

# Current Options in Clipping Versus Coiling of Intracranial Aneurysms: to Clip, to Coil, to Wait and Watch

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## **International Subarachnoid Aneurysm Trial**

Interpretation: in patients with ruptured intracranial aneurysms for which endovascular coiling and neurosurgical clipping are therapeutic options, the outcome in terms of survival free of disability at 1 year is significantly better with endovascular coiling. The data suggest that long-term risks of further bleeding from a treated aneurysm are low with either treatment, although somewhat more frequent with endovascular coiling [1].

## **International Subarachnoid Aneurysm Trial follow-up study**

Interpretation: in patients with intracranial aneurysms suitable for both treatments, endovascular coiling is more likely to result in independent survival at 1 year than neurosurgical clipping; the survival benefit continues for at least 7 years. The risk of rebleeding is low but more common after endovascular coiling than after neurosurgical clipping [2].

## **International Study of Unruptured Intracranial Aneurysms**

Interpretation: many factors are involved in the management of patients with unruptured intracranial aneurysms. Site, size, and group-specific risks of the natural history should be compared with site, size, and age-specific risks of repair for each patient [3].

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## *Introduction*

The treatment of intracranial aneurysms presents patients and practitioners with a challenging clinical paradigm encompassing the potential for catastrophe, cure, or chronic follow-up. Successful management entails a combination of thoughtful surgical and/or medical intervention and management [4–9]. Optimizing outcome requires an integration of technical skills (surgical and interventional), facilities, experience, and technology. Since 1981 several important studies have added significant but controversial data to the intellectual resources used in the decision paradigm for the management of intracranial aneurysms [1,3,10,11]. Practitioners today are faced with a complex decision tree of whether or not to clip, coil, or wait and watch. This article focuses on presenting a pragmatic equipoise for managing patients who have intracranial aneurysms.

### **Epidemiology: few aneurysms rupture, but when they do, outcomes are harsh**

The incidence of aneurysmal rupture is between 6 and 12 per 100,000, yielding 15,000 to 30,000 new aneurysmal subarachnoid hemorrhages (SAHs) annually [12–18]. Overall mortality at 6 months is estimated to be between 40% and 50%, with 15% of patients expiring before reaching the hospital and an additional 25% within 24 hours [19,20]. Only one third of those who survive have functional independent lives [19,21–24]. Treatment of a ruptured aneurysm is imperative. Rebleeding has a catastrophic morbidity of 48% to 78% [25–27].

### **To wait and watch**

Treatment of unruptured aneurysms is exceptionally more controversial with recent data from the International Study of Unruptured Intracranial Aneurysms (ISUIA) [3] adding important natural history data. This landmark study reveals that 5-year cumulative rupture rates for patients who (1) did not have a history of SAH and (2) had aneurysms located on the internal carotid artery, anterior cerebral artery, or middle cerebral artery were 0%, 2.6%, 14.5%, and 40% for aneurysms that were less than 7 mm, 7 to 12 mm, 13 to 24 mm, and 25 mm or greater, respectively. These rates are compared with rates of 2.5%, 14.5%, 18.4%, and 50%, respectively, for the same size categories involving posterior circulation and posterior communicating artery aneurysms (Fig. 1) [3]. Cavernous aneurysms less than 13 mm seemed totally benign. Unruptured aneurysms associated with previous SAH from another aneurysm had statistically higher rupture rates (Table 1 and see Fig. 1). These results are regarded as controversial by the neurosurgical community in light of previously published data [11,27–29]

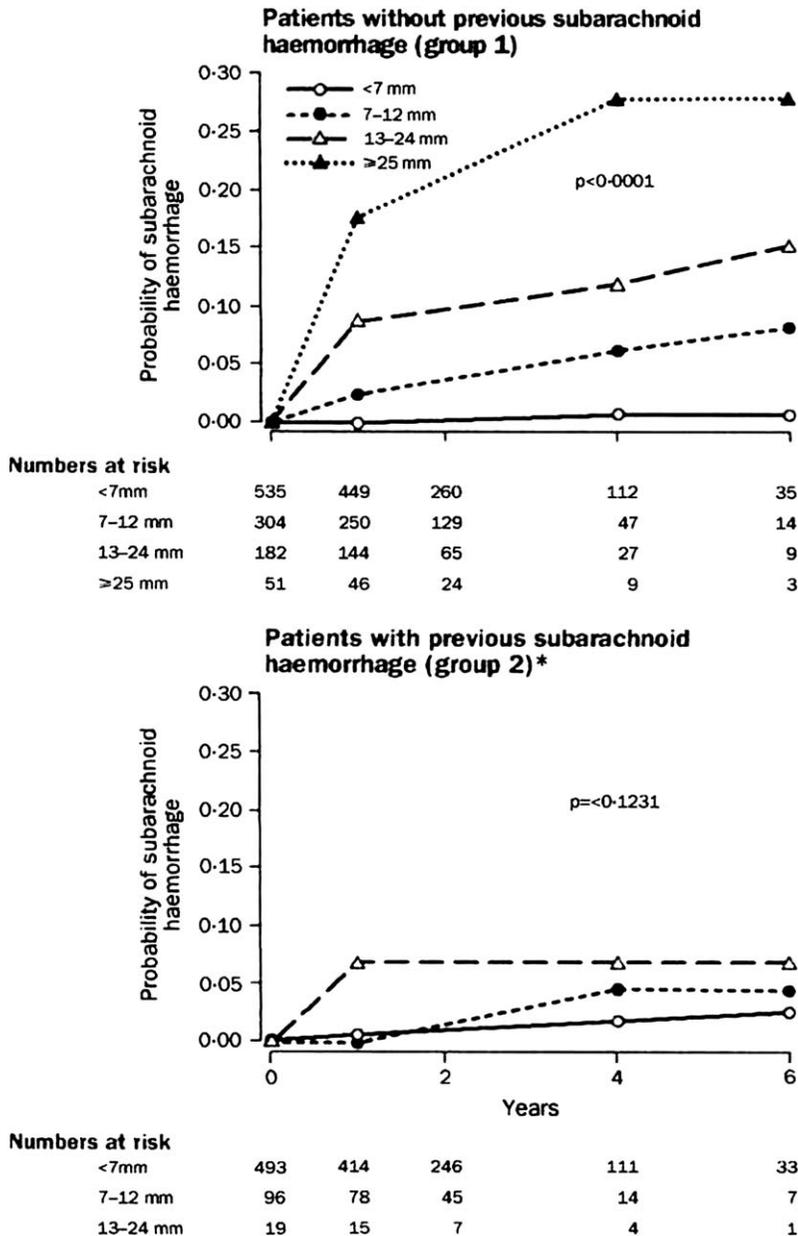


Fig. 1. Probability of subarachnoid hemorrhage over time for patients who did not have surgery. Data not shown for the  $\geq 25$ -mm group because of small sample size. (From Wiebers DO, Whisnant JP, Huston J, 3rd, et al. Unruptured intracranial aneurysms: natural history, clinical outcome, and risks of surgical and endovascular treatment. *Lancet* 2003;362:103-10; with permission.)

Table 1  
Five-year cumulative rupture rates according to size and location of unruptured aneurysm

	<7 mm		7–12 mm	12–24 mm	>25 mm
	Group 1	Group 2			
Cavernous carotid artery (n = 210)	0	0	0	3%	6.4%
AC/MC (n = 1037)	0	1.5%	2.6%	14.5	40%
Post P comm (n = 445)	2.5%	3.4%	14.5%	18.4%	50%

*Abbreviations:* AC, anterior communicating or anterior cerebral artery; IC, internal carotid artery (not cavernous carotid artery); MC, middle cerebral artery; Post P comm, vertebrobasilar posterior cerebral arterial system or the posterior communicating artery.

*From* Wiebers DO, Whisnant JP, Huston J, 3rd, et al. Unruptured intracranial aneurysms: natural history, clinical outcome, and risks of surgical and endovascular treatment. *Lancet* 2003;362:103–10; with permission.

in which the most common aneurysms to rupture were 7 mm with an incidence of 1% to 2% per year. Further exacerbating the controversy are findings that demonstrate that for aneurysms less than 7 mm in diameter in patients who have not had a previous SAH, the rupture rate is low (0.1%/year) and, accordingly, it would be difficult for any treatment to improve on the natural history of these lesions [3]. This study and its wide distribution to the lay press has led to a profound change in the counsel that the neuroscience community gives to patients found to harbor small unruptured aneurysms. It should be remembered that this data-based conservation must be interpreted in regard to the realities of individual patient experiences. Low rupture rates do not mean no rupture. Aneurysms less than 7 mm can and will rupture, and patients bear the morbidity and mortality of aneurysmal SAH. Furthermore, preliminary neuropsychologic studies demonstrate that patients who harbor and know they have untreated intracranial aneurysms have a reduced quality of life [30]. Managing anxiety in this patient population can be challenging when the following questions remain unclear: (1) How often should patients be restudied? (2) Which modality is best for follow-up (angiography, magnetic resonance angiography, or CT angiography)? (3) How much change in an aneurysm should prompt intervention? (4) How should patients modify their lifestyle to accommodate an aneurysm? and (5) What are the medical-legal implications of observation?

### To clip or to coil

Once it is determined that an aneurysm should be or will be treated, two options prevail: endovascular embolization and open surgical clipping. The goal of either treatment should be complete and lasting exclusion of an aneurysm from cerebral circulation with preservation of parent, branching, and perforating arteries.

The gold standard for aneurysm obliteration is open surgery. The International Subarachnoid Aneurysm Trial (ISAT) and the International Study

of Unruptured Intracranial Aneurysms (ISUIA) [1–3] compared interventional endovascular treatment to open surgical clipping. Both landmark studies challenge conventional wisdom and patient management. It is imperative when interpreting these studies to be able to place in equipoise the patient population studied, the clinical talent on hand, and the outcomes assessed with individual patients. It is the generalization of the results to each and every patient wherein lies the rub. Entry criteria to ISAT required subjective agreement that an aneurysm could be treated by either endovascular or open surgery. Many aneurysms failed to meet that criteria: (1) patients who had life-threatening intracerebral or subdural hematomas; (2) incompatible neck-to-dome ratios; (3) parent artery or branch artery incorporation into the dome; (4) fusiform aneurysms; (5) thrombotic aneurysms; (6) giants; (7) blisters; (8) pseudo/traumatic aneurysms; (9) those with mass effect; and (10) those that had failed repeated endovascular treatment. In the ISAT study, 9559 patients who had SAH were assessed; 7416 were excluded (671 refused and 6,745 for “other reasons”); and 2143 were randomized. Outcomes at 1 year are summarized in Table 2 and demonstrate that in this patient population with ruptured intracranial aneurysms for which endovascular coiling and neurosurgical clipping are therapeutic options, the outcomes in terms of survival free of disability at 1 year is significantly better with endovascular coiling. The follow-up ISAT article validates these findings [2]. Patients in both ISAT studies (1) were 88% grade I-II; (2) had 93% small aneurysms less than 10 mm; (3) had 97% anterior circulation; and (4) were 99% European. Mortality was not significantly different. Rebleed rate was approximately 3 times higher in the endovascular group than the surgical group (2.6% versus 0.9%). Retreatment was 4 times as prevalent in the endovascular group than with open surgery (136 versus 34) (Table 3).

The completeness and durability of endovascular treatment should be considered in light of actual data in the surgical literature on partially treated aneurysms where symptomatic rehemorrhage is a late phenomenon reported to occur between 4 and 20 years, with a mean of approximately 10 years and rebleed rates of 71% to 79% [31–34]. These results suggest that a partially treated aneurysm is not a benign pathology and 1-year follow-ups may not define the natural history of the disease. Reinforcing the issue of chronicity of the pathology, the Dutch aneurysm screening after surgical treatment for ruptured aneurysms (ASTRA) Study Group demonstrates a 16% incidence of new aneurysm formation over a 15-year period in 610 patients who underwent surgical clipping of a ruptured aneurysm [35]. Patients who have intracerebral aneurysms may represent a unique form of vasculopathy requiring long-term surveillance.

The fastest growing population of patients who have aneurysms is those who have partially obliterated coiled aneurysms. In a review of 48 studies comprising 1383 patients treated with coil embolization, a permanent complication was observed in 3.7%. Occlusions of greater than 90% were

Table 2  
Outcome at 1 year in 1595 patients (primary outcome)

	Endovascular treatment (n = 801)	Neurosurgery (n = 793)
Modified Rankin scale		
0 No symptoms	207 (25.8%)	152 (19.2%)
1 Minor symptoms	217 (27.7%)	220 (27.7%)
2 Some restriction in lifestyle (0–2 inclusive)	187 (23.4%) 611 (76.3%)	178 (22.4%) 550 (69.4%)
3 Significant restriction in lifestyle	80 (10%)	106 (13.4%)
4 Partly dependent	24 (3%)	32 (4%)
5 Fully dependent	21 (2.6%)	25 (3.2%)
6 Dead (3–6 inclusive)	65 (8.1%) 190 (23.7%)	80 (10.1%) 243 (30.6%)

Data in italics are primary outcome.

From Molyneux A, Kerr R, Stratton I, et al. International Subarachnoid Aneurysm Trial (ISAT) of neurosurgical clipping versus endovascular coiling in 2143 patients with ruptured intracranial aneurysms: a randomised trial. *Lancet* 2002;360:1267–74; with permission.

achieved in 90% [36]. Therefore, approximately 10% had significant residual. Outcomes such as these have led to several patient management nuances, which data have yet to address. A new vernacular has evolved. Terms, such as (1) greater than 95% occlusion, (2) stable residual neck at 2 years, (3) protected dome, and (4) near complete occlusion, now are part of the medical record. These terms and the anxiety they generate in patients who must bear them are difficult to manage until long-term studies are completed. Surgical management of recurrent partially coiled aneurysms seems technically more difficult and significantly underdeveloped [37–41].

During the past decade, open surgical management has evolved as a consequence of subspecialization, technical innovation, and influence of endovascular therapy. The choice of open surgical intervention is influenced by several factors: complexity of the aneurysm, size (too small or too large), geometry, unfavorable dome-to-neck ratio, access (inability to

Table 3  
Time to second procedure on same aneurysm

	<30 days	30 days–1 year	>1 year	Total
Allocated endovascular				
Second procedure endovascular	14	30	9	52
Second procedure neurosurgery	67	10	6	83
Allocated neurosurgery				
Second procedure endovascular	23	5	1	30
Second procedure neurosurgery	4	0	0	4

From Molyneux A, Kerr R, Stratton I, et al. International Subarachnoid Aneurysm Trial (ISAT) of neurosurgical clipping versus endovascular coiling in 2143 patients with ruptured intracranial aneurysms: a randomised trial. *Lancet* 2002;360:1267–74; with permission.

navigate delivery system to aneurysm site), and anatomy (parent artery, branch artery, or perforator incorporation into neck). The cornerstone of open surgical management is microsurgical dissection of the subarachnoid planes, proximal and distal vascular control, direct visualization of clip application, and puncture verification of total aneurysm obliteration [42,43]. Surgical innovations, such as cranial base approaches, have advantaged these goals [44–48]. Intraoperative angiography is a powerful interdiction confirming parent or branch artery patency and aneurysm obliteration [49–55]. Open surgical procedures, although advantaging a more durable and complete obliteration, do so at a higher risk related to neurobehavioral outcomes compared with their endovascularly treated counterparts [2,3,56–58].

Either clipped or coiled, management of intracranial aneurysms is advantaged in centers where both modalities are available and a volume of SAHs are treated routinely [4–9]. Volume drives expertise, technology, facilities, and ancillaries necessary for the complexities associated with the diagnosis, intervention, and medical management of patients who have SAH. Mortality rates in hospital centers managing fewer than 10 SAH per year were 40% higher than those in high volume centers managing more than 35 SAH per year [4]. The ability to perform intracranial angioplasty had a 16% risk reduction for death [5]. The California SAH study of 21,540 patients who had SAH and were admitted revealed 40% lower odds of mortality when 21 or more cases per year were managed [6]. These results were similar to a New York study, where a 43% reduction in mortality was seen for craniotomies for aneurysm in centers that performed 30 or more cases per year [7]. Size (of case load) does matter.

### **Treatment considerations**

Considering the previous information, what should be recommended for patients who have an intracranial aneurysm? What is known for sure?

- Patients who have intracranial aneurysms should be referred to centers that have interventional and surgical capacities. These centers should contain dedicated ICUs and technologies, such as intraoperative angiography, biplane angiography with 3-D capabilities, and transcranial Doppler, and capabilities to do cerebral blood flow studies. Having this, the full capacity to manage the interventional and medical aspects of SAH is advantaged.
- Interventionalists and open surgeons should act as partners, not competitors. All patients should be assessed clinically and radiologically by both practitioners before a decision for treatment is decided.
- The goal of aneurysm management is complete, durable obliteration without neurologic consequence. Experienced teams understand their own capacities, limitations, and patient ability to tolerate each

intervention. Surgical clipping surely is a more invasive procedure but also more durable.

- Initial evaluation by both practitioners advantages consideration for placement of an external ventricular drain in poor grade patients or in patients whose ventricles are increasing in size before systemic heparinization associated with endovascular intervention.
- The initial angiography is done best by interventionalists with an open surgeon present. This allows for real-time decision making. Angiographic runs, which demonstrate collateral circulation, are obtained to facilitate surgical intervention should temporary occlusion be necessary. The 3-D reconstruction is invaluable to assess more accurately dome-to-neck ratio and parent artery or branch orientation to neck and enhances surgical view for clip placement and vessel reconstruction. After review, an experienced team knows what their personal experience is for each aneurysm location relative to success. Literature values are other teams' results.
- At the author's institution, the right of first attempt goes to an interventionalist unless aneurysms are clearly noncoilable, including those with a wide neck, blebs, those that are geometrically complex with incorporation of branch artery, those with inability to navigate delivery system, those that are partially thrombosed fusiform, giants, and those in patients who prefer open surgery.
- Much can be learned by a surgeon observing microcatheter analysis and initial placement of the framing coil. Remember, the goal is complete angiographic obliteration. If the framing coil does not seat or does so with significant asymmetry, leaving a portion of the neck uncovered, the likelihood of complete obliteration declines. Certainly balloon- or stent-assisted coiling is an option. Each adds risk. Stent-assisted coiling requires use of antiplatelet agents, a risk consideration at least in patients who have ruptured aneurysm. Stent-assisted and balloon-assisted interventions are not part of the ISAT or ISUIA data. A classical aneurysm for residual neck after coiling is the "simple" posterior communicating artery aneurysm. It often has an oblong neck, lending itself to residual dog ear and potential for regrowth. Alternatively, a successful strategy can be to treat, recognizing the small residual, getting patients through the acute phase of their SAH, and returning electively with stent placement when patients can tolerate the antiplatelet agents.
- The ISAT and ISUIA studies are statistically significant contributors to the literature on the treatment of cerebral aneurysms. They are not without limitations [59,60]. (Readers are encouraged to review these references.)
- Treatment of intracranial aneurysms involves many factors: patient preference and demographics; aneurysm size, site, geometry, access, and intrinsic; practitioner experience and availability; facility; technology; and ancillaries. Volume counts. Teamwork enhances. Management should be individualized.

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