education to update their knowledge in this rapidly changing field.

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