Re: ‘Management of Extracranial Carotid Artery Aneurysm’

We would like to comment on the recently published study “Management of Extracranial Carotid Artery Aneurysm” by Welleweerd et al.1

In this paper, the authors reviewed 39 papers analyzing a total of 1,239 patients with extracranial carotid artery aneurysm (ECAA). Surgically treated patients had a better 30 day mortality and stroke rate than the conservative group, although the cranial nerve damage (CND) rate remained high (12%).2 The authors omitted to comment on a very important issue regarding elimination of the compression effect of the aneurysm as a limitation of endovascular procedures.

In this study,3 9% of the patients had compression symptoms making a total of 119 patients. In another study by Li et al.,4 the authors reviewed 113 studies involving a total of 224 patients treated by endovascular repair of ECAA with a favorable outcome.2 However, a significant number of patients had compression syndromes, 15.3% of all patients with ECAA and 16.1% of patients with pseudoaneurysms.2

Although a relatively small number of patients were treated by endovascular means in the present study (5%),1 the limitations of endovascular procedures in ECAA treatment are not negligible. We are all aware that we live in an era of endovascular surgery; however, in patients with ECAA and compression syndromes, priority should be given to surgical treatment that has a low rate of post-operative complications, but that on the other hand immediately eliminates compression symptoms.

REFERENCES


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Available online 6 November 2015

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http://dx.doi.org/10.1016/j.ejvs.2015.09.029
DOI of original article: http://dx.doi.org/10.1016/j.ejvs.2015.10.002

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In specialized vascular centers throughout the world, the management of extracranial carotid artery aneurysm (ECAA) disease is currently mainly based on local expertise and lacks evidence based guidance. The paper by Welleweerd et al. points to the fact that basically we do not know the natural follow up course of patients with ECAA and, as a consequence, are not able to balance the indications for, and type of, surgical intervention.1 Naturally, in patients presenting with cerebral thrombo-embolization exclusion of the ECAA seems warranted furthermore, patients with local cervical symptoms related to mass compression are candidates for intervention, but the optimal type of intervention is still under discussion.2,3 As pointed out by Radak et al. (personal communication), complete surgical resection of the aneurysm with direct anastomosis or venous interposition graft may relieve the effects of compression, although it is well known that post-surgery de-tubation in these patients may be hindered by significant post-resection cervical edema in the short term. Alternatively, if compression symptoms are subacute, or the aneurysm is located unfavorably for a safe surgical approach (i.e., near the base of skull) endovascular exclusion may offer an alternative, especially as following full exclusion, these aneurysms have the tendency to shrink with subsequent relief of local compression. Although endovascular therapies are still emerging, at this stage no one specific therapeutic approach for patients with ECAA is advocated. At present, each individual patient presenting with asymptomatic or symptomatic ECAA should be discussed within a multidisciplinary panel, and the optimal treatment approach will be dependent on patient and ECAA characteristics, including anatomical constraints. Owing to the low incidence and prevalence of ECAA it is essential to learn by numbers. Therefore, an international web based registry (www.carotidaneurysmsregistry.com) has been created to collect data prospectively, including imaging for patients with ECAA.4 With full international support, it is anticipated that this registry will provide clinical guidance on this scarce pathology in the near future.

REFERENCES


