Is the future of symptomatic intracranial atherosclerotic stenosis management promising?

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Intracranial atherosclerotic stenosis (ICAS) is one of the most common causes of stroke; it has the highest rate of recurrence compared with other aetiologies. ICAS is especially more prevalent among the Asians. The results of the Chinese Intracranial Atherosclerosis Study indicated that the prevalence of symptomatic ICAS (sICAS) is as high as 46%. The 1-year stroke recurrence rate with sICAS is reported to be 12.2% and 15%. We understand, the following pathological reasons could account for the high recurrence rate in sICAS. First, patients with ICAS are prone to encounter hypoperfusion haemodynamics, especially under poor collateral conditions. Studies on the association of blood pressure (BP) control in the acute stage and clinical outcomes are contradictory, supporting this hypothesis. Second, plaques in stenotic arteries are usually highly vulnerable (due to large lipid cores, thin fibrous caps and intraplaque haemorrhage). These plaques are prone to rupture into downstream arteries, leading to embolic stroke in the territory of the responsible artery. Furthermore, these patients are often comorbid with heightened risk factors strongly correlated with stroke recurrence, including hypertension, metabolic disorders, dyslipidaemia.

Therefore, there is an urgent need to standardise assessment and management of sICAS. The treatment of sICAS nowadays primarily focuses on secondary prevention to reduce stroke recurrence. Therapeutic methods include antiplatelet therapy, interventional therapy and control of risk factors. Two milestone trials, the Warfarin Aspirin Symptomatic Intracranial Disease (WASID) Trial and the Stenting and Aggressive Medical Management for Preventing Recurrent Stroke in Intracranial Stenosis (SAMMPRIS) Trial aim to provide an updated strategy for clinical practice.

The WASID Trial, with a double-blind, multicentre, randomised clinical trial design, aimed to evaluate the efficacy and safety of warfarin over aspirin among patients with 50%–99% degree of ICAS. Aspirin proved to be equally efficient and safer. This led to the investigation of a dual-antiplatelet therapy for secondary prevention in patients with sICAS. The Clopidogrel Plus Aspirin versus Aspirin Alone for Reducing Embolization in Patients with Acute Symptomatic Cerebral or Carotid Artery Stenosis Trial indicated that in patients in the sICAS group, dual-antiplatelet therapy reduced microembolic signals detected by transcranial Doppler ultrasound (TCD) (31% vs 54%, relative risk reduction 42.4%, 95% CI 4.6% to 65.2%, p=0.025) at day 2 of enrolment, which may further reduce the recurrence of artery-origin embolic stroke in these patients. The Clopidogrel in High-Risk Patients with Acute Non-disabling Cerebrovascular Events Trial published in 2013 first verified the benefit of dual-antiplatelet therapy for minor strokes and high-risk transient ischaemic attacks. It showed that combined use of clopidogrel and aspirin started within 24 hours and continued to 21 days was superior to aspirin monotherapy in reducing the risk of stroke in the first 90 days. In the ICAS subgroup analysis, it was found that dual-antiplatelet therapy had a tendency to reduce stroke recurrence over monoa-ntiplatelet therapy at 90 days, but was not statistically significant due to the limited number of participants enrolled.

Interventional therapy beyond the conventional reperfusion therapeutic time window in acute ischaemic stroke (AIS) is considered to modify stenotic status, improve haemodynamics and further reduce stroke recurrence, but its efficacy remains controversial. In the SAMMPRIS Trial, Chinomwiz and colleagues attempted to observe whether angioplasty or stenting plus medical therapy is beneficial for patients with sICAS over medical therapy alone. 451 patients with sICAS of 70%–99% stenosis within 30 days of onset enrolled. During the 30-day follow-up, 14.7% in the stenting group reached primary end points of stroke recurrence or death, versus only 5.8% in the medical management group (p=0.002). Interestingly, the authors further analysed the outcome for those patients who met the SAMMPRIS criteria from the WASID Trial: the 30-day and 1-year stroke recurrence and death rates in the WASID Trial are much higher than those in the SAMMPRIS Trial (10.5% vs 5.8%, 21.9% vs 12.6%, respectively, p=0.009). Interpreting the results, the authors found that aggressive control of risk factors and the ideal target in the SAMMPRIS Trial medical group may contribute to the difference. Therefore, aggressive medical treatment is still the main therapeutic strategy for secondary prevention of sICAS.

Despite the emerging research results, there still persist lots of problems and concerns in clinical practice. Risk factor management targets have not yet been verified. Most of the risk factors of sICAS are managed according to SAMP- PRIS standards: systolic blood pressure (SBP) ≤140 mm Hg (≤130 mm Hg if diabetes), low-density lipoprotein cholesterol (LDL-C) level reduced by 50% or <1.8 mmol/L. Increased SBP is strongly associated with a high recurrence rate in ICAS. However, for patients with AIS with large intracranial vessel stenosis, and potential for hypoperfusion disorders, the ideal BP target and treatment initiation timing remains unclear. It is reasonable to assume that many physicians are cautious about antihypertension treatment in patients with ICAS, especially during the acute stage.

As for dyslipidaemia, the Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL) Trial provided evident reduction in the rate of stroke recurrence with intensive statin therapy. But since SPARCL did not specifically focus on patients with ICAS, this result should be interpreted with caution. The significance of statin therapy in reducing stroke recurrence in ICAS has only been reported in observational studies.

Moreover, despite aggressive medical treatment, some patients with sICAS still face a high stroke recurrence rate. Many researchers have attempted to improve current medical treatment strategy. For example, resorting to new antiplatelet agents such as cilostazol.
Lastly, the process of recognition and assessment of features of ICAS are still under progress. Commonly used methods for vascular and perfusion assessments include TCD, MR angiography, arterial spin labelling, CT angiography, CT perfusion, digital subtraction angiography. Compared with the above imaging methods, high-resolution MRI (HR-MRI), which could provide additional valuable information on the diagnosis of ICAS and plaque, has been further studied and is widely used. HR-MRI could particularly detect plaque components, vessel wall morphology and luminal thrombus. Clinical researchers have considered variation of plaque characteristics on HR-MRI as the primary end points, for further use in clinical practice. Trials detecting the effect of medical therapy guided by HR-MRI in ICAS should be one of the directions in future. Furthermore, recent research on the computational fluid dynamics (CFD) technique providing non-invasive utilisation of dynamic features such as translesional pressure ratio and translesional wall shear stress ratio and clinical relevance of patients with ICAS, might be a promising and helpful guide to a better individualised secondary prevention strategy.

In conclusion, sICAS has been one of the top burdens of stroke, worldwide. Antiplatelet therapy, interventional therapy and control of critical risk factors are the major therapeutic approaches on hand. To further reduce the recurrence of stroke and improve outcome, the potential management strategy could be alternative drugs for antiplatelet and lipid lowering, more precise targets for control of risk factors, and validating particular patients benefiting from interventional therapy. New imaging techniques, such as HR-MRI and CFD, may provide detailed understanding of the pathology and mechanism, significant for governing the risk factors, and reducing risk of recurrent stroke in sICAS. In future, larger-scale studies with more specific patient data are warranted for individualised secondary prevention.

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**REFERENCES**


