Carotid Endarterectomy under Regional Anaesthesia (RACE)

FP II-02

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Introduction
Carotid endarterectomy (CE) is the preferred treatment of severe carotid artery stenosis (CS) while carotid angioplasty and stenting (CAS) is an alternative if not suitable for CE. While technique and safety of CAS is improving, much effort is also paid to reduce the complication rate for CE.

Purpose
We started to use RACE for all patients with increased cardiac risk and as an option for other patients since 2001. The aim is to assess the safety and effectiveness of RACE.

Methods
This is a prospective observational study. A total of 12 RACE performed. Six of the patients had one or more medium AHA risk predictor(s).

Results
None of the cases need to be converted to GA. There was no operative stroke, mortality, or cardiac ischaemic events. Length of stay (LOS) after CE or CAS in our hospital is as follows:

Post-op LOS	RACE (13 cases)	CE under GA (53 cases)	CAS (11 cases)
Mean (days)	3.8	5.4	5.5
Median (days)	3	4	4

After the introduction of RACE very few of the cases were indicated for CAS.

Conclusions
Introduction of RACE led to improvement in outcome and reduced the LOS following treatment of CS.

Clinical Relevance of Severe Initial Hypertension in Acute Intracerebral Haemorrhage

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Objective
To characterise severe initial hypertension (SIH) in the acute intracerebral haemorrhage (ICH) and the related clinical outcomes.

Methodology
We prospectively identified patients admitted to a regional hospital with acute ICH between January 2003 and September 2003. SIH was defined by systolic BP >180 mmHg, diastolic BP >105 mmHg and/or mean BP >130 mmHg for 2 or more readings at 10 or more minutes apart. Clinical data was recorded and analyzed. The modified Rankin score was used to assess disability.

Results
A total of 102 patients were identified. SIH was found in 72 patients (70.6%). Comparing those with SIH and those without SIH, they differed statistically in Glasgow Coma Scale ($p=0.03$), National Institutes of Health Stroke Scale ($p<0.001$), volume of ICH ($p=0.006$), past history of hypertension ($p=0.03$) and time from onset to hospital arrival ($p=0.013$). Patients with SIH had a statistically significant increase in 30-day mortality ($p=0.028$) and 3-month mortality ($p=0.016$) as well as increase in 30-day disability ($p=0.003$) and 3-month disability ($p=0.006$). However, the correlation between SIH and mortality or disability was lost when controlling for the above factors. Furthermore, about half of the patients with SIH had their BP subsided within the first day, and this was associated with a significantly lower 30-day disability ($p=0.033$) and 3-month disability ($p=0.045$).

Conclusion
SIH in acute ICH is related to a poor neurological state, an increased volume of ICH, a past history of hypertension and a shorter delay from onset. SIH is a prognostic indicator for mortality and disability but is not an independent factor. As those with early settle of BP have a lower disability, aggressive BP control in the acute phase of ICH may lessen the morbidity.