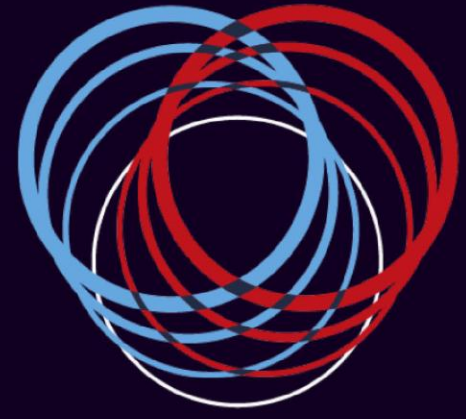


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CHALLENGES & INNOVATIONS IN VASCULAR WORLD

31 MARS
1^{ER} AVRIL **2026**

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PARIS



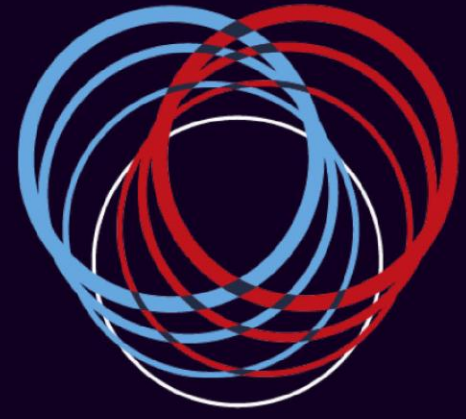
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PARIS

Stenting carotidien: comment choisir son stent ?

Sonia Ronchey MD, PhD
Chief of Vascular Surgery
San Filippo Neri Hospital - Rome -Italy



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Déclaration de conflit d'intérêts :

Nom : SONIA

Prénom : RONCHEY

Fonction : CHIEF OF VASCULAR SURGERY

Etablissement : SAN FILIPPO. NERI HOSPITAL - ROME

Conformément aux recommandations en vigueur, je déclare ne pas avoir de conflit d'intérêts en lien avec le contenu de cette présentation.

FIRST ENDOVASCULAR TREATMENT OF CAROTID ARTERY STENOSIS

Mathias K. Perkutane transluminale Katheterbehandlung supra-aortaler Arterienobstruktionen. *Angiology* 1981;3:47–50



SINCE 1994 CAS HAS BEEN
INVESTIGATED AS AN ALTERNATIVE

Carotid Artery Stenting–Historical Context, Trends, and Innovations

Carotid Stents

Inspired in coronary interventions, the early stent supported CAS procedures were performed using balloon expandable stents. This practice, however, must have been abandoned because of higher risk of stent deformation (external crushing) because of its relatively superficial location, and has been largely replaced by self-expanding stents. In general, the

Contemporary outcomes of carotid revascularization procedures

Table 3 – Stroke/death rates after carotid endarterectomy and transfemoral carotid artery stenting in major randomized controlled trials: Asymptomatic patients.

Trial (year)	Study period	Inclusion criteria	Mean age, y	% Female	Arm	Perioperative stroke rate, %	Perioperative death rate, %	Long-term stroke rate, %
VA Cooperative (1993) [51]	1987–1991	≥50% stenosis	65	<5	CEA	6.5	1.1	8.0 (2-y ipsilateral)
					Medical	2.2	0	20.6 (2-y ipsilateral)
ACAS-1 (1995) [22]	1987–1993	≥60% stenosis	67	34	CEA	2.3	0.1	5.1 (5-y ipsilateral)
					Medical	1.5	0.2	11.0 (5-y ipsilateral)
ACST-1 (2004) [21]	1993–2003	≥60% stenosis	68	35	CEA	3	0.5	6.4 (5-y any stroke)
					Medical	2	0.3	11.8 (5-y any stroke)
CREST (2010) [6]	2000–2008	≥60% stenosis (angiography) or ≥70% (ultrasound)	69	35	CEA	1.4	0.3	6.9 (10-y any stroke)
					tfCAS	2.5	0.4	6.9 (10-y any stroke)
ACT-1 (2016) [53]	2005–2013	≥60% stenosis; standard surgical risk	70	36	CEA	1.44	0.29	Not reported
					tfCAS	2.8	0.09	Not reported
ACST-2 (2021) [52]	2008–2020	≥60% stenosis	70	30	CEA	2.36	0.35	2.5 (5-y fatal/disabling stroke)
					tfCAS	3.58	0.12	2.5 (5-y fatal/ disabling stroke)
CREST-2 (2026) [55]	2014–2025	≥70% stenosis	70	37	CEA	1.5		3.7 (4-y ipsilateral)
					tfCAS	1.3		2.8 (4-y ipsilateral)

Abbreviations: ACAS-1, Asymptomatic Carotid Atherosclerosis Study; ACST-1, Asymptomatic Carotid Surgery Trial; ACST-2, Second Asymptomatic Carotid Surgery Trial; ACT-1, Asymptomatic Carotid Trial 1; CEA, carotid endarterectomy; CREST, Carotid Revascularization Endarterectomy Versus Stenting Trial; CREST-2, Carotid Revascularization and Medical Management for Asymptomatic Carotid Stenosis Trials; tfCAS, transfemoral carotid artery stenting; VA, Veterans Affairs.

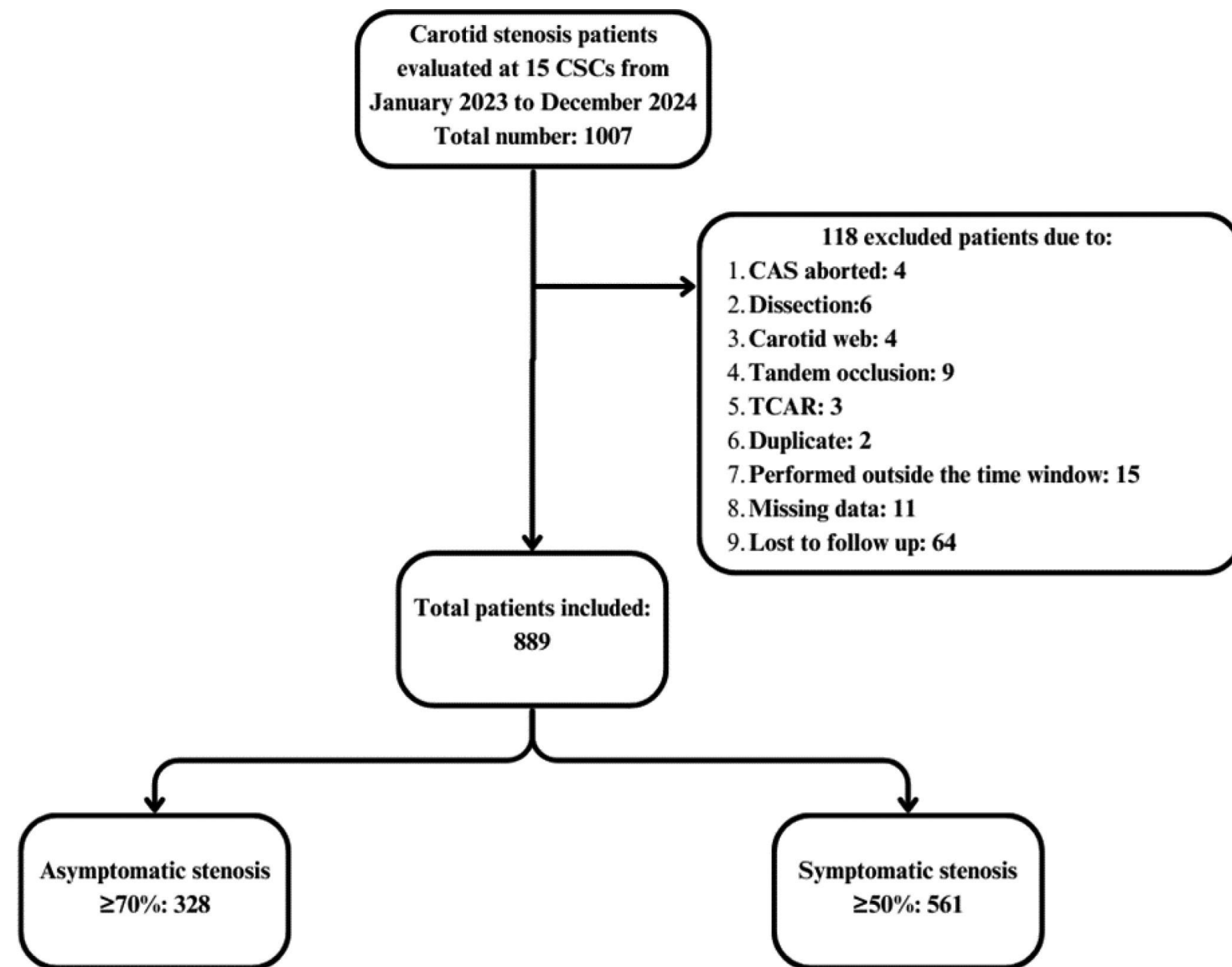
Contemporary outcomes of carotid revascularization procedures

Table 4 – Stroke/death rates after transcarotid artery revascularization in observational studies: Both symptomatic and asymptomatic patients.

Trial (year)	Study period	Inclusion criteria	Age >75 y, %	% Female	Perioperative stroke rate, %	Perioperative death rate, %	1-y stroke/death rate, %
ROADSTER-1 (2015) [11]	2012–2014	Symptomatic, $\geq 50\%$ stenosis; asymptomatic, $\geq 80\%$ stenosis; high surgical risk	43	35	1.4	1.4	4.8
ROADSTER-2 (2020) [57]	2015–2019	Symptomatic, $\geq 50\%$ stenosis; asymptomatic, $\geq 80\%$ stenosis; high surgical risk	42	32	1.9	0.4	2.6
ROADSTER-3 (2025) [58]	2022–2024	Symptomatic $\geq 50\%$ stenosis or asymptomatic $\geq 70\%$ stenosis, standard surgical risk	25	43	0.9	0	1.5

Abbreviation: ROADSTER, Safety and Efficacy Study for Reverse Flow Used During Carotid Artery Stenting Procedure.

Carotid Artery Stenting Outcomes in Comprehensive Stroke Hospitals (CASSH): A Prospective Multicenter Study



CASSH demonstrated an overall primary complication rate of 1.2%. When stratified by symptom status, primary complications occurred in 1.6% of symptomatic patients and 0.6% of asymptomatic patients. In our asymptomatic cohort (n=328), early and short-term event rates were low: overall mortality occurred in 4 patients (1.2%), ischemic stroke in 1 patient (0.3%), and no hemorrhagic strokes were identified. These findings are notable alongside the CREST-2 trial (Carotid Revascularization and Medical Management for Asymptomatic Carotid Stenosis Trial),¹⁹ in which 7 strokes and 1 death (8/616) occurred in the stenting arm during the periprocedural period (1.3% of patients [95% CI, 0.6–2.5]). Importantly, CREST-2 was conducted under highly controlled conditions, with protocol-driven intensive medical therapy, centralized adjudication, and standardized postprocedural surveillance. In contrast, our study reflects real-world practice without mandated postoperative care pathways.

ORIGINAL ARTICLE

Medical Management and Revascularization for Asymptomatic Carotid Stenosis

T.G. Brott,¹ G. Howard,² B.K. Lal,³ J.H. Voeks,⁴ T.N. Turan,⁴ G.S. Roubin,⁵ R.M. Lazar,⁶ R.D. Brown, Jr.,⁷ J. Huston III,⁸ L.J. Edwards,² M. Jones,⁹ W.M. Clark,¹⁰ A. Chamorro,¹¹ L. Lull,¹¹ C. Mena-Hurtado,¹² D. Heck,¹³ R.S. Marshall,¹⁴ V.J. Howard,¹⁵ W.S. Moore,¹⁶ K.M. Barrett,¹ B.M. Demaerschalk,¹⁷ N. Sangha,¹⁸ H. Aronow,¹⁹ M. Foster,²⁰ W.C. Sternbergh III,²¹ F. Shawl,²² G. Lanzino,²³ J. Rapp,²⁴ H.S. Tran,²⁵ R. Ecker,²⁶ A. Mackey,²⁷ V. Ali,²⁸ C. Given II,²⁹ P. Teal,³⁰ V.S. Kashyap,³¹ D. Mukherjee,³² M. Harrigan,³³ S. Silverman,³⁴ M. Koopmann,³⁵ V.G. Wadley,³⁶ Y. Zhang,² J.D. Rhodes,² S. Chaturvedi,³⁷ and J.F. Meschia,¹ for the CREST-2 Investigators*

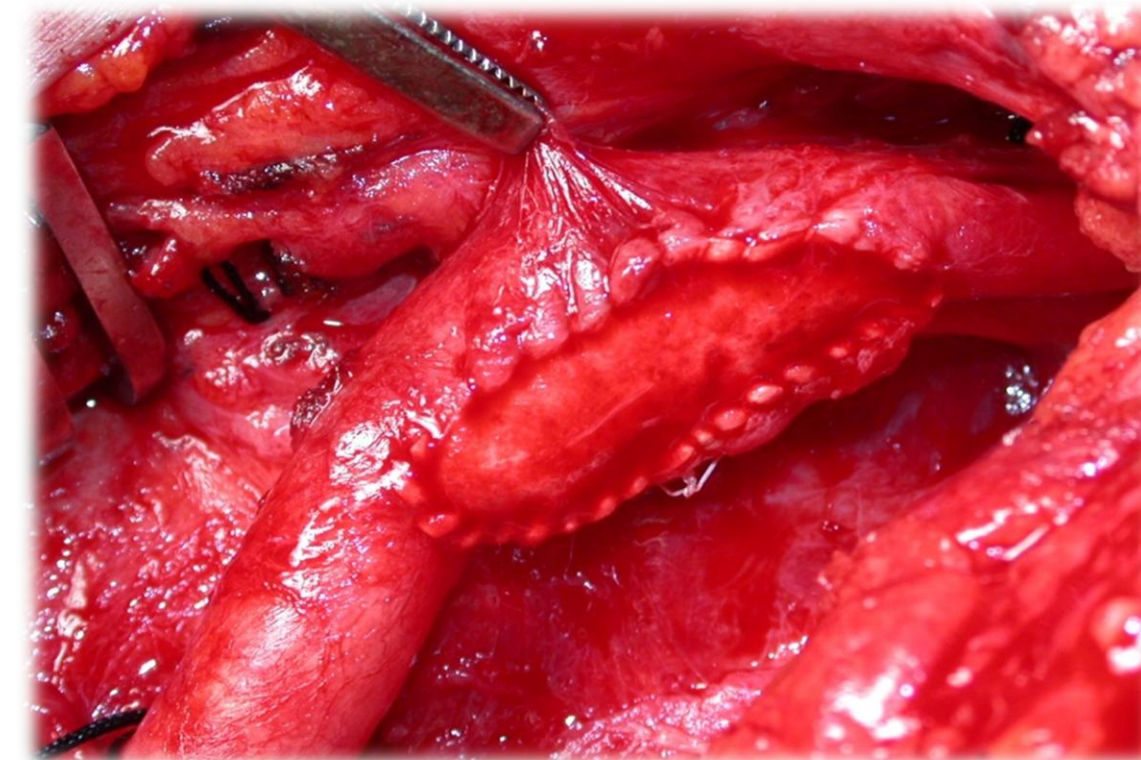


Table 2. Analysis of Primary Outcome and Components.

Variable	Stenting Trial		Endarterectomy Trial	
	Medical Therapy Alone	Stenting	Medical Therapy Alone	Endarterectomy
Primary 4-yr composite outcome*				
Event rate (95% CI) — %	6.0 (3.8 to 8.3)	2.8 (1.5 to 4.3)	5.3 (3.3 to 7.4)	3.7 (2.1 to 5.5)
Absolute difference (95% CI) — percentage points†	3.2 (0.6 to 5.9)		1.6 (-1.1 to 4.3)	
P value for difference	0.02		0.24	
Relative risk (95% CI)†	2.13 (1.15 to 4.39)		1.43 (0.78 to 2.72)	
Components of primary outcome				
Periprocedural period: stroke or death				
No. of events/no. of patients	0/629	8/616	3/623	9/617
Percent of patients with event (95% CI)	0.0 (0.0 to 0.6)	1.3 (0.6 to 2.5)	0.5 (0.1 to 1.4)	1.5 (0.7 to 2.8)
Difference (95% CI) — percentage points	-1.3 (-2.2 to 0.4)		-1.0 (-2.1 to 0.1)	
Postprocedural period: ipsilateral ischemic stroke				
No. of person-yr	1686	1714	1761	1823
No. of events/no. of patients	28/600	7/582	23/600	10/596
Annual event rate per person-yr (95% CI) — %	1.7 (1.1 to 2.4)	0.4 (0.2 to 0.9)	1.3 (0.9 to 2.0)	0.5 (0.3 to 1.0)
Relative risk (95% CI)	4.07 (1.78 to 9.31)		2.38 (1.13 to 5.00)	

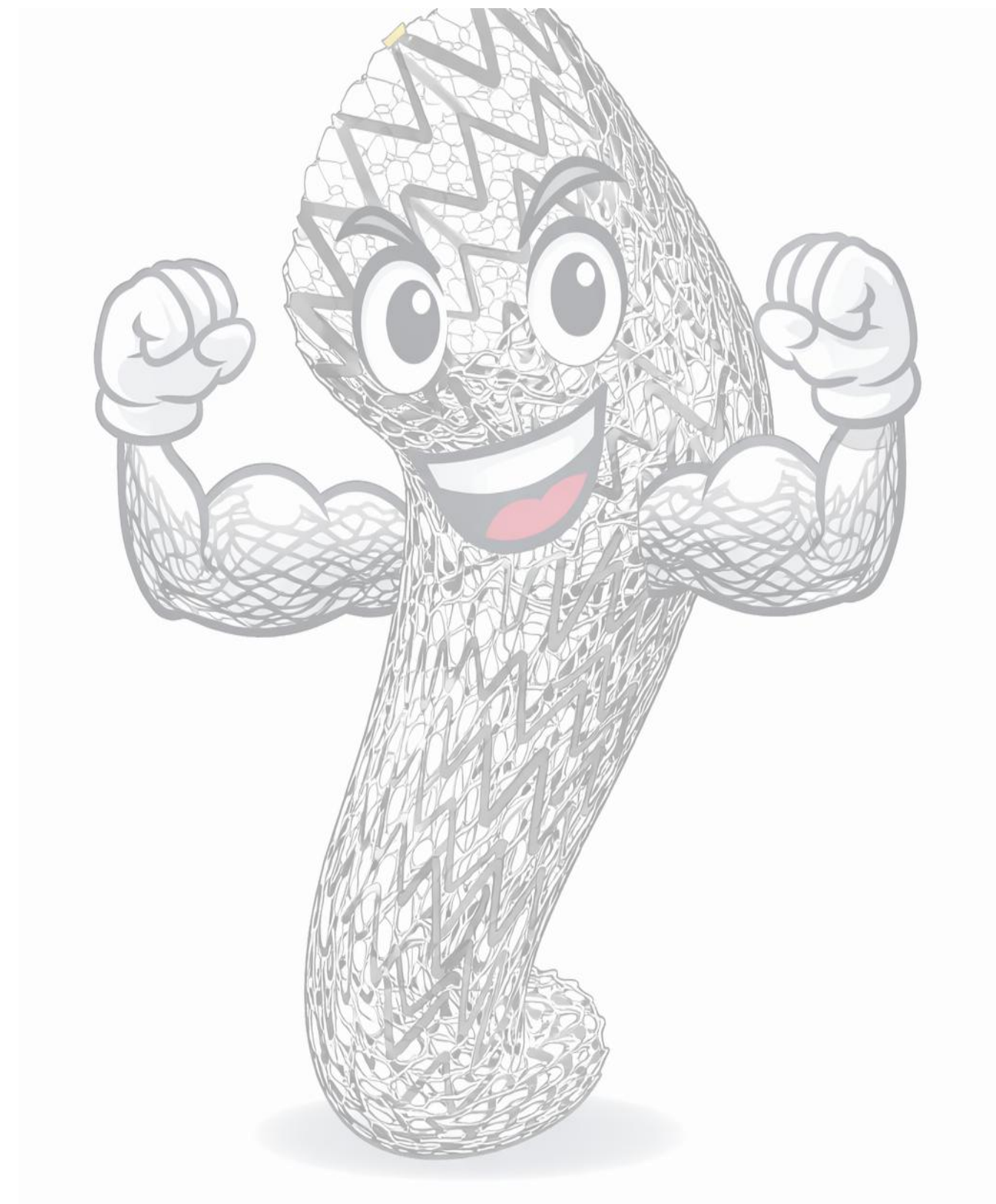


Among patients with high-grade stenosis without recent symptoms, **the addition of stenting** led to a lower risk of a composite of perioperative stroke or death or ipsilateral stroke within 4 years than intensive medical management alone. Carotid endarterectomy did not lead to a significant benefit.

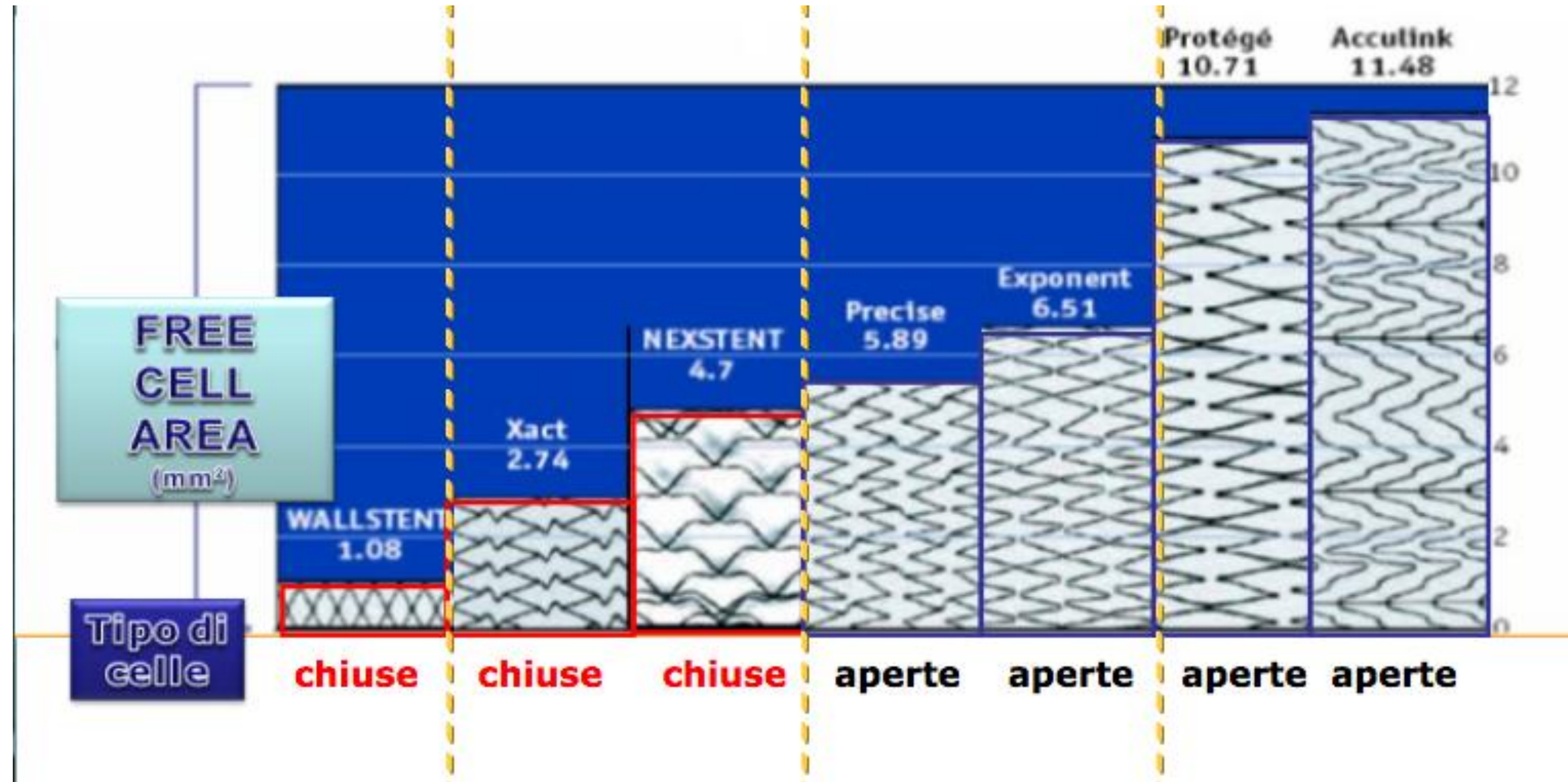
* The primary outcome was a composite of any stroke or death in the periprocedural period (randomization through 44 days) or ipsilateral ischemic stroke in the postprocedural period (the remaining portion of the 4-year follow-up).
 † These 95% confidence intervals for the 4-year composite outcome were adjusted to 95.3% to account for the reduction in the P value from the interim analysis (i.e., to represent the 2.35% and 97.65% thresholds of the bootstrap distribution).

WHAT MADE IT POSSIBLE

- Increasingly standardized technique
- Careful preoperative planning with supra-aortic trunk CT angiography
- Growing use of alternative access routes (radial/brachial or TCAR), avoiding traversal of the aortic arch
- **Adoption of dedicated/high performance stents**
- Routine use of cerebral protection systems
- Procedure routinely performed under local anaesthesia
- Continuous intra-procedural neurological monitoring
- Very short procedure times
- Minimal hospital length of stay



OPEN CELL – CLOSE CELL STENTS

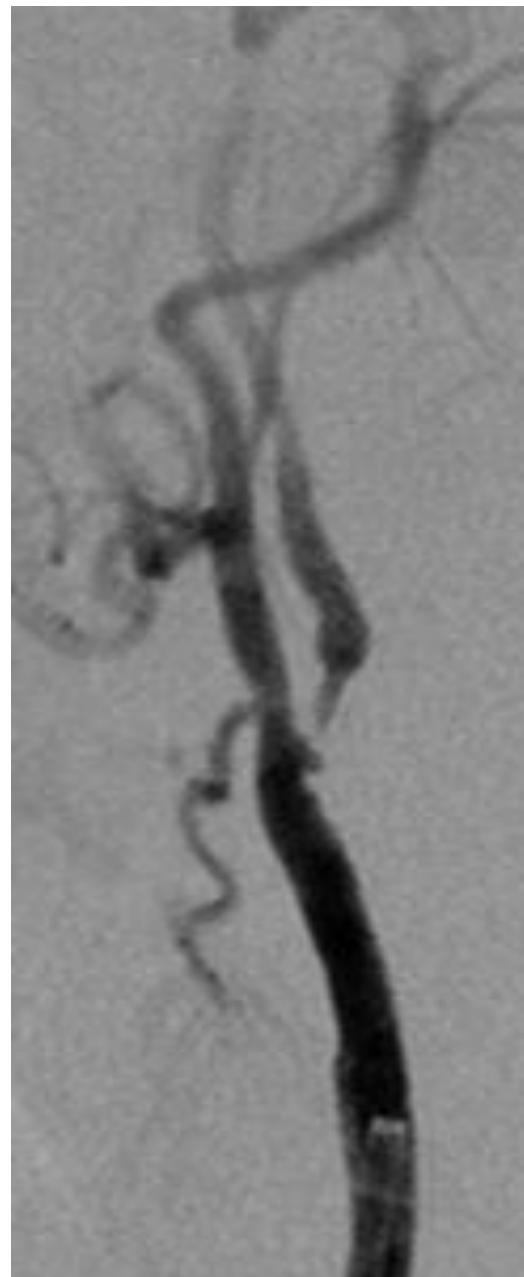


Does Free Cell Area Influence the Outcome in Carotid Artery Stenting?

M. Bosiers,^{1*} G. de Donato,² K. Deloose,¹ J. Verbist,³ P. Peeters,³
F. Castriota,⁴ A. Cremonesi⁴ and C. Setacci⁴

POSTOP NEUROLOGIC EVENTS

	PTS	EVENTS	DELAYED EVENTS
OPEN CELL	937	4,2%	3,4%
CLOSE CELL	2242	2,3%	1,3% *
TOTAL	3179	2,8%	1,9%



Wallstent

1.2% CC (<2.5) 1.3%

mm²

p<0.05

Does Free Cell Area Influence the Outcome in Carotid Artery Stenting?

M. Bosiers,^{1*} G. de Donato,² K. Deloose,¹ J. Verbist,³ P. Peeters,³
 F. Castriota,⁴ A. Cremonesi⁴ and C. Setacci⁴

	Total population			<u>Symptomatic population</u>			Asymptomatic population		
	Patients	All events	Post-procedural events	Patients	All events	Post-procedural events	Patients	All events	Post-procedural events
Cell type									
Open cell		4.2%	3.4%		7.0%	6.3%		2.2%	1.4%
Closed cell		2.3%	1.3%		2.2%	1.3%		2.3%	1.3%
Total	3179	2.83%	1.9%	1317	3.6%	2.73%	1862	2.25%	1.3%

Symptomatic $p < 0.0001$

CLOSE CELLS → LOW FLEXIBILITY

DISTAL KINKING IN TORTUOUS ANATOMY

MALAPPOSITION

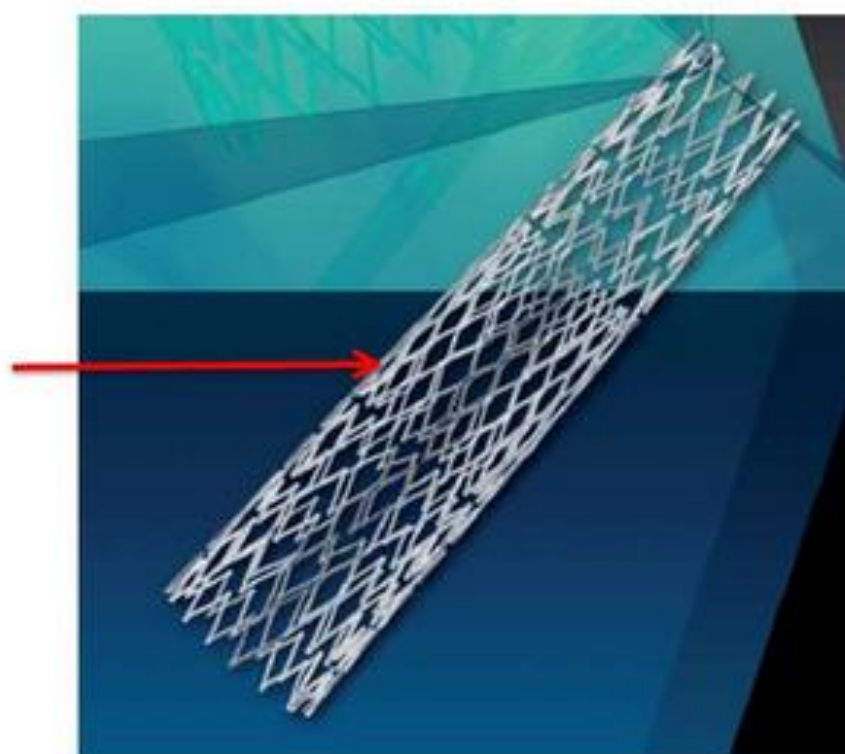


Comparison of closed-cell and hybrid-cell stent designs in carotid artery stenting: clinical and procedural outcomes

Open Cell Stent with Closed Cell Design

Proximal and distal sections – open cell, enhanced flexibility

Central closed cell section



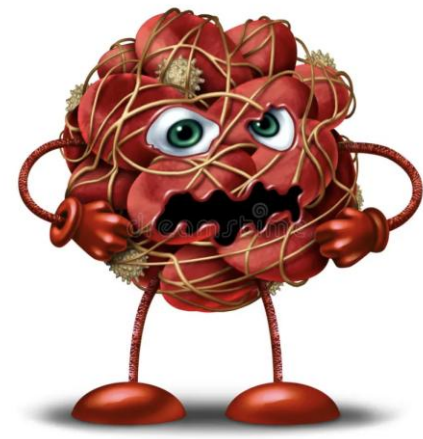
Variables	Closed-cell group (n = 146)	Hybrid-cell group (n = 88)	P-value
Major stroke	4 (2.7)	0 (0)	0.12
Minor stroke	1 (0.7)	2 (2.3)	0.29
Hyperperfusion syndrome	2 (1.3)	1 (1.1)	0.87
TIA	3 (2)	1 (1.1)	0.59
Myocardial infarction	0 (0)	0 (0)	
Death	1 (0.7)	0 (0)	0.43

Values are means \pm SD. TIA – transient ischemic attack.

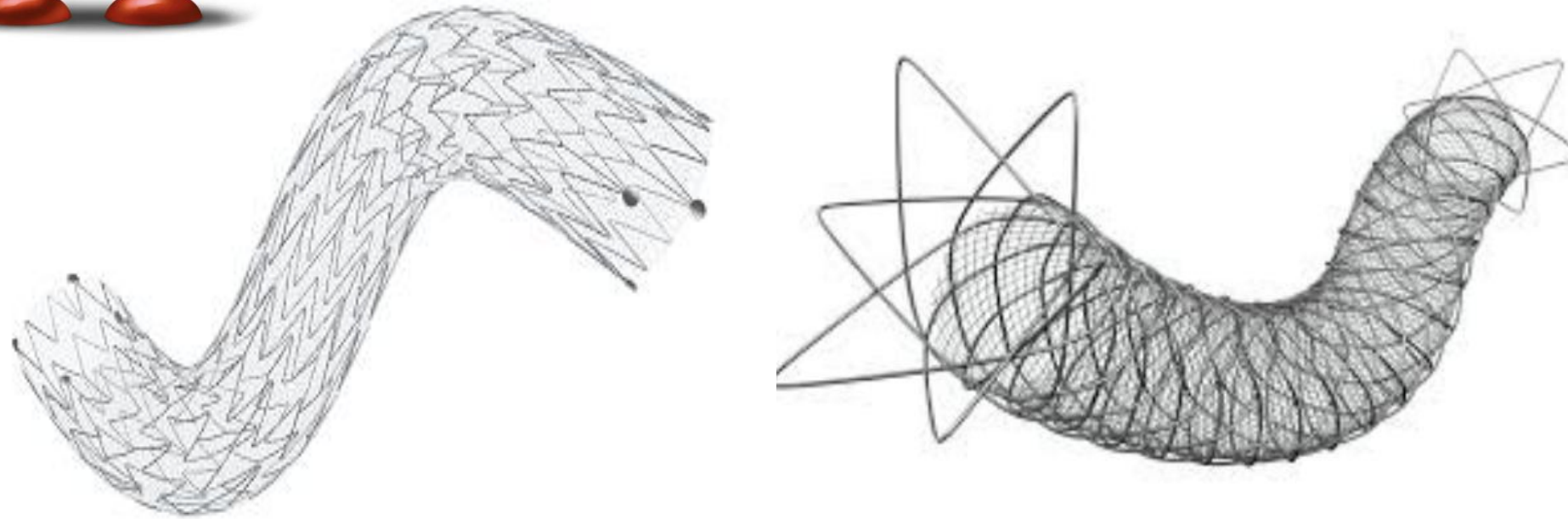
Conclusions: The results of this study showed no significant difference in the clinical adverse event rates after CAS between the closed-cell stent group and the hybrid-cell stent group. However, procedural ICA vasospasm was more common in the closed-cell stent group.

CAROTID STENTS

Stent name (company)	Free cell area, mm ²
Open-cell stents	
RX Acculink Carotid Stent System (Abbott Vascular)	11.48
Protege RX Carotid Stent System (Covidien)	10.71
Precise Pro RX Nitinol Stent System (Cordis)	5.89
Closed-cell stents	
Wallstent endoprosthesis (Boston Scientific)	1.10
X-act (Abbott)	2.74
Hybrid-cell stents	
Cristallo Ideale Stent (Medtronic)	
Proximal	15.17
Middle	3.24
Distal	11.78
Dual-layer micromesh stents	
RoadSaver stent (Terumo)	0.38
CGuard Stent (Inspire MD)	0.15



MICROMESH STENTS







Modern dual-layer stents:

- **Increased plaque coverage**
- **Reduced plaque protrusion**
- **Reduced embolic burden**
- **High flexibility**
- Systematic cerebral protection
- Standardized procedural protocols



C-GUARD

ROADSAVER

	Device name	Free cell area (mm ²)	Cell size (μm)	Delivery system
Terumo Interventional Systems	Roadsaver 	0.38 	375-500	5Fr
Inspire MD	CGuard 	0.15 	150-180	6 Fr

Micromesh technology was engineered to solve early CAS was microembolization

Carotid artery stenting with a new-generation double-mesh stent in three high-volume Italian centres: clinical results of a multidisciplinary approach

- 150 PTS – SYMPTOMATIC 29%

		Overall (n=150)
Bilateral carotid artery disease, n (%)		47 (31)
Aortic arch (elongation variant)	Type I (%)	71%
	Type II (%)	18%
	Type III (%)	11%
Bovine arch (%)		21%
Target lesion severity (%)		80.8±7.5
Lesion length (mm)		20.3±4.1
MLD (mm)		1.43±0.8
ICA RVD (mm)		7.9±0.7
CCA RVD (mm)		9.8±0.9
Doppler flow velocity (m/sec)		2.7±0.7
Severe tortuosity (%)		16 (11)
Severe calcification (%)		13 (9)
Ulcerated plaque (%)		13 (9)
Dissection (%)		4 (3)
CCA: common carotid artery; ICA: internal carotid artery; MLD: minimal lumen diameter; RVD: reference vessel diameter		

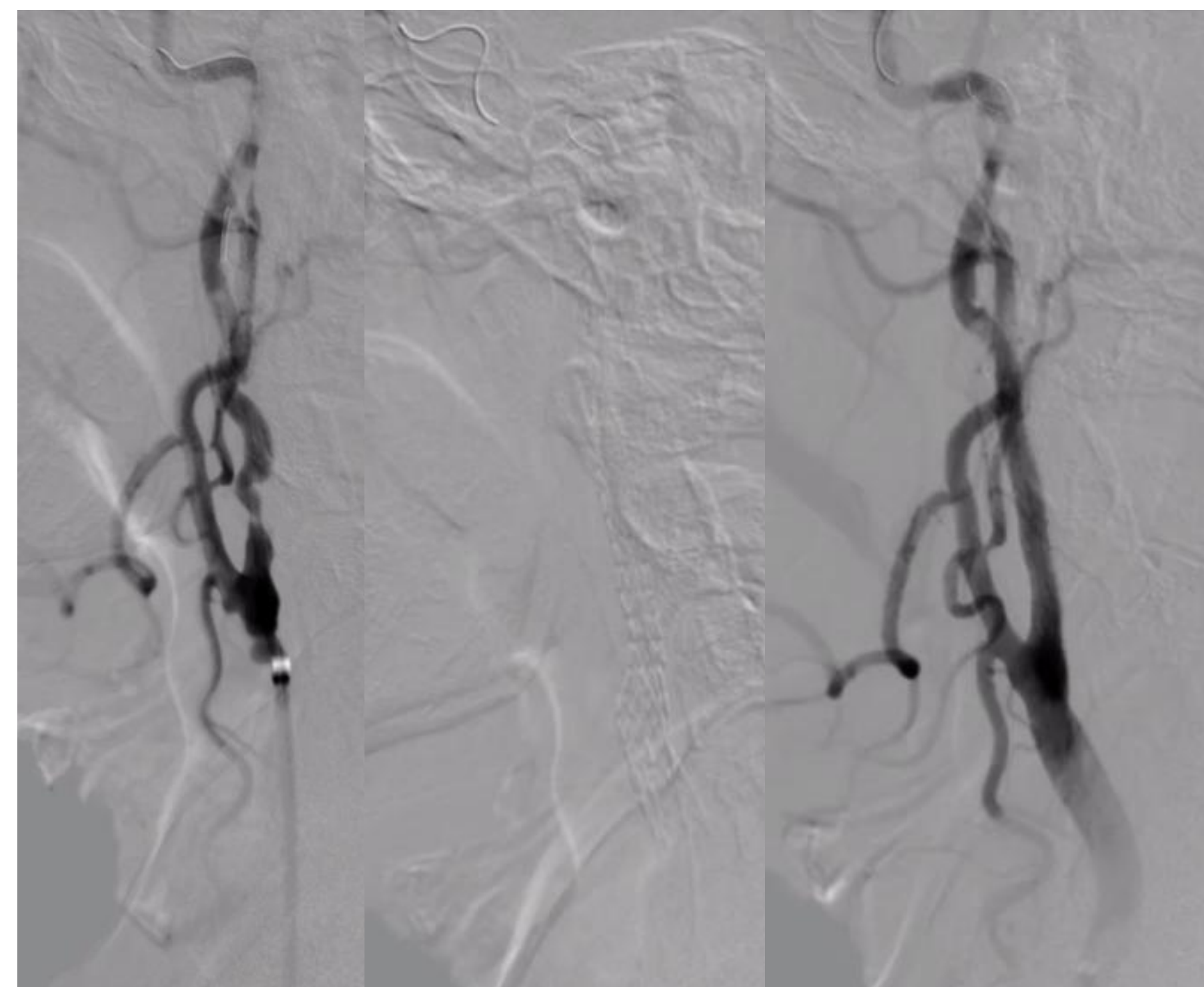
		Overall (n=150)
Target vessel	Left ICA, n (%)	70 (47)
	Right ICA, n (%)	80 (53)
Protection used	Distal filter, n (%)	88 (59)
	Proximal balloon, n (%)	62 (41)
Access site	Femoral, n (%)	140 (93)
	Radial, n (%)	9 (7)
	Brachial, n (%)	1 (0)
Predilatation, n (%)		11 (7)
Post-dilatation, n (%)		150 (100)
Post-dilation pressure (mmHg)		12.4±2.8
Stent deployed, n (%)		150 (100)
Procedure success, n (%)		150 (100)
Stent diameter (mm)		8.6±0.8
Stent length (mm)		25.0±4.5
TIMI 3 flow in ECA, n (%)		150 (100)
Post-procedural residual stenosis (%)		12.4±4.7
ECA: external carotid artery; ICA: internal carotid artery		

- No cerebrovascular event was reported either at discharge or at 30-day follow-up assessment.











1-Year Results From a Prospective Experience on CAS Using the CGuard Stent System: The IRONGUARD 2 Study

The C-Guard dual-layer micromesh stent was associated with extremely low 1-year rates of stroke (<1%) and restenosis (<1%), supporting the safety of modern CAS technology in real-world practice.

Variable / Outcome	Data
Total study population	733 patients
Asymptomatic patients	602 (82.1%)
Inclusion criterion (asymptomatic)	ICA stenosis \geq 80%
Device used	CGuard dual-layer micromesh stent
Cerebral protection device use	99.7%
30-day stroke (overall cohort)	4 strokes (1 fatal, 3 minor) 0.54%
Stroke rate at 1 year (overall cohort)	0.68% cumulative
Ipsilateral stroke (31 days–1 year)	0.13%
TIA (31 days–1 year)	0.55%
1-year mortality (31–365 days)	1.10% (mostly non-neurologic)
1-year ICA restenosis	0.82%
In-stent thrombosis	0
Predictors of stroke	No clinical/anatomical predictors identified
Effect of prolonged DAPT (90 vs 30 days)	No impact on MACE or restenosis



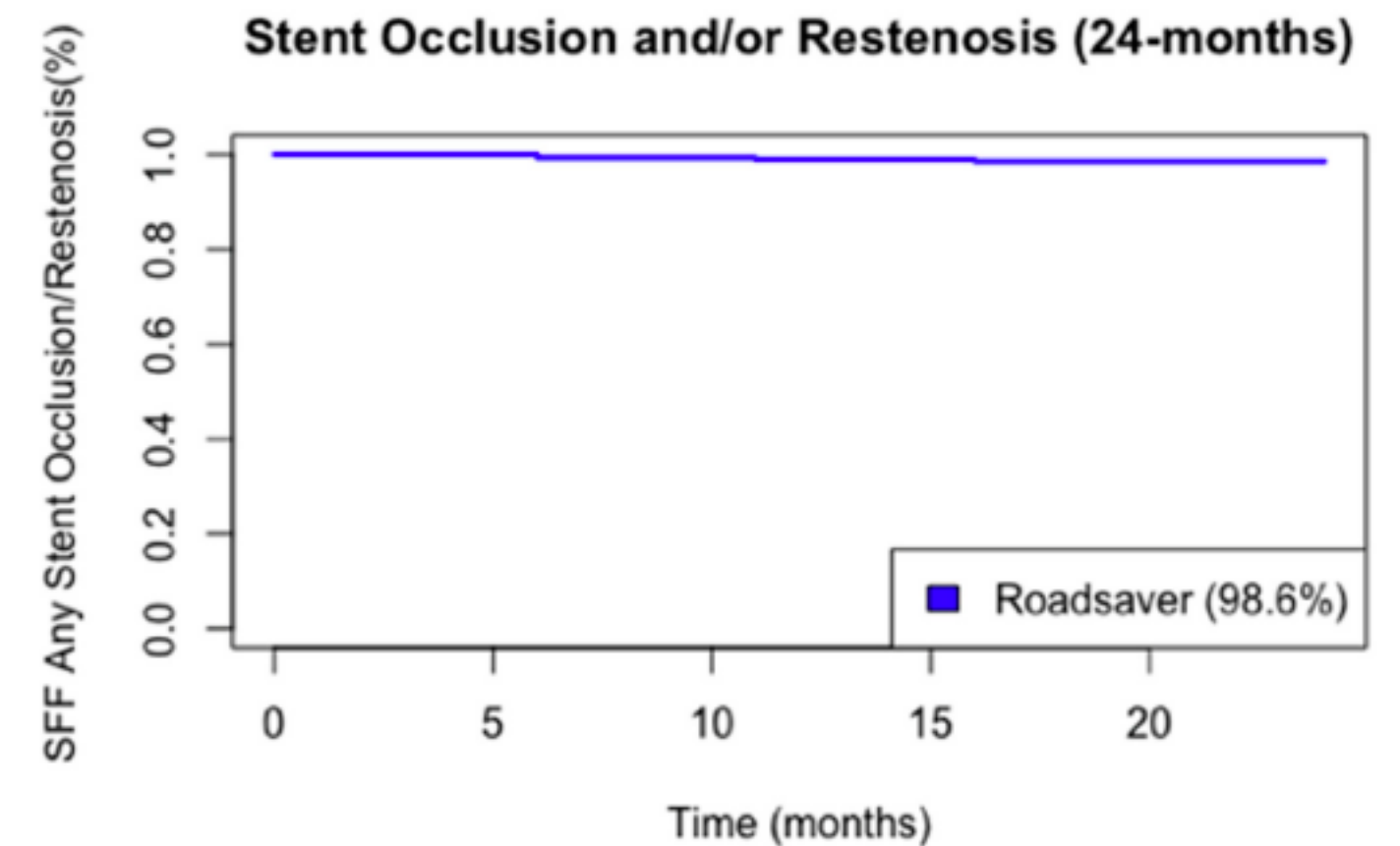
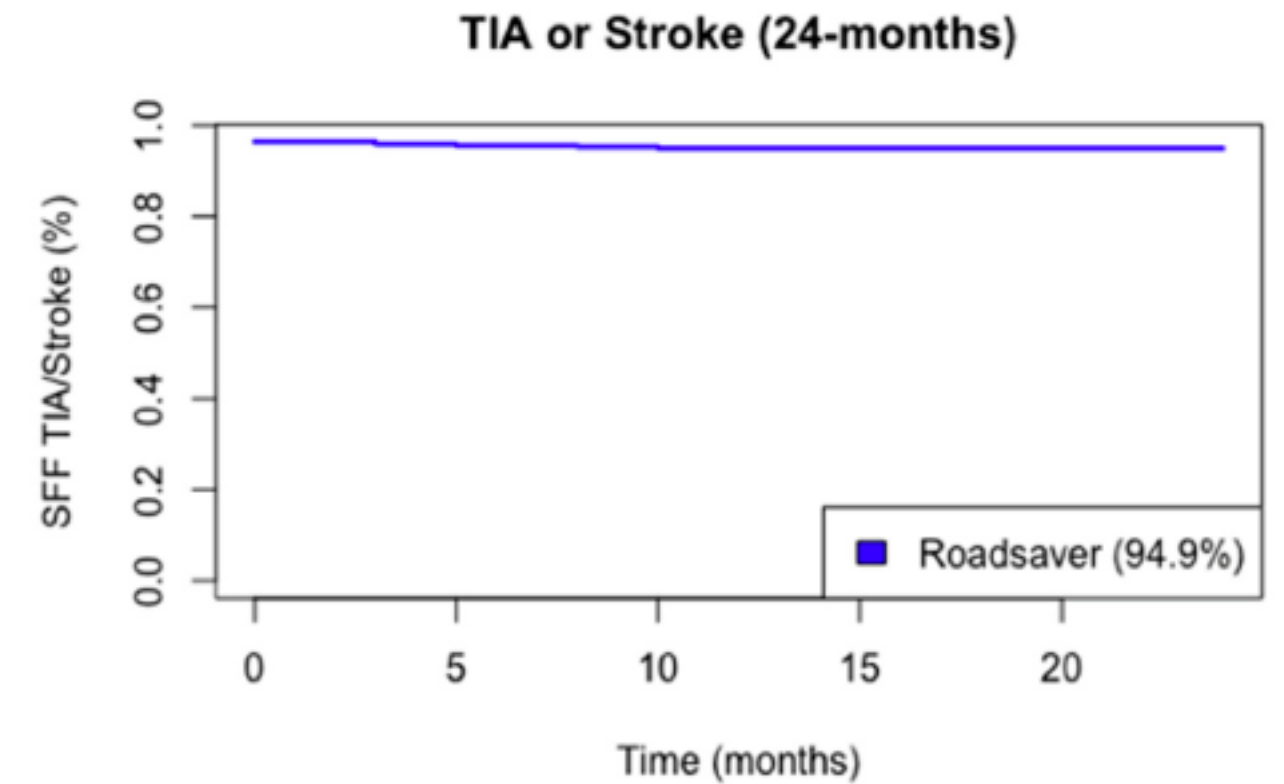
Mid-Term Results of an Italian Multicentric Experience with the Roadsaver™ Dual-Layer Carotid Stent System

Olga Silvestri ¹, Giulio Accarino ^{1,2}, Davide Turchino ^{1,*}, Francesco Squizzato ³, Michele Piazza ³,
Martina Bastianon ⁴, Sara Di Gregorio ⁴, Giovanni Pratesi ⁴, Michele Antonello ³, Davide Costa ^{5,*},
Raffaele Serra ⁵ and Umberto Marcello Bracale ¹

353 Pts 5.9% symptomatic - 7.3% contralateral ICA occlusion

30 days results

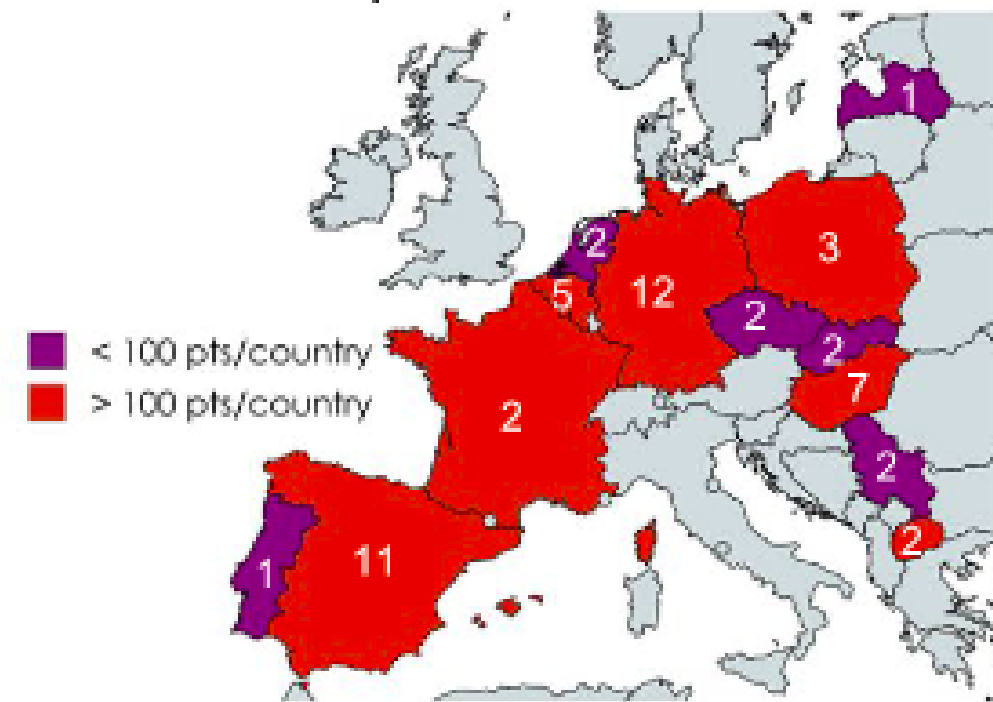
- Technical success 96.9%
- TIAs 1.7%
- Ipsilateral strokes 1.7%
- MI 0%
- Death 0%



CONTEMPORARY CAROTID ARTERY STENTING PRACTICES AND PERI-PROCEDURAL OUTCOMES IN DIFFERENT EUROPEAN COUNTRIES: ROADSaver STUDY MULTICENTRIC INSIGHTS

Study cohort

Symptomatic or asymptomatic carotid artery stenosis patients eligible for an elective stent implantation



Numbers in the map indicate the number of sites per country

Aim

Compare practice & outcomes across countries



Investigate country-specific influence on 30-day MAE incidence rates



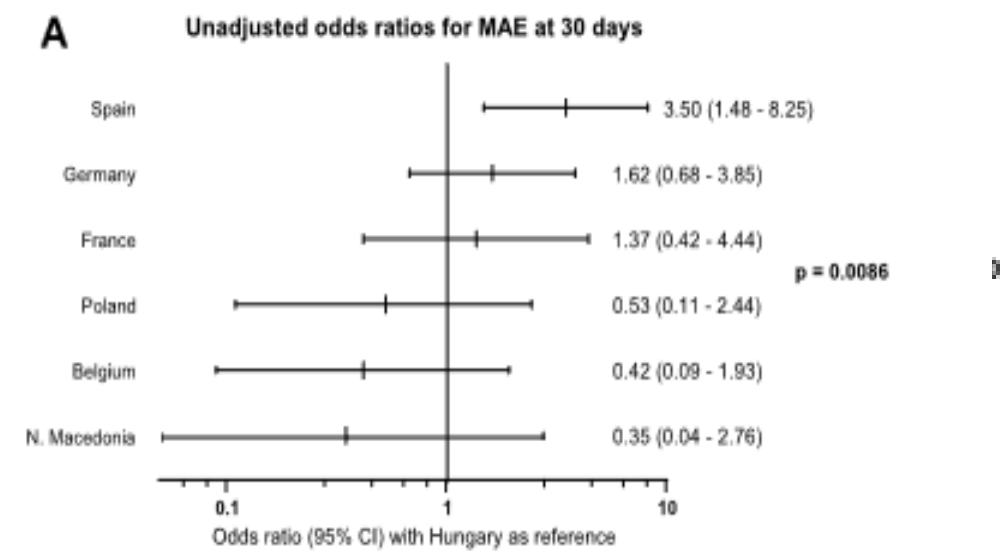
Investigate possible confounders of 30-day MAE differences across countries (in countries with > 100 pts enrolled)

MAE: major adverse event (any death or stroke)

Results

Initially significant country-effect on 30-day MAE was adjusted by:

- Post-dilatation (pressure)
- Number of pts / study site



Multivariable logistic regression model was constructed, including these 2 variables, which among more than 50 patient, procedure and site characteristics considered, were the only ones that significantly adjusted the univariable country-specific effect on 30-day MAE.

There is a variability in carotid artery stenting practice and outcomes across European countries. The differences in 30-day MAE rates between countries may be attributed to differing post-dilatation practices and number of enrolled patients / site.

DUAL-LAYER STENTS

Use of Dual-Layered Stents for Carotid Artery Angioplasty

1-Year Results of a Patient-Based Meta-Analysis

Eugenio Stabile, MD, PhD,^{a,*} Gianmarco de Donato, MD, PhD,^{b,*} Piotr Musialek, MD, PhD,^c Koen Deloose, MD,^d Roberto Nerla, MD,^e Pasqualino Sirignano, MD,^f Adam Mazurek, MD,^c Wassim Mansour, MD,^f Vincenzo Fioretti, MD,^a Fabrizio Esposito, MD,^a Salvatore Chianese, MD,^a Marc Bosiers, MD,^d Carlo Setacci, MD,^b Francesco Speziale, MD,^f Antonio Micari, MD,^e Giovanni Esposito, MD, PhD^a

ABSTRACT

OBJECTIVES This study sought to evaluate 1-year safety and efficacy of dual-layered mesh-covered carotid stent systems (DLS) for carotid artery stenting (CAS).

BACKGROUND Small clinical studies evaluating 1-year outcomes of CAS performed with 2 available DLS, Roadsaver (RS) (Terumo Corp., Tokyo, Japan) and CGuard (CG) (InspireMD, Boston, Massachusetts), have been published.

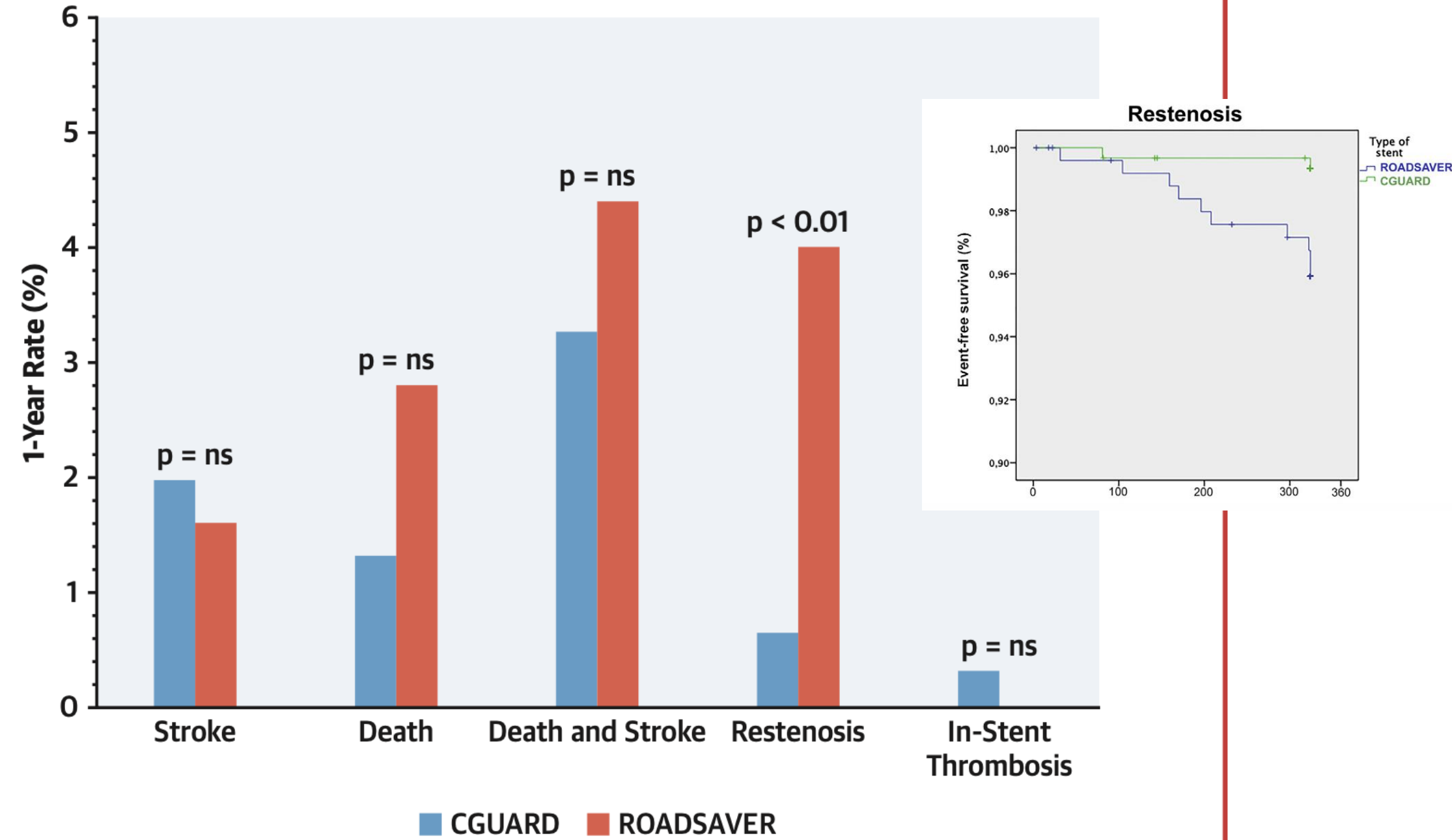
METHODS The authors performed an individual patient-level meta-analysis including studies enrolling more than 100 CAS with DLS. The primary endpoint was the death and stroke rate; secondary endpoints were restenosis and in-stent thrombosis rates at 1 year.

RESULTS Patients were divided into 2 groups according to DLS (RS n = 250; CG n = 306). At 1 year, 11 patients died (1.97%), 7 patients in the group RS (2.8%) and 4 patients in the CG one (1.31%); and 10 strokes occurred, 4 in the group RS (1.6%) and 6 in the CG one (1.96%). Overall death and stroke rate was 3.77% (n = 21), 11 events in the group RS group (4.4%) and 10 in the CG group (3.27%). Symptomatic status was the only predictor of death and or stroke. At 1 year, restenosis occurred in 12 patients (2.1%), 10 in the group RS (4%) and 2 in the CG one (0.65%) (p = 0.007). In-stent thrombosis occurred in 1 patient (0.18%) in the CG group (0.32%). RS use was the only independent predictor of restenosis.

CONCLUSIONS This study suggests that DLS use for CAS is associated with a low 1-year death and stroke rate, and the specific DLS stent used could affect the restenosis rate. (J Am Coll Cardiol Intv 2020;13:1709-15) © 2020 by the American College of Cardiology Foundation.

American College of Cardiology Foundation
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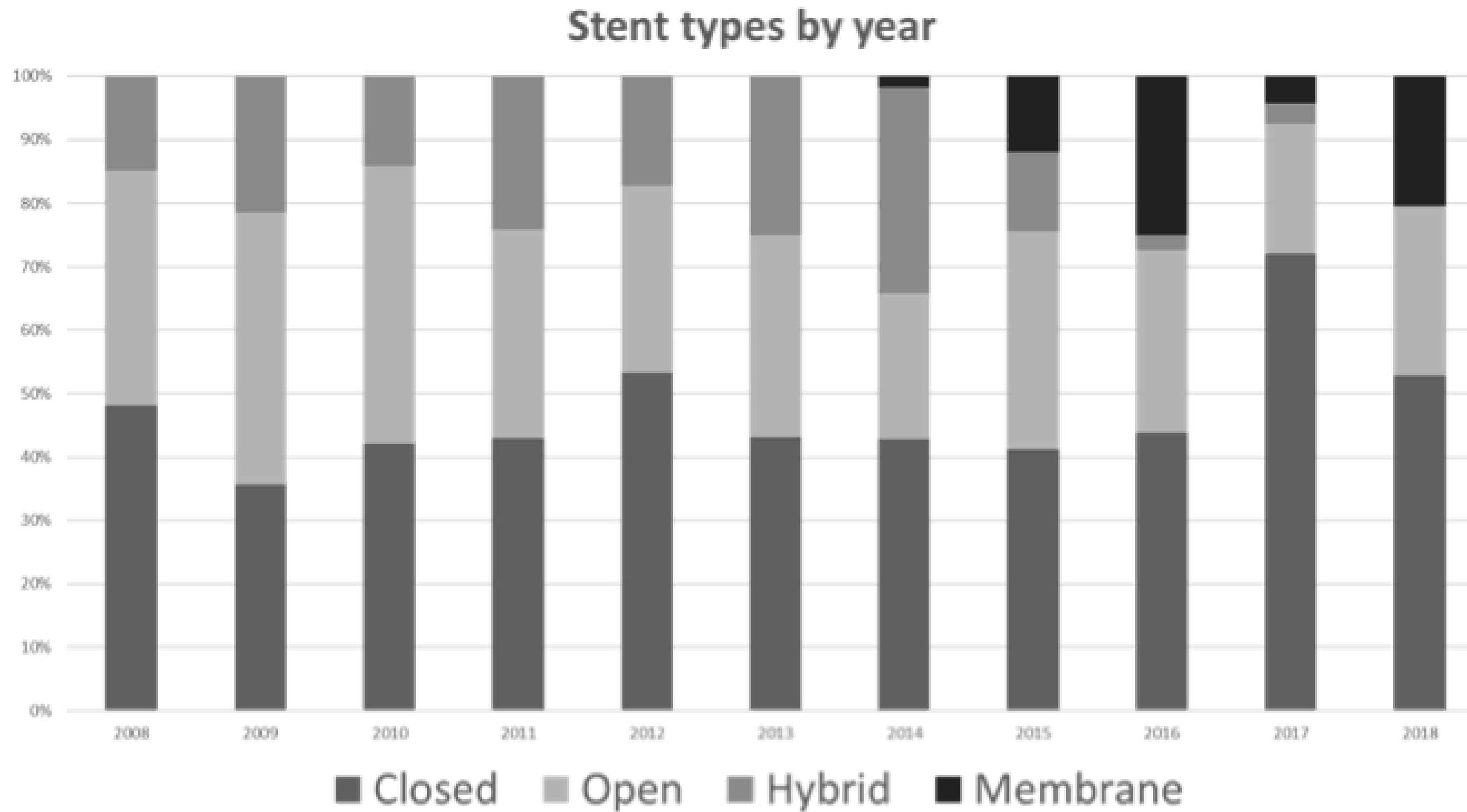
CENTRAL ILLUSTRATION Event Rates at 1 Year



Stabile, E. et al. J Am Coll Cardiol Intv. 2020;13(14):1709-15.

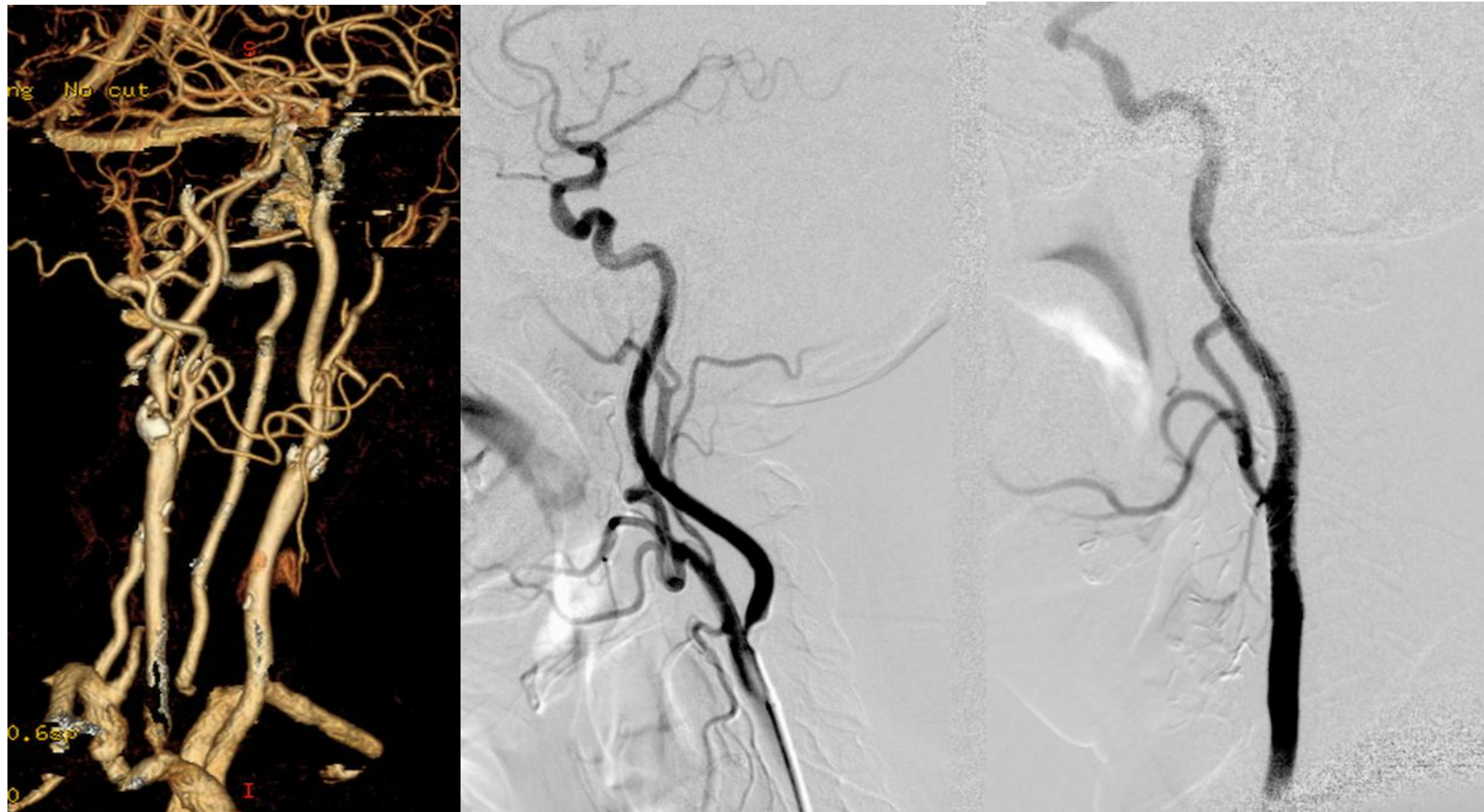
Representative bar graphs depicting specific event rates at 1 year according to the type of DLS used (Roadsaver vs. CGuard).

STENT USE IN THE ACST2 TRIAL



comment choisir son stent?

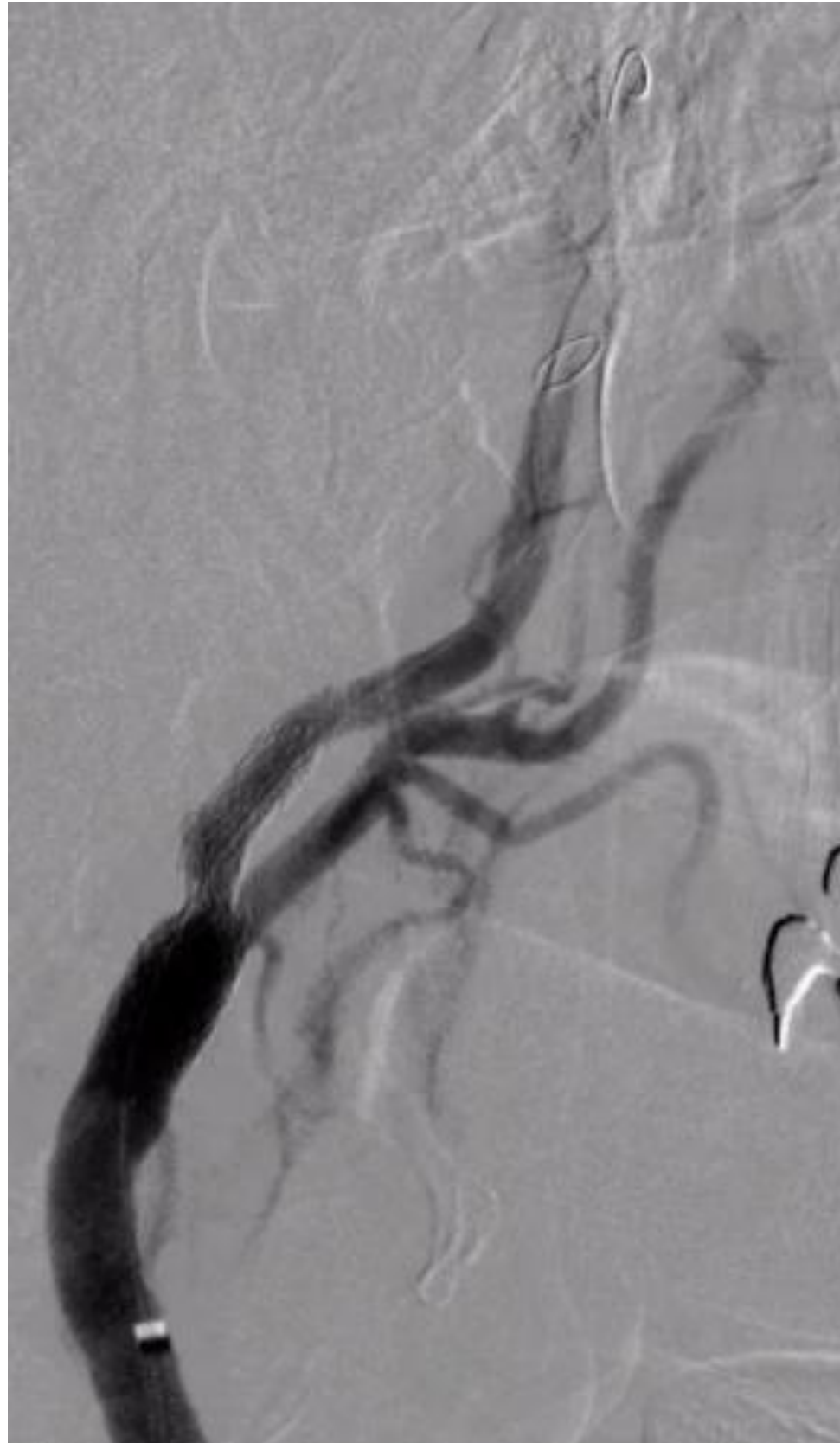
- 1 CHOICE C-GUARD



Symptomatique patient
Unstable plaque
Tortuous anatomy

comment choisir son stent?

- 1 CHOICE C-GUARD



Ulcerated plaque

comment choisir son stent?

- 2 CHOICE WALLSTENT
- PERSONAL EXPERIENCE

MACE 2.1%

Clinical Investigation

Outcomes of 1000 Carotid Wallstent Implantations: Single-Center Experience

Sonia Ronchey, MD¹, Barbara Praquin, MD¹, Matteo Orrico, MD¹, Eugenia Serrao, MD¹, Cristina Ciceroni, MD¹, Vittorio Alberti, MD¹, Stefano Fazzini, MD¹, and Nicola Mangialardi, MD¹

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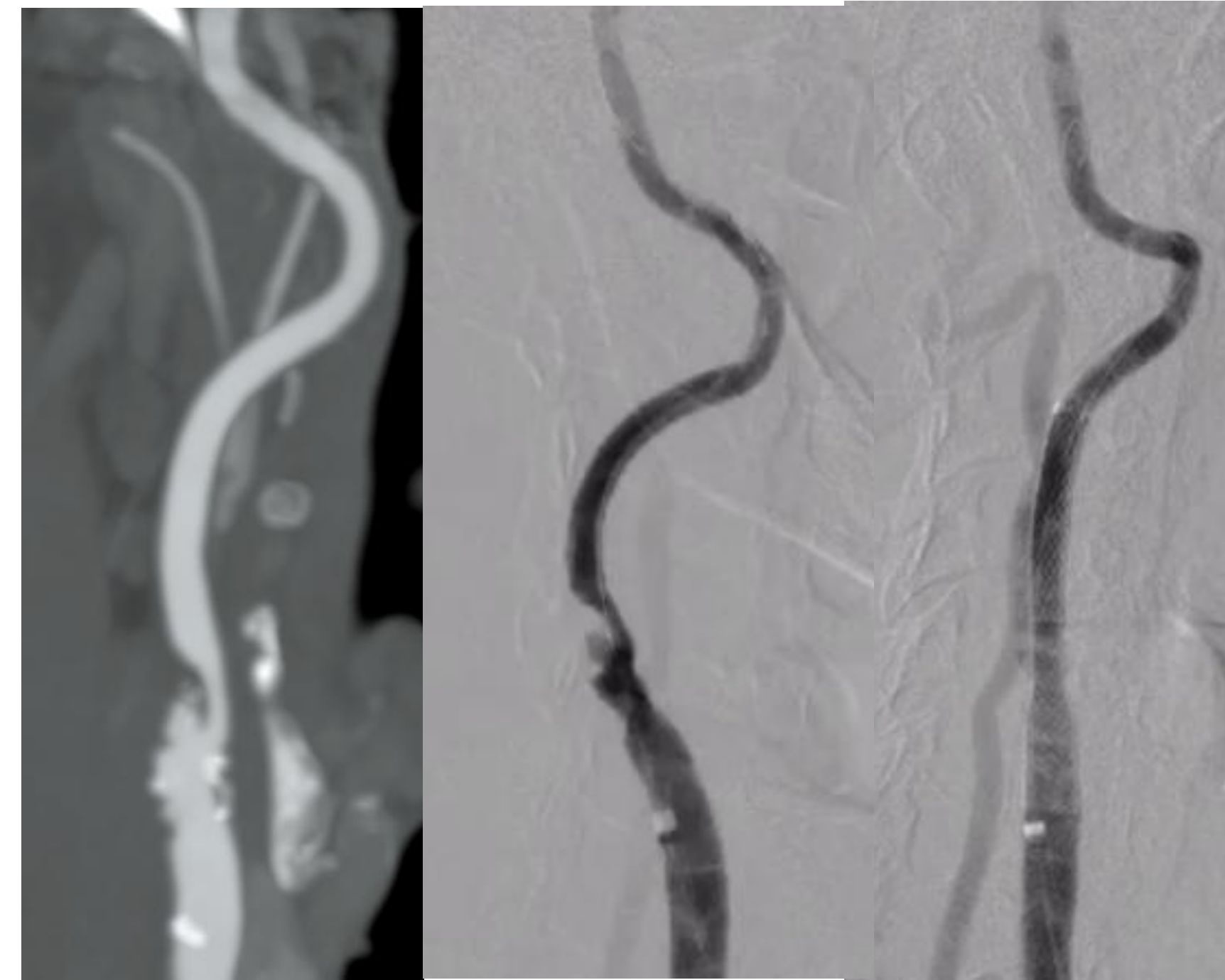
MACE 1,8 %

MAJOR STROKE 0,4%

MINOR STROKE 1,1%

MI 0,1%

DEATH 0,2%

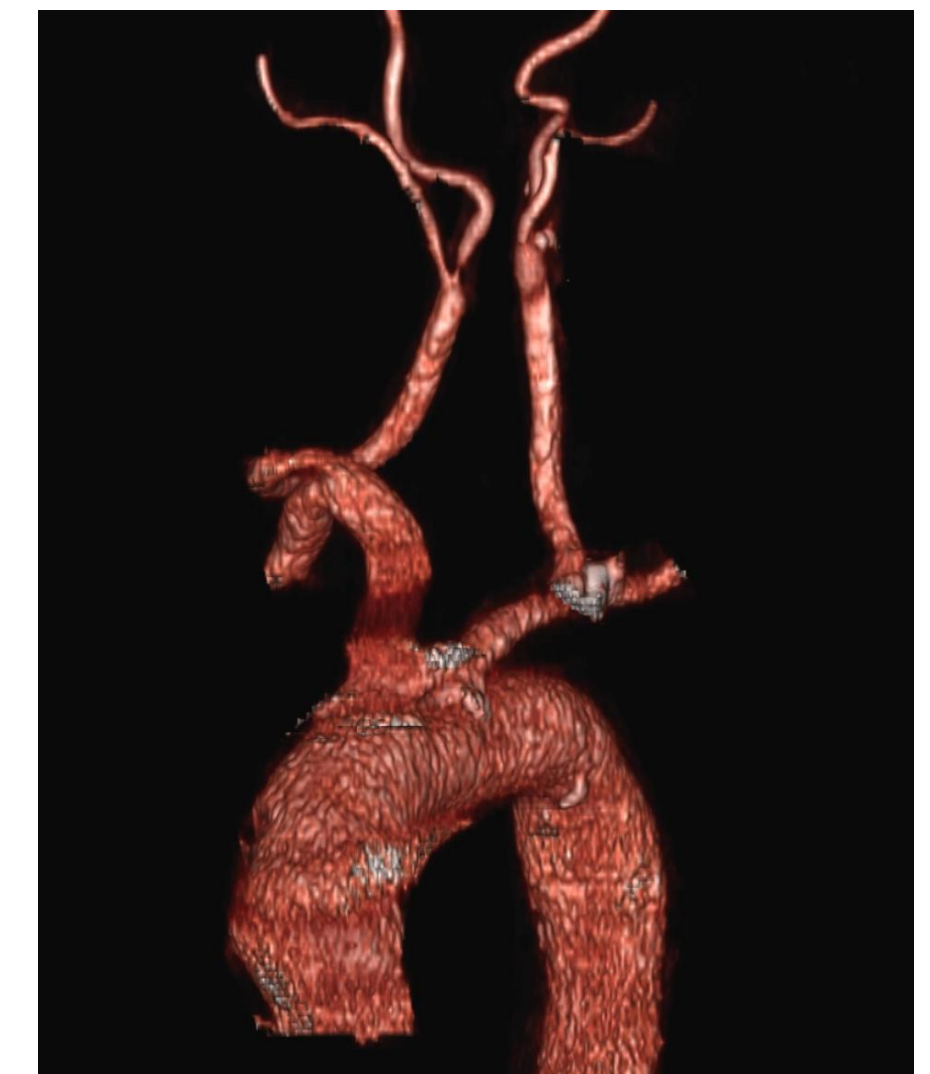


F-up 55.5 ± 9.3 mths (1-142)

- RESTENOSIS 2.8%
- REINTERVENTION 0.7%
- FRACTURES (140 X-Ray) 0%
- MIGRATION 0%

comment choisir son stent?

- 2 CHOICE WALLSTENT
 - EXCELLENT TRACKABILITY



Peri-procedural brain lesions prevention in CAS (3PCAS): Randomized trial comparing CGuard™ stent vs. Wallstent™.

Capoccia L¹, Sirignano P², Mansour W³, d'Adamo A³, Sbarigia E⁴, Mariani P⁵, Di Biasi C⁶, Speziale F⁷.

	CGUARD	WALLSTENT	P (OR; 95%CI)
Positive 72h-DWMRI (n%)	9 (31%)	7 (24.1%)	0.55 (1.41; 0.44-4.50)
72h-DWMRI lesion number per pt (mean±SD; 95%CI)	3.56±2.30 (2.05-5.06)	3.43±1.81 (1.72-5.13)	0.91
72h-DWMRI lesion diameter (mean±SD; 95%CI)	3.87±1.53 (3.3-4.43)	3.56±1.07 (2.87-4.25)	0.49
Preprocedural MMSE (mean±SD; 95%CI)	27.9±3.23 (26.16-29.56)	27.9±2.96 (26.16-29.56)	1
Postprocedural MMSE (mean±SD; 95%CI)	26.8±2.42 (25.66-27.96)	27.3±1.7 (26.17-28.46)	0.53
Preprocedural MoCA (mean±SD; 95%CI)	22.9±4.88 (19.86-25.91)	22.4±3.57 (19.42-25.47)	0.83
Postprocedural MoCA (mean±SD; 95%CI)	24.3±4.77 (21.17-27.49)	25.3±4.11 (22.17-28.49)	0.64
Basal S100B (mean±SD; 95%CI)	0.0548±0.0167 (0.0485-0.0611)	0.0529±0.0172 (0.0466-0.0592)	0.68
2h S100B (mean±SD; 95%CI)	0.0617±0.0217 (0.054-0.0695)	0.0605±0.02 (0.0528-0.0683)	0.83
12h S100B (mean±SD; 95%CI)	0.0686±0.0321 (0.0585-0.0786)	0.0657±0.0206 (0.0557-0.0758)	0.69
24h S100B (mean±SD; 95%CI)	0.0785±0.0442 (0.0649-0.0921)	0.071±0.0265 (0.0575-0.0846)	0.44
48h S100B (mean±SD; 95%CI)	0.09±0.0617 (0.0719-0.108)	0.082±0.0302 (0.0639-0.1001)	0.53
Basal NSE (mean±SD; 95%CI)	6.18±1.87 (5.49-6.85)	5.86±1.78 (5.18-6.54)	0.52
2h NSE	6.46±1.75	6.41±1.67	0.9

Both stents showed

- acceptable rate of subclinical neurological events
- no significant differences at 72-hour DWMRI between groups.

Thank you