

Letter to the Editor

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Letter by Sallustio et al Regarding Article, “Endovascular Thrombectomy and Stroke Physicians: Equity, Access, and Standards”

To the Editor:

We read with great interest the editorial by Davis et al¹ recently published in *Stroke*. We totally agree with the authors about shortage of neurointerventionists. It is undoubted that health systems throughout the world have been taken by surprise and unprepared by the astonishing news of 2015. Health systems and, most of all, economies differ deeply between different countries. Despite cost savings in the social service sector deriving from treating stroke with thrombectomy,² few improvements have been reached in terms of availability of neurointerventionists during the last 2 years. The need for much more thrombectomy performers is going to quickly and further increase in light of the recent results of the Diffusion-weighted imaging or computerized tomography perfusion assessment with clinical mismatch in the triage of wake up and late presenting strokes undergoing neurointervention with Trevo (DAWN) trial, presented last May in Prague at the third European Stroke Organization Conference. We think that one of the main reasons for this famine is the strictness of training standards for neurointervention.³ As a consequence, stroke neurologists seem to be far away from being suitable for this kind of activity, and as usually heard in several conferences, even vascular interventional radiologists do not seem to fit these standards and should not be considered as a reliable resource for neurothrombectomy. We totally disagree with these statements since in the urgency of recruiting thrombectomy performers, it cannot be denied the ability of vascular interventional radiologists to navigate the vascular system. As a matter of fact, in August 2009, the first neurothrombectomy procedure was indicated by a stroke neurologist and performed by a vascular interventional radiologist without previous expertise in neuronavigation in our comprehensive stroke center. Since then, a team of 5 vascular interventional radiologists has been created. Obviously, the learning curve took some years to improve with a number of endovascular stroke-treated patients of >120 in 2016, ≈90 in the first 6 months of current year, and a rate of 3-month good functional outcome of ≈40% in 2016 which can be considered high enough to compete with the results of a pragmatic trial, such as the MR CLEAN (Multicenter Randomized Clinical Trial of Endovascular Treatment for Acute Ischemic Stroke in the Netherlands).⁴ To conclude, we strongly suggest to recruit resource for hyperacute endovascular stroke treatment from the community of vascular interventional radiologists (as soon as possible) and

stroke neurologist (soon after) to urgently face the serious paucity of thrombectomy performers. We are firmly convinced that the higher incidence and burden of ischemic stroke compared to other endovascularly treatable neurovascular diseases, such as aneurysmal subarachnoid hemorrhage and arteriovenous malformations, should justify a training focused on the treatment of stroke secondary to large vessel occlusion. We totally agree that thrombectomy and stenting can be considered the only necessary armamentarium for treating patients with hyperacute ischemic stroke. Since current credentialing requirements seriously limit the chance to bridge this gap and we are not doing the necessary for stroke, we would like to paraphrase Saint Francis of Assisi “Begin by doing what is necessary, then what is possible. And suddenly you’ll be surprised to do the impossible.”

Disclosures

None.

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