

SYSTEMATIC REVIEW

Timing of Carotid Intervention in Symptomatic Carotid Artery Stenosis: A Systematic Review and Meta-Analysis

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WHAT THIS PAPER ADDS

The evidence from this systematic review and meta-analysis suggests that (at present) carotid endarterectomy (CEA) is safer than carotid artery stenting (CAS) when performed within two or seven days of the index event. Also, considering absolute rates of 30 day stroke, mortality, and death/stroke, CEA performed within two days of the index event complies with the accepted thresholds in international guidelines. The findings of this analysis will guide clinical practice when deciding on the type of intervention in the symptomatic patient with severe carotid stenosis. The ideal timing for performing CAS (when indicated against CEA) is not yet defined.

Objective: This review aimed to analyse the timing of carotid endarterectomy (CEA) and carotid artery stenting (CAS) after the index event as well as 30 day outcomes at varying time periods within 14 days of symptom onset.

Methods: A systematic review was performed according to the Preferred Reporting Items for Systematic reviews and Meta-analysis statement, comprising an online search of the Medline and Cochrane databases. Methodical quality assessment of the included studies was performed. Endpoints included procedural stroke and/or death stratified by delay from the index event and surgical technique (CEA/CAS).

Results: Seventy-one studies with 232 952 symptomatic patients were included. Overall, 34 retrospective analyses of prospective databases, nine prospective, three RCT, three case control, and 22 retrospective studies were included. Compared with CEA, CAS was associated with higher 30 day stroke (OR 0.70; 95% CI 0.58 – 0.85) and mortality rates (OR 0.41; 95% CI 0.31 – 0.53) when performed ≤ 2 days of symptom onset. Patients undergoing CEA/CAS were analysed in different time frames (≤ 2 vs. 3 – 14 and ≤ 7 vs. 8 – 14 days). Expedited CEA (vs. 3 – 14 days) presented a sampled 30 day stroke rate of 1.4%; 95% CI 0.9 – 1.8 vs. 1.8%; 95% CI 1.8 – 2.0, with no statistically significant difference. Expedited CAS (vs. 3 – 14 days) was associated with no difference in stroke rate but statistically significantly higher mortality rate (OR 2.76; 95% CI 1.39 – 5.50).

Conclusion: At present, CEA is safer than transfemoral CAS within 2/7 days of symptom onset. Also, considering absolute rates, expedited CEA complies with the accepted thresholds in international guidelines. The ideal timing for performing CAS (when indicated against CEA) is not yet defined. Additional granular data and standard reporting of timing of intervention will facilitate future monitoring.

Keywords: Carotid stenosis, Death, Endarterectomy, carotid, Stent, Stroke

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INTRODUCTION

Carotid revascularisation improves long term stroke free survival in patients with recent ischaemic stroke or transient

ischaemic attack (TIA). Recency of the index event has been recognised as a key determinant of the effectiveness of revascularisation, balancing the natural history risk of a

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second (more severe) event against the potential for a higher peri-procedural risk when carotid interventions are performed very early after the onset of symptoms.

The optimal timing for carotid revascularisation, by either carotid endarterectomy (CEA) or carotid artery stenting (CAS), remains a matter for debate. The 2017 European Society for Vascular Surgery (ESVS) guidelines advise that CEA should be performed within 14 days of the index neurological event, as this was the highest risk time period for recurrent stroke.¹ This is particularly true for neurologically stable patients presenting with TIA or minor stroke. However, it remains unclear as to the optimal timing of either CEA or CAS within this 14 day time period (i.e., Is it better for the carotid intervention to be performed < 2 days, < 7 days, or perhaps 8 – 14 days after symptom onset?).

A recent systematic review reported that the risk of recurrent stroke can vary from 6% within 2 – 3 days of the index event, to 20% within 7 days, and up to 26% within 14 days of the index event.² Conversely, a meta-analysis of published studies comparing expedited carotid interventions (2 days) vs. early (3 – 14 days) found a significantly higher risk of procedural stroke when CEA was performed within 2 days of the index event.³ However, this systematic review did not include two large national CEA registries (> 70 000 CEAs), which confounds meaningful interpretation of their data. In the case of CAS, the available data on safety very early after the onset of symptoms appears limited.⁴

The lack of high quality evidence and consensus definitions for what constitutes “early” or “urgent” carotid interventions has contributed to conflicting results in the literature. Heterogeneity regarding patient symptoms, medical therapy, and varying surgical approaches have also

led to polarised debates about the timing of CEA in patients who present with neurological symptoms.⁵

The aims of the current systematic review and meta-analysis were to analyse temporal changes in the timing of carotid interventions after symptom onset and to determine 30 day outcomes following CEA and CAS when performed at varying time periods in the first 14 days after onset of symptoms, to define the optimal timing and carotid intervention (CEA vs. CAS) in recently symptomatic patients.

METHODS

A systematic review was conducted according to the recommendations of the Preferred Reporting Items for Systematic reviews and Meta-analysis (PRISMA) statement.⁶

The literature search was from January 1995 to January 2021. Using the Medline and Cochrane databases, the following query ((“Carotid Stenosis”[Mesh]) AND “Stents”[Mesh]) OR “Endarterectomy, Carotid”[Mesh]) AND (“Stroke”[Mesh] OR Symptomatic OR timing of intervention) was used for online search.

Eligibility criteria included any publication regarding the revascularisation of symptomatic carotid artery stenosis by either CAS or CEA. Timing of intervention and impact of delay on procedural risks were documented. Only atherosclerotic stenotic carotid disease was considered, with exclusion of procedures performed for non-atherosclerotic pathologies.

Exclusion criteria were (1) articles published in a language other than English; and (2) case reports and literature reviews.

Endpoints included any stroke and/or death within 30 days of intervention stratified by delay of intervention after the index event and by intervention technique (CEA and

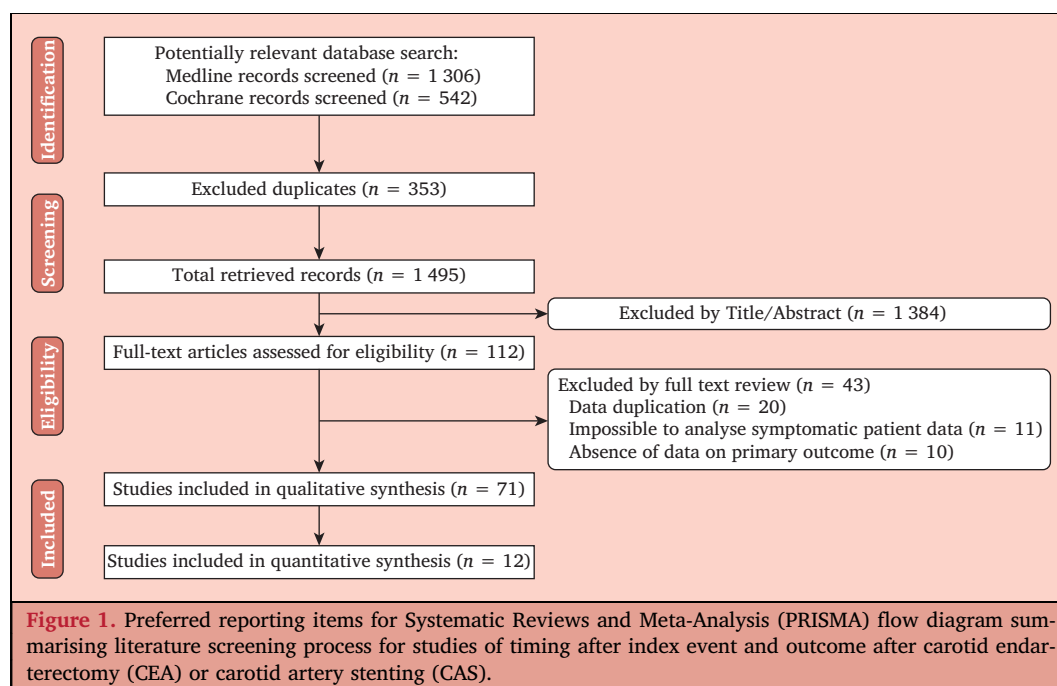


Table 1. Analysis of study characteristics and intervention delay for carotid endarterectomy (CEA) or carotid artery stenting (CAS) after index event

Article (Year) Journal	Type of article	CEA/ CAS	Patients	Symptomatic	Definition delay (days)	Timing of intervention	Mean delay \pm SD – d
Kashyap ³⁴ (2020) <i>Stroke</i>	Prosp; Multicentre	CAS	632	164 (26)	NR	NR	NR
Karpenko ³⁵ (2020) <i>J Stroke Cerebrovasc Dis</i>	Retros; Single centre	CEA/CAS	1 791 CEA: 1215 (57); CAS: 917 (43)	160 (8.9)	NR	NR	NR
Jankowitz ¹³ (2020) <i>Neurosurgery</i>	Retros; analysis of prosp data; Single centre	CEA/CAS	120 CEA: 59 (49.2); CAS: 61 (59.8)	120 (100)	Urgent (0–2)	0–2 d: 120 (100)	CEA: 1.6 \pm 0.8; CAS: 1.0 \pm 0.7; <i>p</i> <.001
Roussopoulos ⁹ (2019) <i>Eur J Neurol</i>	Prosp; Multicentre	CEA	311	311 (100)	Urgent (0–2); Early (3–14)	0–2 d: 63 (20.3); 3–14 d: 248 (79.7)	NR
Howie ³⁶ (2019) <i>World Neurosurg</i>	Retros; Single centre	CEA/CAS	314 CEA: 204 (64.9); CAS: 110 (35.1)	265 (84.5)	NR	NR	NR
Vang ³⁷ (2019) <i>Surgery</i>	Retros; Single centre	CEA	1233	509 (41.3)	NR	NR	NR
Lee ³⁸ (2018) <i>Ann Vasc Surg</i>	Retros; Multicentre	CEA/CAS	677 CEA: 331 (48.9); CAS: 346 (51.1)	677 (100)	NR	NR	NR
Huang ¹⁴ (2018) <i>J Vasc Surg</i>	Retros; Single centre	CEA	238	238 (100)	Early (0–14); (0–2); (3–7); (8–14); Delayed (15–180)	0–2 d: 11 (4.6); 3–7 d: 23 (9.7); 8–14 d: 23 (9.7); 15–180 d: 181 (76.1)	NR
Rocco ²⁰ (2018) <i>J Vasc Interv Radiol</i>	Retros; analysis of prosp data; Single centre	CEA/CAS	110 CEA: 48 (43.6); CAS: 62 (56.4)	110 (100)	NR	NR	CEA: 1.7 \pm 2.4; CAS: 2.8 \pm 2.1
Seguchi ¹⁰ (2017) <i>J Stroke Cerebrovasc Dis</i>	Retros; Single centre	CAS	105	105 (100)	Early (0–2); Delayed (3–180)	0–2 d: 40 (38.1); 3–180 d: 65 (61.9)	NR
Rantner ⁴⁴ (2017) <i>Stroke</i> EVA-3S, SPACE, ICSS, CREST	Retros; analysis of prosp data; Multicentre	CEA vs. CAS	4 138	4 138 (100)	Early (0–7); Delayed (8–180)	0–7 d: 513 (12.4); 8–180 d: 3625 (87.6)	
		CEA	2 045 (49.4)	2 045 (100)	Early (0–7); Delayed (8–180)	0–7 d: 226 (11); 8–180 d: 1819 (89)	34.5 \pm 15.6
		CAS	2 093 (50.6)	2 093 (100)	Early (0–7); Delayed (8–180)	0–7 d: 287 (14); 8–180 d: 1806 (86)	31 \pm 14.4
Hobeantu ⁴² (2017) <i>Stroke</i>	Nested case control study	CEA/CAS vs. BMT	561 CEA/CAS: 187 (33.3) BMT: 374 (66.7)	187 (100)	NR	NR	12.8 \pm 4.9
Nordanstig ⁸ (2017) <i>Eur J Vasc Endovasc Surg</i>	Prosp; Multicentre	CEA	418	418 (100)	Early (0–2); Delayed (3–14)	0–2 d: 46 (11); 3–14 d: 372 (89)	Early: 1.3 \pm 0.69 Delayed: 6.7 \pm 2.9
Kazandjian ⁴⁶ (2016) <i>J Vasc Surg</i>	Retros; analysis of prosp data; Single centre	CEA	114	114 (100)	Early (0–14); Delayed (15–180)	0–14 d: 32 (28); 15–180 d: 82 (72)	22 \pm 33
Tsantilas ²³ (2016) <i>J Vasc Surg</i>	Retros; analysis of prosp data; Single centre	CEA	401	401 (100)	Early (0–14); (0–2); (3–7); (8–14); Delayed (15–180)	0–2 d: 60 (15); 3–7 d: 110 (27.4); 8–14 d: 65 (16.2); 15–180 d: 166 (41.4)	NR
Charbonneau ¹⁷ (2016) <i>J Vasc Surg</i>	Retros; Single centre	CEA	103	103 (100)	(0–14); (15–90); (91–180)	0–14 d: 40 (38.8); 15–90 d: 37 (35.9); 91–180 d: 26 (25.2)	36.5 \pm 21.4
Chisci ¹⁹ (2015) <i>Ann Vasc Surg</i>	Retros; Single centre	CEA	322	322 (100)	Early (0–14); Delayed (15–30);	0–14 d: 100 (31.1); 15–30 d: 222 (68.9)	16.8 \pm 9.2 4.6 \pm 3.1 22.3 \pm 4.6
Kretz ²⁶ (2015) <i>Ann Vasc Surg</i>	Retros; analysis of prosp data; Single centre	CEA	417	417 (100)	Early (0–15); Deferred (16–45); Delayed (46–180)	0–15 d: 158 (37.9); 16–45 d: 79 (18.9); 46–180 d: 180 (43.2)	7.7 \pm 3.8 28.3 \pm 8.6 89.4 \pm 36.7
Charmoille ⁴⁷ (2014) <i>Ann Vasc Surg</i>	Retros; Single centre	CEA	149	149 (100)	Early (0–14); Late (15–180)	0–14 d: 62 (41.6); 15–180 d: 87 (58.4)	NR
Rantner ⁸⁵ (2014) <i>Eur J Vasc Endovasc Surg</i>	Retros; Single centre	CEA	761	761 (100)	Early (0–14); (0–2); (3–7); (8–14); Delayed (15–180)	0–2 d: 206 (27.1); 3–7 d: 219 (28.8); 8–14 d: 136 (17.9); 15–180 d: 200 (26.3)	NR
Tsvigoulis ⁴⁹ (2014) <i>Eur J Neurol</i>	Prosp; Multicentre	CEA	165	165 (100)	Ultra-Early (0–2); Early (3–14)	0–2 d: 20 (12); 3–14 d: 145 (88)	6 \pm 1.7
Mo ⁵¹ (2014) <i>J NeuroIntervent Surg</i>	Retros; analysis of prosp data; Single centre	CAS	402	169 (42.0)	NR	NR	NR
Shahidi ⁵³ (2013) <i>Stroke</i>	Prosp; Single centre	CEA	115	115 (100)	Early (0–14); Deferred (15–30); Delayed (31–180)	NR	36.3 \pm 25.1

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Table 1-continued							
Article (Year) Journal	Type of article	CEA/ CAS	Patients	Symptomatic	Definition delay (days)	Timing of intervention	Mean delay \pm SD - d
Sharpe ¹⁵ (2013) <i>Eur J Vasc Endovasc Surg</i>	Retros; Single centre	CEA	475	475 (100)	Early (0–14); Hyperacute (0–2); (3–7); (8–14); Delayed (15–180)	0–2 d: 41 (8.6); 3–7 d: 167 (35.2); 8–14 d: 133 (28.0); 15–180 d: 134 (28.2)	NR
Faggioli ⁵⁴ (2013) <i>Ann Vasc Surg</i>	Retros; analysis of prosp data; Single centre	CEA	610	162 (27)	Early (0–14); Deferred (15–30); Delayed (31–180)	0–14 d: 60 (37.0); 15–30 d: 18 (11.1); 31–180 d: 84 (51.9)	NR
Hartog ⁵ (2013) <i>Eur J Vasc Endovasc Surg</i>	Retros; Single centre	CEA	555	555 (100)	Early (0–14); Delayed (15–180)	0–14 d: 105 (18.9); 15–180 d: 450 (81.1)	40.3 \pm 15.9
Tas ⁵² (2013) <i>Adv Ther</i>	Retros; Single centre	CEA/CAS	65 CEA 32 (49.2); CAS 33 (50.8)	65 (100)	NR	NR	NR
Annambhotla ⁵⁹ (2012) <i>J Vasc Surg</i>	Retros; Single centre	CEA	312	312 (100)	Early (0–30); (0–7); (8–14); (15–21); (22–30); Delayed (31–180)	0–7 d: 27 (8.7); 8–14 d: 17 (5.4); 15–21 d: 12 (3.8); 22–30 d: 12 (3.8); 31–180 d: 243 (77.9)	NR
Kessler ⁵⁶ (2012) <i>J Neuroradiol</i>	Retros; Single centre	CAS	55	55 (100)	NR	NR	NR
Kimiagar ⁵⁷ (2012) <i>Vasc Endovascular Surg</i>	Retros; Single centre	CEA/CAS	116	116 (100)	NR	NR	NR
Lin ⁶¹ (2009) <i>J NeuroIntervent Surg</i>	Retros; Single centre	CAS	224	224 (100)	Early (0–30); Ultra-Early (0–14); Delayed (31–180)	0–30 d: 122 (54.5); 31–180 d: 102 (45.5)	NR
Gray ⁶⁴ (2009) <i>Circ Cardiovasc Intervent EXACT CAPTURE-2</i>	Prosp; Multicentre	CAS	6320	759 (12.0)	NR	NR	NR
Ballotta ⁶⁸ (2008) <i>J Vasc Surg</i>	Retros; Single centre	CEA	102	102 (100)	Early (0–14)	0–14 d: 102 (100)	6.3 \pm 3.2
Setacci ⁶⁹ (2008) <i>Eur J Vasc Endovasc Surg</i>	Prosp; Multicentre	CAS	57	57 (100)	Deferred for TIA (1–2); Deferred for Stroke (14–30)	1–2 d (TIA): 24 (42); 14–30 (Stroke): 33 (58)	NR
Massop ⁶⁷ (2008) <i>Catheter Cardiovasc Interv</i>	SAPPHIRE Registry	CEA/CAS	2001	555 (27.7)	NR	NR	NR
Steinbauer ⁷⁰ (2008) <i>J Vasc Surg</i>	RCT	CEA/CAS	87 CEA: 44 (50.6); CAS: 43 (49.4)	87 (100)	NR	NR	NR
Topkian ⁷³ (2007) <i>Eur J Neurol</i>	Retros; Single centre	CAS	77	77 (100)	Early (0–14)	0–14 d: 23 (29.9); 15–180 d: 54 (70.1)	NR
Suzue ⁷⁴ (2007) <i>J Vasc Surg</i>	Retros; Single centre	CEA	72	72 (100)	Early (0–30); Delayed (31–180)	0–30 d: 15 (20.8); 31–180 d: 57 (79.2)	NR
Dellagrammaticas ⁷¹ (2007) <i>Clin Med GALA TRIAL</i>	RCT	CEA	1 001	867 (86.6)	NR	NR	86 \pm 30.0
Flanigan ⁷² (2007) <i>J Vasc Surg</i>	Retros; analysis of prosp data; Single centre	CEA	442	170 (38.5)	NR	NR	NR
Sbarigia ⁷⁶ (2006) <i>Eur J Vasc Endovasc Surg</i>	Prosp; Multicentre	CEA	96	96 (100)	NR	NR	1.5 \pm 2
Imai ⁷⁷ (2005) <i>Am J Neuroradiol</i>	Retros; Single centre	CAS	17	17 (100)	NR	NR	2.3 \pm 2.4
Rantner ⁷⁸ (2005) <i>Eur J Vasc Endovasc Surg</i>	Retros; Single centre	CEA	104	104 (100)	Acute (0–24 hours); Ultra-Early (0–6 hours); (0–27); (28–180)	0 d: 7 (6.7); <28 d: 29 (27.9); \geq 28 d: 62 (59.6)	NR
Ecker ⁸⁰ (2004) <i>J Neurosurg</i>	Case Control	CEA/CAS	436 CEA: 391 (89.7) CAS: 45 (10.3)	436 (100)	NR	NR	NR
Kastrup ⁸³ (2003) <i>Cerebrovasc Dis</i>	Case Control	CEA/CAS	242 CEA: 142 (58.7); CAS: 100 (41.3)	155 (64.0)	NR	NR	NR
Welsh ⁸¹ (2003) <i>Cerebrovasc Dis</i>	Prosp; Multicentre	CEA	40	40 (100)	Early (0–1); Delayed (60–180)	0–1 d: 19 (47.5); 60–180 d: 21 (52.5)	NR
ECST ⁸⁴ (1988) <i>Lancet</i>	RCT	CEA vs. BMT	1 807	1 807 (100)	NR	NR	NR

Table 1-continued							
Article (Year) Journal	Type of article	CEA/ CAS	Patients	Symptomatic	Definition delay (days)	Timing of intervention	Mean delay \pm SD – d
<i>National Registry</i>							
Kuhrij ²¹ (2019) <i>Eur J Vasc Endovasc Surg</i> Dutch Audit for Carotid Intervention	Retrospect analysis of prosp data; Multicentre	CEA	8 620	8 620 (100)	Early (0–14)	0–14 d: 6645 (78)	11 \pm 1.7
Faateh ³⁹ (2018) <i>J Vasc Surg</i> National Quality Improvement	Retrospect analysis of prosp data; Multicentre	CEA	9 271	9 271 (100)	Emergency: Performed within the same hospitalisation OR reported as emergency by the team	Emergency: 546 (5.9); Non-emergency: 8725 (94.1)	NR
Tsantilas ⁴⁰ (2018) <i>J Am Heart Assoc</i> German Statutory Quality Assurance	Retrospect analysis of prosp data; Multicentre	CAS	4 717	4 717 (100)	Early (0–14); (0 –2); (3–7); (8–14); Delayed (15–180)	0–2 d: 550 (11.6); 3–7 d: 1579 (33.4); 8–14 d: 1244 (26.3); 15–180 d: 1344 (28.4)	NR
Blay ⁴¹ (2018) <i>Ann Vasc Surg</i> ACS-NSQIP	Retrospect analysis of prosp data; Multicentre	CEA	3 427	3 427 (100)	Early (0–7); Delayed (8–180)	0–7 d: 3247 (94.7); 8–180 d: 180 (5.3)	NR
Avgerinos ⁴³ (2017) <i>J Vasc Surg</i> VSGNE Database	Retrospect analysis of prosp data; Multicentre	CEA	989	989 (100)		0 d: 96 (9.8); 1–2 d: 322 (32.6) 3–5 d: 94 (9.1); 6–180 d: 477 (48.2)	NR
Venermo ⁴⁵ (2017) <i>Eur J Vasc Endovasc Surg</i> VQL/Vascunet	Retrospect analysis of prosp data; Multicentre	CEA/CAS	58 607 CEA: 52 434 (89.5); CAS: 6 173 (10.5)	30 520 (52.1)	NR	NR	NR
Kjorstad ¹⁸ (2017) <i>Eur J Vasc Endovasc Surg</i> National Norwegian Carotid Study	Retrospect analysis of prosp data; Multicentre	CEA	368	368 (100)	Early (0–14)	0–14 d: 227 (61.7); 15–180 d: 141 (36.8)	12.75 \pm 4.3
Loftus ²⁴ (2016) <i>Eur J Vasc Endovasc Surg</i> UK National Vascular Registry	Retrospect analysis of prosp data; Multicentre	CEA	33 194	23 235 (70.0)	Early (0–14); (0 –2); (3–7); (8–14); (15–21); Delayed (22–180)	0–2 d: 780 (3.4); 3–7 d: 5126 (22.1); 8–14 d: 6292 (27.1); 15–21 d: 2765 (11.9); 22–180 d: 8272 (35.6)	2009: 9.3 \pm 4.9; 2010: 7.0 \pm 4.1; 2011: 5.5 \pm 2.90; 2012: 5.0 \pm 2.3; 2013: 4.5 \pm 2.3; 2014: 5.75 \pm 6.7
Jonsson ¹⁶ (2015) <i>Eur J Vasc Endovasc Surg</i> Swedvasc Registry	Retrospect analysis of prosp data; Multicentre	CAS	323	323 (100)	Early (0–14); (0 –2); (3–7); (8–14); Delayed (15–180)	0–2 d: 13 (4.0); 3–7 d: 85 (26.3); 8–14 d: 80 (24.8); 15–180 d: 145 (44.9)	NR
Geraghty ⁵⁰ (2014) <i>J Vasc Surg</i> SVS Vascular Registry	Retrospect analysis of prosp data; Multicentre	CEA/CAS	8 640 CEA: 5 758 (66.6); CAS: 2 882 (33.3)	2 904 (33.6)	Symptomatic: Neurologic events in the previous 12 months	NR	NR
Villwock ¹² (2014) <i>J Stroke</i> <i>Cerebrovasc Dis</i> Nationwide Inpatient Sample	Retrospect analysis of prosp data; Multicentre	CEA vs. CAS	72 797 CEA: 62 327 (85.6); CAS: 13 470 (18.4)	72 797 (100)	Ultra-Early (0–2); Early (3–14)	0–2 d: 41008 (56.3); 3–14 d: 31789 (43.7)	NR
Witt ²⁵ (2013) <i>Stroke</i> Danish Stroke Registry/Danish Vascular Registry	Retrospect analysis of prosp data; Multicentre	CEA	813	813 (100)	Early (0–14)	NR	Decrease in the delay to CEA with time: 13% underwent CEA in two weeks in 2007, 33% in 2008, 37% in 2009, 47% in 2010 (OR 5.8, 95% CI 4.3–10.1)
Schermerhorn ⁵⁵ (2013) <i>J Vasc Surg</i> CMS	Retrospect analysis of prosp data; Multicentre	CEA/CAS	10 107 CEA: 6 370 (63.0); CAS: 3 737 (37.0)	3 916 (38.7)	NR	NR	NR
Nolan ⁵⁸ (2012) <i>J Vasc Surg</i> VSGNE 2003–2010	Retrospect analysis of prosp data; Multicentre	CEA/CAS	8 079 CEA: 7 649 (94.6); CAS: 430 (5.4)	2 763 (34.2)	NR	NR	NR

Continued

Table 1-continued

Article (Year) Journal	Type of article	CEA/ CAS	Patients	Symptomatic	Definition delay (days)	Timing of intervention	Mean delay \pm SD – d
Stromberg ²⁷ (2012) <i>Stroke</i> Swedvasc Registry	Retrospective analysis of prospective data; Multicentre	CEA	2 596	2 596 (100)		0–2 d: 148 (5.7); 3–7 d: 804 (31.0); 8–14 d: 677 (26.1); 15–180 d: 967 (37.2)	NR
Garg ⁶⁰ (2011) <i>Ann Vasc Surg</i> National Surgery Quality Improvement	Retrospective analysis of prospective data; Multicentre	CEA	17 388	8 103 (46.6)	NR	NR	NR
Palombo ⁶² (2009) <i>J Cardiovasc Surg</i> Italian Vascular Registry	Retrospective analysis of prospective data; Multicentre	CEA	5 809	1 894 (32.6)	NR	NR	NR
Halliday ⁸⁶ (2009) <i>BMJ</i> UK Surgeons undertaking CEA	Retrospective analysis of prospective data; Multicentre	CEA	5 513	4 576 (83)	Early (0–12); (0–2); (2–4); (5–12); Delayed (13–180)	0–2 d: 944 (20.0); 3–4 d: 654 (14); 5–12 d: 1621 (34); 13–180 d: 1372 (30)	45.3 \pm 19.4
Vogel ⁶⁵ (2009) <i>J Vasc Surg</i> Nationwide Inpatient Sample (2005)	Retrospective analysis of prospective data; Multicentre	CEA/CAS	80 498 CEA: 73 929 (91.8); CAS 6 569 (8.2)	2 237 (2.8)	NR	NR	NR
Gladstone ⁶³ (2009) <i>Stroke</i> Canadian Stroke Network	Retrospective analysis of prospective data; Multicentre	CEA	105	105 (100)	Early (0–14); Deferred (15–30); Delayed (31–180)	0–14 d: 38 (36.2); 15–30 d: 53 (50.5); 31–180 d: 26 (24.8)	37.8 \pm 20.5
Goodney ⁶⁶ (2008) <i>J Vasc Surg</i> VSGNE 2003–2007	Retrospective analysis of prospective data; Multicentre	CEA	3 092	1 360 (44)	Emergency (0–6 h); Urgent (0–24 h)	0–1 d: 309 (10)	NR
McPhee ⁷⁵ (2007) <i>J Vasc Surg</i> Nationwide Inpatient Sample	Retrospective analysis of prospective data; Multicentre	CEA/CAS	259 080 CEA: 245 045 (94.6); CAS 14 035 (5.4)	20 750 (8)	NR	NR	NR
Pell ⁷⁹ (2004) <i>Scott Med J</i> National Prospective Survey Scotland	Retrospective analysis of prospective data; Multicentre	CEA	877	855 (97.5)	Early (0–30); Deferred (31–60)	0–30 d: 103 (27); 31–60 d: 222 (58)	NR
Tu ⁸² (2003) <i>Stroke</i> Ontario Carotid Endarterectomy Registry	Retrospective analysis of prospective data; Multicentre	CEA	6 038	4 192 (69.4)	NR	NR	NR

Data are presented as *n* (%) unless stated otherwise. NR = not reported; Retrospective = retrospective; Prospective = prospective.

CAS). An analysis of reporting of timing of CEA and CAS after the index event was also performed.

Stroke was defined as a rapidly developing clinical syndrome of focal disturbance of cerebral function lasting more than 24 hours or leading to death with no apparent cause other than that of vascular origin. Stroke was considered procedural if the event occurred at any time between the revascularisation procedure (day 0) and day 30 after revascularisation.

Stroke was classified as disabling if there was an increase in the modified Rankin score (mRS) to ≥ 3 , attributable to the event 30 days after the procedure. Neurological symptomatic status was defined as a transient ischaemic attack or minor disabling ischaemic stroke in the previous six months attributable to the ipsilateral carotid artery territory.

For the purpose of this meta-analysis, “expedited intervention” was used to define any intervention performed within two days of the index event. Index event was defined as the symptom that led the patient to seek medical advice as suggested in the ESVS guidelines.¹

Two reviewers (AC and JP) screened the identified studies independently and were also responsible for data extraction (Fig. 1). Collected data included type of study, year of publication, number of patients and consecutiveness, adjudication of events by a clinical event committee (CEC), age, gender, and criteria for carotid revascularisation (presence and type of neurological symptoms and their timing). The definition of intervention delay regarding the index event was registered in different studies. Neurological events after the index event and before intervention were registered as well as procedural (30 day) events: stroke, myocardial infarction (MI), and death. Comparative data between early and delayed intervention were analysed, especially for interventions performed ≤ 2 days vs. between 3 and 14 days and for interventions performed ≤ 7 days vs. between 8 and 14 days of the index event.

When duplicates were identified, the most recent study was included unless the earlier version reported more data on specific parameters included in the analysis.

Table 2. Analysis of patient characteristics including the type of neurological symptoms undergoing carotid endarterectomy (CEA) or carotid artery stenting (CAS) after index event

Article (Year)	CEA / CAS	Time periods	Symptomatic CEA / CAS	Age	Male sex	Type of event				New events before intervention
						TIA	Crescendo TIA / stroke in evolution	Afx	Minor / major stroke	
Jankowitz ¹³ (2020)	CEA vs. CAS	All (0–2 d)	120 (100)							
	CEA		59 (49.2)	68.4 ± 11.3	38 (64)	NR	NR	NR	NR	NR
	CAS		61 (50.8)	71.5 ± 12.9	42 (71)	NR	NR	NR	NR	NR
Roussopoulou ⁹ (2019)	CEA	All (0–14 d)	311 (100)	69 ± 11	230 (74)	128 (41)	28 (9)	–	183 (59)	NR
		0–2 d	63 (20.3)	67 ± 15	45 (71)	31 (49)	13 (21)	–	32 (51)	NR
		3–14 d	248 (79.7)	69 ± 10	186 (75)	99 (40)	17 (7)	–	124 (50)	NR
Huang ¹⁴ (2018)	CEA	All (0–180 d)	238 (100)	72 ± 9.1	158 (68)	176 (74)	–	71 (30)	62 (26)	NR
		Group 1 (0–14 d)	57 (23.9)	72 ± 10	34 (60.7)	48 (84)	–	18 (32)	9 (16)	NR
		0–2 d	11 (4.6)							
		3–7 d	23 (9.7)							
		8–14 d	23 (9.7)							
		Group 2 (14–180 d)	181 (76.1)	72 ± 8.8	124 (70)	128 (71)	–	53 (29)	53 (29)	NR
Seguchi ¹⁰ (2017)	CAS	All (0–180 d)	105 (100)							
		0–2 d	40 (38.1)	74.8 ± 2.5	37 (92.5)	9 (22.5)	25 (62.5)	–	31 (77.5)	NR
		3–180 d	65 (61.9)	77.0 ± 3.5	59 (90.8)	NR	0 (0)	NR	NR	NR
Rantner ⁴⁴ (2017) EVA-3S, SPACE, ICSS, CREST	CEA vs. CAS	All (0–180 d)	4138 (100)							
		0–7 d	513 (12.4)		355 (8.6)	258 (6.2)	–	258 (6.2)	67 (1.6)	NR
		CEA	226 (11)	69.2 ± 8.9	157 (3.8)	112 (2.7)	–	112 (2.7)	30 (0.7)	NR
	CEA vs. CAS	8–180 d	3625 (87.6)		2536 (61.3)	1277 (30.9)	–	1277 (30.9)	643 (15.5)	NR
		CEA	1819 (89)	69.6 ± 9.4	1285 (31.1)	649 (15.7)	–	649 (15.7)	317 (7.7)	NR
		CAS	1806 (86)	69.6 ± 9.2	1251 (30.2)	628 (15.2)	–	628 (15.2)	326 (7.9)	NR
Nordanstig ⁸ (2017)	CEA	0–2 d [*]	75 (18)	73.0 ± 8.5	55 (73)	28 (37)	14 (19)	18 (24)	15 (20)	NA
		3–14 d [*]	343 (82)	73.7 ± 8.5	237 (69)	106 (31)	17 (5)	12 (24)	138 (40)	NA
		All	401 (100)	69.8 ± 3.7	273 (68.1)	174 (43.4)	–	102 (25.4)	125 (31.1)	NR
Tsantilas ²³ (2016)	CEA	All (0–180 d)	401 (100)							
		0–2 d	60 (15)	70.8 ± 10.1	44 (72)	32 (53)	–	13 (22)	15 (3.7)	NR
		3–7 d	110 (27.4)	70.8 ± 14.1	75 (68)	46 (42)	–	29 (26)	35 (8.7)	NR
		8–14 d	65 (16.2)	70.8 ± 18.8	41 (63.1)	25 (39)	–	9 (14)	31 (7.7)	NR
		14–180 d	166 (41.4)	68.5 ± 3.5	113 (68.1)	71 (43)	–	51 (31)	44 (10.9)	NR
		All	103 (100)	68.5 ± 13.3	71 (68.9)	42 (40.8)	–	21 (20.4)	40 (38.8)	43 (42)
Charbonneau ¹⁷ (2016)	CEA	0–14 d	40 (38.8)		26 (36.6)	12 (28.6)	–	5 (23.8)	23 (57.5)	NR
		15–90 d	37 (35.9)		26 (36.6)	18 (42.9)	–	7 (33.3)	12 (30.0)	NR
		91–180 d	26 (25.2)		19 (26.8)	12 (28.6)	–	9 (42.9)	5 (12.5)	NR
		All	322 (100)	73.2 ± 9	235 (73)	166 (51)	43 (13)	27 (9)	129 (40)	NR
Chisci ¹⁹ (2015)	CEA	All (0–30 d)	322 (100)							
		0–14 d	100 (31.1)	72.5 ± 9.1	75 (75)	52 (52)	17 (17)	5 (5)	43 (43)	NR
		15–30 d	222 (68.9)	73.5 ± 8.9	160 (72)	114 (51)	26 (12)	22 (10)	86 (39)	NR
Kretz ²⁶ (2015)	CEA	All (0–180 d)	417 (100)							
		0–15	158 (37.9)	73.8 ± 10	116 (73.4)	58 (36.7)	–	20 (12.7)	56 (35.4)	NR
		16–45	79 (18.9)	73.8 ± 11	53 (67.1)	33 (41.8)	–	9 (11.4)	24 (30.4)	NR
		46–180	180 (43.2)	73.1 ± 9.6	136 (75.6)	55 (30.6)	–	21 (11.7)	77 (42.8)	NR
Jonsson ¹⁶ (2015)	CAS	All (0–180 d)	323 (100)							
		0–2 d	13 (4.0)	69 ± 6.4	10 (76.9)	2 (15.4)	0 (0)	2 (15.4)	9 (69.2)	NR
		3–7 d	85 (26.3)	71 ± 8.7	58 (68.2)	37 (43.5)	0 (0)	15 (17.6)	33 (38.9)	NR
		8–14 d	80 (24.8)	72 ± 9.3	60 (74.1)	37 (46.3)	1 (1.3)	9 (11.1)	34 (30)	NR
		15–180 d	145 (44.9)	70 ± 8.7	98 (67.6)	62 (42.8)	0 (0)	35 (24.1)	38 (33.1)	NR
Charmoille ⁴⁷ (2014)	CEA	All (0–180 d)	149 (100)	71.5	119 (79.9)	60 (40.3)	19 (12.7)	14 (9.4)	75 (50.3)	NR
		0–14 d	62 (41.6)	69.7 ± 10.9	68 (78.2)	29 (46.8)	11 (17.7)	6 (9.7)	27 (43.5)	NR
		15–180 d	87 (58.4)	71.2 ± 13.3	51 (82.3)	31 (35.6)	8 (21.8)	8 (9.2)	48 (55.2)	NR
Rantner ⁴⁸ (2014)	CEA	All (0–180 d)	761 (100)	70.1 ± 9.7	559 (73.5)	305 (40.1)	–	162 (21.3)	294 (38.6)	NR
		0–2 d	206 (27.1)	70.1 ± 10.3	152 (73.8)	115 (55.8)	–	37 (18)	54 (26.2)	NR
		3–7 d	219 (28.8)	70.9 ± 9.4	159 (72.6)	91 (41.6)	–	51 (23.3)	77 (35.2)	NR
		8–14 d	136 (17.9)	71.0 ± 9.2	102 (75.0)	54 (39.7)	–	33 (24.3)	49 (36.0)	NR
		15–180 d	200 (26.3)	68.5 ± 9.5	146 (73.0)	45 (22.5)	–	41 (20.5)	114 (57.0)	NR

Continued

Table 2-continued

Article (Year)	CEA / CAS	Time periods	Symptomatic CEA / CAS	Age	Male sex	Type of event				New events before intervention
						TIA	Crescendo TIA / stroke in evolution	Afx	Minor / major stroke	
Tsvigoulis ⁴⁹ (2014)	CEA	All (0–14 d)	165 (100)	69 ± 10	114 (69)	50 (30)	–	–	115 (70)	NR
		0–2 d	20 (12)	70 ± 12	11 (55)	7 (35)	–	–	13 (65)	NR
		3–14 d	145 (88)	68 ± 10	154 (71)	44 (30)	–	–	101 (70)	NR
Shahidi ⁵³ (2013)	CEA	All	115 (100)	NR	NR	39 (34)	–	11 (9)	65 (56.5)	NR
Sharpe ¹⁵ (2013)	CEA	All	475 (100)	NR	NR	72 (57)	–	94 (20)	109 (23)	NR
Faggioli ⁵⁴ (2013)	CEA	All (0–180 d)	162 (100)	NR	NR	81 (50)	–	9 (5.6)	72 (44.4)	NR
		0–14	60 (37)	NR	NR	36 (60)	–	2 (3.3)	22	NR
		15–30	18 (11.1)	NR	NR	12 (66.7)	–	2 (11.1)	4	NR
		31–180	84 (51.9)	NR	NR	33 (39.3)	–	5 (5.9)	46	NR
Annambhotla ⁵⁹ (2012)	CEA	All (0–180 d)	312 (100)	NR	200 (64.1)	106 (34.0)	–	–	205 (65.6)	NR
		0–7 d	27 (8.7)	68.6 ± 9.8	16 (59.3)	7 (25.9)	–	–	20 (74.1)	NR
		8–14 d	17 (5.4)	68.8 ± 14.7	9 (52.9)	3 (17.6)	–	–	14 (82.4)	NR
		15–21 d	12 (3.8)	67.5 ± 14.3	8 (66.7)	3 (25)	–	–	9 (75)	NR
		22–30 d	12 (3.8)	70.7 ± 9.3	8 (66.7)	1 (8.3)	–	–	11 (91.7)	NR
		31–180 d	243 (77.9)	70.4 ± 9.7	159 (65)	92 (38)	–	–	151 (62)	NR
Lin ⁶¹ (2009)	CAS	All (0–180 d)	224 (100)							
		0–30 d [†]	122 (54.5)	72 ± 10.2	80 (65.6)	77 (62.6)	–	–	46 (37.4)	
		31–180 d	102 (45.5)	69 ± 9.9	63 (61.8)	72 (71.3)	–	–	29 (28.7)	
				<i>p</i> = .002	<i>p</i> = .39					
Ballotta ⁶⁸ (2008)	CEA	0–14 d	102 (100)	NR	65 (65.7)	0 (0)	0 (0)	0 (0)	102 (100) [‡]	NR
Setacci ⁶⁹ (2008)	CAS	All (0–30 d)	57 (100)	76.7 ± 8.0	37 (64.9)	–	–	–	–	NR
		0–2 d	24 (42)	–	–	24 (100)	–	–	0 (0)	NR
		14–30 d	33 (58)	–	–	0 (0)	–	–	33 (100)	NR
Suzue ⁷⁴ (2007)	CEA	All (0–180 d)	72 (100)							NR
		0–30 d	15 (20.8)	65.4 ± 7.0	14 (93.3)	7 (46.7)	–	–	8 (14.0)	NR
		31–180 d	57 (79.2)	69.2 ± 7.4	47 (76.9)	27 (47.4)	–	–	30 (52.6)	NR
Dellagrammaticas ⁷¹ (2007) GALA Trial	CEA		867 (100)	71.5 ± 3.5	687 (69)	303 (35)	–	146 (17)	231 (27)	NR
Flanigan ⁷² (2007)	CEA		170 (38.5)	NR	NR	NR	NR	NR	NR	NR
Sbarigia ⁷⁶ (2006)	CEA		96 (100)	69.4 ± 9.8	81 (84.3)	NR	NR	NR	NR	NR
Imai ⁷⁷ (2005)	CAS		17 (100)	69.9	13 (76.4)	NR	NR	NR	NR	NR
Rantner ⁷⁸ (2005)	CEA	All (0–180 d)	104 (100)	69.4 ± 9.8	80 (87.1)	NR	NR	NR	NR	NR
		0–6 hours	7 (6.7)							
		0–27 d	29 (27.9)							
		28–180 d	62 (59.6)							
Welsh ⁸¹ (2003)	CEA	All (0–180 d)	40 (100)							
		0–1 d	19 (47.5)	65.8 ± 8.9	11 (57.9)	NR	NR	NR	NR	NR
		60–180 d	21 (52.5)	68.3 ± 9.5	12 (57.1)	NR	NR	NR	NR	NR
ECST ⁸⁴ (1988)	CEA vs. BMT		1 807 (100)	NR	NR	NR	NR	NR	NR	NR
<i>National audits</i>										
Kuhrij ²¹ (2019) Dutch Audit for Carotid Intervention	CEA	All	8 620 (100)	72 ± 9.0	6010 (70)	NR	NR	NR	NR	NR
		0–14 d	6 645 (78)	NR	NR	NR	NR	NR	NR	NR
Faateh ³⁹ (2018) National Quality Improvement	CEA	All	9 271 (100)	NR	NR	NR	NR	NR	NR	NR
		eCEA	546 (5.9)	70.5 ± 11.2	348 (63.7)	206 (37.7)	–	61 (11.2)	279 (51.1)	NR
	Non-eCEA	8 725 (94.1)	70.8 ± 9.9	5 390 (61.8)	3 282 (37.6)	–	1 507 (17.3)	3 935 (45.1)	NR	
Tsantilas ⁴⁰ (2018) German Statutory Quality Assurance	CAS	All (0–180 d)	4 717 (100)	69.8 ± 9.8	3 201 (67.8)	1 351 (28.6)	–	797 (16.9)	2 126 (45.1)	NR
		0–2 d	550 (11.6)	69.1 ± 10.1	386 (70.2)	155 (28.2)	–	65 (11.8)	268 (48.7)	NR
		3–7 d	1 579 (33.4)	69.6 ± 9.9	1070 (67.8)	472 (29.9)	–	212 (13.4)	796 (50.4)	NR
		8–14 d	1 244 (26.3)	70.1 ± 9.9	835 (67.1)	306 (24.6)	–	234 (18.8)	622 (50.0)	NR
		15–180 d	1 344 (28.4)	69.9 ± 9.5	910 (67.7)	418 (31.1)	–	286 (21.3)	440 (32.7)	NR
Blay ⁴¹ (2018)	CEA	All (0–180 d)	3 427 (100)	NR	2181 (63.6)	NR	NR	NR	NR	
ACS-NSQIP		0–7d	3 247 (94.7)	NR	NR	NR	NR	NR	NR	
		8–180 d	180 (5.3)	NR	NR	NR	NR	NR	NR	
Rocco ²⁰ (2018)	CEA / CAS		110 (100)	NR	78 (70.9)	10 (9.1)	–	–	100 (90.9)	NR

Table 2-continued

Article (Year)	CEA / CAS	Time periods	Symptomatic CEA / CAS	Age	Male sex	Type of event				New events before intervention
						TIA	Crescendo TIA / stroke in evolution	Afx	Minor / major stroke	
Avgerinos ⁴³ (2017) VSGNE Database	CEA	All (0–180 d)	989 (100)	69.6 ± 10.7	653 (66)	NR	NR	NR	NR	NR
		0 d	477 (48.2)	69.4 ± 10.5	307 (64.4)	NR	NR	NR	NR	NR
		1–2 d	96 (9.8)	70.1 ± 10.9	66 (68.8)	NR	NR	NR	NR	NR
		3–5 d	322 (32.6)	69.9 ± 10.8	210 (65.2)	NR	NR	NR	NR	NR
		6–180 d	94 (9.1)	69.3 ± 11.4	70 (74.5)	NR	NR	NR	NR	NR
Kjorstad ¹⁸ (2017) National Norwegian Carotid Study	CEA		368 (100)	NR	NR	135 (36.7)	–	64 (17.4)	167 (45.4)	12 (3.3%)
Hobeau ⁴² (2017)	CEA/CAS		187 (100)	71 ± 10	142 (75.9)	NR	NR	NR	NR	NR
Loftus ²⁴ (2016) UK National Vascular Registry	CEA		23 235 (70.0)	72.8 ± 3.7	15 510 (66.8)	11 029 (47.5)	–	3 553 (15.3)	8 229 (35.4)	NR
Villwock ¹² (2014) NIS Registry	CEA vs. CAS	All (0–14 d)	72 797 (100)	NR				NR		
		0–2 d	41 008 (56.3)	NR	22 601 (55.1)	38 001 (52.2)	3 007 (4.1)	NR		NR
			31 899 (43.8)	NR	17 105	29 936 (41.1)	1 963 (2.7)	NR		NR
			9 109 (12.5)	NR	5 496	8065 (11.1)	1 044 (1.4)	NR		NR
		3–14 d	31 789 (43.7)	NR	25 146 (79.1)	22 207 (30.5)	12 582 (17.3)	NR		NR
			30 428 (41.8)	NR	22 436	19 729 (27.1)	10 699 (14.7)	NR		NR
Stromberg ²⁷ (2012) Swedvasc Registry	CEA	All (0–180 d)	2 596 (100)	71.9 ± 8.2	1 731 (66.7)	1 041 (40.1)	54 (2.1)	508 (19.6)	993 (38.3)	NR
		0–2 d	148 (100)	69.8 ± 8.6	104 (70.3)	70 (47.3)	17 (11.5)	23 (15.5)	38 (25.7)	NR
		3–7 d	804 (100)	72.6 ± 8.2	526 (65.4)	363 (45.1)	19 (2.4)	122 (15.2)	300 (37.3)	NR
		8–14 d	677 (100)	72.7 ± 8.2	438 (64.7)	279 (41.2)	14 (2.1)	107 (15.8)	259 (38.3)	NR
		15–180 d	967 (100)	71.0 ± 8.1	663 (68.6)	329 (34.0)	4 (0.4)	256 (26.5)	411 (42.5)	NR
Garg ⁶⁰ (2011) National Surgery Quality Improvement	CEA		8 103 (46.6)	NR	NR	NR	NR	NR	NR	NR
Palombo ⁶² (2009) Italian Vascular Registry	CEA		1 894 (32.6)	NR	NR	NR	NR	NR	NR	NR
Halliday ⁸⁶ (2009) UK Surgeons undertaking CEA	CEA	All (0–180 d)	4 576 (100)	NR	NR	1 914 (41.8)	–	916 (20.0)	1 634 (35.7)	NR
		0–2 d	944 (20.6)	NR	NR	NR	NR	NR	NR	NR
		3–4 d	654 (14.3)	NR	NR	NR	NR	NR	NR	NR
		5–12 d	1 621 (35.4)	NR	NR	NR	NR	NR	NR	NR
		13–180 d	1 372 (30.0)	NR	NR	NR	NR	NR	NR	NR
Vogel ⁶⁵ (2009) Nationwide Inpatient Sample (2005)	CEA/CAS		2 237 (100)	NR	NR	NR	NR	NR	NR	NR
Gladstone ⁶³ (2009) Canadian Stroke Network	CEA		105 (100)	NR	NR	NR	NR	NR	NR	NR
Goodney ⁶⁶ (2008) VSGNE (2003–2007)	CEA	All	1 360 (100)	NR	NR	680 (50)	–	572 (42.1)	340 (25)	NR
		Emergency / Urgent	309 (22.7)	NR	NR	NR	–	NR	NR	NR
Pell ⁷⁹ (2004) National Prospective Survey Scotland	CEA	All (0–60 d)	855 (100)	NR	510 (58.2)	NR	NR	NR	NR	NR
		0–30 d	103 (27)	NR	NR	NR	NR	NR	NR	NR
		31–60 d	222 (58)	NR	NR	NR	NR	NR	NR	NR
Tu ⁸² (2003) Ontario Carotid Endarterectomy Registry	CEA		4 192 (69.4)	NR	NR	NR	NR	NR	NR	NR

Data are presented as *n* (%) or mean ± standard deviation, unless stated otherwise. NA = not applicable; NR = not reported. *p* value is considered significant if $\leq .050$.

* Of the most recent neurological event before intervention.

† Early category was subclassified into ultra-early (0–14 d) with not significant difference compared with other categories.

‡ Only minor strokes were included.

Table 3. Analysis of post-procedural outcomes after carotid endarterectomy (CEA) or carotid artery stenting (CAS), stratified by delay after index event

Study, year	CEA/CAS	0–2 d	3–7 d	8–14 d	15–30 d	31–180 d
30 day stroke – % (n)						
Jankowitz, 2020 ¹³	CEA	5.1 (3)	–	–	–	–
	CAS	3.3 (2)	–	–	–	–
Huang, 2018 ¹⁴	CEA	27 (3)	0 (0)	4.3 (1)	–	0.6 (1)
Tsantilas, 2018 ⁴⁰ German Statutory Quality	CAS	3.8 (21)	3.5 (56)	1.8 (22)	–	2.2 (30)
Sharpe, 2013 ¹⁵	CEA	2.4 (1)	1.8 (3)	0.8 (1)	–	0.8 (1)
Stromberg, 2012 Swedvasc ²⁷	CEA	10.8 (16)	2.5 (20)	3.4 (23)	–	4.0 (39)
Nordanstig, 2017 ⁸	CEA	8.0 (6)	–	3.0 (9)	–	–
Avgerinos, 2017 VSGNE ⁴³	CEA	3.5 (20)	–	–	2.4 (10)	–
Tsantilas, 2016 ²³	CEA	0 (0)	1.8 (2)	1.5 (1)	–	1.8 (3)
Loftus, 2016 UK National Vascular Registry ²⁴	CEA	3.1 (24)	2.0 (103)	1.7 (107)	–	1.8 (199)
Jonsson, 2015 ¹⁶	CAS	0 (0)	3.5 (3)	6.3 (5)	–	3.5 (5)
Rantner, 2014 ⁴⁸	CEA	8 (3.9)	4 (1.8)	6 (4.4)	–	5 (2.5)
Villwock, 2014	CEA	1.1 (341)	–	1.6 (496)	–	–
NIS ^{*,12}	CAS	1.7 (154)	–	1.8 (77)	–	–
Roussopoulou, 2019 ⁹	CEA	7.9 (5)	–	4.4 (11)	–	–
Seguchi, 2017 ¹⁰	CAS	2.5 (1)	–	–	6.2 (4)	–
Setacci, 2007 ⁶⁹	CEA	0 (0)	–	0 (0)	–	–
Blay, 2018 ACS-NSQIP ⁴¹	CEA	–	2.7 (86)	–	2.8 (5)	–
Rantner, 2017 ⁴⁴	CEA	–	1.3 (3)	–	3.4 (63)	–
	CAS	–	8.0 (23)	–	6.8 (122)	–
Annambhotla, 2012 ⁵⁹	CEA	–	0 (0)	–	0 (0)	1.6 (4)
Chisci, 2016 ¹⁹	CEA	–	–	3.0 (3)	–	0.4 (1)
Kretz, 2015 ²⁶	CEA	–	–	1.3 (2)	–	1.5 (4)
Charmoille, 2014 ⁴⁷	CEA	–	–	0 (0)	–	3.5 (3)
Faggioli, 2013 ⁵⁴	CEA	–	–	6.6 (4)	–	2.9 (3)
Ballotta, 2008 ⁶⁸	CEA	–	–	0 (0)	–	–
Suzue, 2007 ⁷⁴	CEA	–	–	0 (0)	–	0 (0)
30 day myocardial infarction – % (n)						
Jankowitz, 2020 ¹³	CEA	3.4 (2)	–	–	–	–
	CAS	4.9 (3)	–	–	–	–
Huang, 2018 ¹⁴	CEA	0 (0)	0 (0)	0 (0)	–	3.3 (6)
Tsantilas, 2018 German Statutory Quality ⁴⁰	CAS	0.3 (1)	0.1 (1)	0 (0)	–	0.1 (1)
Jonsson, 2015 ¹⁶	CAS	0 (0)	3.5 (3.0)	2.5 (2)	–	1.4 (2)
Avgerinos, 2017 VSGNE ⁴³	CEA	1.4 (8)	–	–	1.2 (5)	–
Tsantilas, 2016 ²³	CEA	2.0 (1)	1.0 (1)	0 (0)	–	1.0 (1)
Roussopoulo, 2019 ⁹	CEA	0 (0)	–	0.8 (2)	–	–
Seguchi, 2017 ¹⁰	CAS	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Setacci, 2007 ⁶⁹	CEA	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Annambhotla, 2012 ⁵⁹	CEA	0 (0)	0 (0)	0 (0)	0 (0)	0.8 (2)
Chisci, 2016 ¹⁹	CEA	0 (0)	0 (0)	0 (0)	1.8 (4)	–
Charmoille, 2014 ⁴⁷	CEA	0 (0)	0 (0)	0 (0)	–	3.5 (3)
Faggioli, 2013 ⁵⁴	CEA	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Ballotta, 2008 ⁶⁸	CEA	0 (0)	0 (0)	0 (0)	–	–
Blay, 2018 ACS-NSQIP ⁴¹	CEA	–	0.99 (32)	–	0.56 (1)	–
Kretz, 2015 ²⁶	CEA	–	–	0.6 (1)	–	1.2 (3)
30 day mortality – % (n)						
Jankowitz, 2020 ¹³	CEA	0 (0)	–	–	–	–
	CAS	1.6 (1)	–	–	–	–
Huang, 2018 ¹⁴	CEA	0 (0)	0 (0)	0 (0)	–	0.6 (1)
Tsantilas, 2018 German Statutory Quality ⁴⁰	CAS	2.2 (12)	0.9 (14)	0.6 (8)	–	0.7 (10)
Jonsson, 2015 ¹⁶	CAS	0 (0)	0 (0)	3.8 (3)	–	0.7 (1)
Sharpe, 2013 ¹⁵	CEA	0 (0)	0 (0)	0.8 (1)	–	0 (0)
Stromberg, 2012 Swedvasc ²⁷	CEA	2.0 (3)	1.2 (10)	1.5 (10)	–	1.7 (16)
Avgerinos, 2017 VSGNE ⁴³	CEA	1.2 (7)	–	–	1.4 (6)	–
Tsantilas, 2016 ²³	CEA	3.0 (2)	1.0 (1)	0 (0)	–	1.0 (1)
Loftus, 2016 ²⁴ UK National Vascular Registry	CEA	1.0 (8)	0.9 (46)	0.7 (44)	–	0.8 (88)
Rantner, 2014 ⁴⁸	CEA	0.5 (1)	0 (0)	0.7 (1)	–	0.5 (1)
Villwock, 2014	CEA	0.4 (129)	–	0.8 (258)	–	–
NIS ^{*,12}	CAS	2.1 (191)	–	1.6 (69)	–	–
Roussopoulo, 2019 ⁹	CEA	0 (0)	–	0.4 (1)	–	–
Nordanstig, 2017 ⁸	CEA	0 (0)	–	0.3 (1)	0 (0)	0 (0)
Seguchi, 2017 ¹⁰	CAS	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Annambhotla, 2012 ⁵⁹	CEA	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Chisci, 2016 ¹⁹	CEA	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)

Table 3-continued

Study, year	CEA/CAS	0–2 d	3–7 d	8–14 d	15–30 d	31–180 d
Blay, 2018 ACS-NSQIP ⁴¹	CEA	1.2 (38)			2.8 (5)	
Kretz, 2015 ²⁶	CEA		1.9 (3)			1.5 (4)
Charmoille, 2014 ⁴⁷	CEA		1.7 (1)			1.2 (1)
Faggioli, 2013 ⁵⁴	CEA		1.6 (1)		0 (0)	3.6 (3)
Ballotta, 2008 ⁶⁸	CEA		0 (0)		–	–
<i>30 day death / stroke – % (n)</i>						
Jankowitz, 2020 ¹³	CEA	5.1 (3)	–	–		–
	CAS	4.9 (3)	–	–		–
Roussopoulou, 2019 ⁹	CEA	7.9 (5)	4.8 (12)	–		–
Huang, 2018 ¹⁴	CEA	27 (3)	0 (0)	4.3 (1)		1.1 (2)
Nordanstig, 2017 ⁸	CEA	8.0 (6)		3.0 (9)		–
Tsantilas, 2016 ²³	CEA	3.0 (2)	3.0 (3)	2.0 (1)		2.0 (3)
Loftus, 2016 UK National Vascular Registry ²⁴	CEA	29 (3.7)	128 (2.5)	132 (2.1)		254 (2.3)
Jonsson, 2015 ¹⁶	CAS	0 (0)	4.7 (4)	6.3 (6)		4.1 (6)
Rantner, 2014 ⁴⁸	CEA	4.4 (9)	1.8 (4)	5.1 (7)		2.5 (5)
Sharpe, 2013 ¹⁵	CEA	2.4 (1)	1.8 (3)	0.8 (1)		0.8 (1)
Stromberg, 2012	CEA	11.5 (17)	3.6 (29)	4.0 (27)		5.4 (52)
Swedvasc ²⁷						
Nordanstig, 2017 ⁸	CEA	6 (8)		10 (3)		–
Seguchi, 2017 ¹⁰	CAS	2.5 (1)			6.2 (4)	
Rantner, 2017 ⁴⁴	CEA		1.3 (3)			3.6 (65)
	CAS		8.4 (24)			7.1 (129)
Chisci, 2016 ¹⁹	CEA		3.0 (3)			0.4 (1)
<i>Mean 30 day death / stroke ± standard deviation</i>						
Jankowitz, 2020 ¹³	CEA	5.6±3.2	–	–		–
	CAS	5.3±4.1	–	–		–
		<i>p</i> =.66	–	–		–
Huang, 2018 ¹⁴	CEA	4.7±7.2	3.3±1.7	2.0±1.5		1.8±1.5
Tsantilas, 2018 German Statutory Quality ⁴⁰	CAS	3.5±1.2	3.3±0.9	2.5±0.6	–	–
Villwock, 2014 ¹² NIS*	CEA for Stroke	3.5±1.2	7.3±1.5		–	–
	CAS for Stroke	4.3±1.5	7.3±1.5		–	–
	CEA for TIA/AFX	1.8±0.1	6.5±1.2		–	–
	CAS for TIA/AFX	1.3±0.4	6.0±1.2		–	–
Roussopoulo, 2019 ⁹	CEA	6.5±1.7	10.3±2.0		–	–
Seguchi, 2017 ¹⁰	CAS	22.5±6.3			21.5±4.6	
Chisci, 2016 ¹⁹	CEA		3.7±2.2		2.5±1.5	–

TIA = transient ischaemic attack; AFX = amaurosis fugax

* In hospital data

Quality assessment

The methodology of the studies and risk of bias were systematically assessed by two independent reviewers (AC and JP) using the Methodological Index for Non-Randomized Studies (MINORS) score,⁷ with a maximum score of 16 for non-comparative and 24 for comparative studies. A score ≤ 8 was considered poor quality, 9 – 14 moderate quality, and 15 – 16 good quality for non-comparative studies. Cut off points were ≤ 14, 15 – 22, and 23 – 24, respectively, for comparative studies.

Authorship of the studies was unblinded during review. Discrepancies between the reviewers during the search, selection, and quality assessment were resolved by discussion. In case of persisting disagreement, a third reviewer was consulted.

Statistical analysis

The software Review Manager 5.4 (REVMAN) was used to analyse data. Odds ratios (OR) and 95% confidence intervals (CI) were used for dichotomous variables, and mean differences (MDs) with 95% CI for continuous data.

Statistical heterogeneity, defined as a measure of the variability of outcomes between studies, was assessed by the Cochran's Q test: the H² test (Higgins and Thompson) was used to quantify the magnitude of heterogeneity. The parameter I² retrieved from the H² test was used with a cut off of 25% for low, 25% – 50% for intermediate, and above 50% for high heterogeneity. A fixed effects model was used when heterogeneity (I²) was less than 50% and a random effects model was used when heterogeneity (I²) was high.

RESULTS

A total of 1 495 potentially relevant articles were identified initially. After reviewing title or abstract, 112 articles were retrieved and 71 judged eligible for inclusion (Fig. 1). Agreement between reviewers was reached for all articles and arbitration by the third reviewer was unnecessary.

Overall, there were 24 retrospective analyses of prospective national databases, 10 retrospective analyses of prospective databases, nine prospective studies, three RCTs, and three case control studies. The remaining 22 studies

were retrospective, single centre, or multicentre, analysis of patient data. The total number of symptomatic patients in the constituent studies was 232 952 (Table 1). Methodological quality is reported in Supplementary Table S1. A total of 18 non-comparative studies of moderate quality and 53 comparative studies (50 moderate, two poor quality, and one good quality) were included (Supplementary Table S1).

Definitions

The definitions of “delay” and “index event” were heterogeneous (Table 1). Most studies defined “early intervention” when CEA or CAS were performed within 14 days of the index event, although some studies applied stricter or looser definitions (Table 1). Stratification of the timing of events within the first 14 days was described in some studies, for example as “acute/urgent/emergency/ultra-early interventions” (Table 1). One study was identified that defined the timing of intervention as the time from the qualifying event (defined as the most recent neurological event before intervention, rather than the index event).⁸

Symptomatic status and timing of intervention

Considering all symptomatic patients (232 952), the time to intervention was reported for 148 653 patients (63.8%), of whom 44 410 (29.9%) underwent either CEA or CAS within the first 48 hours and 108 139 (72.7%) within the first 14 days after the index event.

Thirty-five studies reported outcomes after CEA alone (73 242), while five studies reported outcomes after CAS alone (5 443). Five studies reported mixed outcomes, three of which compared CEA (64 430) with CAS (15 624) (Table 2).

Stratification of demographic data, type of neurological index event, and occurrence of new neurological symptoms, stratified by intervention delay are detailed in Table 2.

Where reported, patients presenting with crescendo TIAs were more likely to undergo an early intervention.^{9,10} The remaining presenting events (TIA, amaurosis fugax and stroke) were evenly distributed by intervention delay, with few exceptions (Table 2).

Primary and secondary outcomes

Peri-operative (30 day) outcomes along with data on hospitalisation duration (in days), stratified by intervention delay and by type of revascularisation (CEA vs. CAS) are detailed in Table 3. Almost all of the CAS procedures in the varying meta-analyses were performed via the transfemoral route. No published studies have evaluated outcomes for transcarotid artery revascularisation (TCAR) vs. CEA, with stratification for delays to treatment.¹¹

Carotid endarterectomy vs. carotid artery stenting

Overall data. Outcome data from eight CEA studies (88 129) and two CAS studies (3 551) are detailed in Table 4. In CEA patients, 30 day stroke was 1.4% (95% CI 0.9 – 1.8) when performed within 0 – 2 days, vs. 1.8% (95% CI 1.5 – 2.0) when performed between three and 14 days. In CAS

patients, 30 day stroke was 1.8% (95% CI 1.3 – 2.3) when performed within two days, vs. 2.2% (95% CI 0.3 – 4.2) between three and 14 days (Table 4). Across all intervention timings, there were higher rates of stroke after CAS (vs. CEA), while there were higher rates for MI after CEA (vs. CAS). Individual study data used to calculate the pooled rates are available in Supplementary Table S2 (Supplementary material).

Carotid endarterectomy vs. carotid artery stenting when performed ≤ 2 days after the index event.

Two moderate quality studies reported outcomes after CEA vs. CAS (75 917) when performed within two days of the index event, including one retrospective analysis of prospective single centre data (120) and one retrospective analysis of Nationwide Inpatient Sample (NIS) database (72 797).^{12,13} Compared with CEA, meta-analysed data revealed significantly higher risks for 30 day stroke when CAS was performed within ≤ 2 days (OR 0.70; 95% CI 0.58 – 0.85) as well as significantly higher rates of 30 day death (OR 0.41; 95% CI 0.31 – 0.53) (Fig. 2). One of the above mentioned registries (72 797) analysed patients with and without cerebral infarction separately and concluded that expedited revascularisation in patients with cerebral infarction on admission increased the risk of iatrogenic stroke and death; the increase in mortality was more dramatically seen in patients treated by CAS. No differences were found in stroke/death rates between CEA and CAS if patients presented without infarction.¹²

Carotid endarterectomy vs. carotid artery stenting when performed 3 – 14 days after index event.

The same large national registry (72 797) cited in the previous section also reported comparative outcomes between CEA vs. CAS when performed 3 – 14 days after the index event (with or without cerebral infarction). There was no statistically significant difference in 30 day stroke after CAS (1.8%) vs. after CEA (1.6%; OR 1.1; 95% CI 0.9 – 1.4). However, 30 day mortality was statistically significantly higher after CAS (1.6%) vs. after CEA (0.8%; OR 1.9; 95% CI 1.4 – 2.5). Again, no differences were found in stroke/death rates between CEA and CAS if patients presented without infarction.¹²

Outcomes after carotid endarterectomy

≤ 2 days vs. 3 – 14 days after index event. A total of nine moderate quality manuscripts were included in this analysis, three of which were retrospective analyses of national registries, two prospective multicentre studies, and four retrospective studies. CEA performed 3 – 14 days after the index event was associated with a statistically significantly lower 30 day death/stroke risk (OR 2.05; 95% CI 1.56 – 2.68) compared with performing CEA within ≤ 2 days of index event. No statistically significant difference was attained regarding 30 day stroke, MI, and mortality (OR 1.87; 95% CI 0.99 – 3.51, OR 1.50; 95% CI 0.21 – 10.45, and OR 1.11; 95% CI 0.58 – 2.14, respectively) (Fig. 3).

Meta-analysis of 30 day stroke, mortality, and MI included the same core studies, while in the analysis of 30 day death/stroke, three studies were excluded as they did not report the composite outcome,^{9,12,14} while one study was included that only reported combined stroke/death data, with worse outcomes reported in the expedited cohort (Fig. 3).¹⁵

≤ 7 days vs. 8 – 14 days after index event. A total of five moderate quality manuscripts were included in this analysis, two of which were retrospective analyses of national registries and three retrospective studies. Meta-analyses (Fig. 4) revealed that CEA performed within 7 days of the index event was associated with a significantly lower risk of 30 day stroke compared with 8 – 14 days (OR 0.67; 95% CI 0.54 – 0.84). There was no difference regarding CEA performed within 7 days of the index event (vs. 8 – 14) in the outcomes 30 day mortality (OR 1.86; 95% CI 0.19 – 18.21), 30 day death/stroke (OR 0.79; 95% CI 0.47 – 1.34), or 30 day MI (OR 1.94; 95% CI 0.09 – 41.03) (Fig. 4).

Outcomes after carotid artery stenting

≤ 2 days vs. 3 – 14 days after index event. This systematic review identified 17 578 patients who underwent CAS ≤ 14 days of symptom onset, including 9 833 (55.9%) who underwent CAS within ≤ 2 days of the index symptom. Two moderate quality national registries compared outcomes when CAS was performed within ≤ 2 days vs. 3 – 14 days of the index symptom.^{14,16} Compared with CAS interventions within 3 – 14 days, performing CAS ≤ 2 days was not associated with significant differences in 30 day stroke (OR 1.36; 95% CI 0.84 – 2.21) or 30 day MI (OR 2.23; 95% CI 0.34 – 14.41). However, performing CAS within ≤ 2 days of the index symptom was associated with significantly higher risks of 30 day death (OR 2.76; 95% CI 1.39 – 5.50) compared with CAS interventions within 3 – 14 days of the index event (Fig. 5). A single study ($n = 323$) reported the results of a comparative analysis of 30 day death/stroke and showed no significant difference when CAS was performed in either time period (OR 0.61; 95% CI 0.03 – 11.06).¹⁶

≤ 7 days vs. 8 – 14 days after index event. The same national registries that compared outcomes when CAS was performed ≤ 2 days vs. 3 – 14 days, also analysed outcomes ≤ 7 days vs. 8 – 14 days.^{14,16} Forest Plot analyses (Fig. 6) revealed that there was no significant difference in 30 day stroke, MI, or mortality when CAS was performed ≤ 7 days vs. 8 – 14 days after the index event (OR 1.18; 95% CI 0.29 – 4.83, OR 1.62; 95% CI 0.35 – 7.43, and OR 0.67; 95% CI 0.04 – 10.12, respectively).

Recurrent events while awaiting a carotid intervention

Recurrent neurological events occurring after a decision to perform CEA but before it was performed were reported

rarely. In one single centre study, 42% of patients who waited 0 – 180 days to undergo CEA suffered a recurrent TIA or stroke prior to CEA.¹⁷ The National Norwegian Carotid Study reported that 3.3% suffered recurrent symptoms prior to undergoing CEA within 14 days of the index event (Table 2).¹⁸

Neurological outcome

Surprisingly, few studies used the National Institutes of Health Stroke Scale (NIHSS) to quantify improvements in neurological disability after carotid interventions, stratified for the timing of carotid interventions (Table 3). A single centre study reported improved neurological outcomes for interventions performed within 14 days vs. 15 – 30 days of the index event (NIHSS range 0.9 ± 0.4 vs. 0.5 ± 0.2 ; $p = .011$).¹⁹ Other studies report NIHSS range but with no discriminative data concerning carotid intervention delay from index event.^{13,18,20}

Hospital stay

Hospital stay analysis presented a trend towards prolonged stay in patients undergoing CEA between 3 – 14 days after the index event vs. ≤ 2 days, with a mean difference (MD) of -1.28 (95% CI $-6.96 - 4.40$) (Fig. 7).

Only one study¹⁰ reported length of hospital stay after CAS, with non-significant difference between intervention ≤ 2 vs. 3 – 14 days (MD -1.0 ; 95% CI $-3.1 - 1.1$).

DISCUSSION

The ESVS guidelines advise that CEA (CAS) should be performed within 14 days of symptom onset.¹ Evidence suggests that there has been a major drive towards performing interventions < 14 days (especially in Europe), where the median delay to CEA is now 11 days in the Netherlands,²¹ 7 days in Sweden,²² 9 days in Germany,²³ and 11 days in the UK.²⁴ A temporal trend towards a progressive decrease in delays from index event to undergoing CEA (or CAS) has been reported by several national registries.^{24–26} The proportion of Danish Stroke Registry patients¹⁷ undergoing carotid interventions within two weeks of the index event increased from 13% in 2007 to 47% by 2010 (OR 5.8; 95% CI 4.3 – 10.1).²⁵ Similar findings were reported by the UK National Vascular Registry.²⁴ However, uncertainty persists regarding the ideal timing for either CEA or CAS within the 14 day time frame to balance the dichotomy between recurrent stroke prevention and minimising peri-operative risks.²⁵

The Swedish Vascular Registry (Swedvasc) were the first to highlight concerns about intervening within ≤ 48 hours of the index event, as they observed an 11.5% rate of 30 day death/stroke, compared with 3.6% (3 – 7 days), 4% (8 – 14 days), and 5.4% (> 14 days) for CEA. However, only a small proportion of Swedvasc patients were treated ≤ 48 hours (5.7%), which may have limited the generalisability of the Swedish registry data.²⁷ Other (much larger) national

Table 4. Pooled estimated prevalence in different sized samples on main outcomes, stratified by intervention timing and type of procedure

	CEA		CAS	
	0–2 days – % (95% CI)	3–14 days – % (95% CI)	0–2 days – % (95% CI)	3–14 days – % (95% CI)
30 d stroke	1.4 (0.9–1.8); SE 0.2 ^{*,†}	1.8 (1.5–2.0); SE 0.1 ^{†,‡}	1.8 (1.3–2.3); SE 0.2 ^{*,†}	2.2 (0.3–4.2); SE 0.5 ^{†,‡}
30 d MI	1.5 (0.7–2.2); SE 0.2	0.9 (0.0–1.7); SE 0.2	0.6 (0.0–2.5); SE 0.6	0.2 (0.0–1.3); SE 0.3
30 d mortality	0.5 (0.4–0.6); SE 0.0	0.8 (0.8–0.9); SE 0.0	2.2 (1.8–2.6); SE 1.4	1.3 (0.3–2.2); SE 0.3
30 d death/stroke	4.9 (2.0–7.9); SE 1.2	2.5 (1.8–3.2); SE 0.2	3.5 (0.0–8.4)	2.4 (0.7–6.1)

CAS = carotid artery stenting; CEA = carotid endarterectomy; CI = confidence interval; MI = myocardial infarction; SE = standard error.

* Lower risk of stroke with CEA vs. CAS within two days of index event.

† Lower risk of stroke with CEA vs. CAS within 3–14 days of index event.

‡ In either category (CEA or CAS) stroke risk is lower within two days vs. 3–14 days of index event.

registries have not corroborated the Swedvasc findings. In the German CEA registry (56 000 CEAs), there was no difference in 30 day death/stroke between patients treated ≤ 48 hours by CEA (3%) vs. later time periods (2.5% between 3 – 7 days; 2.6% between 8 – 14 days; 2.3% for CEA thereafter).²³ In the UK national registry involving 20 000 patients, conclusions were that the pathway from most recent symptom to surgery for patients with symptomatic carotid stenosis, could be shortened to maximise the benefit of intervention, without increased peri-operative risk in the period. However, they admitted a slight increase in peri-operative risk of stroke and death in the first 48 hours.²⁴

In this systematic review, 44 410 (29.9%) carotid interventions were undertaken within ≤ 2 days of the index event with no significant difference in 30 day stroke, mortality, and MI, while CEA performed 3 – 14 days after the index event was associated with a significantly lower risk of the composite outcome 30 day death/stroke. On the other hand, CEA within 7 days was associated with a significantly lower risk of stroke (vs. 8 – 14 days).

These contradictory results may be explained by the differences in included studies in each analysis, as already shown. Compared with the analysis of the outcomes stroke

and mortality, analysis of the composite outcome stroke/death did not include data from two national registries and one prospective multicentre study,^{9,12,14} while it included data from one retrospective single centre study that only reported combined stroke/death data.¹⁵ Therefore, studies included in the analysis of 30 day stroke, death, and MI are of better study design compared with the studies in the 30 day death/stroke analysis, even though quality assessment is similar.

There were inconsistent findings regarding timing and outcomes in CAS patients. In patients undergoing CAS ≤ 2 days of the index event (vs. 3 – 14), there was no apparent difference in 30 day stroke or MI but there was a statistically significantly higher risk of death. Conversely, there were no differences in 30 day outcomes between CAS performed ≤ 7 days (vs. 8 – 14). The pathophysiology of procedural stroke may differ with expedited (vs. delayed) interventions in line with acute changes in atherosclerotic plaque vulnerability, which have been associated with an increased risk of embolism and neurological events after CAS.²⁸

The systematic review also addressed the question of whether CEA or CAS was safer (or equivalent) when performed in the first 14 days after symptom onset. Compared

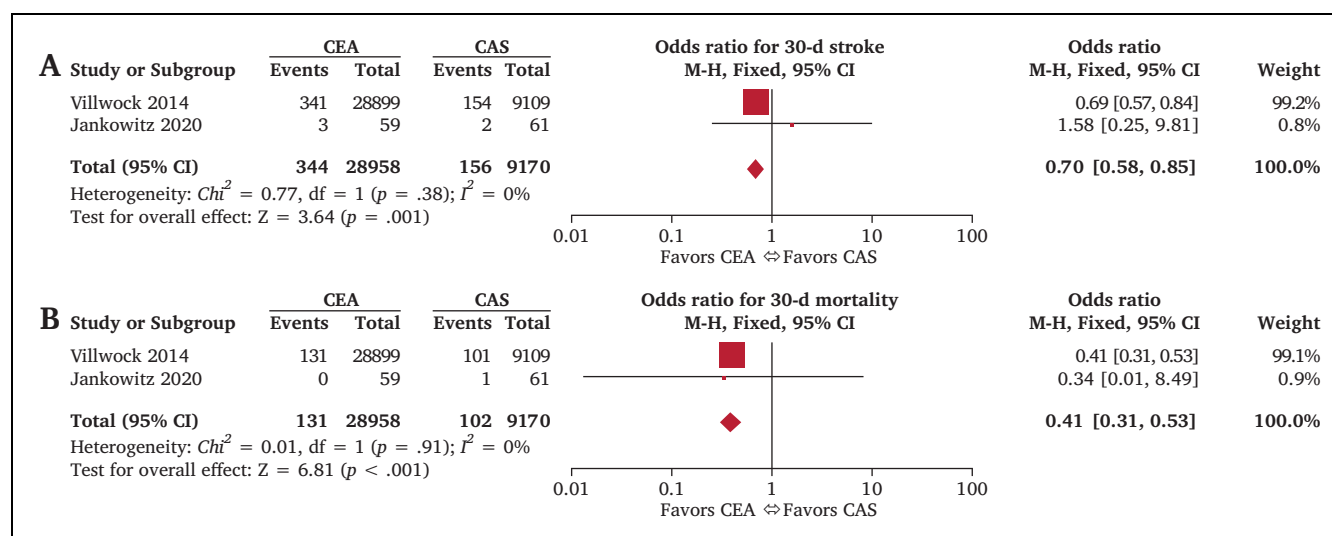
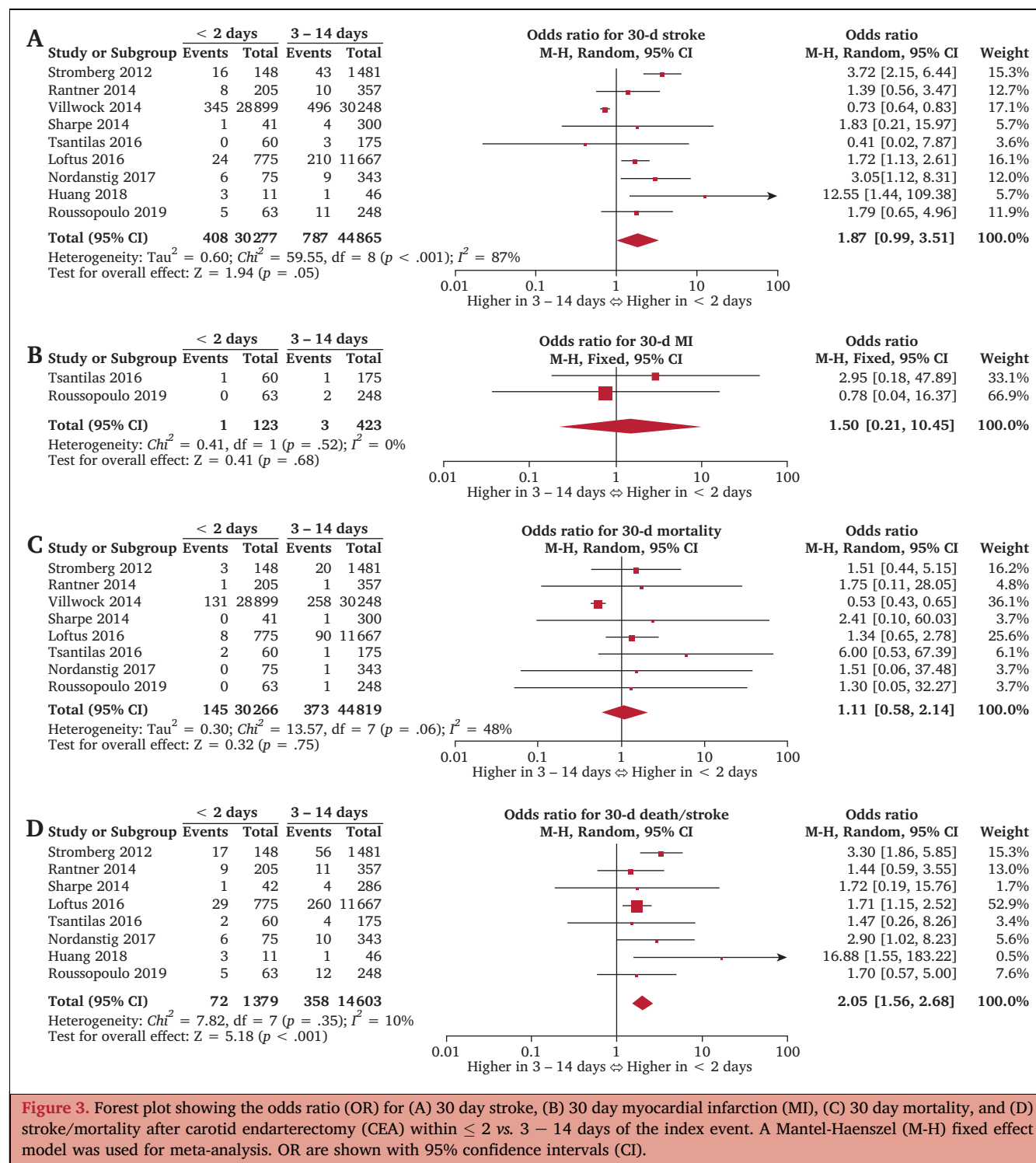


Figure 2. Forest plot showing the odds ratio (OR) for (A) 30 day stroke and (B) 30 day mortality after carotid endarterectomy (CEA) vs. carotid artery stenting (CAS) within two days of index event. A Mantel-Haenszel (M-H) fixed effect model was used for meta-analysis. OR are shown with 95% confidence intervals (CI).



with CEA, CAS was associated with significantly higher 30 day stroke and death rates when performed within ≤ 2 days of symptom onset. In an individual patient meta-analysis of data from the four largest RCTs comparing CEA with CAS (4 138 patients), CAS was associated with significantly higher risks of 30 day stroke, mortality, and death/stroke when performed within ≤ 7 days of the index event.¹²

These data suggest that, at the current time, CEA is probably safer than CAS both when performed ≤ 2 days and ≤ 7 days after symptom onset. However, virtually all of the CAS procedures in the current meta-analyses were performed via the transfemoral route. Registry data suggest that TCAR can be performed with 30 day outcomes similar to CEA in symptomatic patients.²⁹ Unfortunately, no studies

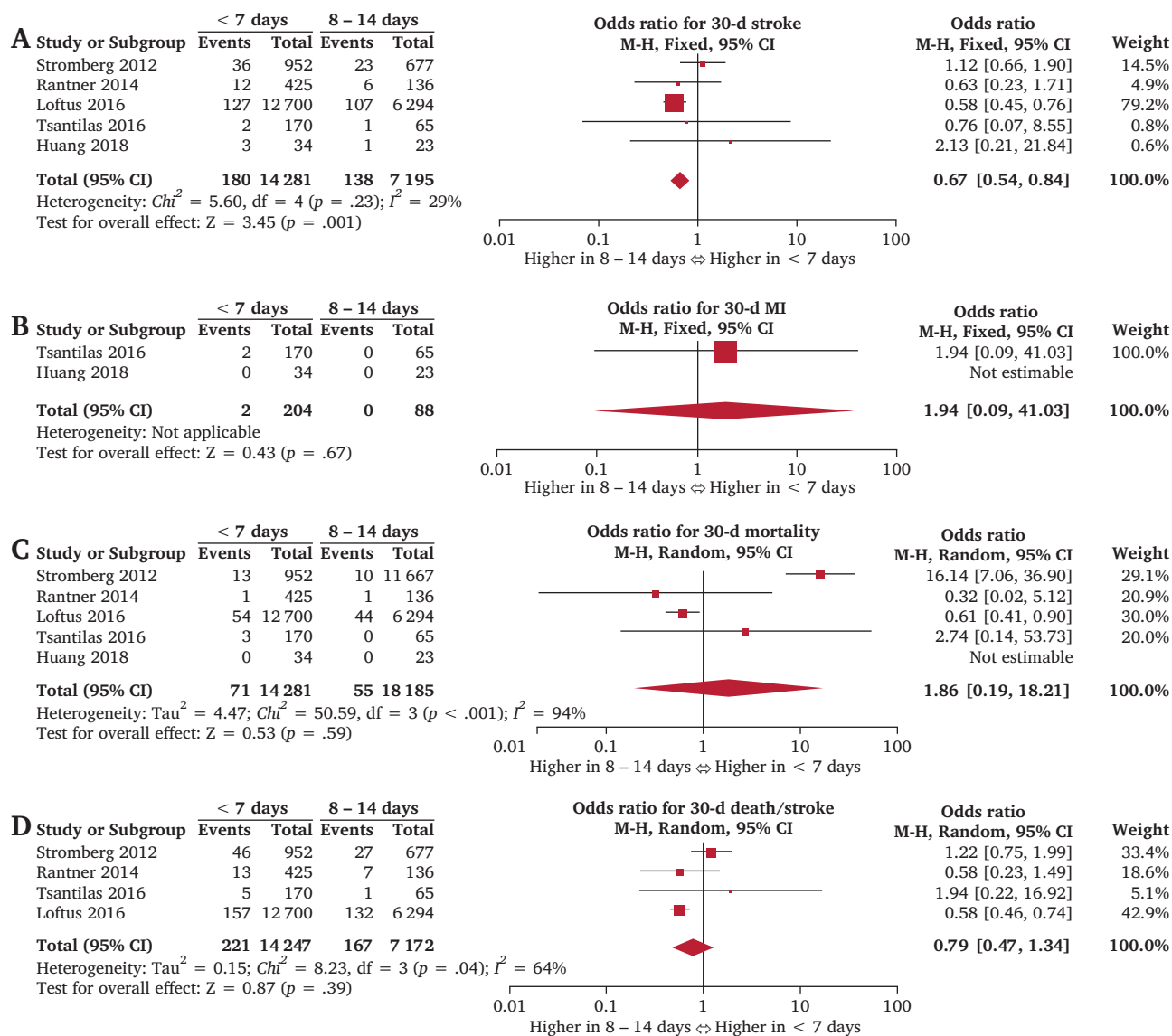


Figure 4. Forest plot showing the odds ratio (OR) for (A) 30 day stroke, (B) 30 day myocardial infarction (MI), (C) 30 day mortality, and (D) stroke/mortality after carotid endarterectomy (CEA) within ≤ 7 vs. 8 – 14 days of the index event. A Mantel-Haenszel (M-H) fixed effect model was used for meta-analysis. OR are shown with 95% confidence intervals (CI).

have published outcome data for TCAR when used in the first 14 days after symptom onset,¹¹ and these data are keenly awaited.

There are relatively few data published on the incidence of recurrent events prior to expedited interventions. A prospective cohort study concluded that the risk was about 12% with modern best medical therapy, but that half of all recurrent events occurred within two days of the index event.³⁰ On the other hand, a recent meta-analysis revealed a cumulative 120 day risk of recurrent stroke of 1.97% (95% CI 0.75 – 3.17) in recent large RCTs, which was statistically significantly lower than in historical controls.³¹

Historically, vascular surgeons have not really considered the prevention of recurrent stroke in the time period between initiating investigation and initial management

and undergoing CEA as being their primary responsibility. However, this attitude is likely to change as more symptomatic patients are started on dual antiplatelet therapy (DAPT) within 24 hours of symptom onset. The 2017 ESVS guidelines recommended that early treatment with DAPT “may be considered” to prevent recurrent events (prior to CEA) in patients with TIA or minor ischaemic stroke and an ipsilateral 50% – 99% stenosis awaiting CEA (Evidence IIb, Level C).¹ At the time, the ESVS Writing Group were unable to recommend routine DAPT in all symptomatic patients because there was no compelling evidence that this strategy conferred additional benefit over antiplatelet monotherapy.

However, based on a meta-analysis of three recent RCTs (CHANCE, POINT, and FASTER) in which 10 447 patients

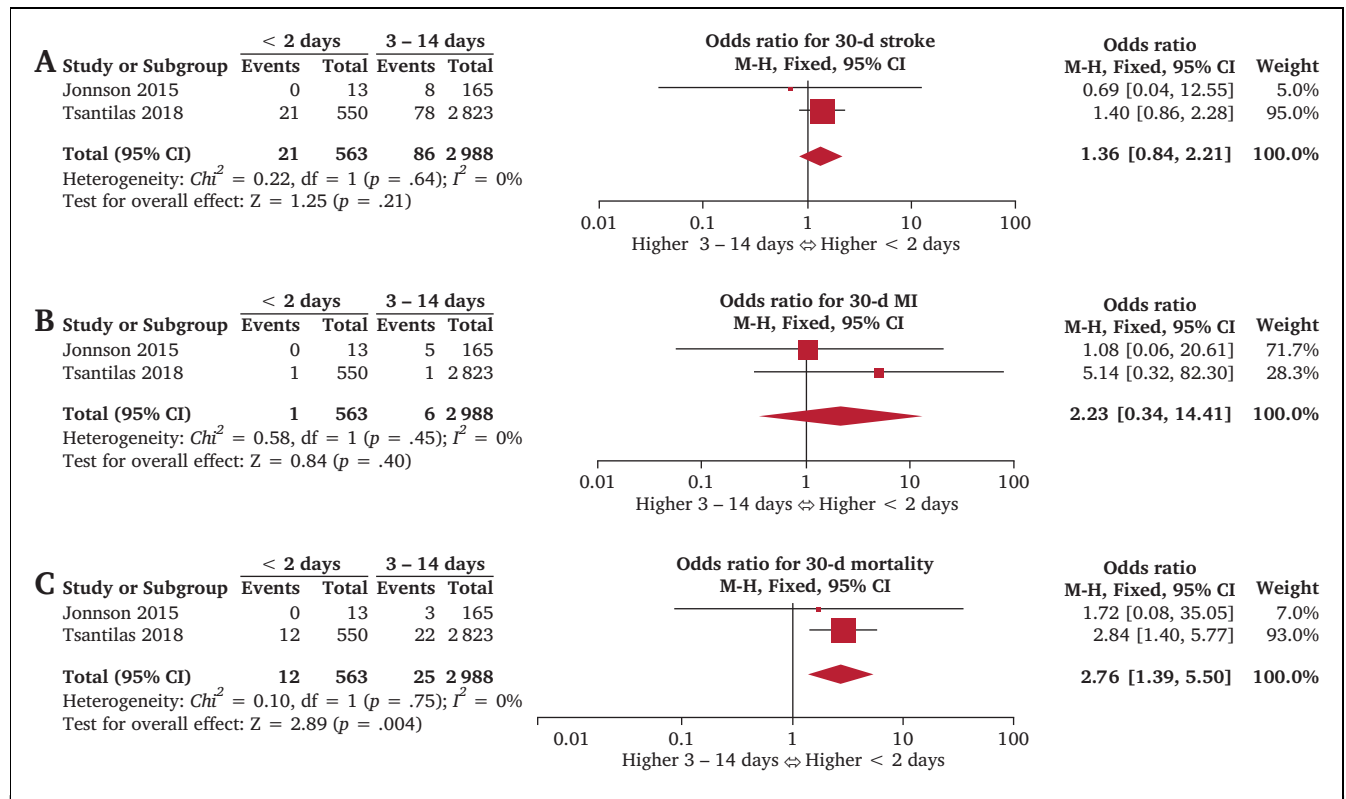


Figure 5. Forest plot showing the odds ratio (OR) for (A) 30 day stroke, (B) 30 day myocardial infarction (MI), and (C) 30 day mortality after carotid artery stenting (CAS) within ≤ 2 vs. 3 – 14 days of the index event. A Mantel-Haenszel (M-H) fixed effect model was used for meta-analysis. OR are shown with 95% confidence intervals (CI).

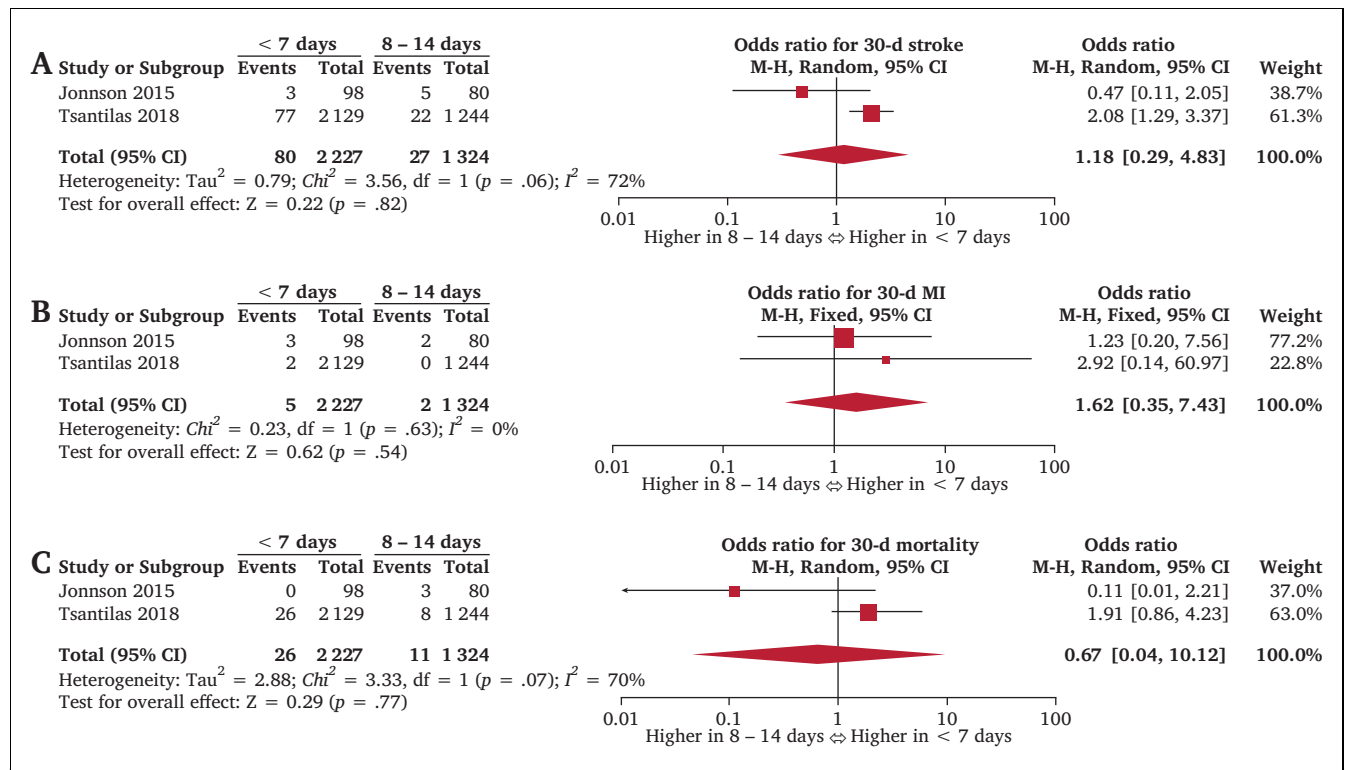
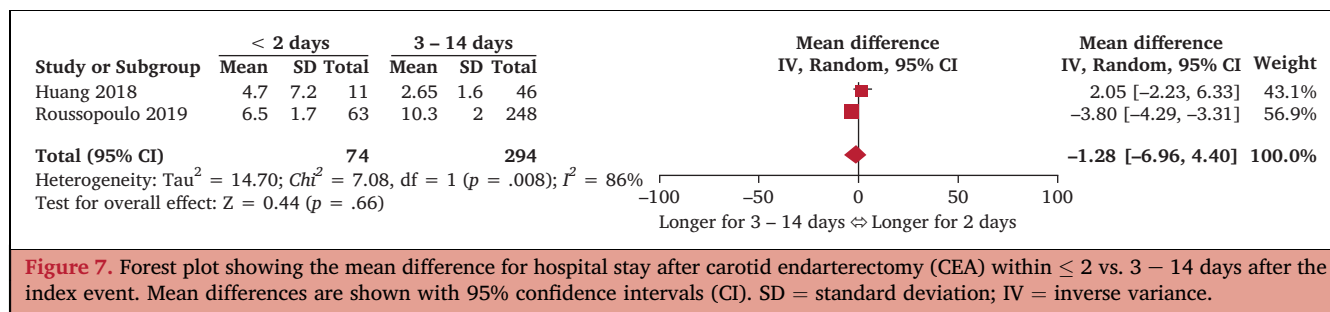


Figure 6. Forest plot showing the odds ratio (OR) for (A) 30 day stroke, (B) 30 day myocardial infarction (MI), and (C) 30 day mortality after carotid artery stenting (CAS) within ≤ 7 vs. 8 – 14 days of the index event. A Mantel-Haenszel (M-H) fixed effect model was used for meta-analysis. OR are shown with 95% confidence intervals (CI).



were randomised within 24 hours of experiencing a minor ischaemic stroke (NIHSS ≤ 3) or “high risk TIA” (ABCD² score ≥ 4) to aspirin monotherapy or short term aspirin and clopidogrel DAPT, there is now compelling evidence to support short term treatment with DAPT in these patient subgroups.³² A recently published RCT also proved that in the subgroup of stroke patients with carotid artery stenosis, ticagrelor added to aspirin in the first 24 hours after the event, had greater absolute risk reduction of stroke or death at 30 days than stroke patients without carotid artery stenosis with a clinically meaningful benefit with a number needed to treat of 34 (95% CI 19 – 171).³³

Methodological quality assessment revealed that the included studies are moderate to low quality, with a single high quality study in this analysis. Only a small number of studies was eligible for quantitative analysis, hindering conclusions. Also, heterogeneity of quantitative synthesis is significant, as determined by the I^2 test. Risk of bias is therefore significant. Probably one of the main biases was introduced in the election for CAS/CEA (selection bias), with fit patients treated by CEA while high risk patients were treated by CAS. Also, with the inclusion of mainly prospective cohort studies the risk of confounding is inherent.

In conclusion, the predicted magnitude of procedural risks will ultimately determine whether CEA or CAS is safer in the early time period after onset of symptoms.³⁴ The evidence from the current systematic review and meta-analysis suggests that (at present) CEA is still safer than transfemoral CAS when performed ≤ 2 days of the index event. Also, considering absolute rates, expedited CEA complies with the accepted thresholds in international guidelines. The ideal timing for performing CAS (when indicated against CEA) is not yet defined and it remains to be seen whether newer CAS technologies (such as TCAR) can provide outcomes similar to CEA when performed in the first 2 – 7 days after symptom onset. Additional granular data and standard reporting of timing of intervention will facilitate future clinical decisions.

CONFLICT OF INTEREST

None.

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APPENDIX A. SUPPLEMENTARY DATA

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ejvs.2021.08.021>.

REFERENCES

- Naylor AR, Ricco JB, de Borst GJ, Debus S, de Haro J, Halliday A. Editor's Choice - Management of Atherosclerotic Carotid and Vertebral Artery Disease: 2017 Clinical Practice Guidelines of the European Society for Vascular Surgery (ESVS). *Eur J Vasc Endovasc Surg* 2018;55:3–81.
- Tsantilas P, Kuhn A, Kallmayer M, Knappich C, Schmid S, Kuetchou A, et al. Stroke risk in the early period after carotid related symptoms: a systematic review. *J Cardiovasc Surg (Torino)* 2015;56:845–52.
- Milgrom D, Hajibandeh S, Antoniou SA, Torella F, Antoniou GA. Editor's Choice - Systematic Review and Meta-Analysis of Very Urgent Carotid Intervention for Symptomatic Carotid Disease. *Eur J Vasc Endovasc Surg* 2018;56:622–31.
- Naylor AR. Time is brain: an update. *Expert Rev Cardiovasc Ther* 2015;13:1111–26.
- den Hartog AG, Moll FL, van der Worp HB, Hoff RG, Kappelle LJ, de Borst GJ. Delay to carotid endarterectomy in patients with symptomatic carotid artery stenosis. *Eur J Vasc Endovasc Surg* 2014;47:233–9.
- Moher D, Liberati A, Tetzlaff J, Altman DG, PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Int J Surg* 2010;8:336–41.
- Slim K, Nini E, Forestier D, Kwiatkowski F, Panis Y, Chipponi J. Methodological Index for Non-Randomized Studies (MINORS): development and validation of a new instrument. *ANZ J Surg* 2003;73:712–6.
- Nordanstig A, Rosengren L, Stromberg S, Osterberg K, Karlsson L, Bergstrom G, et al. Editor's Choice - Very Urgent Carotid Endarterectomy is Associated with an Increased Procedural Risk: The Carotid Alarm Study. *Eur J Vasc Endovasc Surg* 2017;54:278–86.
- Roussopoulos A, Tsivgoulis G, Krogias C, Lazaris A, Moulakakis K, Georgiadis GS, et al. Safety of urgent endarterectomy in acute non-disabling stroke patients with symptomatic carotid artery stenosis: an international multicenter study. *Eur J Neurol* 2019;26:673–9.
- Seguchi M, Shibata M, Sato Y, Maekawa K, Kitano Y, Sano T, et al. The safety of carotid artery stenting for patients in the acute poststroke phase. *J Stroke Cerebrovasc Dis* 2018;27:83–91.
- Coelho A, Prassaparo T, Mansilha A, Kappelle J, Naylor R, de Borst GJ. Critical appraisal on the quality of reporting on safety and efficacy of transcarotid artery stenting with flow reversal. *Stroke* 2020;51:2863–71.
- Villwock MR, Singla A, Padalino DJ, Deshaies EM. Stenting versus endarterectomy and the impact of ultra-early revascularization for emergent admissions of carotid artery stenosis. *J Stroke Cerebrovasc Dis* 2014;23:2341–9.

- 13 Jankowitz BT, Tonetti DA, Kenmuir C, Rao R, Ares WJ, Zussman B, et al. Urgent treatment for symptomatic carotid stenosis: the Pittsburgh Revascularization and Treatment Emergently After Stroke (PIRATES) Protocol. *Neurosurgery* 2020;**87**:811–5.
- 14 Huang Y, Gloviczki P, Duncan AA, Kalra M, Oderich GS, DeMartino RR, et al. Outcomes after early and delayed carotid endarterectomy in patients with symptomatic carotid artery stenosis. *J Vasc Surg* 2018;**67**:1110–9.
- 15 Sharpe R, Sayers RD, London NJ, Bown MJ, McCarthy MJ, Nasim A, et al. Procedural risk following carotid endarterectomy in the hyperacute period after onset of symptoms. *Eur J Vasc Endovasc Surg* 2013;**46**:519–24.
- 16 Jonsson M, Gillgren P, Wanhainen A, Acosta S, Lindström D. Peri-procedural risk with urgent carotid artery stenting: a population based Swedvasc Study. *Eur J Vasc Endovasc Surg* 2015;**49**:506–12.
- 17 Charbonneau P, Bonaventure PL, Drudi LM, Beaudoin N, Blair JF, Elkouri S. An institutional study of time delays for symptomatic carotid endarterectomy. *J Vasc Surg* 2016;**64**:1726–33.
- 18 Kjørstad KE, Baksaas ST, Bundgaard D, Halbakken E, Hasselgard T, Jonung T, et al. Editor's Choice - The National Norwegian Carotid Study: Time from Symptom Onset to Surgery is too Long, Resulting in Additional Neurological Events. *Eur J Vasc Endovasc Surg* 2017;**54**:415–22.
- 19 Chisci E, Pigozzi C, Troisi N, Tramacere L, Zaccara G, Cincotta M, et al. Thirty-day neurologic improvement associated with early versus delayed carotid endarterectomy in symptomatic patients. *Ann Vasc Surg* 2015;**29**:435–42.
- 20 Rocco A, Sallustio F, Toschi N, Rizzato B, Legramante J, Ippoliti A, et al. Carotid artery stent placement and carotid endarterectomy: a challenge for urgent treatment after stroke-early and 12-month outcomes in a comprehensive stroke center. *J Vasc Interv Radiol* 2018;**29**:1254–61.
- 21 Kuhrij LS, Meershoek AJA, Karthaus EG, Vahl AC, Hamming JF, Nederkoorn PJ, et al. Factors associated with hospital dependent delay to carotid endarterectomy in the Dutch Audit for Carotid Interventions. *Eur J Vasc Endovasc Surg* 2019;**58**:495–501.
- 22 Kragsterman B, Nordanstig A, Lindstrom D, Stromberg S, Thuresson M, Nordanstig J. Editor's Choice - Effect of more expedited carotid intervention on recurrent ischaemic event rate: a national audit. *Eur J Vasc Endovasc Surg* 2018;**56**:467–74.
- 23 Tsantilas P, Kühnl A, Kallmayer M, Pelisek J, Poppert H, Schmid S, et al. Short time interval between the neurologic index event and carotid endarterectomy is not a risk factor for carotid surgery. *J Vasc Surg* 2017;**65**:12–20.
- 24 Loftus IM, Paraskevas KI, Johal A, Waton S, Heikkila K, Naylor AR, et al. Editor's Choice - Delays to surgery and procedural risks following carotid endarterectomy in the UK National Vascular Registry. *Eur J Vasc Endovasc Surg* 2016;**52**:438–43.
- 25 Witt AH, Johnsen SP, Jensen LP, Hansen AK, Hundborg HH, Andersen G. Reducing delay of carotid endarterectomy in acute ischemic stroke patients: a nationwide initiative. *Stroke* 2013;**44**:686–90.
- 26 Kretz B, Kazandjian C, Bejot Y, Abello N, Brenot R, Giroud M, et al. Delay between symptoms and surgery for carotid artery stenosis: modification of our practice. *Ann Vasc Surg* 2015;**29**:426–34.
- 27 Stromberg S, Gelin J, Osterberg T, Bergstrom GM, Karlstrom L, Osterberg K, et al. Very urgent carotid endarterectomy confers increased procedural risk. *Stroke* 2012;**43**:1331–5.
- 28 van Lammeren GW, Reichmann BL, Moll FL, Bots ML, de Kleijn DP, de Vries JP, et al. Atherosclerotic plaque vulnerability as an explanation for the increased risk of stroke in elderly undergoing carotid artery stenting. *Stroke* 2011;**42**:2550–5.
- 29 Malas MB, Dakour-Aridi H, Wang GJ, Kashyap VS, Motaganahalli RL, Eldrup-Jorgensen J, et al. Transcarotid artery revascularization versus transfemoral carotid artery stenting in the Society for Vascular Surgery Vascular Quality Initiative. *J Vasc Surg* 2019;**69**:92–103.
- 30 Eriksson H, Koskinen S, Nuotio K, Heikkila HM, Vikatmaa P, Silvennoinen H, et al. Predictive Factors for Pre-operative Recurrence of Cerebrovascular Symptoms in Symptomatic Carotid Stenosis. *Eur J Vasc Endovasc Surg* 2020;**60**:809–15.
- 31 Fisch U, von Felten S, Wiencierz A, Jansen O, Howard G, Hendrikse J, et al. Editor's Choice - Risk of stroke before revascularisation in patients with symptomatic carotid stenosis: a pooled analysis of randomised controlled trials. *European journal of vascular and endovascular surgery : the official journal of the European Society for Vascular Surgery Eur J Vasc Endovasc Surg* 2021;**61**:881–7.
- 32 Prasad K, Siemieniuk R, Hao Q, Guyatt G, O'Donnell M, Lytvyn L, et al. Dual antiplatelet therapy with aspirin and clopidogrel for acute high risk transient ischaemic attack and minor ischaemic stroke: a clinical practice guideline. *BMJ* 2018;**363**:k5130.
- 33 Amarenco P, Denison H, Evans SR, Himmelmann A, James S, Knutsson M, et al. Ticagrelor added to aspirin in acute nonsevere ischemic stroke or transient ischemic attack of atherosclerotic origin. *Stroke* 2020;**51**:3504–13.
- 34 Kashyap VS, Schneider PA, Foteh M, Motaganahalli R, Shah R, Eckstein HH, et al. Early outcomes in the ROADSTER 2 study of transcarotid artery revascularization in patients with significant carotid artery disease. *Stroke* 2020;**51**:2620–9.
- 35 Karpenko A, Starodubtsev V, Ignatenko P, Dixon F, Bugurov S, Bochkov I, et al. Comparative analysis of carotid artery stenting and carotid endarterectomy in clinical practice. *J Stroke Cerebrovasc Dis* 2020;**29**:104751.
- 36 Howie BA, Witek AM, Hussain MS, Bain MD, Toth G. Carotid endarterectomy and carotid artery stenting in a predominantly symptomatic real-world patient population. *World Neurosurg* 2019;**127**:e722–6.
- 37 Vang S, Hans SS. Carotid endarterectomy in patients with high plaque. *Surgery* 2019;**166**:601–6.
- 38 Lee J, You JH, Oh SH, Shin S, Kim BM, Kim TS, et al. Outcomes of stenting versus endarterectomy for symptomatic extracranial carotid stenosis: a retrospective multicenter study in Korea. *Ann Vasc Surg* 2019;**54**:185–92.
- 39 Faateh M, Dakour-Aridi H, Kuo PL, Locham S, Rizwan M, Malas MB. Risk of emergent carotid endarterectomy varies by type of presenting symptoms. *J Vasc Surg* 2019;**70**:130–7.
- 40 Tsantilas P, Kuehnl A, Kallmayer M, Knappich C, Schmid S, Breitkreuz T, et al. Risk of stroke or death is associated with the timing of carotid artery stenting for symptomatic carotid stenosis: a secondary data analysis of the German Statutory Quality Assurance Database. *J Am Heart Assoc* 2018;**7**:e007983.
- 41 Blay Jr E, Balogun Y, Nooromid MJ, Eskandari MK. Early carotid endarterectomy after acute stroke yields excellent outcomes: an analysis of the procedure-targeted ACS-NSQIP. *Ann Vasc Surg* 2019;**57**:194–200.
- 42 Hobeau C, Lavallée PC, Rothwell PM, Sissani L, Albers GW, Bornstein NM, et al. Symptomatic patients remain at substantial risk of arterial disease complications before and after endarterectomy or stenting. *Stroke* 2017;**48**:1005–10.
- 43 Avgerinos ED, Farber A, Abou Ali AN, Rybin D, Doros G, Eslami MH. Early carotid endarterectomy performed 2 to 5 days after the onset of neurologic symptoms leads to comparable results to carotid endarterectomy performed at later time points. *J Vasc Surg* 2017;**66**:1719–26.
- 44 Rantner B, Kollerits B, Roubin GS, Ringleb PA, Jansen O, Howard G, et al. Early endarterectomy carries a lower procedural risk than early stenting in patients with symptomatic stenosis of the internal carotid artery: results from 4 randomized controlled trials. *Stroke* 2017;**48**:1580–7.
- 45 Venermo M, Wang G, Sedrakyan A, Mao J, Eldrup N, DeMartino R, et al. Editor's Choice - Carotid Stenosis Treatment: Variation in International Practice Patterns. *Eur J Vasc Endovasc Surg* 2017;**53**:511–9.
- 46 Kazandjian C, Kretz B, Lemogne B, Aboa Eboulé C, Béjot Y, Steinmetz E. Influence of the type of cerebral infarct and

- timing of intervention in the early outcomes after carotid endarterectomy for symptomatic stenosis. *J Vasc Surg* 2016;**63**:1256–61.
- 47 Charmoille E, Brizzi V, Lepidi S, Sassoust G, Rouillet S, Ducasse E, et al. Thirty-day outcome of delayed versus early management of symptomatic carotid stenosis. *Ann Vasc Surg* 2015;**29**:977–84.
 - 48 Rantner B, Schmidauer C, Knoflach M, Fraedrich G. Very urgent carotid endarterectomy does not increase the procedural risk. *Eur J Vasc Endovasc Surg* 2015;**49**:129–36.
 - 49 Tsvigoulis G, Krogias C, Georgiadis GS, Mikulik R, Safouris A, Meves SH, et al. Safety of early endarterectomy in patients with symptomatic carotid artery stenosis: an international multicenter study. *Eur J Neurol* 2014;**21**:1251–7.
 - 50 Geraghty PJ, Brothers TE, Gillespie DL, Upchurch GR, Stoner MC, Siami FS, et al. Preoperative symptom type influences the 30-day perioperative outcomes of carotid endarterectomy and carotid stenting in the Society for Vascular Surgery Vascular Registry. *J Vasc Surg* 2014;**60**:639–44.
 - 51 Mo D, Wang B, Ma N, Gao F, Miao Z. Comparative outcomes of carotid artery stenting for asymptomatic and symptomatic carotid artery stenosis: a single-center prospective study. *J Neurointerv Surg* 2016;**8**:126–9.
 - 52 Taş MH, Simşek Z, Colak A, Koza Y, Demir P, Demir R, et al. Comparison of carotid artery stenting and carotid endarterectomy in patients with symptomatic carotid artery stenosis: a single center study. *Adv Ther* 2013;**30**:845–53.
 - 53 Shahidi S, Owen-Falkenberg A, Hjerpsted U, Rai A, Ellemann K. Urgent best medical therapy may obviate the need for urgent surgery in patients with symptomatic carotid stenosis. *Stroke* 2013;**44**:2220–5.
 - 54 Faggioli G, Pini R, Mauro R, Gargiulo M, Freyrie A, Stella A. Perioperative outcome of carotid endarterectomy according to type and timing of neurologic symptoms and computed tomography findings. *Ann Vasc Surg* 2013;**27**:874–82.
 - 55 Schermerhorn ML, Fokkema M, Goodney P, Dillavou ED, Jim J, Kenwood CT, et al. The impact of Centers for Medicare and Medicaid Services high-risk criteria on outcome after carotid endarterectomy and carotid artery stenting in the SVS Vascular Registry. *J Vasc Surg* 2013;**57**:1318–24.
 - 56 Kessler I, Gory B, Macian F, Nakiri G, Al-Khawaldeh M, Riva R, et al. Carotid artery stenting in patients with symptomatic carotid stenosis: a single-center series. *J Neuroradiol* 2013;**40**:38–44.
 - 57 Kimiagar I, Gur AY, Auriel E, Peer A, Sacaggiu T, Bass A. Long-term follow-up of patients after carotid stenting with or without distal protective device in a single tertiary medical center. *Vasc Endovascular Surg* 2012;**46**:536–41.
 - 58 Nolan BW, De Martino RR, Goodney PP, Schanzer A, Stone DH, Butzel D, et al. Comparison of carotid endarterectomy and stenting in real world practice using a regional quality improvement registry. *J Vasc Surg* 2012;**56**:990–6.
 - 59 Annambhotla S, Park MS, Keldahl ML, Morasch MD, Rodriguez HE, Pearce WH, et al. Early versus delayed carotid endarterectomy in symptomatic patients. *J Vasc Surg* 2012;**56**:1296–302.
 - 60 Garg J, Frankel DA, Dilley RB. Carotid endarterectomy in academic versus community hospitals: the national surgical quality improvement program data. *Ann Vasc Surg* 2011;**25**:433–41.
 - 61 Lin R, Mazighi M, Yadav J, Abou-Chebl A. The impact of timing on outcomes of carotid artery stenting in recently symptomatic patients. *J Neurointerv Surg* 2010;**2**:55–8.
 - 62 Palombo D, Lucertini G, Mambrini S, Spinella G, Pane B. Carotid endarterectomy: results of the Italian Vascular Registry. *J Cardiovasc Surg (Torino)* 2009;**50**:183–7.
 - 63 Gladstone DJ, Oh J, Fang J, Lindsay P, Tu JV, Silver FL, et al. Urgency of carotid endarterectomy for secondary stroke prevention: results from the Registry of the Canadian Stroke Network. *Stroke* 2009;**40**:2776–82.
 - 64 Gray WA, Chaturvedi S, Verta P. Thirty-day outcomes for carotid artery stenting in 6320 patients from 2 prospective, multicenter, high-surgical-risk registries. *Circ Cardiovasc Interv* 2009;**2**:159–66.
 - 65 Vogel TR, Dombrovskiy VY, Haser PB, Scheirer JC, Graham AM. Outcomes of carotid artery stenting and endarterectomy in the United States. *J Vasc Surg* 2009;**49**:325–30.
 - 66 Goodney PP, Likosky DS, Cronenwett JL. Factors associated with stroke or death after carotid endarterectomy in Northern New England. *J Vasc Surg* 2008;**48**:1139–45.
 - 67 Massop D, Dave R, Metzger C, Bachinsky W, Solis M, Shah R, et al. Stenting and angioplasty with protection in patients at high-risk for endarterectomy: SAPHIRE Worldwide Registry first 2,001 patients. *Catheter Cardiovasc Interv* 2009;**73**:129–36.
 - 68 Ballotta E, Meneghetti G, Da Giau G, Manara R, Saladini M, Baracchini C. Carotid endarterectomy within 2 weeks of minor ischemic stroke: a prospective study. *J Vasc Surg* 2008;**48**:595–600.
 - 69 Setacci C, de Donato G, Chisci E, Setacci F, Stella A, Faggioli G, et al. Deferred urgency carotid artery stenting in symptomatic patients: clinical lessons and biomarker patterns from a prospective registry. *Eur J Vasc Endovasc Surg* 2008;**35**:644–51.
 - 70 Steinbauer MG, Pfister K, Greindl M, Schlachetzki F, Borisch I, Schuirer G, et al. Alert for increased long-term follow-up after carotid artery stenting: results of a prospective, randomized, single-center trial of carotid artery stenting vs carotid endarterectomy. *J Vasc Surg* 2008;**48**:93–8.
 - 71 Dellagrammaticas D, Lewis S, Colam B, Rothwell PM, Warlow CP, Gough MJ. Carotid endarterectomy in the UK: acceptable risks but unacceptable delays. *Clin Med (Lond)* 2007;**7**:589–92.
 - 72 Flanigan DP, Flanigan ME, Dorne AL, Harward TR, Razavi MK, Ballard JL. Long-term results of 442 consecutive, standardized carotid endarterectomy procedures in standard-risk and high-risk patients. *J Vasc Surg* 2007;**46**:876–82.
 - 73 Topakian R, Strasak AM, Sonnberger M, Haring HP, Nussbaumer K, Trenkler J, et al. Timing of stenting of symptomatic carotid stenosis is predictive of 30-day outcome. *Eur J Neurol* 2007;**14**:672–8.
 - 74 Suzue A, Uno M, Kitazato KT, Nishi K, Yagi K, Liu H, et al. Comparison between early and late carotid endarterectomy for symptomatic carotid stenosis in relation to oxidized low-density lipoprotein and plaque vulnerability. *J Vasc Surg* 2007;**46**:870–5.
 - 75 McPhee JT, Hill JS, Ciocca RG, Messina LM, Eslami MH. Carotid endarterectomy was performed with lower stroke and death rates than carotid artery stenting in the United States in 2003 and 2004. *J Vasc Surg* 2007;**46**:1112–8.
 - 76 Sbarigia E, Toni D, Speziale F, Acconcia MC, Fiorani P. Early carotid endarterectomy after ischemic stroke: the results of a prospective multicenter Italian study. *Eur J Vasc Endovasc Surg* 2006;**32**:229–35.
 - 77 Imai K, Mori T, Izumoto H, Watanabe M, Majima K. Emergency carotid artery stent placement in patients with acute ischemic stroke. *AJNR Am J Neuroradiol* 2005;**26**:1249–58.
 - 78 Rantner B, Pavelka M, Posch L, Schmidauer C, Fraedrich G. Carotid endarterectomy after ischemic stroke—is there a justification for delayed surgery? *Eur J Vasc Endovasc Surg* 2005;**30**:36–40.
 - 79 Pell JP, Slack R, Dennis M, Welch G. Improvements in carotid endarterectomy in Scotland: results of a national prospective survey. *Scott Med J* 2004;**49**:53–6.
 - 80 Ecker RD, Brown Jr RD, Nichols DA, McClelland RL, Reinalda MS, Piepgras DG, et al. Cost of treating high-risk symptomatic carotid artery stenosis: stent insertion and angioplasty compared with endarterectomy. *J Neurosurg* 2004;**101**:904–7.

- 81 Welsh S, Mead G, Chant H, Picton A, O'Neill PA, McCollum CN. Early carotid surgery in acute stroke: a multicentre randomised pilot study. *Cerebrovasc Dis* 2004;**18**:200–5.
- 82 Tu JV, Wang H, Bowyer B, Green L, Fang J, Kucey D. Risk factors for death or stroke after carotid endarterectomy: observations from the Ontario Carotid Endarterectomy Registry. *Stroke* 2003;**34**:2568–73.
- 83 Kastrup A, Skalej M, Krapf H, Nägele T, Dichgans J, Schulz JB. Early outcome of carotid angioplasty and stenting versus carotid endarterectomy in a single academic center. *Cerebrovasc Dis* 2003;**15**:84–9.
- 84 Randomised trial of endarterectomy for recently symptomatic carotid stenosis: final results of the MRC European Carotid Surgery Trial (ECST). *Lancet* 1998;**351**:1379–87.
- 85 Rantner B. How safe are carotid endarterectomy and carotid artery stenting in the early period after carotid-related cerebral ischemia? *J Cardiovasc Surg* 2015;**56**:853–7.
- 86 Halliday AW, Lees T, Kamugasha D, Grant R, Hoffman A, Rothwell PM, et al. Waiting times for carotid endarterectomy in UK: observational study. *BMJ* 2009;**338**:b1847.