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Writing Group for the American Academy of Neurology, AANS/CNS Cerebrovascular Section, Society of NeuroInterventional Surgery, and the Society of Vascular & Interventional Neurology, P.M. Meyers, H.C. Schumacher, M.J. Alexander, C.P. Derdeyn, A.J. Furlan, R.T. Higashida, C.J. Moran, R.W. Tarr, D.V. Heck, J.A. Hirsch, M.E. Jensen, I. Linfante, C.G. McDougall, G.M. Nesbit, P.A. Rasmussen, T.A. Tomsick, L.R. Wechsler, J.R. Wilson and O.O. Zaidat

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CONSENSUS STATEMENT

Writing Group for the American Academy of Neurology, AANS/CNS Cerebrovascular Section, Society of NeuroInterventional Surgery, and the Society of Vascular & Interventional Neurology

P.M. Meyers¹

H.C. Schumacher²

M.J. Alexander³

C.P. Derdeyn⁴

A.J. Furlan⁵

R.T. Higashida⁶

C.J. Moran⁴

R.W. Tarr⁷

D.V. Heck⁸

J.A. Hirsch⁹

M.E. Jensen¹⁰

I. Linfante¹¹

C.G. McDougall¹²

G.M. Nesbit¹³

P.A. Rasmussen¹⁴

T.A. Tomsick¹⁵

L.R. Wechsler¹⁶

J.R. Wilson¹⁷

O.O. Zaidat¹⁸

Performance and Training Standards for Endovascular Ischemic Stroke Treatment

ABSTRACT: Stroke is the third leading cause of death in the USA, Canada, Europe, and Japan. According to the American Heart Association and the American Stroke Association, there are now 750 000 new strokes that occur each year, resulting in 200 000 deaths, or 1 of every 16 deaths, per year in the USA alone. Endovascular therapy for patients with acute ischemic stroke is an area of intense investigation. The American Stroke Association has given a qualified endorsement of intra-arterial thrombolysis in selected patients. Intra-arterial thrombolysis has been studied in two randomized trials and numerous case series. Although two devices have been granted FDA approval with an indication for mechanical stroke thrombectomy, none of these thrombectomy devices has demonstrated efficacy for the improvement of patient outcomes. The purpose of the present document is to define what constitutes adequate training to perform neuroendovascular procedures in patients with acute ischemic stroke and what performance standards should be adopted to assess outcomes. These guidelines have been written and approved by multiple neuroscience societies which historically have been directly involved in the medical, surgical and endovascular care of patients with acute stroke. The participating member organizations of the Neurovascular Coalition involved in the writing and endorsement of this document are the Society of NeuroInterventional Surgery, the American Academy of Neurology, the American Association of Neurological Surgeons/Congress of Neurological Surgeons Cerebrovascular Section, and the Society of Vascular & Interventional Neurology.

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¹ New York Presbyterian Hospital, Columbia University, College of Physicians & Surgeons, Neurological Institute, New York, New York

² Albert Einstein College of Medicine, New York, New York

³ Cedars-Sinai Medical Center, Los Angeles, California

⁴ Washington University, St Louis, Missouri

⁵ Case Western Reserve University, Cleveland, Ohio

⁶ University of California San Francisco, San Francisco, California

⁷ University Hospitals Case Medical Center, Cleveland, Ohio

⁸ Forsyth Medical Center, Winston-Salem, North Carolina

⁹ Harvard University, Boston, Massachusetts

¹⁰ University of Virginia Health Sciences Center, Charlottesville, Virginia

¹¹ Miami Vascular Institute, Miami, Florida

¹² Barrow Neurological Institute, Phoenix, Arizona

¹³ Oregon Health Sciences, Portland, Oregon

¹⁴ Cleveland Clinic, Cleveland, Ohio

¹⁵ University of Cincinnati, Cincinnati, Ohio

¹⁶ University of Pittsburgh, Pittsburgh, Pennsylvania

¹⁷ Wake Forest University School of Medicine, Winston-Salem, North Carolina

¹⁸ Medical College of Wisconsin, Milwaukee, Wisconsin

Please address correspondence to Philip M. Meyers, Associate Professor, Radiology and Neurological Surgery, New York Presbyterian Hospital, Columbia University, College of Physicians & Surgeons, Neurological Institute, 710 West 168th Street, Suite 428, New York, New York 10032, USA; pmm2002@columbia.edu

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Stroke is the third leading cause of death in the USA, Canada, Europe, and Japan. According to the American Heart Association and the American Stroke Association, there are now 750 000 new occurrences of stroke each year, resulting in 200 000 deaths, or 1 of every 16 deaths, per year in the USA alone.¹ Ischemic stroke accounts for more than 80% of the total, while hemorrhagic stroke accounts for the remainder. Stroke is the leading cause of adult disability in North America² and the primary cause for in-patient Medicare reimbursement for long-term adult care.^{3,4} The National Institutes of Health (NIH) estimates that stroke costs now exceed \$62 billion in US healthcare dollars per year.¹

At present, the only therapy demonstrated to improve clinical outcomes from acute ischemic stroke is thrombolysis of the clot responsible for the ischemic event.⁵ Specifically, the only Food and Drug Administration (FDA)-approved stroke therapy is intravenous tissue plasminogen activator within 3 h of stroke onset.⁵ Endovascular therapy for patients with acute ischemic stroke is an area of intense investigation. The American Stroke Association has given a qualified endorsement of intra-arterial thrombolysis in selected patients. Intra-arterial thrombolysis has been studied in two randomized trials^{6,7} and numerous case series. Although two devices have been granted FDA approval with an indication for mechanical stroke thrombectomy,⁸ none of these thrombectomy devices has

demonstrated efficacy for the improvement of patient outcomes.

The purpose of the present document is to define what constitutes adequate training to perform neuroendovascular procedures in patients with acute ischemic stroke and what performance standards should be adopted to assess outcomes. Neuroendovascular procedures are technically challenging: the necessary skills are not directly transferable from other vascular systems; and these procedures involve an organ with unique physiology and anatomy, requiring careful patient selection because of the risk of potentially fatal brain hemorrhage. It has become abundantly clear over the past 20 years that inadequate physician training and experience can adversely affect clinical outcomes in studies of emerging technologies. Overexuberance both on the part of physicians and industry has led unqualified physicians to perform endovascular carotid revascularization procedures yielding inferior results.^{9,10} Therefore, it is especially important that the involved physicians strictly adhere to appropriate standards when performing high-risk procedures such as endovascular stroke treatment. Standardization of training requirements is of critical importance as the interest in and utilization of endovascular methods increases among various specialties. These guidelines are modeled after prior standards documents such as the training, competency and credentialing standards for diagnostic cerebral angiography, carotid stenting and treatment of acute stroke, written and endorsed by multispecialty groups^{11–13}; and training standards for the performance of uterine artery embolization written by the Society of Interventional Radiology.¹⁴ These guidelines also parallel the training standards of successful sub-specialty training programs such as Interventional Cardiology, and the credentialing standards for the performance of acute coronary intervention.¹⁵ These guidelines have been written and approved by multiple neuroscience societies which historically have been directly involved in the medical, surgical and endovascular care of patients with acute stroke. These organizations include the Neurovascular Coalition and its participating societies including Society of NeuroInterventional Surgery, American Academy of Neurology, American Association of Neurological Surgeons/Congress of Neurological Surgeons Cerebrovascular Section, and Society of Vascular & Interventional Neurology.

Minimum Training Requirements for Acute Stroke Interventions

Cognitive Training and Qualifications:

1. Accreditation Council for Graduate Medical Education (ACGME)-approved residency training including documented cerebrovascular training including the diagnosis and management of acute stroke, and the interpretation of cerebral arteriography and brain imaging under the supervision of a board-certified neurologist, neurosurgeon or neuroradiologist with subsequent National Board of Medical Examiners eligibility or certification. A minimum of 6 months during a 4-year residency is suggested.
2. One year of graduate medical education in endovascular surgical neuroradiology. An ACGME-approved program is preferred but not required.

Technical Training and Qualifications:

1. Documented prior training and experience in catheter arteriography including 100 cerebral arteriograms. Clinical outcomes must meet or exceed American College of Rheumatology benchmarks for technical success and complications.^{11,16}
2. Documented prior training and experience in microcatheter (≤ 3 French) and microguidewire (≤ 0.014 inches) navigation under the supervision of fellowship-trained and credentialed neurointerventionalist(s).
3. Documented prior experience in assessment and performance of endovascular stroke interventional procedures as the primary operator in 10 patients under the supervision of fellowship-trained and credentialed neurointerventionalists(s).
4. Previously credentialed physicians who perform intra-arterial catheter-directed stroke procedures at their local institutions should have documented procedural and clinical outcomes that meet national standards and published evidence-based guidelines.^{12,13}

During the next 2–3 years as the nation progresses to regional stroke care with comprehensive stroke centers it is conceivable that selective hospitals may choose to credential individuals for intra-arterial stroke therapy, who have not had a full year of neurointerventional fellowship training. While this is not endorsed as best clinical practice, if such local situations occur and if hospitals choose to credential individuals who have not had a full year of neurointerventional training, it is recommended that at a minimum these individuals should have had adequate neuroscience cognitive training (including a minimum of 6 months' documented neuroscience training in an ACGME-approved postgraduate training program); adequate technical and interpretive cerebral angiography training (including a minimum primary operator experience of 100 appropriately supervised cerebral angiograms, which is the minimum prerequisite for neurointerventional training); adequate cerebral microcatheter experience (including a minimum of 30 cases as primary operator in the intracranial internal carotid artery/vertebral basilar circulation mentored by a credentialed fellowship-trained neurointerventionalist); and mentored experience in intra-arterial stroke therapy (including a minimum of 10 cases mentored by a credentialed fellowship-trained neurointerventionalist credentialed in intra-arterial stroke therapy) prior to being credentialed to perform intra-arterial therapy. It is anticipated that by 2012 stroke centers that are providing intra-arterial stroke therapy will be staffed with exclusively fellowship-trained neurointerventionalists and/or practitioners who have met the above prerequisite guidelines and have demonstrated credentialed experience in intra-arterial therapy with adequate outcomes. Further, it is anticipated that after 2012 additional manpower for providing intra-arterial stroke therapy in stroke centers will come exclusively from fellowship-trained neurointerventionalists.

Training in Endovascular Surgical Neuroradiology

In the USA, Canada, Europe, and Japan, educational programs are specifically designed to train neuroscience physicians to treat acute hemorrhagic and ischemic stroke. This training represents the "gold standard" for performance of

endovascular cerebrovascular procedures including the endovascular treatment of acute stroke.

Since the year 2000, program requirements have been formally established and published in North America to ensure uniform training in endovascular surgical neuroradiology, a field specializing in the endovascular treatment of acute stroke.¹⁷ "Endovascular Surgical Neuroradiology" is the title or moniker used to describe the training pathway that is recognized by the ACGME.^{17,18}

Mechanical revascularization (thrombectomy/embolectomy) devices have not yet been proven to improve patient outcomes. In addition, it is not possible to define general training requirements when there is currently significant clinical experience with only one mechanical revascularization clot retrieval device and it is unknown what the necessary interventional skills would be for newer generations of clot retrieval devices. There is consensus that the skills needed and risks associated with use of these devices are greater than the skills needed and risks associated with use of catheter-based pharmacologic lysis, but it is not possible to make specific training recommendations at this time. However, at a minimum, the physician must meet the training criteria described herein for pharmacologic lysis for emergency stroke therapy and have successfully completed a training course for use of any specific device. Furthermore, procedural complication rates including intracerebral hemorrhage should conform to evidence-based national guidelines.

Maintenance of Physician and Facility Qualifications

The physician should have ongoing stroke-specific continuing medical education of at least 16 h/2 years according to Joint Commission requirement. The physician should have procedural outcomes that conform to national standards and institutional requirements.

Neuroendovascular acute ischemic stroke procedures should be performed only at Joint Commission or state-certified primary or comprehensive stroke centers.¹⁹ Outlying and community hospitals should develop access to endovascular acute stroke therapy through the development of stroke systems of care.²⁰ The interventionalist must have 24/7 access to neurologists and neurosurgeons knowledgeable in patient selection and in the pre- and postneurological critical care of endovascularly treated patients with stroke. There must be 24/7 neurology and neurosurgical availability to treat possible complications of stroke therapy. There must be an active quality assurance program for stroke therapy to monitor outcomes both in the periprocedural period and at 90 days. All emergency interventional stroke therapy patients must be reviewed by the quality assurance program. Outcomes should be tracked and recorded. All centers should participate in and enroll all patients with stroke in available national stroke registries or multicenter stroke trials.

Conclusions

Medical disciplines with ACGME-approved training in neurosciences and the care of patients with stroke agree on the importance of safety and quality of care for patients with stroke. Due to the grave consequences of inadequate or deficient training, stringent credentialing criteria with formal neuroscience training as specified herein and by peer-

viewed published standards should be mandated for emergent endovascular stroke therapy,^{17–21} analogous to vascular interventions for acute myocardial infarction or other high morbidity and mortality conditions.^{22–30} Credentialing committees at each healthcare facility are empowered to enforce training and practice standards and, thus, have an obligation to maintain recognized accreditation standards and to be aware of recommendations endorsed by the national organizations most directly involved in the diagnosis and management of acute stroke. Physician credentials, maintenance of certification, and quality improvement programs must be consistent with mandated and accepted standards defined by the ACGME, American Medical Association, American Board of Medical Specialties, and state licensing boards.

References

1. Rosamond W, Flegal K, Furie K, et al. **Heart disease and stroke statistics—2008 update: a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee.** *Circulation* 2008;117:e25–146.
2. Sacco RL, Benjamin EJ, Broderick JP, et al. **American Heart Association Prevention Conference. IV. Prevention and rehabilitation of stroke. Risk factors.** *Stroke* 1997;28:1507–17.
3. Adelman SM. **The National Survey of Stroke. Economic impact.** *Stroke* 1981;12:1 (169–87).
4. Taylor TN, Davis PH, Torner JC, et al. **Lifetime cost of stroke in the United States.** *Stroke* 1996;27:1459–66.
5. The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group. **Tissue plasminogen activator for acute ischemic stroke.** *N Engl J Med* 1995;333:1581–87.
6. del Zoppo GJ, Higashida RT, Furlan AJ, et al. **Proact Investigators. PROACT: a phase II randomized trial of recombinant pro-urokinase by direct arterial delivery in acute middle cerebral artery stroke. Prolyse in acute cerebral thromboembolism.** *Stroke* 1998;29:4–11.
7. Furlan A, Higashida R, Wechsler L, et al. **Intra-arterial prourokinase for acute ischemic stroke. The PROACT II study: a randomized controlled trial. Prolyse in acute cerebral thromboembolism.** *JAMA* 1999;282:2003–11.
8. Smith WS, Sung G, Starkman S, et al. **Safety and efficacy of mechanical embolectomy in acute ischemic stroke: results of the MERCI trial.** *Stroke* 2005;36:1432–38.
9. Mas JL, Chateletier G, Beyssen B, et al. **Enderectomy versus stenting in patients with symptomatic severe carotid stenosis.** *N Engl J Med* 2006;355:1660–71.
10. Ringleb PA, Allenberg J, Bruckmann H, et al. **30 day results from the SPACE trial of stent-protected angioplasty versus carotid endarterectomy in symptomatic patients: a randomised non-inferiority trial.** *Lancet* 2006;368:1239–47.
11. **Practice guideline for the performance of diagnostic cervicocerebral angiography in adults. 2007; Resolution 12m:15.** http://www.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/iv/cervicocerebral_angio.aspx
12. Adams HP, Jr, del Zoppo G, Alberts MJ, et al. **Guidelines for the early management of adults with ischemic stroke: a guideline from the American Heart Association/American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups: the American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists.** *Circulation* 2007;115:e478–534.
13. Connors JJ, 3rd, Sacks D, Furlan AJ, et al. **Training, competency, and credentialing standards for diagnostic cervicocerebral angiography, carotid stenting, and cerebrovascular intervention: a joint statement from the American Academy of Neurology, the American Association of Neurological Surgeons, the American Society of Interventional and Therapeutic Neuroradiology, the American Society of Neuroradiology, the Congress of Neurological Surgeons, the AANS/CNS Cerebrovascular Section, and the Society of Interventional Radiology.** *J Vasc Interv Radiol* 2004;15:1347–56.
14. Spies JB, Sacks D. **Credentials for uterine artery embolization.** *J Vasc Interv Radiol* 2004;15:111–13.
15. King SB, 3rd, Aversano T, Ballard WL, et al. **ACC/AHA/SCAI 2007 update of the clinical competence statement on cardiac interventional procedures: a report of the American College of Cardiology Foundation/American Heart Association/American College of Physicians Task Force on Clinical Competence and Training (writing Committee to Update the 1998 Clinical Competence Statement on Recommendations for the Assessment and Maintenance of Proficiency in Coronary Interventional Procedures).** *J Am Coll Cardiol* 2007;50:82–108.

16. American Society of Neuroradiology. **Quality improvement guidelines for adult diagnostic neuroangiography. Cooperative study between the ASNR, ASITN, and the SCVIR.** *AJNR Am J Neuroradiol* 2000;21:146–50.
17. Higashida RT, Hopkins LN, Berenstein A, et al. **Program requirements for residency/fellowship education in neuroendovascular surgery/interventional neuroradiology: a special report on graduate medical education.** *AJNR Am J Neuroradiol* 2000;21:1153–59.
18. Neurology AAo. **Stroke and vascular neurology fellowship core curriculum.** *Stroke Section* 2001;1–5.
19. Adams R, Acker J, Alberts M, et al. **Recommendations for improving the quality of care through stroke centers and systems: an examination of stroke center identification options: multidisciplinary consensus recommendations from the Advisory Working Group on Stroke Center Identification Options of the American Stroke Association.** *Stroke* 2002;33:e1–7.
20. Schwamm LH, Holloway RG, Amarenco P, et al. **Review of the evidence for the use of telemedicine within stroke systems of care.** *Stroke*. In press.
21. Barr JD, Connors JJ, 3rd, Sacks D, et al. **Quality improvement guidelines for the performance of cervical carotid angioplasty and stent placement.** *AJNR Am J Neuroradiol* 2003;24:2020–34.
22. Pepine CJ, Allen HD, Bashore TM, et al. **ACC/AHA guidelines for cardiac catheterization and cardiac catheterization laboratories.** American College of Cardiology/American Heart Association Ad Hoc Task Force on Cardiac Catheterization. *Circulation* 1991;84:2213–47.
23. Friesinger GC, Adams DF, Bourassa MG, et al. **Examination of the Chest and Cardiovascular System Study Group. Optimal resources for examination of the heart and lungs: cardiac catheterization and radiographic facilities.** *Circulation* 1983;68:891A–930A.
24. Conti CR, Faxon DP, Gruentzig A, et al. **17th Bethesda conference: adult cardiology training. Task force III. Training in cardiac catheterization.** *J Am Coll Cardiol* 1986;7:1205–06.
25. Hodgson JM, Tommaso CL, Watson RM, et al. **Core curriculum for the training of adult invasive cardiologists: report of the society for cardiac angiography and interventions committee on training standards.** *Cathet Cardiovasc Diagn* 1996;37:392–408.
26. Hirshfeld JW, Jr, Ellis SG, Faxon DP. **Recommendations for the assessment and maintenance of proficiency in coronary interventional procedures: statement of the American College of Cardiology.** *J Am Coll Cardiol* 1998;31:722–43.
27. Ryan TJ, Faxon DP, Gunnar RM, et al. **Guidelines for percutaneous transluminal coronary angioplasty. A report of the American College of Cardiology/American Heart Association Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular Procedures (Subcommittee on Percutaneous Transluminal Coronary Angioplasty).** *Circulation* 1988;78:486–502.
28. Ryan TJ, Klocke FJ, Reynolds WA. **Clinical competence in percutaneous transluminal coronary angioplasty. A statement for physicians from the ACP/ACC/AHA Task Force on Clinical Privileges in Cardiology.** *J Am Coll Cardiol* 1990;15:1469–74.
29. Ryan TJ, Bauman WB, Kennedy JW, et al. **Guidelines for percutaneous transluminal coronary angioplasty. A report of the American Heart Association/American College of Cardiology Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular Procedures (Committee on Percutaneous Transluminal Coronary Angioplasty).** *Circulation* 1993;88:2987–3007.
30. Cowley MJ, Faxon DP, Holmes DR, Jr. **Guidelines for training, credentialing, and maintenance of competence for the performance of coronary angioplasty: a report from the Interventional Cardiology Committee and the Training Program Standards Committee of the Society for Cardiac Angiography and Interventions.** *Cathet Cardiovasc Diagn* 1993;30:1–4.