Asymptomatic Carotid Atherosclerosis Study

A large trial that randomized patients in good health with asymptomatic stenosis (calculated in the same manner as the NASCET study) ≥ 60% to CEA plus aspirin, or aspirin alone85 found a reduced 5-year risk of ipsilateral stroke if CEA was performed with < 3% perioperative morbidity and mortality and is added to aggressive management of modifiable risk factors.

CEA reduced 5-year stroke risk by 66% in males, 17% in females (not statistically significant), and 53% overall (males & females lumped together).

CEA did not significantly protect against major stroke or death (P=0.16) (half of the strokes were not disabling) and was somewhat protective against any stroke or death (P=0.08). The study group was 95% Caucasian, and 66% were male. Excluded patients (age>79 yrs, unstable CAD, uncontrolled HTN) may have been a higher risk. Surgeons were carefully selected and the surgical morbidity (1.5%) and mortality (0.1%) was very low. Surprisingly, ≈ half of the total morbidity (1.2%) was related to angiography. The implication is that for a generally healthy white male with ACAS > 60%, management with CEA (when performed by a surgeon with a low complication rate, as described) reduces his annual risk of all strokes from 0.5% to 0.17% (the reduction of risk for severe stroke is less). The benefit of CEA is realized within less than one year after the CEA. This is in contrast to the ACST trial and is most likely due to the lower perioperative event rate. The risk of mortality from other causes (including MI) is ≈ 3.9% per year. Combined stroke and death rates in community hospitals, while improved over the last 20 yrs, remains higher at ≈ 6.3% than at centers used in this study.

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The largest multicenter randomized trial to date revealed a moderate benefit for immediate CEA vs. medical management in patients age < 75 with asymptomatic stenosis ≥ 60%.

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