

# CLINICAL EVIDENCE OF CAS

P.Bergeron, V.Piret, Jc.Trastour

Saint Joseph Hospital fundation

ABBOTT Symposium

**MEET 2008**

26-29 June 2008

Cannes, France

# Current situation worldwide



- Controversal **opinions** between physicians
- Controversal **interpretation** of trials
- Various **regulation** by countries



We are today "paralysed" waiting for a strong event which could be indisputable



**Dream or near futur ?**

# Clinical evidence



- ➔ Percutaneous Access
- ➔ Local anaesthesia is offered
- ➔ Painless and short hospital stay
- ➔ Less psychological trauma for elderly (not an operation)
- ➔ No nerve palsy

## Clinical evidence 2



- ➔ Feasibility  $\approx$  100% when combining accesses
- ➔ Low non neurological complications rate except iodine contrast
- ➔ Safety acceptable
- ➔ There is no evidence that CAS provides **better result** in the prevention of stroke compared with CEA
- ➔ CAS offer **Higher risk** for elderly patients (anatomy and access)

# Clinical evidence 3



## Comparable risks to surgery ?

- ↳ Similar ipsi lateral brain embolization
  - ➔ TIA & strokes , ICH
  - ➔ Massive strokes prevented with CPD
- ↳ **Contralateral** and **basilar** infarction not existing with surgery
- ↳ Unknown long term prevention of stroke

# Clinical evidence 4



## 1. Technique still in infancy

- Current dedicated stents not ideal
  - ➡ ECA lost or covered
  - ➡ Debris profusion with immediate or delayed (50%) infraction
  - ➡ Instent restenosis
- Failed Filter protection
  - Stent size, mal apposition , tortuosities.....
- Reverse flow limitation
  - Size , tolerance.....

## 2. Experienced interventionalists can offer comparable results to surgery

# Clinical evidence 5

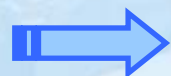


- Failure of trials
- They do not reflect the real world decision making
- Be aware of institutions COCHRANE or EBM experts who are not physicians
- Are they necessary ?
- Are they efficient ?   ⇒ yes for **comparable** techniques !
- Why do they give disparate results ?

**SPACE** (German) **failure of equivalence** due to **lake of enrolment**.

**SAPPHIRE** (US) **advantage to CAS** in term of **carotid risk** (3years results, NEMJ, 2008)

**EVA-3S** (FRANCE) **surgeons are better than interventionists**



Future trials?   **CREST** - **ECST2** ...

# Clinical evidence 6



- Formal indications of CAS

- Hostile necks
- Ostial stenosis
- Distal and diffused stenosis
- Severe cardiac comorbidities

- Formal contra indications

- Floating thrombus
- Occlusion
- Circumferential calcification
- Better surgical indication

- Technical advices

- A traumatic manners
- Know when to quit (15')
- Access choice upon anatomy



# Clinical evidence



**MEET** 2008  
MULTIDISCIPLINARY EUROPEAN  
ENDOVASCULAR THERAPY  
[www.meetcongress.com](http://www.meetcongress.com)

- There is a lot to do by clinicals and industrials
- Be confident CAS is an **extra weapon**
- Comparative data with modern medical treatment may change things
- The future might be in :

➔ 1. Drug therapy

➔ 2. CAS

➔ 3. Surgery

# Clinical evidence 8



- Make your choice based on :
  - ➔ Your personal **experience** (improve it)
  - ➔ The patient **presentation**
  - ➔ A **consensual multi disciplinary decision**
  - ➔ Be **critical and selective**, we can reach **0% complication rate**