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Supplementary information

Carotid stenosis management: time to address the misconceptions ('furphies')

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Supplementary Table 1 | **Summary of current best management of patients with carotid stenosis**

Population	**Current best management**
Patients with asymptomatic carotid arterial disease (including stenosis)	Current best medical intervention alone, commenced immediately
Symptomatic men with low or average surgical risk, ipsilateral 70–99% carotid stenosis (NASCET criteria) without near occlusion, and a life expectancy of at least 3–5 years[a]	Current best medical intervention immediately and expert endarterectomy preferably within 2–3 weeks (but up to 3 months) of the last ipsilateral stroke or transient ischaemic attack if the independently determined 30-day peri-operative rate of stroke or death is acceptable[b]
Symptomatic men with low or average surgical risk, ipsilateral 50–69% carotid stenosis (NASCET criteria), and a life expectancy of at least 3–5 years[a]	Current best medical intervention immediately and expert endarterectomy within 2–3 weeks of the last ipsilateral stroke or transient ischaemic attack if the independently determined 30-day peri-operative rate of stroke or death is acceptable[b]
Symptomatic women with low or average surgical risk, ipsilateral 70–99% carotid stenosis (NASCET criteria) without near occlusion, and a life expectancy of at least 3–5 years[a]	
All other symptomatic patients with carotid arterial disease (including stenosis)	Current best medical intervention alone, commenced immediately

'Low or average surgical risk' refers to individuals whose risk factor profile matches that of patients recruited into previous randomized trials of carotid endarterectomy versus medical intervention alone[1,2]. 'Ipsilateral' means on the same side as the implicated eye or brain region. 'Near occlusion' means severe stenosis with evidence of reduced distal flow[2]. NASCET, North American Symptomatic Carotid Endarterectomy Trial. [a]Patients should also satisfy the other inclusion and exclusion criteria of the relevant past randomized trials[1,2]. [b]This figure is approximately 6% on the basis of past randomized trials but is probably now excessive, and the

window of opportunity for procedural benefit might now be shorter, given the improvements in medical intervention[1,2].

References

1. Abbott, A. L. et al. Misconceptions regarding the adequacy of best medical intervention alone for asymptomatic carotid stenosis. *J. Vasc. Surg.* **71**, 257–269 (2020).
2. Abbott, A. L. et al. Systematic review of guidelines for the management of asymptomatic and symptomatic carotid stenosis. *Stroke* **46**, 3288–3301 (2015).