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CAROTID STENOSIS: TO REVASCULARIZE, OR NOT TO REVASCULARIZE: THAT IS THE QUESTION

Bart M. Demaerschalk, Scottsdale, AZ; George Howard, Birmingham, AL; Thomas G. Brott, Jacksonville, FL: In their editorial, Drs. Marquardt and Barnett¹ contend that because the CREST trial² grouped symptomatic and asymptomatic patients together, the trial denied information about the benefit of endarterectomy (CEA) and stenting (CAS) in these separate conditions. We respectfully disagree.

In CREST,² a prespecified aim was estimation of modification of the treatment effect by symptomatic status assessed through inclusion of the interaction term in the proportional hazards model as a single variable. By that method, there was no evidence of a

differential effect for patients with symptomatic or with asymptomatic carotid stenosis for any of the primary or secondary outcomes.² For example, Drs. Marquardt and Barnett may take issue with the inclusion of periprocedural myocardial infarction as a component of the primary outcome in CREST. However, we found no evidence of treatment effect by symptomatic status for stroke and death. Furthermore, after the periprocedural period the incidences of ipsilateral stroke with CAS and CEA were similarly low (2% and 2.4%, respectively; $p=0.85$).

Our conclusions differ substantially from those of Drs. Marquardt and Barnett. Both endarterectomy and stenting have an important role to play in the management of carotid stenosis. Clinicians and their patients now have 2 safe and effective options³ for revascularization of the carotid artery.

Editor's Note: The authors of the article were offered the opportunity to respond but declined.

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CORRECTION

Determinants of survival in progressive multifocal leukoencephalopathy

In the article “Determinants of survival in progressive multifocal leukoencephalopathy” by A. Marzocchi et al. (*Neurology*[®] 2009;73:1551–1558), there is an error in the labeling of the y-axis in figures 3 and 4. The y-axis should read “Cumulative probability of survival categorized by the presence of IRIS” in figure 3 and “Cumulative probability of survival categorized by CD4 count at baseline” in figure 4.

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Neurology 2012;78;294

DOI 10.1212/WNL.0b013e318244364a

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