

Update On ACST 2: This RCT Found That CEA And CAS For ACS Had Comparable Adverse Event Rates And Implied That Both Invasive Treatments Were Superior To Now Obsolete BMT

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Disclosures and Acknowledgments

- No disclosures
- Acknowledge >6500 ACST participants and our large network of collaborators, without whom this work would not be possible

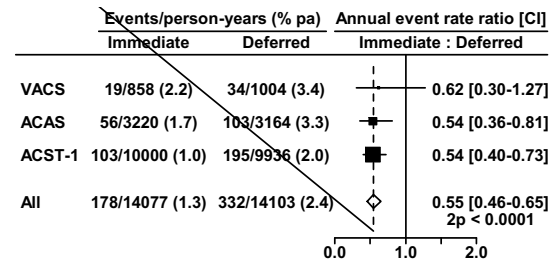
The title: this is 2 presentations!

Q1: Is intervention (CEA or CAS) still better than medical therapy alone in asymptomatic carotid disease?

Answer: I don't know, and ACST-2 was not designed to answer this (important) question. But here's some Level 1A evidence...

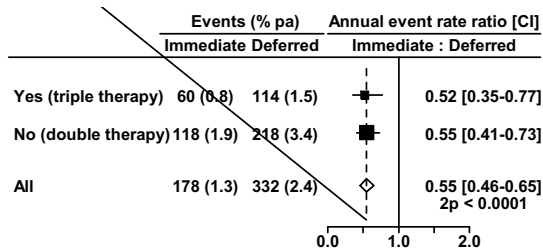
Non-perioperative stroke

Risks appear to have been halved by CEA in all three trials



Non-perioperative stroke by lipid-lowering therapy before any stroke

CEA halves stroke rate whether or not statins are used (& statins halve stroke rates whether or not CEA is done)



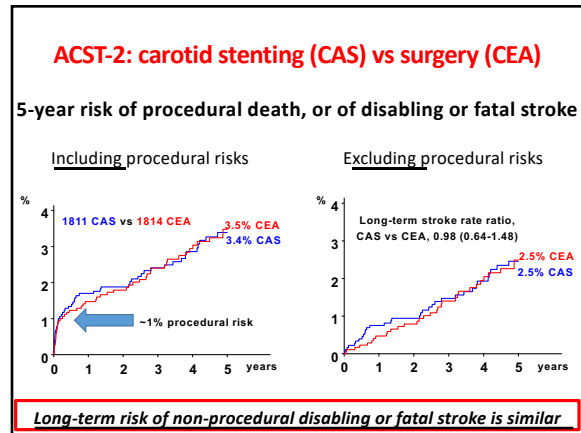
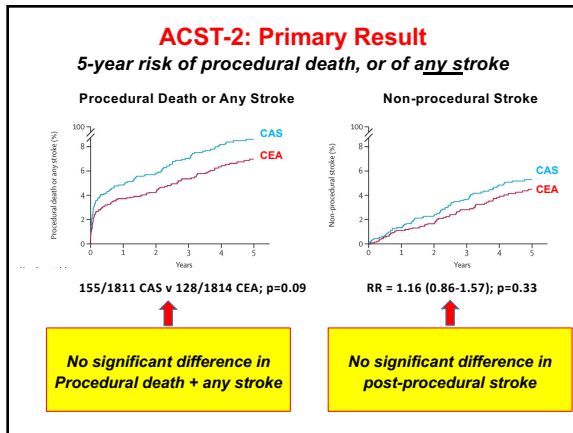
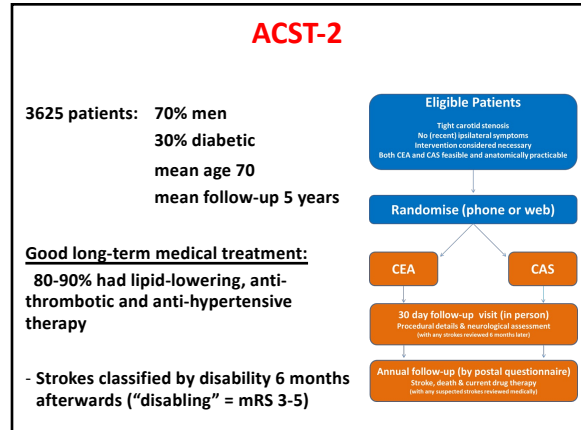
New 'INTERVENTION v MT' Trials

429 (closed) 2486/2400 Paused

Meaningful results awaited

Q2: Are CEA & CAS comparable in ACST-2?

Answer: Broadly, yes! Particularly for disabling stroke...

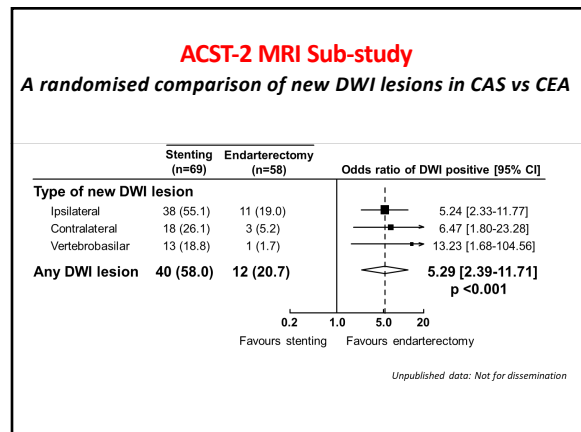


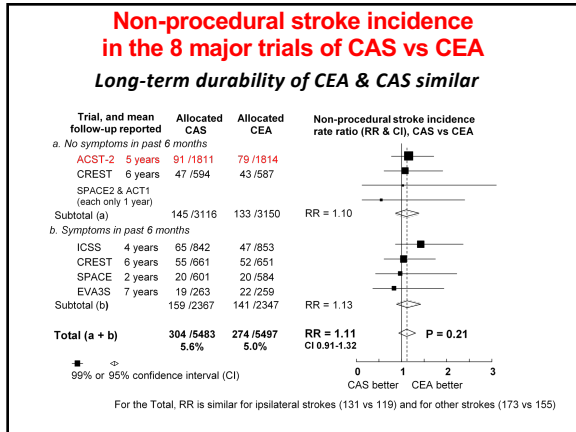
ACST-2: carotid stenting (CAS) vs surgery (CEA)

Any procedural death or any stroke at any time, by severity

	Allocated CAS n=1811	Allocated CEA n=1814
mRS >1: Fatal, disabling, or unable to carry out some previously usual activities	77	77
mRS 0-1: Non-disabling, and still able to carry out all previously usual activities	77 (4.2%)	49 (2.7%)

1-2% excess risk of non-disabling stroke associated with CAS largely procedural





ACST-2: Take Home Message and Future Challenges

Competent CEA & CAS both good interventions for ACS

Allows 'best choice' given specific patient's circumstances

The challenges:

- 1. Selecting 'high-risk for stroke' patients for intervention**
- 2. Reduce procedural risks (esp minor CAS-related strokes)**