2025 SRES, Marseille, France, 11-12 September 2025

CAS: LAST NEWS AND RESULTS

(Another Cinderella Story)

Laura Capoccia

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DISCLOSURE

No financial conflict of interest to disclose

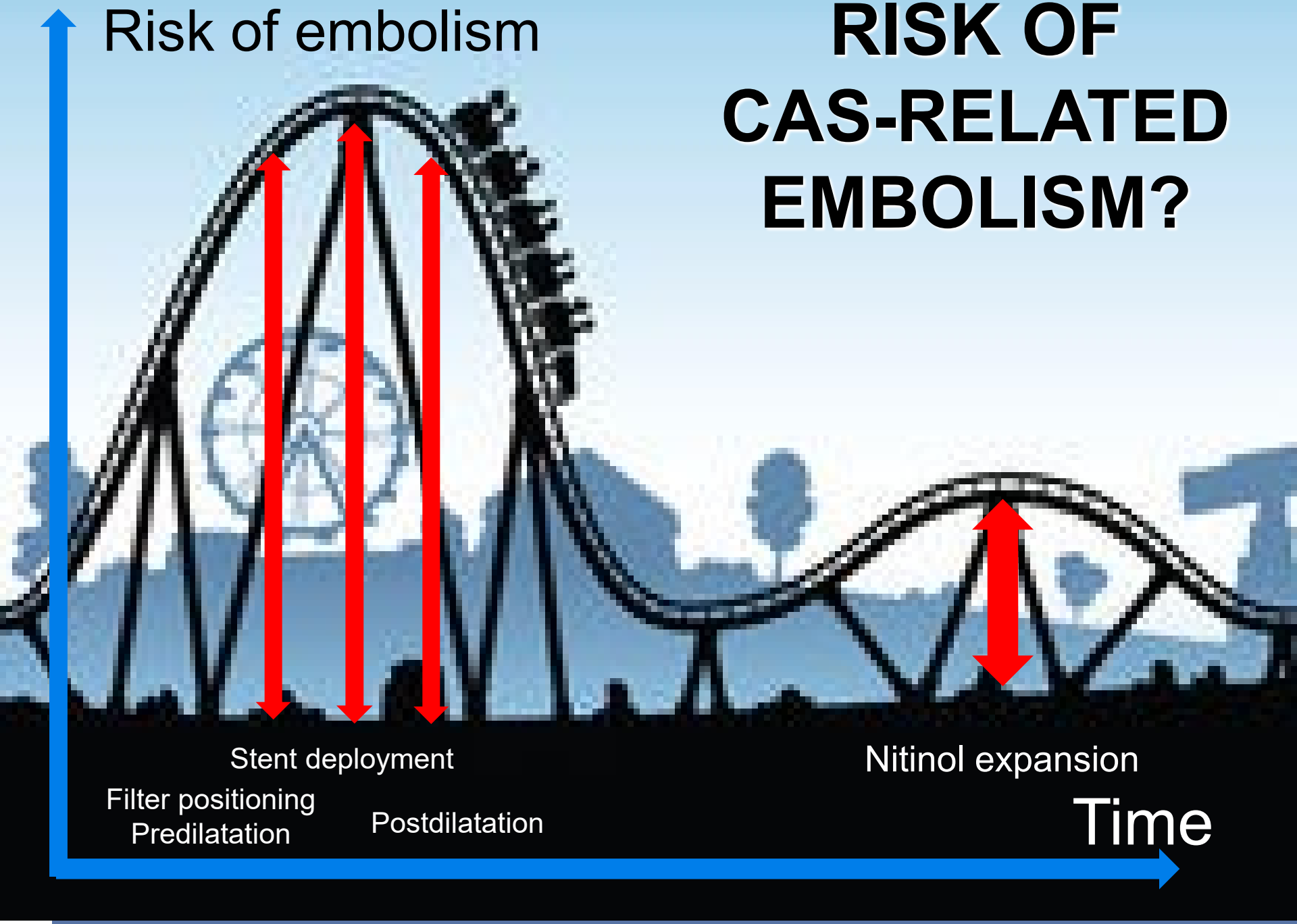
Main limitation of CAS is that the plaque is not taken off…

CAS RATIONALE

Prevention of plaque proplase and distal embolization through the stent struts

both in the periprocedural and long-term periods

RISK OF CAS-RELATED EMBOLISM?



PLAQUE HEALING

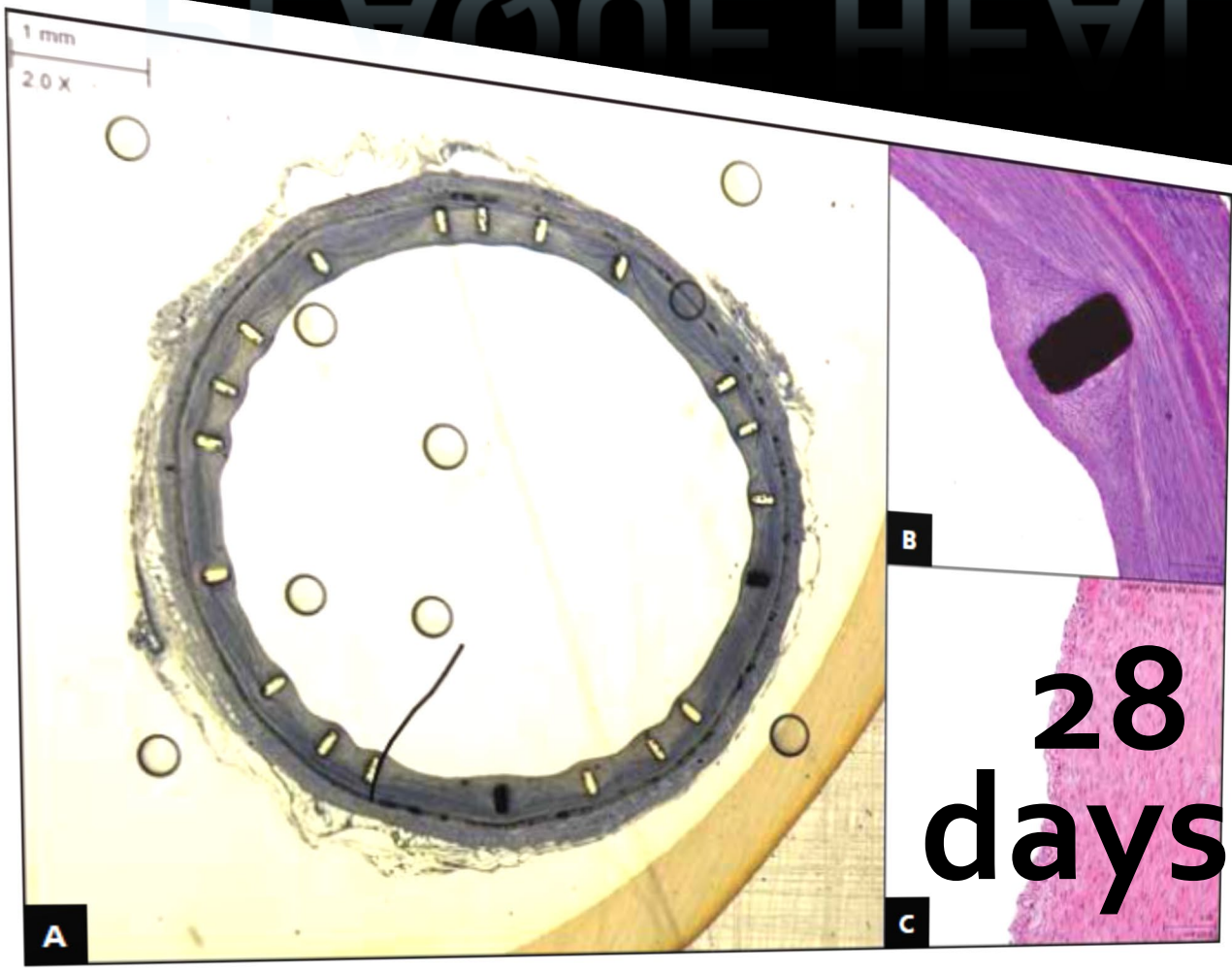


Figure 2. Representative microscopic section of carotid artery 28 days after MER® stent implantation; ×2, VVG (**A**). Stent strut compressing media, internal elastic lamina layer intact (injury 0); ×20, H & E (**B**). Normal, mature and endothelialised neointima; ×20, H & E (**C**)

In patients with symptomatic carotid stenosis at standard surgical risk, endovascular treatment was associated with a higher risk of the following outcome measures occurring between randomisation and 30 days after treatment than endarterectomy: death or any stroke (the primary safety outcome) (OR 1.72, 95% CI 1.29 to 2.31, P = 0.0003; I^2 = 27%), death or any stroke or myocardial infarction (OR 1.44, 95% CI 1.15 to 1.80, P = 0.002; I^2 = 7%), and any stroke (OR 1.81, 95% CI 1.40 to 2.34, P < 0.00001; I^2 = 12%).

Bonati L, Lyrer P, Ederle J, Featherstone R, Brown MM 2012

So CAS is continued to be looked at as a poor maid…

CLINICAL PRACTICE GUIDELINE DOCUMENT

European Society for Vascular Surgery (ESVS) 2023 Clinical Practice Guidelines on the Management of Atherosclerotic Carotid and Vertebral Artery Disease☆

Ross Naylor [a,*], Barbara Rantner [a], Stefano Ancetti [a], Gert J. de Borst [a], Marco De Carlo [a], Alison Halliday [a], Stavros K. Kakkos [a], Hugh S. Markus [a], Dominick J.H. McCabe [a], Henrik Sillesen [a], Jos C. van den Berg [a], Melina Vega de Ceniga [a], Maarit A. Venermo [a], Frank E.G. Vermassen [a]

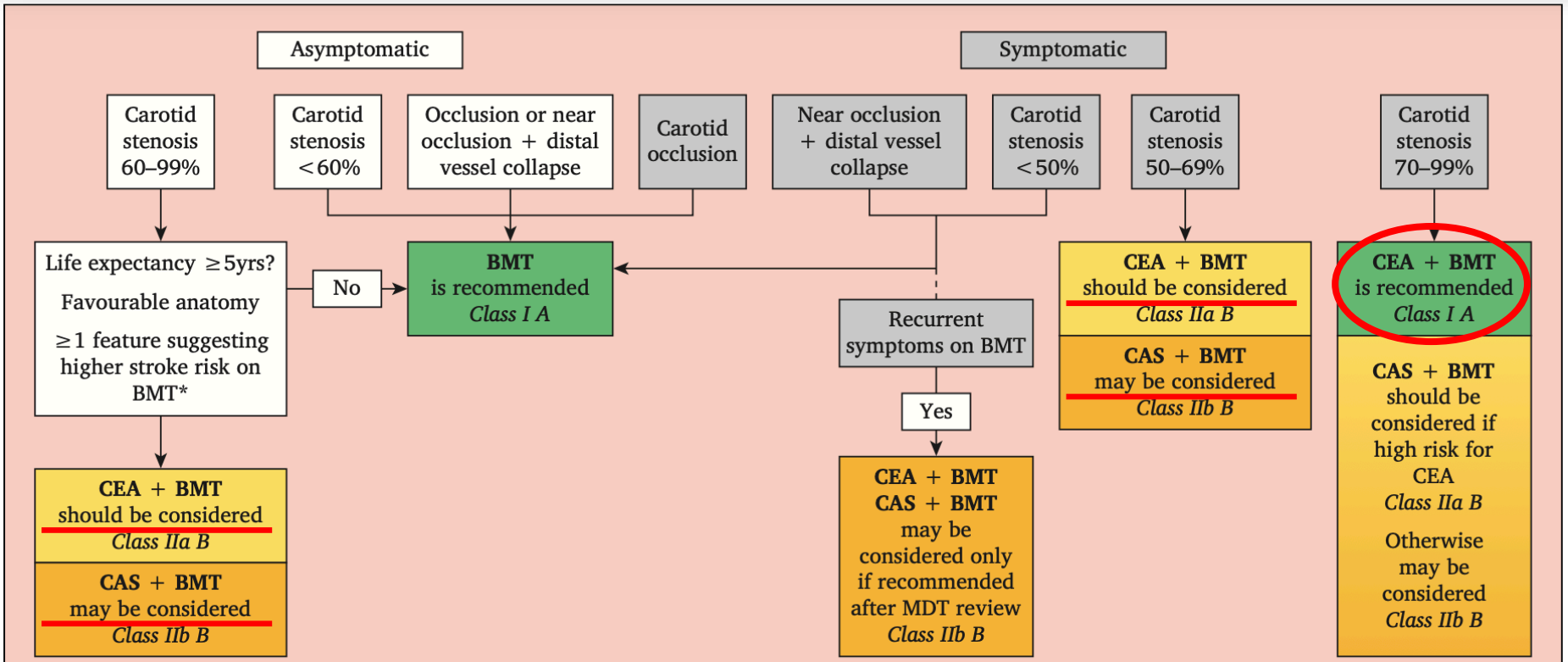


Figure 2. Management of "average risk" patients with asymptomatic and symptomatic carotid stenoses with best medical therapy (BMT), carotid endarterectomy (CEA), and/or carotid artery stenting (CAS). *See Table 8 for imaging/clinical criteria that confer an increased risk of stroke on BMT.

MINIMALLY-INVASIVE GRAND BALL had been called…

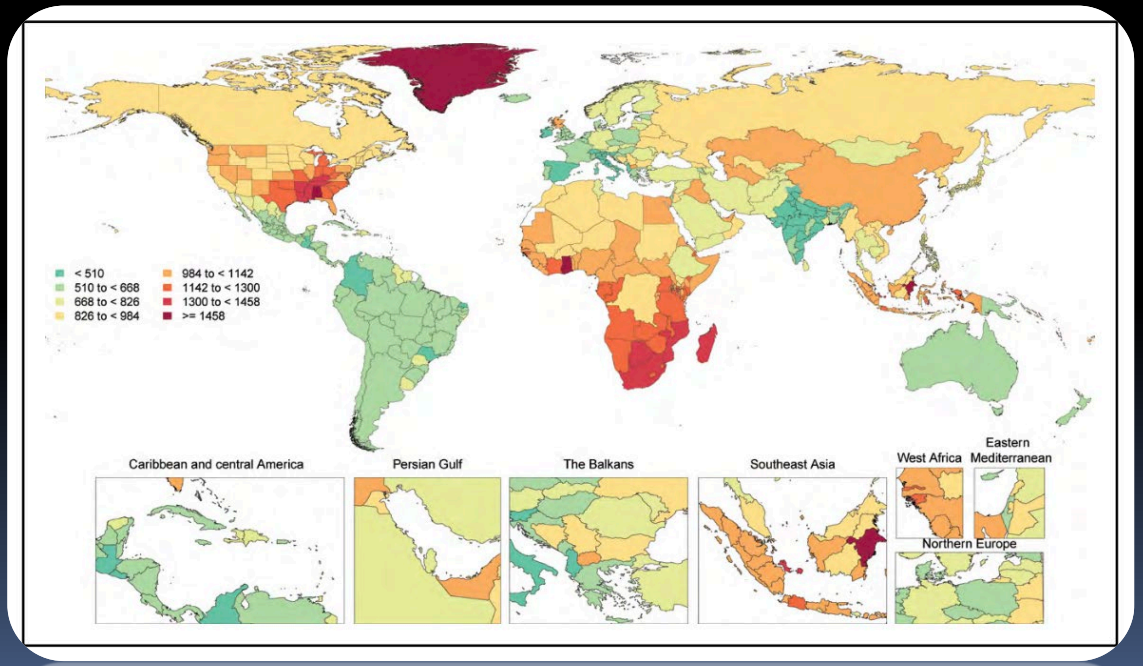
…so CAS dressed accordingly,

…entered the grand-ball room,

…and started to dance in a new role

BURDEN OF STROKE IN THE WORLD

Age-standardized global prevalence rates of ischemic stroke per 100000, both sexes, 2020



Each year, ≈795000 people experience a new or recurrent stroke

Of all strokes, 87% are ischemic, 10% are ICHs, and 3% are SAHs

In 2020 global incidence of stroke was 11.71 million people

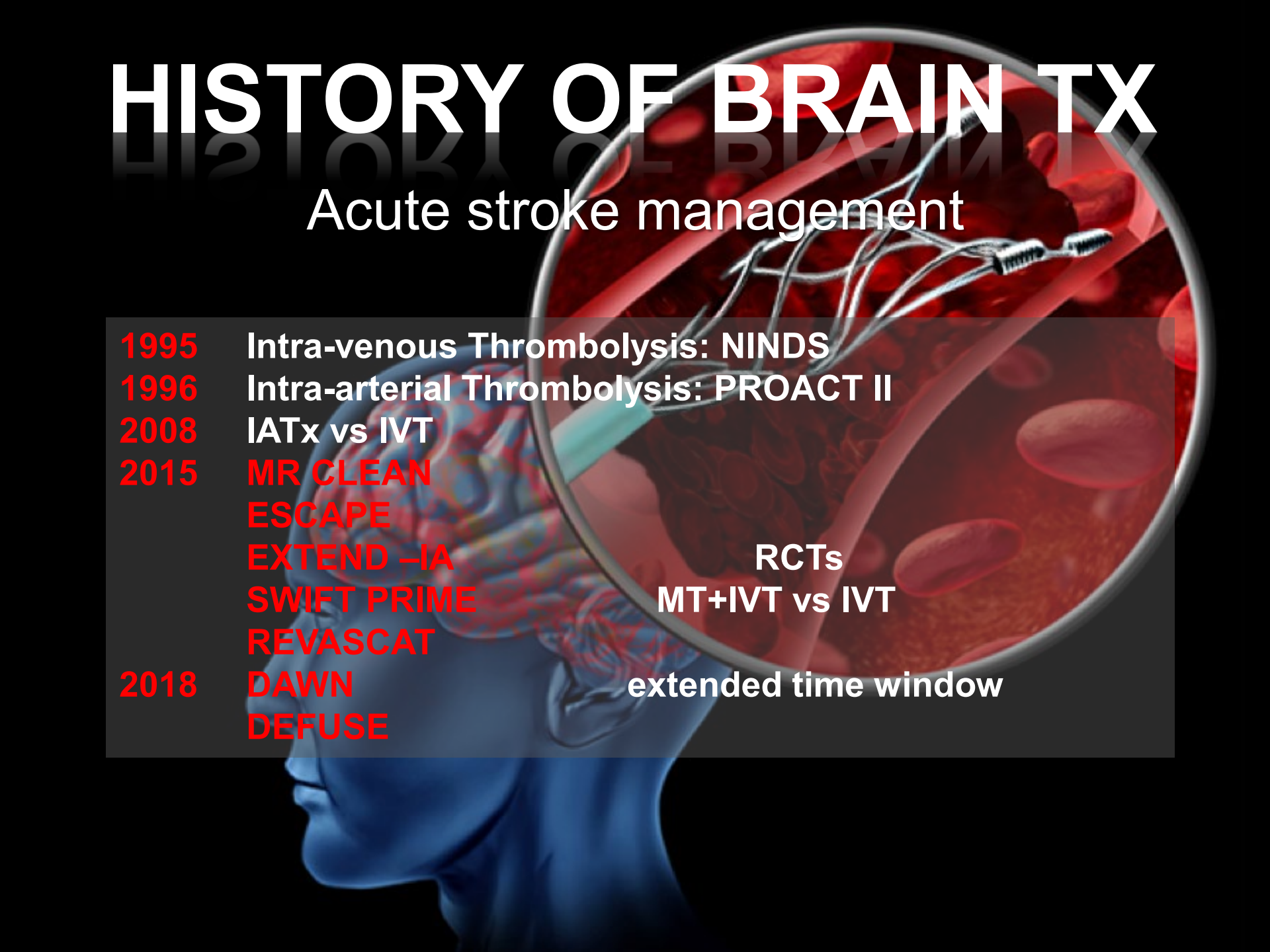
Ischemic stroke was 7.59 million

Deaths attributable to stroke were 7.08 million

Tsao et al. Circulation 2023

HISTORY OF BRAIN TX

Acute stroke management



1995	Intra-venous Thrombolysis: NINDS	
1996	Intra-arterial Thrombolysis: PROACT II	
2008	IATx vs IVT	
2015	MR CLEAN	RCTs
	ESCAPE	MT+IVT vs IVT
	EXTEND –IA	
	SWIFT PRIME	
	REVASCAT	
2018	DAWN	extended time window
	DEFUSE	

STROKE TREATMENT

There is an overwhelming need for stroke procedures

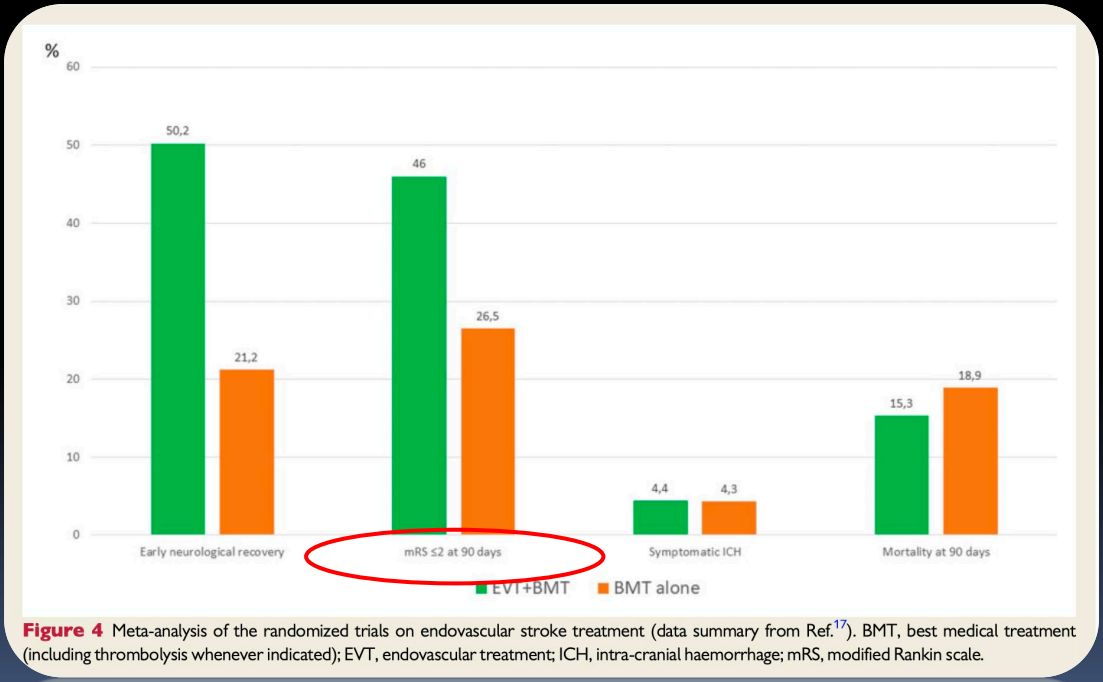
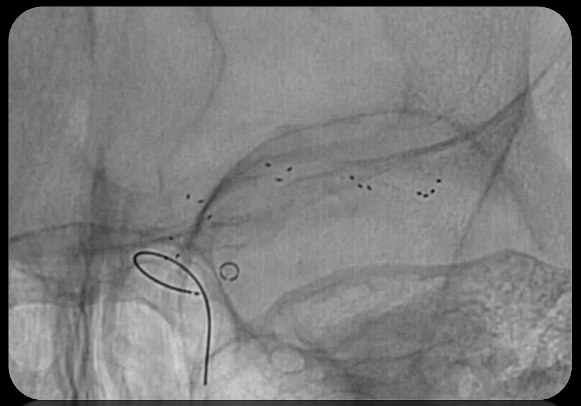


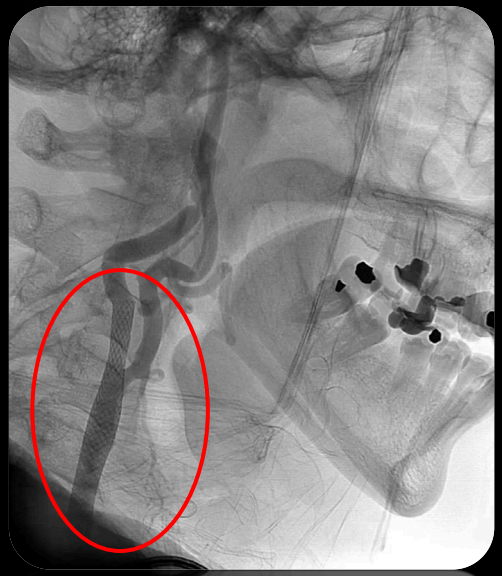
Figure 4 Meta-analysis of the randomized trials on endovascular stroke treatment (data summary from Ref.[17]). BMT, best medical treatment (including thrombolysis whenever indicated); EVT, endovascular treatment; ICH, intra-cranial haemorrhage; mRS, modified Rankin scale.

Data demonstrate superiority of EVT+BMT vs BMT alone in stroke pts

Nardai S et al. Eur Heart J 2021

TANDEM LESIONS





CAS performed in urgent cases together with intracranial MT

Endovascular Therapy of Anterior Circulation Tandem Occlusions

Pooled Analysis From the TITAN and ETIS Registries

Tandem occlusions (concurrent intracranial and extracranial) constitute 10% to 20% of all large vessel occlusion strokes

	No stent (n=262)	Stent (n=341)	IPTW adjusted* OR (95%CI)	p-value	p-het
Overall	118/262 (45.0)	194/341 (57.0)	1.09 (1.01 to 1.19)	0.036	
Subgroups					
IVT					
No	37/96 (38.5)	63/127 (49.6)	1.40 (0.95 to 2.07)	0.091	0.88
Yes	81/166 (48.8)	131/214 (61.2)	1.46 (1.05 to 2.03)	0.027	
Etiology					
Atherosclerosis	68/175 (38.9)	151/264 (57.2)	1.74 (1.30 to 2.35)	<0.001	0.013
Dissection	50/87 (57.5)	43/77 (55.8)	0.88 (0.55 to 1.40)	0.59	
Procedural antiplatelet					
No	100/223 (44.8)	15/34 (44.1)	0.96 (0.42 to 2.20)	0.92	0.87
Yes	18/39 (46.2)	179/307 (58.3)	1.05 (0.59 to 1.85)	0.87	
Age					
<75	104/211 (49.2)	164/267 (61.4)	1.44 (1.09 to 1.91)	0.010	0.94
≥75	14/51 (27.4)	30/74 (41.1)	1.48 (0.84 to 2.62)	0.18	
NIHSS score					
<10	20/32 (61.1)	57/65 (87.0)	3.93 (1.49 to 10.34)	0.006	0.018
≥10	98/230 (42.8)	137/276 (49.9)	1.21 (0.94 to 1.57)	0.14	
ASPECTS score					
<8	65/164 (39.7)	70/153 (46.1)	1.26 (0.90 to 1.77)	0.18	0.21
8-10	53/98 (54.0)	124/188 (65.8)	1.72 (1.18 to 2.51)	0.005	
Onset to puncture time					
<180	42/82 (51.1)	105/168 (62.6)	1.53 (1.04 to 2.26)	0.031	0.45
≥180	76/180 (42.2)	89/173 (51.5)	1.27 (0.91 to 1.75)	0.16	
Study					
ETIS	62/133 (46.6)	43/78 (55.1)	1.22 (0.78 to 1.89)	0.38	0.31
TITAN	56/129 (43.4)	151/263 (57.4)	1.59 (1.18 to 2.14)	0.002	

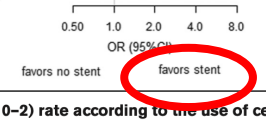


Figure 3. Comparisons in favorable outcome (90-d modified Rankin Scale score, 0–2) rate according to the use of cervical internal carotid artery stent and key subgroups before and after inverse probability treatment weighting (IPTW).

CAS favourable outcomes in pts with intracranial and carotid >90% stenosis/occlusion

Jacquin et al. Stroke 2019
Anadani et al. Stroke 2021

Original Investigation | Neurology

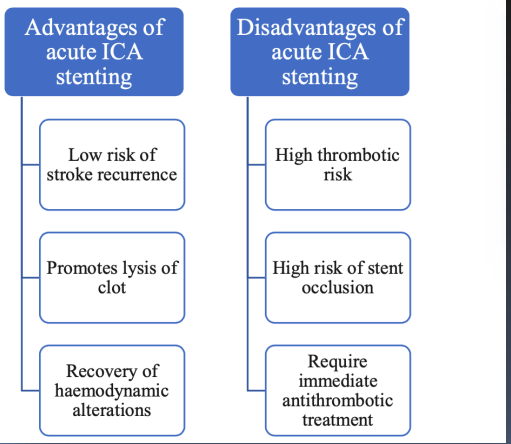
Functional and Safety Outcomes of Carotid Artery Stenting and Mechanical Thrombectomy for Large Vessel Occlusion Ischemic Stroke With Tandem Lesions

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional study included consecutive patients with acute anterior circulation TLs admitted across 17 stroke centers in the US and Spain between January 1, 2015, and December 31, 2020. Data analysis was performed from August 2021 to February

RESULTS Of 685 patients, 623 (mean [SD] age, 67 [12.2] years; 406 [65.2%] male) were included in the analysis, of whom 363 (58.4%) were in the CAS group and 260 (41.6%) were in the nonstenting group. The CAS group had a lower proportion of patients with atrial fibrillation (38 [10.6%] vs 49

CONCLUSIONS AND RELEVANCE In this multicenter, international cross-sectional study, CAS of the cervical lesion during MT was associated with improvement in functional outcomes and reperfusion rates without an increased risk of sICH and mortality in patients with TLs.

Table 1
Diagram summarizing the main advantages and disadvantages of acute stent placement vs PTA alone.



Diagnosis and management of *tandem* occlusion in acute ischemic stroke

Antonio Di Donna [a], Gianluca Muto [c], Flavio Giordano [a], Massimo Muto [a], Gianluigi Guarnieri [a], Giovanna Servillo [b], Antonio De Mase [b], Emanuele Spina [b], Giuseppe Leone [a,*]

[a] *Unit of Interventional Neuroradiology, Department of Advanced Diagnostic and Therapeutic Technologies, A.O.R.N. Antonio Cardarelli Hospital, Via Cardarelli 1, Naples 80131, Italy*
[b] *Unit of Neurorology and Stroke Unit, Department of Emergency and Acceptance, A.O.R.N. Antonio Cardarelli Hospital, Via Cardarelli 1, Naples 80131, Italy*
[c] *Division of Diagnostic and Interventional Neuroradiology, Geneva University Hospitals, 1205 Geneva, Switzerland*

Farooqui JAMA Network Open 2023
Di Donna Eur J Radiol Open 2023

TANDEM OCCLUSION/STENOSIS IN STROKE TREATMENT

Despite some uncertainty, based on the available evidence, the American Heart Association/American Stroke Association considered the treatment of cervical ICA during EVT as reasonable (level IIb evidence)

8. Treatment of tandem occlusions (both extracranial and intracranial occlusions) when performing mechanical thrombectomy may be reasonable.	IIb	B-R

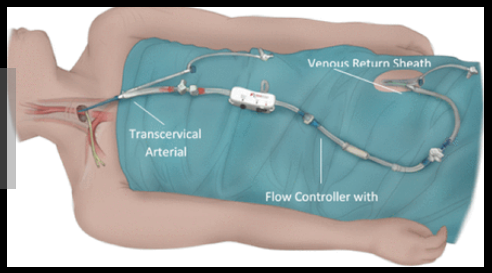
Tandem occlusions were included in recent endovascular trials that showed benefit of mechanical thrombectomy over medical management alone. In the HERMES meta-analysis, 122 of 1254 tandem occlusions (RR, 1.81 [95% CI, 0.96–3.4]) and 1132 of 1254 nontandem occlusions (RR, 1.71 [95% CI, 1.40–2.09]) were reported compared with medical management.[189] In THRACE, 24 of 196 tandem occlusions (RR, 1.82 [95% CI, 0.55–6.07]) and 172 of 196 nontandem occlusions (RR, 1.34 [95% CI, 0.87–2.07]) were treated compared with IV alteplase alone.[109] In HERMES, there is heterogeneity of treatment methods directed to the proximal extracranial carotid occlusion (no revascularization of the proximal lesion versus angioplasty versus stenting). A retrospective analysis of pooled data from 18 centers examined 395 patients with AIS caused by tandem lesion of the anterior circulation who underwent mechanical thrombectomy (TITAN [Thrombectomy in Tandem Lesions]). mTICI grade 2b/3 was achieved in 76.7% of patients. At 90 days, 52.2% achieved an mRS score of 0 to 2, 13.8% had parenchymal hematoma, and 13.2% were dead.[202] Multiple retrospective reports detail the technical success of mechanical thrombectomy for tandem occlusions but do not provide specifics on comparative approaches. No conclusions about the optimum treatment approach for patients with tandem occlusions are therefore possible.

Powers et al. Stroke 2019

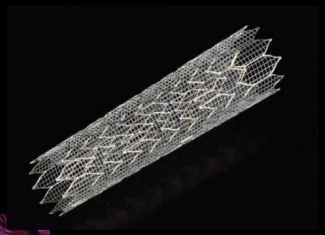
***While** the vascular community goes (quite pompously) **on** discussing non-inferiority of CAS…*

REDUCTION OF PERIOPERATIVE NEUROLOGIC EMBOLIZATION

TO AVOID THE ARCH

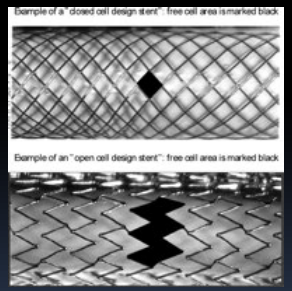


Membrane-covered stent



Distal embolic protection device

stenting



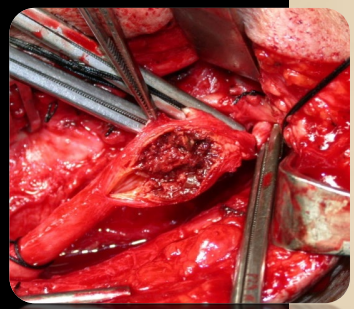
ballooning

Flow-reversal embolic protection device

TIME

CAROTID REVASCULARIZATION

HOW?



CEA

TF-CAS

TC-CAS

KEY POINTS FOR CAS SUCCESS

- ✓Adjuvant medical therapy
- ✓Access route
- ✓Stent design
- ✓Pre and post-dilation
- ✓Cerebral protection device
- ✓Hospital/operator volumes and experience

Eur J Vasc Endovasc Surg (2019) 58, 479–493

REVIEW

Editor's Choice — Overview of Primary and Secondary Analyses From 20 Randomised Controlled Trials Comparing Carotid Artery Stenting With Carotid Endarterectomy

Andrew J. Batchelder, Athanasios Saratzis, A. Ross Naylor *

The Leicester Vascular Institute, Glenfield Hospital, Leicester, UK

CREST-1
ACT-1
CAVATAS
EVA-3S
ICSS
LEICESTER
LEXINGTON-1
LEXINGTON-II
SPACE-1
SAPPHIRE

BACASS
KULIHA
WALLSTENT
MANNHEIM
STEINBAUER
SPACE-2
TESCAS-C
Li
Liu
WANG

After CEA, 93% were ipsilateral, with 7% contralateral or vertebrobasilar.
After CAS, 91% were ipsilateral, with 9% contralateral/vertebrobasilar.

The risk of " immediate" stroke (day of procedure) was 4.7% after CAS vs.1.9% after CEA (OR 2.6, 95% CI 1.9-3.8).

Delayed stroke (days 1-30) was 2.5% after CAS
vs. 2% after CEA (OR 1.3, 95% CI 0.9-1.9).

Eur J Vasc Endovasc Surg (2019) 58, 479–493

REVIEW

Editor's Choice — Overview of Primary and Secondary Analyses From 20 Randomised Controlled Trials Comparing Carotid Artery Stenting With Carotid Endarterectomy

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The Leicester Vascular Institute, Glenfield Hospital, Leicester, UK

	Death	Stroke	Death/ Stroke	Disabling Stroke	Death/ Disabling stroke	MI	Death/ Stroke/MI
	7 RCTs n = 2286	8 RCTs n = 3467	8 RCTs n = 3467	5 RCTs n = 2918	Insufficient data	5 RCTs n = 2948	5 RCTs n = 2948
CEA	0.7% (0.3–1.8)	1.9% (1.3–2.9)	2.1% (1.5–3.1)	0.5% (0.2–1.2)	Insufficient data	1.8% (1.1–2.8)	3.1% (2.2–4.3)
CAS	0.7% (0.3–1.7)	3.0% (2.3–3.8)	3.1% (2.4–4.0)	0.5% (0.3–1.0)	Insufficient data	0.8% (0.5–1.4)	3.3% (2.5–4.2)
OR (95% CI)	1.02 (0.18–5.90)	1.73 (1.06–2.84)	1.64 (1.02–2.64)	1.57 (0.40–6.19)	Insufficient data	0.53 (0.24–1.16)	1.14 (0.72–1.81)

Significant benefit favouring CEA No significant difference between CAS and CEA

Figure 2. Thirty day outcomes after carotid artery stenting (CAS) *vs.* carotid endarterectomy (CEA) in 3467 asymptomatic patients randomised within seven randomised controlled trials (RCTs).[10,12,28,65,101,105,106] OR = odds ratio; CI = confidence interval; MI = myocardial infarction.

3467 asympt

7 RCTs

CEA +++

CAS IS A REALITY!

Optimised medical therapy alone versus optimised medical therapy plus revascularisation for asymptomatic or low-to-intermediate risk symptomatic carotid stenosis (ECST-2): 2-year interim results of a multicentre randomised trial

Simone J A Donners, Twan J van Velzen, Suk Fun Cheng, John Gregson, Audinga-Dea Hazewinkel, Francesca B Pizzini, Bart J Emmer, Robert Simister, Toby Richards, Philippe A Lyrer, Marina Maurer, Gemma Smith, Gareth Tervit, Laurine van der Steen, Gwynedd E Pickett, Gordon Gubitz, Bob Roozenbeek, Maaike Scheele, John M Bamford, M Eline Kooi, Gert J de Borst, Hans Rolf Jäger, Martin M Brown*, Paul J Nederkoorn*, Leo H Bonati*, on behalf of the ECST-2 investigators†*

«The results support treating patients with asymptomatic and low or intermediate risk symptomatic carotid stenosis with OMT alone until further data from the 5-year analysis of ECST-2 and other trials become available»

Lancet Neurol 2025

Stroke

CURRENT ISSUE | ARCHIVE

REVIEW ARTICLE | Originally Published 1 August 2025

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Shrinking Role for Carotid Revascularization in Stroke Prevention

Colin P. Derdeyn, MD, Seemant Chaturvedi, MD, and Bruce A. Wasserman, MD | AUTHOR INFO & AFFILIATIONS

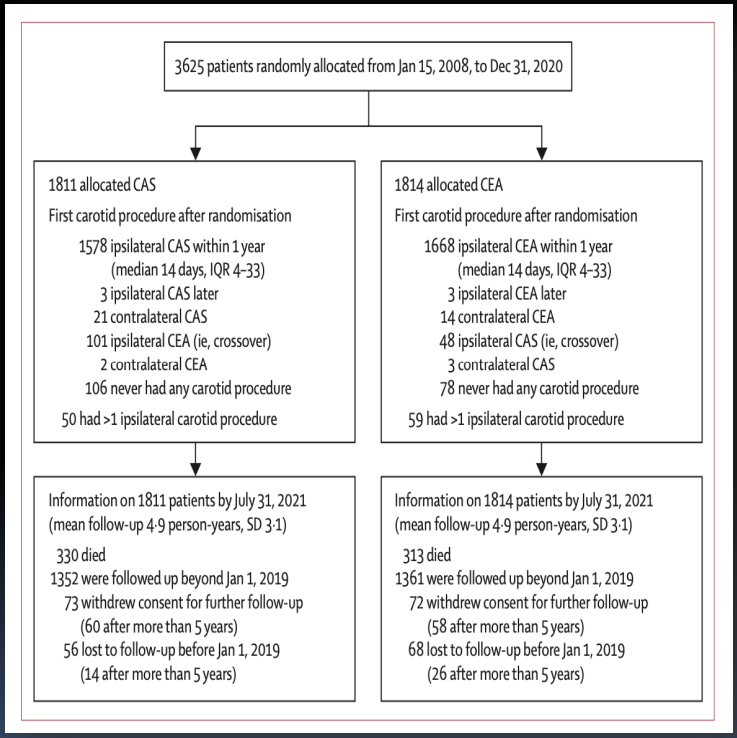
Stroke • Volume 56, Number 9 • https://doi.org/10.1161/STROKEAHA.125.051981

What's new?

3625 pts randomized to CEA or CAS

Second asymptomatic carotid surgery trial (ACST-2): a randomised comparison of carotid artery stenting versus carotid endarterectomy

Alison Halliday, Richard Bulbulia*, Leo H Bonati, Johanna Chester, Andrea Cradduck-Bamford, Richard Peto†, Hongchao Pan†, for the ACST-2 Collaborative Group‡*



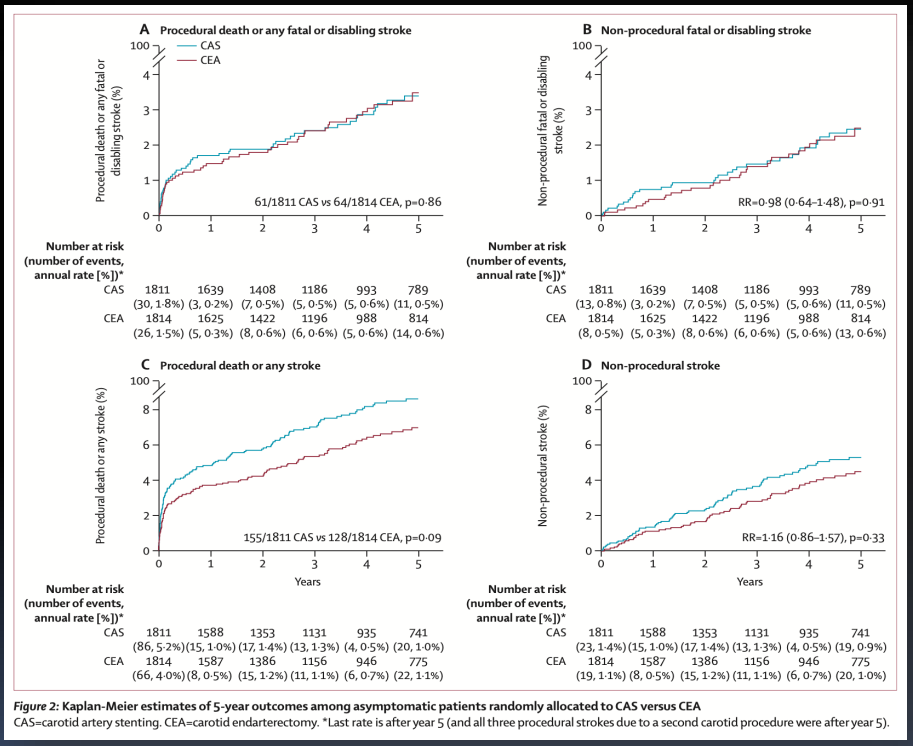


Figure 2: **Kaplan-Meier estimates of 5-year outcomes among asymptomatic patients randomly allocated to CAS versus CEA**
CAS=carotid artery stenting. CEA=carotid endarterectomy. *Last rate is after year 5 (and all three procedural strokes due to a second carotid procedure were after year 5).

«With ACST-2 included, there is now as much evidence among asymptomatic as among symptomatic patients, … with CAS about as effective as CEA at reducing the annual risk of stroke, at least for the first few years»

Halliday et al. Lancet 2021

Second asymptomatic carotid surgery trial (ACST-2): a randomised comparison of carotid artery stenting versus carotid endarterectomy

Alison Halliday, Richard Bulbulia*, Leo H Bonati, Johanna Chester, Andrea Cradduck-Bamford, Richard Peto†, Hongchao Pan†, for the ACST-2 Collaborative Group‡*

The trials of CAS versus CEA now provide better evidence than existed before that both procedures carry similar risks and provide comparable benefits

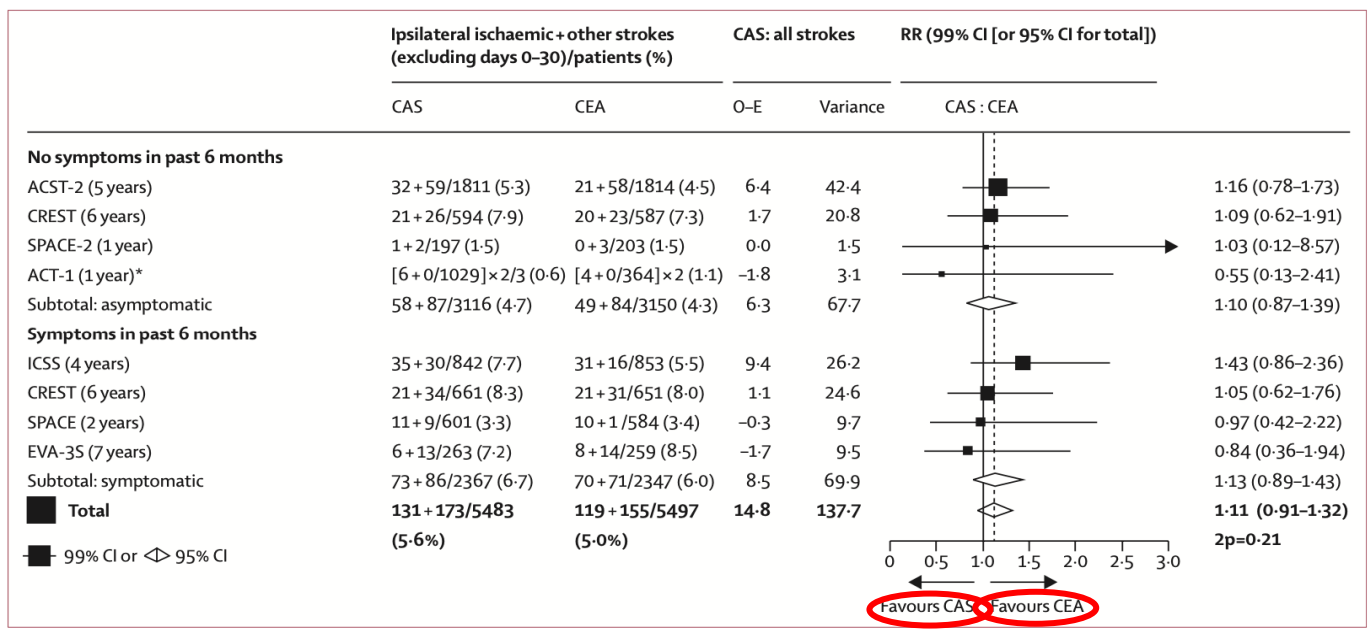


Figure 4: **Trials of CAS versus CEA for asymptomatic or symptomatic carotid stenosis—ITT analyses of non-procedural strokes (ipsilateral ischaemic stroke plus other strokes)**

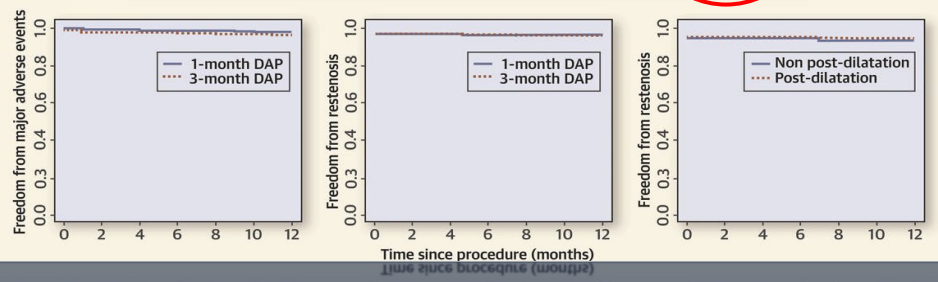
Halliday et al. Lancet 2021

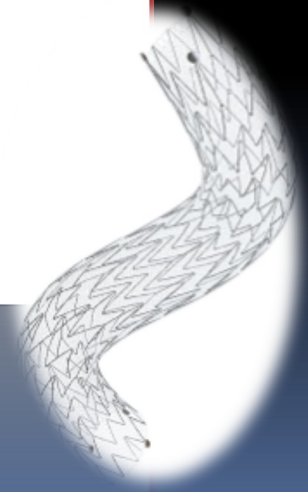
IRONGUARD

CENTRAL ILLUSTRATION: Event Rates in the IRONGUARD 2 Study

IRONGUARD 2
733 CAS Procedure
in 20 enrolling Italian Centers

	24 hours	30 days	1 year
Stroke	3; 0.41%	4; 0.54%	5; 0.68%
Death	1; 0.13%	1; 0.13%	9; 1.22%
Stroke & Death	4; 0.54%	5; 0.68%	14; 1.90%
AMI	1; 0.13%	4; 0.54%	6; 0.81%





8 (1.09%) intraprocedural ECA occlusion
6 (0.82%) ICA restenosis at follow-up
(2 occlusions, 4 asymptomatic in-stent restenoses)

Sirignano et al. JACC 2021

Systematic Review

Clinical Outcomes of Second- versus First-Generation Carotid Stents: A Systematic Review and Meta-Analysis

Adam Mazurek [1,*], Krzysztof Malinowski [2], Kenneth Rosenfield [3], Laura Capoccia [4], Francesco Speziale [4], Gianmarco de Donato [5], Carlo Setacci [5], Christian Wissgott [6], Pasqualino Sirignano [4], Lukasz Tekieli [7], Andrey Karpenko [8], Waclaw Kuczmik [9], Eugenio Stabile [10], David Christopher Metzger [11], Max Amor [12], Adnan H. Siddiqui [13], Antonio Micari [14], Piotr Pieniążek [1,7], Alberto Cremonesi [15], Joachim Schofer [16], Andrej Schmidt [17] and Piotr Musialek [1,*,†] on behalf of CARMEN (CArotid Revascularization Systematic Reviews and MEta-aNalyses) Investigators

Table 2. The 30-day and 12-month event rates by stent type (random-effect model).

	FGS	SGS	Casper/ Roadsaver	Gore	CGuard
30-day Stroke (%) (95% CI)	**3.01** (2.63–3.38)	**0.60** (0.28–0.92)	**0.50** (0–1.15)	**2.89** (1.03–4.76)	**0.54** (0.17–0.92)
30-day Death/Stroke/MI (%) (95% CI)	**4.11** (3.65–4.56)	**1.30** (0.64–1.96)	**1.33** (0–2.66)	**4.82** (2.44–7.2)	**1.08** (0.55–1.60)
12-mo Ipsilateral Stroke (%) (95% CI)	**3.51** (2.52–4.50)	**0.7** (0–1.47)	**0.26** (0–1.27)	**3.1** (1.11–5.1)	**0.38** (0–0.9)
12-mo Restenosis (%) (95% CI)	**3.97** (0.28–5.14)	**3.38** (1.39–5.37)	**7.16** (5.45–9.86)	**4.83** (2.36–7.29)	**0.34** (0–0.82)
12-mo Ipsilateral Stroke/Restenosis (%) (95% CI)	**8.15** (6.63–9.96)	**5.12** (3.14–6.10)	**7.86** (5.04–10.68)	**7.93** (4.82–11.04)	**0.73** (0–1.44)

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https://doi.org/10.1007/s00270-025-04003-z

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CLINICAL INVESTIGATION ARTERIAL INTERVENTIONS

30-Day Outcomes of Real-World Elective Carotid Stenosis Treatment Using a Dual-Layer Micromesh Stent (ROADSAVER Study)

CVIR
The official journal of the Cardiovascular and Interventional Radiological Society of Europe
CardioVascular and Interventional Radiology
Springer
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30-day Outcomes of Real-world Elective Carotid Stenosis Treatment using a Dual-layer Micromesh Stent (ROADSAVER Study)

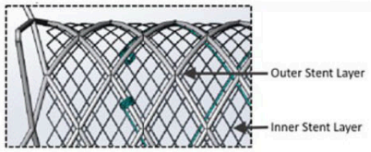
Study cohort

Carotid artery stenosis patients eligible for elective stenting

1967 Patients | **52** Sites | **13** Countries

Study device

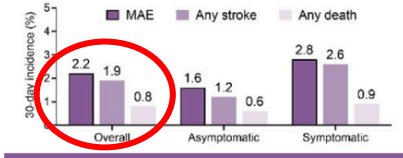
Dual-layer micromesh stent for sustained cerebral embolic protection



Patient, lesion & procedural characteristics

Sex (male)	70.4%
Symptomatic	49.4%
Age	70.6 ± 8.8 years
Lesion length	18.1 ± 8.4 mm
Lesion calcification	58.5%
Lesion ulceration	24.9%
Irregular surface lesion	56.5%
Radial/ulnar access	26.3%
Embolic protection device	63.8%
Pre-dilatation	25.6%
Post-dilatation	96.1%

Primary endpoint & components



Risk factors for 30-day MAE

- Residual stenosis > 30%
- Thromboembolic venous disease
- Myocardial infarction
- Age ≥ 75 years
- Family history of atherosclerosis
- Non-insulin dependent diabetes mellitus
- Symptomatic carotid stenosis
- Stent length

Dual-layer micromesh stenting of the carotid artery is safe, with a low 30-day major adverse event incidence in real-world asymptomatic and symptomatic patients, supporting the sustained embolic protection design concept.

A multi-center study of the MicroNET-covered stent in consecutive patients with acute carotid-related stroke: SAFEGUARD-STROKE*

Lukasz Tekieli[1,2,3], Andrej Afanasjev[4], Maciej Mazgaj[5], Vladimir Borodetsky[6], Kolja Sievert[7], Zoltan Ruzsa[8], Magdalena Knapik[2,9], Audrius Širvinskas[4], Adam Mazurek[1,2], Karolina Dzierwa[10], Thomas Sanczuk[11], Valerija Mosenko[12], Malgorzata Urbanczyk-Zawadzka[13], Mariusz Trystula[14], Piotr Paluszek[1,14], Lukasz Wiewiorka[13], Justyna Stefaniak[15], Piotr Pieniazek[2,3,14], Inga Slautaitė[16], Tomasz Kwiatkowski[14], Artūras Mackevičius[17], Michael Teitcher[18], Horst Sievert[7], Iris Q. Grunwald[19,20], Piotr Musialek[1,2]

Material and methods: Seventy-five patients (age 40-89 years, 26.7% women) were enrolled in 7 interventional stroke centers.

Results: The median Alberta Stroke Program Early CT Score (ASPECTS) was 9 (6–10). Study stent use was 100% (no other stent types implanted); retrograde strategy predominated (69.2%) in tandem lesions. Technical success was 100%. Post-dilatation balloon diameter was 4.0 to 8.0 mm. 89% of patients achieved final modified Thrombolysis in Cerebral Infarction (mTICI) 2b-c/3. Glycoprotein IIb/IIIa inhibitor use as intraarterial (IA) bolus + intravenous (IV) infusion was an independent predictor of symptomatic intracranial hemorrhage (OR = 13.9, 95% CI: 5.1–84.5, $p < 0.001$). The mortality rate was 9.4% in-hospital and 12.2% at 90 days. Ninety-day mRS0-2 was 74.3%, mRS3-5 13.5%; stent patency was 93.2%. Heparin-limited-to-flush predicted patency loss on univariate (OR = 14.3, 95% CI: 1.5–53.1, $p < 0.007$) but not on multivariate analysis. Small-diameter balloon/absent post-dilatation was an independent predictor of stent patency loss (OR = 15.2, 95% CI: 5.7–73.2, $p < 0.001$).

Conclusions: This largest to-date study of the MicroNET-covered stent in consecutive CRS patients demonstrated a high acute angiographic success rate, high 90-day patency and favorable clinical outcomes despite variability in procedural strategies and pharmacotherapy (SAFEGUARD-STROKE NCT05195658).

75 pts, 7 stroke centers, 93.2% stent patency

Small-diameter balloon/absent post-dilatation was an independent predictor of stent patency loss (OR = 15.2, 95% CI: 5.7–73.2, p < 0.001)

Tekieli et al. Adv Interv Cardiol 2024

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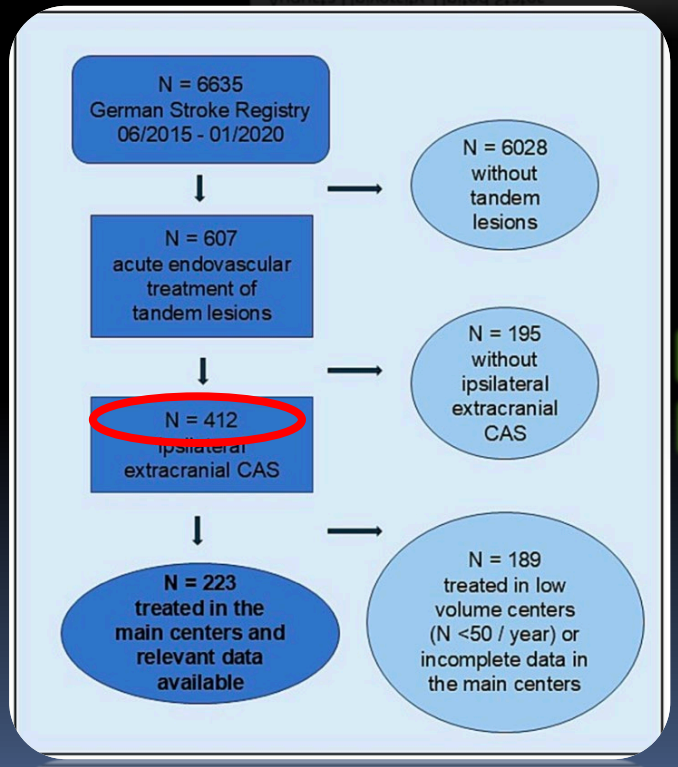
2015-2020

*CORRESPONDENCE
Fee Keil

Safety, efficacy and timing of antithrombotic therapy in emergency stenting of acute stroke patients with tandem lesions, German multicenter data-analysis

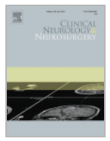


Outcome	n	%
Successful recanalization mTICI 2b-3	203	91
Good clinical outcome mRS 0–2		
At discharge	68	30.5
After 90 days	82	36.8
Mortality in hospital	22	9.9
Mortality after 90 days	43	19.3
Complications		
Any intracranial hemorrhage	58	26.0
Symptomatic intracranial hemorrhage	15	6.7
Stent thrombosis	24	10.8
Stent occlusion	18	8.1

«The use of DAPT within the first day after thrombectomy and CAS in tandem lesions led to better clinical outcome. Specifically, early DAPT was linked to a reduced rate of occlusive stent thrombosis without an increased risk of sICH»

Keil et al. Frontiers in Neurology 2025

Clinical Neurology and Neurosurgery
Volume 251, July 2025, 108930



Novel artificial intelligence approach in neurointerventional practice: Preliminary findings on filter movement and ischemic lesions in carotid artery stenting

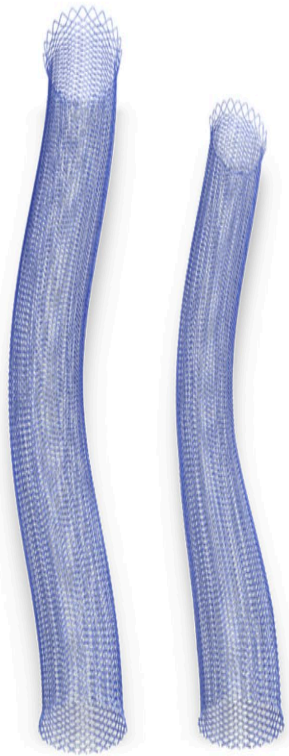
Hirotaka Sagawa [a 1], Yuya Sakakura [b 1], Ryoichi Hanazawa [c], Satoru Takahashi [a], Hikaru Wakabayashi [a], Shoko Fujii [a], Kyohei Fujita [a], Sakyo Hirai [a], Akihiko Hirakawa [c], Kenichi Kono [d e], Kazutaka Sumita [a]

Highlights

- A novel AI-based approach quantified filter movement during CAS in clinical practice.
- Increased filter movement during CAS was correlated with higher DWI lesion incidence.
- AI-based quantification may validate previously unproven endovascular recommendations.

CARESTO FLOW-MODULATOR HEAL STENT

HEAL TECHNOLOGY



Braided, self-expanding nitinol stent with HEAL Technology

CARESTO® heal Stent

- First coated carotid stent - with unique HEAL Technology
- Highly flexible, single layer closed-cell stent
- Small pore size with plaque coverage
- Flexible low profile delivery system (0.068" OD)
- Excellent visibility due to nitinol composite wires with platinum core
- Available in cylindrical and tapered version
- CE mark approved for vessel diameters from 4.0 mm – 10.0 mm

Note:

The CARESTO® heal Stent is currently in Limited Market Release. Please contact your Acandis® representative for product availability.

CONCLUSIONS

Systematic reviews, metanalysis, and guidelines still consider/prove CAS not equal to CEA

Nevertheless, CAS widespread is a reality, especially when performed by neurointerventionalists in combination with intracranial mechanical thrombectomy (tandem lesions)

Increase in endovascular Tx of carotid disease is expected since new techniques (TC- CAS), devices (mesh-covered stents, flow-modulator) and adjuncts (flow-reversal PDs) are available nowadays


Thanks for your attention