Why Not TCAR?

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We are seeing a revolution in the treatment of carotid artery occlusive disease unfold right before our eyes in a field that has seen little progressive change in the past several decades. Winston Churchill once said, "To improve is to change. To be perfect is to change often." We have just heard from the top experts in their field on how transcarotid artery revascularization (TCAR) is changing their practice, decision-making, and treatment of patients. Dr. Jim and colleagues stated, "TCAR is the new standard." Excellent clinical outcomes, patient preference, shorter procedure times, and ease of adoption are a few examples mentioned driving this adaptation. TCAR has not only become an adjunct to carotid intervention but has expanded our treatment of the disease in patients who may otherwise not have been great candidates for alternate interventions. Dr. Watch mentioned regarding her practice, "…with expanded treatment options, carotid disease patients have been screened, and the surgically challenging cases have been offered TCAR." The jury is out; the data and clinical outcomes speak for themselves—TCAR is here to stay. The question is no longer, should we be doing TCAR? Instead, it should be, why not TCAR? A procedure that was once reserved for the high-risk patient proves to be a promising alternative to the gold standard treatment of carotid disease. There is consensus on keeping endarterectomy and transfemoral stenting in the toolkit, though, as the procedure has some limitations and pitfalls. Dr. Shah said it best, "TCAR is a compelling procedure that must be in the toolkit."

As discussed earlier, our indications for treatment utilizing the TCAR system are based on Medicare guidelines, whose policies are aligned with transfemoral stenting. As we continue to see the positive outcomes and safety profile of TCAR pull away from transfemoral stenting, we will see new guidelines, treatment indications, and reimbursement in the very near future. Dr. Aranson kindly "unpacked" the TCAR data demonstrating that there is almost a decade of long-term data, a short learning curve, and two-thirds of patients undergoing carotid intervention meet high-risk criteria.

These ongoing studies, reviews, and analyses in the world of carotid disease continue to solidify that TCAR is a safe, effective, durable, and straightforward treatment modality that requires proficiency. As stated earlier, "expert level" can be obtained in as little as 25 procedures. I, for one, have embraced the TCAR revolution and have a TCAR-first approach to all my patients who qualify for the procedure. In our practice, not only are we able to reproduce the success and safety presented in the literature but we have seen an overwhelmingly positive response from both patients and referring doctors. Dr. Ricotta said it best, "…not having the capacity to offer all treatment options to patients with carotid stenosis does them a disservice." With TCAR in your tool belt, terms like high lesion, bad arch, or this patient is too high risk become less of a factor when considering carotid intervention. Instead, for me, new terms like patient satisfaction, smaller incision site, benefits of local anesthesia, and fewer risks of cranial nerve injuries have been added. It has been a win-win for the practice and our patients.

I congratulate and applaud the authors on their efforts to educate us on carotid disease and their insight and experiences with TCAR and carotid interventions. It allows us all to continue to change as physicians and surgeons to provide the best care and treatment options to our patients. "Progress is impossible without change, and those who cannot change their minds cannot change anything." – George Bernard Shaw. ■