Beneficial effects of prolonged blood pressure control after carotid artery stenting

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Introduction

Hemodynamic hypotension is a well-recognized phenomenon observed in patients shortly after undergoing carotid artery stenting (CAS); its incidence rate ranges from 10% to 42%.¹ However, there has been conflicting results on whether this hypotensive effect of CAS sustains for a long term. Altinbas et al reported no significant blood pressure (BP) reduction 1 year post-CAS, although less number of patients were required to receive antihypertensive agents.² Nevertheless, Chung et al provided supportive evidence and showed BP reductions 1 year post-CAS in two other similar studies.³,⁴ Although a previous study has established independent risk factors of short-term post-CAS hypotension, including older age and female sex,⁵ no study has attempted to identify a link between hemodynamic changes in the short and long term in patients undergoing CAS.

On the basis of the fact that those patients who undergo CAS may have improved cerebral autoregulation in long term, this study has hypothesized that BP control...
would improve after CAS and that medical treatment alone would sustain BP long term by either decreasing BP levels or diminishing the amount of antihypertensive agents required for optimized BP control. In addition, this study has sought to assess the predictive value of each validated definitions of post-CAS hypotension within 6 h to identify patients prone to significant long-term BP reductions.

Materials and methods
Patients
This study conducted a retrospective cohort study of all patients with severe internal carotid artery (ICA) stenosis between March 2005 and March 2013 at the Shin Kong Wu Ho-Su Memorial Hospital, a tertiary-centered hospital in northern Taiwan. All patients had severe ICA stenosis with >70% of diameter, which was defined as peak systolic velocity ≥200 cm/s at extracranial carotid Doppler evaluation, and without occlusion. Patients in the CAS group included those who chose to undergo CAS and receive medication, whereas patients in the medication group received only the medication. Clinical data were extracted from the medical file of each patient. Patients were excluded from the study if they had any life-threatening or disabling conditions that could interfere with the interpretation of outcomes (eg, shock, unstable coronary artery disease or heart failure, recurrent cerebral infarcts, and death) in the past year, or a history of manipulation of the other side of the carotid artery in the past year. Patients with missing BP or antihypertensive agent data were also excluded from the analysis. CAS was performed using standard procedures, including placement of a protection device, pre-stent angioplasty, stent placement with a self-expandable stent, and post-stent angioplasty if necessary. The protocols and informed consents were approved by the Institutional Review Board of Shin Kong Wu Ho-Su Memorial Hospital, and all participants gave written informed consent for using their medical files in this study.

Treatment and follow-up
Systolic BP (SBP) and diastolic BP (DBP) were recorded for all patients in the CAS group at baseline using the mean BP records of the day of admission and the night before and morning of CAS. In addition, SBP and DBP were recorded 6 h, 3 days, 1 month, 6 months, and 12 months post-CAS. SBP and DBP were recorded at baseline in the medication group using the mean of three consecutive BP measurements at an outpatient clinic before the carotid Doppler examination date, as well as at 6 and 12 months post-examination. BP was measured by clinical nurses using the conventional auscultatory method or automated device on either arm without distinction. Patients were instructed to sit after a 5-min resting period, and three measurements were taken at least 1 min apart and averaged.

The medical management of BP was identical in both the groups throughout the entire follow-up period. Antihypertensive agents were used to target BP (SBP <140 mmHg; DBP <90 mmHg) during regular 1–3 months follow-ups at neurology or cardiology outpatient clinics. The number of classes of antihypertensive drugs taken by the patients at each time point were summated and recorded by drug classes, including alpha-blockers, diuretics, nitrates, calcium channel blockers, angiotensin receptor blockers or angiotensin-converting enzyme inhibitors, and/or beta blockers; combination drugs were recorded as total classes (eg, Hyzaar FC, a combo of losartan and hydrochlorothiazide, as 2). Then, the amount of antihypertensive agents in each class at different points of follow-up (ie, 6 months and 12 months) were compared to the amount in each class at baseline and regarded as increased, reduced, or unchanged.

Post-CAS hypotension
The study recorded consecutive hourly intervals of SBP values for up to 6 h post-stenting in patients in the CAS group. Data were assessed using previous reported definitions of post-CAS hypotension, including any decrease in SBP within 6 h of ≥30 mmHg, 30–40 mmHg, or 40% compared with the pre-stent value, and a mean decrease in SBP within 6 h of ≥30 mmHg, 40 mmHg, or 40% compared with the pre-stent value. All the patients who underwent CAS were grouped into either the “greater SBP-reduction at 1 year” group, which was defined as patients with a SBP decrease of greater than or equal to the total average decrease at 1 year, or the “lesser SBP-reduction at 1 year” group, which was defined as patients with a SBP decrease of lesser than the total group average decrease at 1 year.

Outcome measures
The primary outcome measures were changes in SBP, DBP, and the number of classes of antihypertensive agents that patients received between baseline and follow-up. Secondary outcome measures included the correlation between post-CAS SBP reduction at 1 year and post-CAS SBP reduction within 6 h using post-CAS hypotension definitions.

Statistical analysis
The Student’s t-test was used to compare continuous variables between groups, and the chi-square test was applied to test the
differences in categorical variables. BP differences within a
group during the study period were tested by repeated analy-
sis of variance (ANOVA) measurements. If the assumption
of sphericity was violated, adjusted $P$-values were calculated
using the Greenhouse–Geisser Epsilon (G–G) correction.
Univariate linear regressions were performed to test the
relationship between SBP changes from baseline to 6 or
12 months of follow-up in both the groups. This relationship
was further analyzed using multivariate linear regression
and adjusting for potential confounding factors, including
diabetic mellitus (DM), smoking, stroke, and changes in
the number of classes of antihypertensive agents patients
received. In addition, univariate linear regression was used
to determine correlations between SBP reductions at 1 year
and the maximal or mean SBP reductions 6 h post-CAS. The
statistical significance was set at a $P$-value <0.05. Analyses
were performed using the SAS statistical software 9.1 (SAS
Institute, Cary, NC, USA).

**Results**

**Baseline characteristics**

A total of 202 patients were recruited for this study (Figure 1).
After omitting patients who met the exclusion criteria,
72 patients were enrolled in the CAS group and 82 in the
medication group. According to the baseline characteristics
(Table 1), the number of patients who smoked was significantly
higher in the CAS group than in the medication group (55.7% vs
33.7%). There were also more patients with a history of
stroke in the CAS group than in the medication group (57.1%
vs 41.5%). However, more patients in the medication group
had DM than in the CAS group (53% vs 34.3%). Other base-
line characteristics were similar between groups.

Mean baseline BP was also similar between groups
(Table 2). However, the mean baseline SBP was at border-
line, which is statistically and significantly higher in the CAS
group than in the medication group. The number of classes
of antihypertensive agents that patients received at baseline
was similar between groups; both the groups used nearly two
classes of antihypertensive agents on average at baseline.

**Changes of BPs and number of classes of antihypertensive agents used at different
time points**

While comparing the SBP and DBP at different time points
from baseline to 1 year of follow-up in each group (Table 2),
it was found that the CAS group had large decreases in SBP
and DBP 6 h post-stenting (mean SBP, 111.36 mmHg; mean
DBP, 56.17 mmHg), which gradually increased 3 days (mean
SBP, 121.11 mmHg; mean DBP, 65.07 mmHg) and 1 month
(mean SBP, 128.35 mmHg; mean DBP, 73.53 mmHg) post-
stenting. Mean BP slightly decreased again at 6 months
(mean SBP, 128.03 mmHg; mean DBP, 72.24 mmHg) and 12 months post-stenting (mean SBP, 124.93 mmHg;
mean DBP, 70.08 mmHg). ANOVA demonstrated that
SBP and DBP significantly decreased in the CAS group
throughout follow-up (G–G adjusted, $P<0.0001$ and G–G

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**Figure 1** Flow chart of patients enrolled and reasons for exclusion.

**Abbreviation:** CAS, carotid artery stenting.
### Table 1 Comparison of baseline characteristics between medication and CAS groups

<table>
<thead>
<tr>
<th></th>
<th>Medication (n=82)</th>
<th>CAS (n=72)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (mean ± SD)</strong></td>
<td>73 (10.2)</td>
<td>70.64 (8.9)</td>
<td>0.1291</td>
</tr>
<tr>
<td><strong>Sex (male)</strong></td>
<td>58 (69.9)</td>
<td>56 (80.0)</td>
<td>0.1266</td>
</tr>
<tr>
<td><strong>Medical history</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>44 (53.0)</td>
<td>24 (34.3)</td>
<td>0.0223</td>
</tr>
<tr>
<td>Hypertension</td>
<td>77 (92.8)</td>
<td>59 (84.3)</td>
<td>0.1097</td>
</tr>
<tr>
<td>Treated hyperlipidemia</td>
<td>43 (51.8)</td>
<td>37 (52.9)</td>
<td>0.7691</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>40 (48.2)</td>
<td>43 (61.4)</td>
<td>0.0742</td>
</tr>
<tr>
<td>Angina</td>
<td>17 (20.5)</td>
<td>10 (14.3)</td>
<td>0.2804</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>9 (10.8)</td>
<td>4 (5.71)</td>
<td>0.2362</td>
</tr>
<tr>
<td>Myocardial ischemia</td>
<td>6 (7.2)</td>
<td>6 (8.6)</td>
<td>0.5765</td>
</tr>
<tr>
<td>CABG</td>
<td>6 (7.2)</td>
<td>12 (17.1)</td>
<td>0.0674</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>7 (8.4)</td>
<td>2 (2.9)</td>
<td>0.1332</td>
</tr>
<tr>
<td>Peripheral artery occlusive disease</td>
<td>12 (14.5)</td>
<td>4 (5.8)</td>
<td>0.0736</td>
</tr>
</tbody>
</table>

**Note:** Values presented as number (percentage) unless stated otherwise.

**Abbreviations:** CABG, coronary artery bypass grafting; CAS, carotid artery stenting.

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adjusted, $P<0.0001$, respectively); this was not seen in the medication group (G–G adjusted, $P=0.9180$ and G–G adjusted, $P=0.4071$, respectively). Using univariate linear regression model, this study found that patients in the CAS group had a greater decrease in SBP (average, 12.05 mmHg), compared with those in the medication group after 6 months of follow-up ($\beta=-12.05, P=0.0005$). This tendency remained (average, 13.56 mmHg) after adjusting for DM, smoking, stroke, and changes in the number of classes of antihypertensive agents ($\beta=-13.56, P=0.0002$). A greater BP-lowering effect was observed at 12 months of follow-up in the CAS group, compared with the medication group. A greater reduction in SBP (average, 16.98 mmHg) was observed in CAS group ($\beta=-16.98, P<0.0001$) after adjusting for confounding factors.

The mean number of classes of antihypertensive agents used were similar between the medication at 6 months (1.82 vs 2.03, $P=0.3747$) and 12 months (1.88 vs 1.96, $P=0.8681$) of follow-up (Table 2). Similarly, there were no differences between the groups when the study compared the amount in each class of antihypertensive agents at different points of follow-up (ie, 6 and 12 months) to the baseline (data not shown).

### Correlation between post-CAS hypotension and SBP reduction 6 h and 1 year post-CAS

“Greater SBP reduction at 1 year” was defined as patients having greater than or equal to the mean post-CAS SBP reduction at 1 year (which was 15 mmHg; Table 3). When defining post-CAS hypotension as “any SBP drop of ≥30 mmHg 6 h post-CAS”, significantly more patients had post-CAS hypotension in the group of greater SBP reduction at 1 year compared to those in the group of lesser SBP reduction during the same duration (80% vs 46%, $P=0.0029$). Similarly, when defining post-CAS hypotension as “mean SBP drop of ≥30 mmHg 6 h post-CAS”, significantly more patients had post-CAS hypotension in the group of greater SBP reduction at 1 year, compared to those in the group of lesser SBP reduction during the same duration (57.1% vs 27%, $P=0.0096$).

A significant positive correlation ($\beta=0.47\pm0.10, P<0.0001$) was seen between post-CAS SBP reduction at 1 year and maximal SBP reduction 6 h post-CAS (Figure 2A). A similar linear relationship ($\beta=0.20\pm0.07, P=0.0067$) was observed between SBP reduction 1 year post-CAS and the mean SBP reduction 6 h post-CAS (Figure 2B).

### Table 2 Comparisons between the medication group and the CAS group in terms of changes in SBPs, DBPs, and the number of classes of antihypertensive agents used at different time periods

<table>
<thead>
<tr>
<th></th>
<th>SBP Mean</th>
<th>CAS Mean</th>
<th>P-value*</th>
<th>DBP Mean</th>
<th>CAS Mean</th>
<th>P-value*</th>
<th>Number of classes of antihypertensive agent Mean</th>
<th>CAS Mean</th>
<th>P-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>134.81 (16.8)</td>
<td>140.04 (16.2)</td>
<td>0.0508</td>
<td>74.16 (14.1)</td>
<td>76.29 (10.2)</td>
<td>0.2883</td>
<td>1.77 (1.35)</td>
<td>1.89 (1.37)</td>
<td>0.7939</td>
</tr>
<tr>
<td>Post-CAS 6 h</td>
<td>111.36 (20.7)</td>
<td>121.11 (13.2)</td>
<td>0.0199</td>
<td>56.17 (13.8)</td>
<td>65.07 (11.1)</td>
<td>0.0003</td>
<td>1.82 (1.28)</td>
<td>2.03 (1.26)</td>
<td>0.3747</td>
</tr>
<tr>
<td>Post-CAS 3 days</td>
<td>128.35 (14.5)</td>
<td>128.53 (12.3)</td>
<td>0.0001</td>
<td>73.88 (10.1)</td>
<td>72.24 (11.9)</td>
<td>0.3535</td>
<td>1.88 (1.38)</td>
<td>1.96 (1.25)</td>
<td>0.8681</td>
</tr>
<tr>
<td>Post-CAS 1 month</td>
<td>134.88 (18.0)</td>
<td>124.93 (13.8)</td>
<td>0.0003</td>
<td>73.88 (10.1)</td>
<td>70.08 (10.1)</td>
<td>0.1903</td>
<td>1.88 (1.38)</td>
<td>1.96 (1.25)</td>
<td>0.8681</td>
</tr>
</tbody>
</table>

**Notes:** *P*-value from Student’s t-test; G–G adjusted P-value from repeated measures ANOVA. Values are presented as the mean ± standard deviation.

**Abbreviations:** CAS, carotid artery stenting; DBP, diastolic blood pressure; SBP, systolic blood pressure; G–G, Greenhouse–Geisser; ANOVA, analysis of variance.
Table 3 Correlations between each definitions of post-CAS hypotension within 6 h and 1 year post-CAS SBP reductions

<table>
<thead>
<tr>
<th>Definitions of post-CAS hypotension within 6 h</th>
<th>Overall (n=72)</th>
<th>Lesser SBP reduction at 1 year (n=35)</th>
<th>Greater SBP reduction at 1 year (n=37)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any SBP drop</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥30 mmHg</td>
<td>55 (76.4)</td>
<td>25 (67.6)</td>
<td>30 (85.7)</td>
<td>0.0700</td>
</tr>
<tr>
<td>≥40 mmHg</td>
<td>45 (62.5)</td>
<td>17 (46.0)</td>
<td>28 (80.0)</td>
<td>0.0029</td>
</tr>
<tr>
<td>≥40% of present SBP</td>
<td>18 (25.0)</td>
<td>6 (16.2)</td>
<td>12 (34.3)</td>
<td>0.0768</td>
</tr>
<tr>
<td>Mean SBP drop</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥30 mmHg</td>
<td>30 (41.7)</td>
<td>10 (27.0)</td>
<td>20 (57.1)</td>
<td>0.0096</td>
</tr>
<tr>
<td>≥40 mmHg</td>
<td>11 (15.3)</td>
<td>3 (9.1)</td>
<td>8 (22.9)</td>
<td>0.0821</td>
</tr>
<tr>
<td>≥40% of present SBP</td>
<td>5 (6.9)</td>
<td>2 (5.4)</td>
<td>3 (8.6)</td>
<td>0.6696</td>
</tr>
</tbody>
</table>

Note: Values are presented as the number (percentage) of patients with post-CAS hypotension within 6 h.
Abbreviations: CAS, carotid artery stenting; SBP, systolic blood pressure.

Discussion
This study demonstrated that patients undergoing CAS for severe carotid artery stenosis had long-term benefits in BP control. Specifically, the research observed a reduction in SBP 1 year post-CAS, despite changes in the number of classes of antihypertensive agent required for optimal BP control. This study holds the first to evaluate the long-term changes in BP levels and the number of classes of antihypertensive agents used between a group of patients who underwent CAS and received medical treatment, and patients who received just medical treatments. Furthermore, this study identified a correlation between BP reductions 6 h and 1 year post-CAS. Compared with baseline SBP, any SBP decrease of ≥40 mmHg or a decrease of ≥30 mmHg of mean SBP 6 h post-CAS may be a predictive factor, indicating a significant decrease in BP in the long term. It may also be important in adjusting antihypertensive agents during BP monitoring.

Early post-procedural decreases in BP have been observed rather commonly after patients undergo CAS,10–12 and several studies have been proposed to confirm whether such condition would persist.2–4,13 In 2003, McKevitt et al recruited 49 patients with carotid endarterectomy (CEA) and 55 patients with different types of endovascular treatment and found significant BP reduction solely in CEA groups for up to 6 months post-procedure.13 However, it is believed that the results were inconclusive, because there was no record of the number of classes of antihypertensive agents patients received and the author included a limited number of cases in their study. A much larger and multicentered analysis was later conducted with participants (587 patients with CAS and 637 patients with CEA) from the International Carotid Stenting Study.2 The investigators showed that BP-lowering effects were significant in 6 months post-CAS or -CEA, although the reductions were seen only in SBPs.

Figure 2 Correlation between SBP reductions 1 year and 6 h post-CAS.
Notes: Significant positive correlations were seen between (A) SBP reduction 1 year post-CAS (Y) and the maximal SBP reduction 6 h post-CAS (X1); (B) SBP reduction 1 year post-CAS (Y) and mean SBP reduction 6 h post-CAS (X2).
Abbreviations: CAS, carotid artery stenting; SBP, systolic blood pressure.
long-term calcium antagonists may have neutral effects on the adrenergic drive or even trigger a sympathoexcitation.\textsuperscript{14} Alternatively, it should be noted that beta-blockers produce a sympathoinhibition and sympathetic deactivation with drugs acting on the renin–angiotensin system, such as angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers.\textsuperscript{15} Although no such clear correlation was observed in this study – of the 44 patients who used either diuretics or calcium antagonists before CAS, only 17 had significant BP-lowering effect after 1 year – this can be promising in the future in a much larger study.

Previous studies have suggested that mechanical stretch and increased distension of the carotid sinus from the compression of stent dilatation acts as the key reason for BP decreasing post-CAS.\textsuperscript{13,16} Changes in the baroreflex function in terms of baroreflex sensitivity (BRS) has also been recently suggested. In a study, investigators compared the short-term (8 and 24 h post-procedure) effects on BRS in patients who underwent CEA and CAS procedures and found that the parasympathetic predominance with hypotensive effect was shown only in patients who underwent CAS.\textsuperscript{17} Although the ability of the baroreceptor to buffer acute changes in arterial BP through modulation in sympathetic nerve activity is well established, its role in the long-term role has been debated since the 1970s.\textsuperscript{18} Animal and human studies have demonstrated that prolonged activation of carotid baroreflex may produce significant and sustained BP reductions without any trend for adaptation.\textsuperscript{19,20} Carotid atherosclerosis and stenosis have also been reported to be associated with reduced BRS.\textsuperscript{21} In an another minor study, investigators sought to assess long-term BRS in patients who underwent CAS and hypothesized that CAS could restore the BRS and result in a better long-term control of BP.\textsuperscript{22} Surprisingly, the authors did not observe a significant improvement in BRS from baseline. However, this study believes that the data need to be re-evaluated, because the investigators used a short-term study period (6 months) and has a smaller study population. The possible restoration of BRS after 1-year post-CAS needs to be studied further.

This study had several limitations. Due to the retrospective data collection, the protocol of antihypertensive agent usage in controlling BPs was not standardized by different attending physicians; hence, bias may have produced statistical significance. In addition, the small number of participants included may have yielded unsubstantial conclusions. The study may have also underestimated the occurrences of actual post-CAS hypotension when setting the time period to 6 h, though this specific time setting is considered to be more practical clinically in recording hourly BPs.
Conclusion
This study shows that the patients undergoing CAS for severe carotid artery stenosis may benefit from long-term BP control, compared with those who receive only medication, despite changes in the number of classes of antihypertensive agent required for optimal BP control. In addition, this study illustrates the possible predictive value of a significant long-term reduction of BP if there is any SBP decrease of ≥40 mmHg or a decrease of ≥30 mmHg of mean SBP 6 h post-CAS, compared with baseline SBP. This may be an important factor when adjusting antihypertensive agents during BP monitoring.

Acknowledgment
This work was supported by a grant from Shin Kong Wu Ho-Su Memorial Hospital (SKH-8302-102-DR-15).

Disclosure
The authors report no conflicts of interest in this work.

References