in 14 pts. Importantly, there was significant difference in MS clinical severity of group A versus group B (EDSS 1.8±1.3 vs 3.0±2.2, p<0.05). Similarly, there was significant difference in MS duration in group A versus group C (4.5±3 years versus 9.5 years, p<0.005).

Conclusions: The clinical severity of multiple sclerosis as well as duration of disease seems to be associated with pathological drainage of the central nervous system. To answer the question if CSCSI is only the accompanying secondary process, or the underlying condition of MS, the blinded randomized studies are needed.

TCT-197
Carotid Artery Stenting with or without Predilatation, protected or unprotected: Acute Results and Complications
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Background: Various techniques are used for the treatment of internal carotid artery stenosis, consisting of predilatation of the lesion, self-expanding or balloon-expandable stents with or without protective devices. The aim of our study was to evaluate the feasibility, safety, and efficacy of four different interventional techniques.

Methods: In a series of 1075 consecutive patients (346 female/729 male, mean age 70 years) carotid artery stenting (CAS) was performed. Indications for CAS were either symptomatic patients with a stenosis ≥60% or asymptomatic stenoses ≥80%. Adverse events were defined as death, stroke (>24 hours), PRIND (<72 hours). We evaluated four different techniques in two subgroups: 1. predilatation with a balloon (PBS-with) and 2. without cerebral protection (PBS-no-pro), and 3. stenting without predilatation (NPBS-with-pro) with and 4. without cerebral protection (NPBS-no-pro).

Results: Technical success was achieved in 491 NPBS-with-pro patients (99%) and in 209 PBS-with patients (96%). In patients with predilatation, technical success could be achieved in 114 PBS-with-pro (99%) and in all (100%) PBS-no-pro patients. The groups with the highest risk of procedural adverse events were PBS-with-pro with 4.8% and NPBS-no-pro with 4.7%. Adverse events occurred in the NPBS-with-pro patients in 2%, and in the PBS-with patients in 0.8%. However, these differences did not reach statistical significance (NPBS-with-pro vs. PBS-with-pro = ns, NPBS-with-pro vs. PBS-with-no-pro = ns, NPBS-with-pro vs. PBS-with-no-pro = ns, NPBS-with-pro vs. PBS-no-pro = ns, NPBS-with-pro vs. PBS-no-pro = ns, NPBS-with-pro vs. PBS-no-pro = ns). The only significant difference in the risk of procedural events was found for patients, with versus patients without the use of protective devices (NPBS-with-pro vs. PBS-with-pro vs. PBS-with-no-pro vs. PBS-no-pro = ns, n=612, adverse events, 1.7%) vs. NPBS-no-pro (n=463, 19 adverse events, 4.1%, p<0.05).

Conclusions: The risk of adverse events (stroke/death) during CAS is associated with the use of cerebral protection rather than the use of predilatation or not.

TCT-198
EuroSCORE Risk Model as Predictor of Early and 1-year Results After Carotid Artery Stenting and Carotid Endarterectomy
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Background: To study early and 1-year outcomes of carotid artery stenting (CAS) and carotid endarterectomy (CEA) in patient with medical comorbidities according to Euroscore risk evaluation model.

Methods: We retrospectively reviewed 312 patients who were treated for symptomatic carotid stenosis between 2002 and 2012 (142 CASs and 170 carotid endarterectomies (CEAs)).

Results: Patients undergoing CEA were older than CAS (78 years vs. 70 years, P < 0.001). Embolic protection devices were used in 98.6% of cases. Depending on comorbidities all patient were divided in two groups: EuroSCORE ≤ 20 (n = 181) and EuroSCORE > 20 (n = 131). EuroSCORE ≤ 20 (n = 181) was performed in 75 patients, CEA – in 106 patients. The 30-days stroke rate did not differ between subgroups (2.7% in CAS vs. 1.9% CEA, p > 0.05). The 1-year freedom from stroke was 93.4% in CAS subgroup and 94.3% in CEA subgroup (p > 0.05). There was no difference in the all-cause death rate (stroke-related, coronary, other) at 1-year follow-up (2.7% in CAS vs. 2.1% in CEA). In EuroSCORE > 20 (n = 131) CAS was performed in 31 patients, CEA – in 58 patients. There was no difference in the incidence of 30-days stroke (2.8% in CAS vs. 1.7% CEA, p > 0.05). The 1-year freedom from stroke was 93.2% in CAS subgroup and 94.9% in CEA subgroup (p > 0.05). The all-cause death rate among CAS patients was lower (1.4%) compared to CEA patients (12%, p = 0.044). Univariate analysis in patients undergoing CAS showed that and age > 70 years was related with postprocedural neurological complications (p = 0.046). However, age was not independent risk factors on multivariate analysis.

Conclusions: In the low-risk patients (EuroSCORE ≤ 20) the rates of peri-procedural, local neurological complications and all-cause death rates did not differ between CAS and CEA subgroups. In high-risk patients (EuroSCORE > 20) there was no significant difference in the incidence of peri-procedural and long-term neurological complications between subgroups, but patients after CEA are at higher risk for any-cause related death.