

**PLEASE SIGN IN
(NAME AND EMAIL)**

**AANS/CNS
Cerebrovascular Section**

Executive Council Meeting, CV Sect 2012

Monday, January 30, 2012

Belle Chase Room

Hilton New Orleans Riverside Hotel

New Orleans, LA 5:00-6:00pm



Approval of Minutes

Dr. Sean D. Lavine

Call to Order (Dr. Connolly)

Approval of Minutes from CNS 2011 (Dr. Lavine)

Moment of Silence (Remembrance Christopher C. Getch, MD, 1961-2012)

Treasurer's Report (Dr. Hoh)

Annual Meeting Updates

- 2012 CV Annual Meeting (Dr Ringer)
- 2012 ISC Meeting (Drs Albuquerque, Carter, Patel)
- 2012 AANS Meeting (Drs Bulsara and Bambakidis)

Standing Committee/Project Updates

- Coding & Reimbursement (Dr Vates)
- Joint Guidelines Committee/CV Section Guidelines Committee (Dr. Hanjani)
- National Quality Forum (Dr Cockroft)
- Endovascular Task Force (Dr Thompson)
- Neurovascular Coalition (Drs. Wilson and Cockroft)
- SNIS update (Dr Felipe Albuquerque)
- Brain Attack Coalition (Dr. Huang)
- Membership Update (Dr. Zipfel)
- Fundraising Committee (Drs. Hoh and Rasmussen)
- Research Fellowship (Drs. Dempsey and Rasmussen)
- Newsletter Committee (Drs. David and Bulsara)
- Website Committee (Drs Zipfel and Carter)
- Curriculum Development and Education Committee (Dr. Bendok)
- Bylaws/Rules & Regulations Committee (Dr. Prestigiacomo)

Meeting Agenda

Old Business Updates

- Junior Resident Endovascular Course (Drs Mocco, Bendok)
- Neuropoint Alliance (Dr Cockroft)
- 3C meeting (Drs Levy, Siddiqui)
- Joint Meeting – Cerebrovascular Society of India (Abdulrauf)
- Brain Aneurysm Foundation (Dr David)

New Business

- COSS Trial Statement by CV Sect (Dr. Hanjani)
- MedCAC Voting on Carotid Atherosclerosis (Dr Wilson)
- Senior Society Matrix/Milestones and Modules (Connolly)
- Massimo Collice award for cerebrovascular malformations
- SVIN Liaison (Dr Mocco)

- **In Memoriam... CNS Past-President, Christopher C. Getch, MD, 1961-2012**
- **The CNS suffered a tragic and unexpected loss on Monday, January 9 with the news of Dr. Christopher C. Getch's untimely death.**
- **Dr. Getch, the immediate past-president of the Congress of Neurological Surgeons, was an inspiring leader who worked tirelessly on behalf of the CNS, its members, and the profession of Neurosurgery. He will be remembered by all as a great father, husband, leader, surgeon, and friend.**
- **In less than 15 years, Dr. Getch rose to the top of national neurosurgical leadership, including progressively increased responsibility with the Congress of Neurological Surgeons, culminating with his role as president from 2010 to 2011. Dr. Getch was also president of the Illinois State Neurosurgical Society and had been an active member in the Medical Faculty Senate Council for Northwestern University and several Northwestern Memorial Hospital committees. Dr. Getch spent his entire faculty career at Northwestern, joining the Feinberg School of Medicine in 1996 as an assistant professor in the Department of Neurosurgery. He was twice promoted, to associate professor in 2005, and professor in 2010. After growing up in Boston, Dr. Getch earned his medical degree at Tufts University School of Medicine. His residencies in neurological surgery were at Temple University Hospital and Thomas Jefferson University Hospital, both in Philadelphia. He also was a clinical fellow of neurological surgery at the University of Pittsburgh, where he completed fellowships in microsurgery and stereotactic radiosurgery.**
- **Joining the Illinois State Neurosurgical Society in 1996 upon moving to Chicago, Dr. Getch was actively involved in the society's efforts on liability reform and the practice of defensive medicine by neurosurgeons. Dr. Getch had been involved in resident education at Northwestern since joining the faculty, and more recently as a regional director of the Senior Society Boot Camp course.**
- **His clinical research interests included the surgical and stereotactic radiosurgical treatment of cerebrovascular disease. Additionally, he had extensive experience with posterior fossa surgery, particularly in the treatment of trigeminal neuralgia. His academic work generated 75 publications and 30 published abstracts.**
- **Dr. Getch is survived by his wife, Gale England, GME '00, a surgeon who trained at Northwestern, and four sons, Christopher, Oliver, Charles, and William.**
- **As an alternative to, or in lieu of flowers, the family suggested that a donation in the memory of Chris can be made to Midwest Labrador Retriever Rescue, where Dr. Getch and Gale adopted their beloved lab, Wilbur Gale.**
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Treasurer's Report

Dr. Brian Hoh

AANS/CNS Section on Cerebrovascular Surgery
Statement of Financial Position
As of December 31, 2011 and 2010

	<u>Current Year 12/31/11</u>	<u>Prior Year 12/31/10</u>
ASSETS		
Checking & Short Term Investments	\$183,876	\$181,131
Accounts Receivable, net of Allowance for Uncollectible Accounts	108,100	89,886
Prepaid Expenses		30,000
Long-Term Investment Pool, at Market	564,159	572,348
TOTAL ASSETS	<u>\$856,134</u>	<u>\$873,365</u>
 LIABILITIES AND NET ASSETS		
Liabilities		
Deferred Dues	60,300	56,950
Total Liabilities	<u>\$60,300</u>	<u>\$56,950</u>
 Net Assets		
Unrestricted	\$554,937	\$440,568
Unrestricted - Donaghy	\$48,684	\$43,490
Unrestricted - Galbraith	\$26,762	\$24,239
Unrestricted - Resident	\$17,033	\$23,043
Unrestricted - Leussenhop	\$19,924	\$19,273
Unrestricted - Drake	\$10,415	\$9,678
Unrestricted - Yasargil Lectureship	\$52,727	
Net Revenue (Expense)	65,352	256,123
Total Net Assets	<u>\$795,834</u>	<u>\$816,415</u>
 TOTAL LIABILITIES AND NET ASSETS	 <u>\$856,134</u>	 <u>\$873,365</u>

AANS/CNS Section on Cerebrovascular Surgery
Statement of Activities
For the Six Months Ending December 31, 2011

	FY '08 Final	FY '09 Final	FY '10 Final	FY '11 Final	YTD FY '12	FY '12 Budget
REVENUES						
Membership Dues	\$30,900	\$34,563	\$46,750	\$54,648	\$24,116	\$54,900
Mailing List Sales	295	0	0	295	0	0
Contributions/Sponsorships	17,500	27,500	7,500	85,000	7,773	37,500
Advertising Revenue	0	0	0	1,300	0	1,300
Miscellaneous Revenue	325	0	0	0	0	0
Contributions for Operating Expenses	7,925	8,661	9,143	9,347	4,260	10,200
Annual Meeting Revenue	220,437	93,785	167,709	255,771	149,625	235,078
TOTAL REVENUES & SUPPORT	\$277,382	\$164,509	\$231,102	\$406,361	\$185,774	\$338,978
EXPENSES						
Audio Visual	\$2,152	\$1,874	\$1,477	\$1,192		\$1,500
Bank Fee	423	535	518	930	277	780
Contributions & Affiliations	110,000	10,000	60,000	10,000	0	10,000
Decorating	0	205	607	741	0	350
Food & Beverage	3,812	5,498	8,160	9,959	2,222	10,000
Honoraria & Awards	33,734	35,407	35,890	40,960	30,000	36,000
Office & other Supplies	271	448	343	200	58	450
Photocopy	3	1	95	1	0	25
Postage & Distribution	462	595	468	901	1,184	825
Printing/Typesetting	0	0	0	1,282	0	0
Newsletter Postage	0	0	0	998	0	1,025
Newsletter Printing	0	0	0	2,015	0	2,025
Newsletter Professional Fees	0	0	0	195	0	200
Website	0	0	540	699	600	1,190
Staff Travel	0	0	0	0	0	225
Telephone	109	120	566	268	152	325
Temporary Personnel	38,479	7,500	0	0	0	0
Volunteer Travel	3,379	1,140	386	0	0	1,000
Staff Coordination	9,864	9,259	10,081	11,539	4,870	18,142
Annual Meeting Expense	121,583	134,752	198,562	239,529	50,982	256,556
TOTAL EXPENSES	\$324,271	\$207,334	\$317,693	\$321,409	\$90,345	\$340,618
Investment Earnings	(12,438)	(82,961)	55,192	85,240	(30,078)	27,168
NET REVENUE	(\$59,327)	(\$125,786)	(\$31,399)	\$170,192	\$65,351	\$25,528

AANS/CNS Section on Cerebrovascular Surgery
Annual Meeting
For the Six Months Ending December 31, 2011

	FY '08 Final	FY '09 Final	FY '10 Final	FY '11 Final	YTD FY '12	FY '12 Budget
Revenues						
Registration Fees	46,751	37,250	48,500	66,625	28,750	88,500
Exhibitor Fees	70,850	43,200	53,200	59,275	40,200	49,200
Exhibitor Sponsorship Revenue	100,000	6,000	15,000	29,000	15,000	20,000
Resident Hands-on Course Revenue	0	0	44,100	84,000	65,000	70,000
Special Event Revenues	1,350	1,425	1,725	6,675	675	3,000
Housing/Reg/Tape Revenue	1,486	5,910	5,184	10,196	0	4,378
Total Revenues	220,437	93,785	167,709	255,771	149,625	235,078
Expenses						
Scientific Program	22,209	40,553	39,685	46,091	11,489	51,564
Poster Session	0	3,558	4,941	5,016	0	5,602
Abstract Management	79	0	0	0	0	0
Program Book	2,282	13,083	14,785	11,331	1,300	11,500
Special Course	0	0	3,026	3,920	0	3,108
Opening Reception	11,361	18,804	21,197	30,876	0	19,496
Committee Dinners/Events	2,987	5,720	5,422	4,787	0	5,200
Exhibit Program	2,724	3,226	5,729	9,122	1,000	6,060
Exhibit Marketing	0	2,848	2,289	1,025	1,950	1,500
Advanced Registration	11,570	11,544	12,425	13,795	10,171	14,200
On-Site Registration	399	4,543	1,470	2,214	0	5,175
Preliminary Program	813	2,497	2,932	950	0	950
Annual Meeting Promotion	2,000	3,636	3,316	2,328	945	1,300
On-Site Coordination	1,201	4,382	5,908	5,073	268	7,900
Scientific Program Planning Cmte	0	0	0	0	0	0
Annual Meeting Planning Cmte	672	24	0	0	0	0
Staff Coordination	63,285	20,334	32,302	34,540	23,858	41,550
Resident Hands-on Course Expenses	0	0	43,134	68,463	0	81,452
Total Expenses	121,583	134,752	198,562	239,529	50,982	256,556
Net Excess (Loss)	98,854	(40,967)	(30,854)	16,242	98,643	(21,478)

AANS/CNS SECTION ON CEREBROVASCULAR SURGERY

NOTES TO FINANCIAL STATEMENTS

December 31, 2011

General and Administrative

Expense

Postage – Budget \$825, Actual \$1,184

1,004 certificates were mailed to CV Resident members in July 2011 at a cost of \$.88 each per Dr. Zipfel.

Sponsorship Update - 12/31/11

CV Section

Budgeted Sponsorships:	Budgeted Amount	Date Received	Amount Received
Synthes	\$ 7,500.00	10/6/2011	\$ 7,500.00
Resident Research Award -1	\$ 15,000.00		
Resident Research Award -2	\$ 15,000.00		
Total Amount Received for FY12			\$ 7,500.00
Also received:			
Return of Unused Grant Funds (from Yale University - Resident Research Award)		11/2/2011	\$ 273.46



2012 CV Section Annual Meeting

New Orleans LA

Dr Ringer



CV Section 2012 New Orleans

- **MONDAY, JANUARY 30, 2012**
- 12:00 – 7:00 PM
Registration
-
- 1:00 – 5:00 PM
- **2 Concurrent Practical Courses**
-
- 6:00 - 7:30 PM
- **Opening Reception in the Exhibit Hall**




CV Section 2012 New Orleans

- **TUESDAY, JANUARY 31, 2012**
- 7:00 AM – 4:00 PM
- **Registration**
-
- 7:00 – 8:00 AM
- **Continental Breakfast in Exhibit Hall**
-
- 8:00 - 8:10 AM
- **Welcome**
- E. Sander Connolly, Jr. MD
- AANS/CNS Cerebrovascular Section Chair
- Andrew J. Ringer, MD, FAANS
- Annual Meeting Chair
-
-

CV Section 2012 New Orleans

- 8:10 - 10:00 AM
- **Scientific Symposium I – Ischemic Stroke and the Neurosurgeon (8:10-9:30)**
- Moderators: Rich Fessler and Jay Howington
- Speakers:
- Endovascular Techniques for Acute Revascularization (Ketan Bulsara)
- Bypass Surgery: The Red-Headed Step Child (incl. COSS review) (Dave Langer)
- Surgical and Endovascular Stroke Prevention (SAMMPRIS/CREST rev.) (Mark Chimowitz)
- Hemicraniectomy for Stroke (Stephan Mayer)
- Oral Abstracts (4-5 abstracts, 5 minutes each w/ 1 minute for questions) (9:30-10)



■ 10:00 - 10:30 AM

■ **Coffee Break in the Exhibit Hall**

■ 10:00 - 4:30 PM

■ **Exhibit Hall**

■

■ 10:30 - 12:00 PM

■ **Scientific Symposium II – Aneurysms (10:30-11:30)**

■ Moderators: Giuseppe Lanzino and Shah-Naz Khan

■ Speakers:

■ Giant aneurysm management: surgical, endovascular and combined (Carlos David)

■ New endovascular techniques for aneurysms (liquid embolics, flow diverters) (J Mocco)

■ A modern dilemma: The unruptured aneurysm (Andy Ringer)

■ Oral Abstracts (4-5 abstracts, 5 minutes each w/ 1 minute for questions) (11:30-12)

■



2:00 – 3:00 PM

- **Scientific Symposium III – Lussenhop**

- 2:00 – 2:15 PM
- **Chair's Address**
- E. Sander Connolly, Jr. MD
- AANS/CNS Cerebrovascular Section Chair
- 2:15-2:20 PM
- **CV Section Resident Research Award**
- Presentation of award - Cameron McDougal
- 2:20-2:25
- **Introduction of Luessenhop Lecturer**
- Kim Nelson
-
- 2:25 – 2:55 PM
- **Luessenhop Lecture**
-
- 2:55 – 3:00 PM
- **Question & Answer**

CV Section

- **Scientific Symposium IV – AVMs**
- Moderators: Bernard Bendok and Alan Boulos
- Speakers:
- 3:00 - 4:00 PM
 - Embolization for Radiosurgery: A useful tool (point) (Babu Welch)
 - Embolization for Radiosurgery: A waste of time (counterpoint) (Gavin Britz)
 - A modern dilemma: The unbled AVM (ARUBA update) (Kevin Cockroft)
 -
- 4:00 - 4:30 PM
- **Coffee Break in the Exhibit Hall**
-

CV Section

- 4:30 - 6:00 PM
- **Scientific Symposium V – ICH: Trials and Tribulations (4:30-5:30)**
- Moderators: Rafael Rodriguez and Adam Arthur
- Speakers:
 - Surgery for ICH (David Mendelow)
 - Minimally Invasive Surgery for ICH and IVH (Isaam Awad)
 - Coagulopathy, Anticoagulants and ICH (Joseph Beshay)
- Oral Abstracts (4 abstracts, 5 minutes each w/ 1 minute for questions)
5:30-6pm




2012 ISC Conference

New Orleans, LA

Dr. Bob Carter

Dr Felipe Albuquerque

Dr Aman Patel



ISC Meeting Ischemic Stroke: Endovascular Treatment

Felipe C. Albuquerque, MD



Debate Session

- The Ethics of Device Use for Acute Stroke Intervention



Invited Symposium

- Imaging Biomarkers in Endovascular Stroke Therapy: Translation from Clinical Research to Practice



Academic Sessions

- 2 Oral Abstract Sessions
 - 4 moderators and 4 alternates from CV Section
 - 7 abstracts per session
- 2 Oral Poster Sessions
 - 2 moderators and 2 alternates from CV Section
 - 6 abstracts per session
- 2 General Poster Sessions
 - 37 abstracts total



CV Section Involvement: ISC 2012

- Connolly
- Cockroft
- Riina
- Hoh
- Siddiqui
- Zipfel
- Albuquerque
- Levy, E.
- Pandey
- Gunel
- Khalessi
- Barnwell
- McDougall
- Niemann
- Harbaugh
- Patel
- Woo
- Prestigiacomo
- Steinberg
- Rosenwasser
- Jabbour
- Dumont
- Stiefel
- Rasmussen
- Carter
- Lavine
- Dashti
- Arthur
- Lanzino



ISC 2013

- Preparations underway
- Suggested Session Submission
Opens: 1/30/2012
Closes: 3/5/2012
- Abstract Submission
Opens: 5/23/2012
Closes: 8/14/2012
- Late Breaking Science Submission
Opens: 10/10/2012
Closes: 11/7/2012



ISC 2012 – Vascular malformations

Aman Patel

- 2 symposiums
- Oral abstract session will be combined with aneurysm section
 - 3 Vascular malformation, 4 Aneurysm abstracts
- 6 moderated poster abstracts
- 4 posters



Symposiums

- Hemodynamic and Research Principles of AVMS –
Friday Feb 3, 8am – 9:30 am
 - Aberrant Angiogenic Signaling And Animal Modeling Studies: William Young
 - Human Genetic Studies: Murat Gunel
 - Randomized Trials: Christian Staph
 - Animal Models of AVMs and What Have We Learned regarding Hemodynamics: Henry Woo
 - AVM Anatomy Relating to Hemodynamic Principles: Charles Prestigiacomo



Symposiums

- Seizures and Vascular Malformations: How to Treat?
 - Pathophysiology, Epidemiology and Diagnosis of Seizures in Patients with Vascular Malformations: Paul Vespa
 - Medical Management of Seizures in the Setting of Vascular Malformations: Madeline Fields
 - Surgical Planning in Seizures and Vascular Malformations: Domingos Coiteiro
 - Radiosurgery for the Treatment of Seizures in Vascular Malformations: Howard Riina



2012 AANS Conference

Miami, FL

Dr. Ketan R. Bulsara

Dr. Nicholas Bambakidis

CEREBROVASCULAR SECTION (April 17th, 2012)

Section Day Layout

Speaker Slate (2:00 to 3:30)

Moderators: Ketan R. Bulsara and Nicholas Bambakidis

2:00 to 2:10	Sander Connolly	Introduction of Donaghy Lecturer
2:10 to 2:35	Robert Solomon	Donaghy Lecture
2:35 to 2:50	Jacques Morcos	Current Indications for EC-IC bypass: Fall out from COSS
2:50 to 3:05	Doug Kondziolka;	Pre-radiosurgery embolization for AVMS- helpful or harmful
3:05 to 3:20	Brian Hoh	SAMMPRIS and its implications

Abstract Section (4:00 to 5:30)

Moderators: Andy Ringer and Henry Woo

of abstracts you would like presented in your section: 10

of minutes for each abstract presentation: 8

Time slot you want abstracts presented in: 4:00-4:40 for abstracts 1-5
(10 minute buffer for speaker's over time) 4:50 -5:30 PM for abstracts 6-10



Standing Committees/ Project updates



Washington Committee Update

Katie Orrico


Rachel Groman

AANS/CNS Washington Committee

Coding and Reimbursement Subcommittee

Dr. Edward Vates

Dr. John Wilson



Joint Guidelines Committee & CV Section Guidelines Committee

Dr. Sepideh Amin-Hanjani



AHA/ASA projects: Joint Guidelines Committee

Flag ship guidelines: 1^o prevention, 2^o prevention, ICH, SAH, Acute Stroke, Rehab

Recently endorsed by AANS/CNS through JGC

- SAH guidelines: (Writing Committee Chair: Connolly; Official AANS/CNS representative designated: Hoh).

Recently reviewed by JGC subcommittee

- Acute Stroke guidelines: reviewed (CV designated peer reviewer: J Mocco; JGC review: Cockroft, Hoh, Khalessi, Mack + 4 non CV JGC members)

In process of re-commissioning:

- 2^o prevention: writing group development

AHA/ASA project: CV Section Guidelines Committee

Other projects reviewed

- Definition of Stroke: reviewed by CV GC for endorsement by AANS/CNS (Babu Welch, Ketan Bulsara, Henry Woo, Clemens Schirmer, Justin Fraser)

Other upcoming projects:

- Unruptured Aneurysms Update: Co-Chairs: Greg Thompson, Bob Brown – writing group being developed
- Risk of Cervical Dissection after Chiropractic Manipulation: AANS/CNS writing group rep: Felipe Albuquerque
- Evaluation and Management of Malignant Infarctions: AANS/CNS writing group rep: Bob Carter
- Palliative and End of Life Care: AANS/CNS writing group rep: Greg Zipfel

Other potential projects:

- Women's Guidelines for Stroke
- Update on Brain AVMs



CV Section Guidelines Committee

- Roster updated August 2011
- Review of documents outside purview of JGC (consensus statements, scientific statements, advisory statements etc)
- Volunteers: please contact hanjani@uic.edu
 - EBM background
 - AHA/ASA membership, FAHA
 - COI

AANS/CNS Washington Committee

National Quality Forum

Dr. Kevin Cockroft

Rachel Groman



Endovascular Task Force

Dr. Greg Thompson



Neurovascular Coalition

Dr. John Wilson



SNIS Update

Dr Felipe Albuquerque

Update on the SNIS 2012



Felipe C. Albuquerque, MD
Member At Large, SNIS



Executive Committee

Joshua Hirsch

Michael Alexander

Phillip Meyers

Cameron McDougall

Colin Derdeyn

Don Heck

Felipe Albuquerque

David Fiorella

Don Frei

Charles Prestigiacomo

Jeffrey Sunshine

Peter Rasmussen

Raul Nogueira

Rob Tarr – non voting

Cooperative Projects

- *Brain Attack Coalition – Stroke care issues*
- *Neurovascular Coalition – Neurovascular issues*
- *ACGME Endovascular Surgical Neuroradiology Fellowship*
- *Meeting programming*
- *Standards*

Ischemic stroke

Performance and training standards for endovascular ischemic stroke treatment

Writing Group for the American Academy of Neurology, AANS/CNS Cerebrovascular Section, Society of NeuroInterventional Surgery, and the Society of Vascular & Interventional Neurology, P M Meyers,¹ H C Schumacher,² M J Alexander,³ C P Derdeyn,⁴ A J Furlan,⁵ R T Higashida,⁶ C J Moran,⁴ R W Tarr,⁷ D V Heck,⁸ J A Hirsch,⁹ M E Jensen,¹⁰ I Linfante,¹¹ C G McDougall,¹² G M Nesbit,¹³ P A Rasmussen,¹⁴ T A Tomsick,¹⁵ L R Wechsler,¹⁶ J R Wilson,¹⁷ O O Zaidat¹⁸

¹New York Presbyterian Hospital, Columbia University, College of Physicians & Surgeons, Neurological Institute, New York, New York, USA
²Albert Einstein College of Medicine, New York, New York, USA
³Cedar Sinai Medical Center, Los Angeles, California, USA
⁴Washington University,

ABSTRACT

Stroke is the third leading cause of death in the USA, Canada, Europe, and Japan. According to the American Heart Association and the American Stroke Association, there are now 750 000 new strokes that occur each year, resulting in 200 000 deaths, or 1 of every 16 deaths, per year in the USA alone. Endovascular therapy for patients with acute ischemic stroke is an area of intense inves-

At present, the only therapy demonstrated to improve clinical outcomes from acute ischemic stroke is thrombolysis of the clot responsible for the ischemic event.⁵ Specifically, the only Food and Drug Administration (FDA)-approved stroke therapy is intravenous tissue plasminogen activator within 3 h of stroke onset.⁵ Endovascular therapy for patients with acute ischemic stroke is an area of intense in-



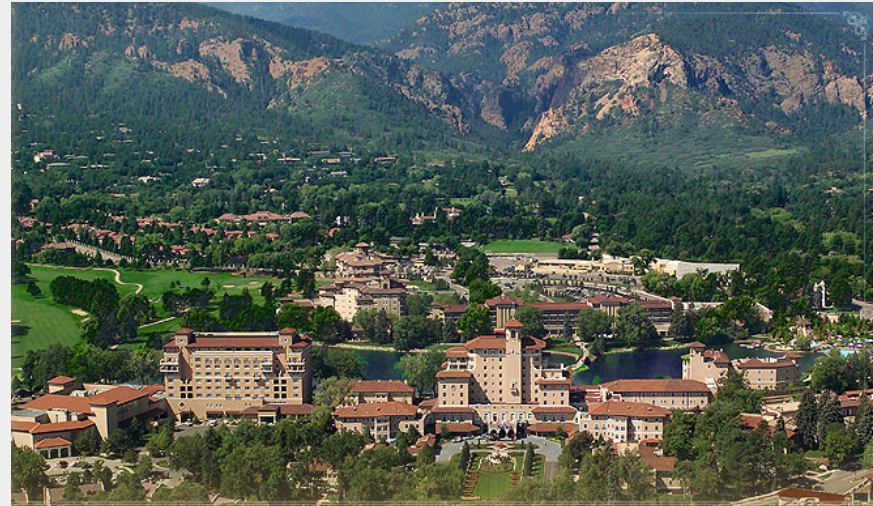
Standards

- Currently writing/revising standards pertaining to the management of spinal AVMs, tumor embolization, and intracranial atherosclerotic disease

Meetings

*SNIS Annual Meeting
Colorado Springs, CO
630 attendees*

*Fellows course
45 attendees*



*Stroke Practicum at ASNR
Boston, MA
250 attendees*



Meetings

- Currently in discussions with CV Section over joint meeting around ISC Honolulu in 2013

Publications - Journal Update

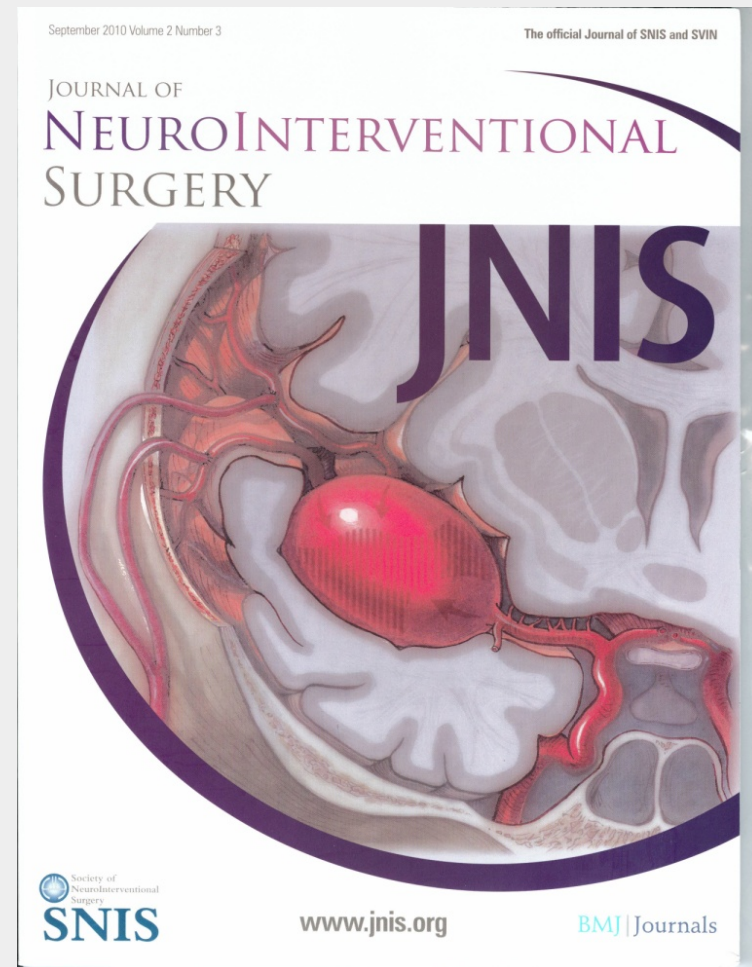
Initial publication July 2009 as a quarterly journal

Indexed in Thomson-Reuters 2010

Initial impact factor 1.07

*Pub Med / Medline indexing
September 2011*

*With increased U.S. and
International submissions will
transition to bi-monthly
publication in January 2012*





Societal Converging Goals

- *Quality outcomes data*
- *Pay for performance evaluation and issues*
- *Medicare reductions in payment*
- *Standards of practice – stroke, carotids, aneurysms*
- *Defining the appropriate randomized trials*
- *Coding – angiography bundling*
- *“Comprehensive Stroke Center” designation*
- *Coordination of meetings / content*
 - *annual meetings, fellows courses*
- *Refining standards of training in Endovascular*
- *Generating resident interest in Neurovascular*



Other SNIS Efforts

- Developing a Fellows Committee within SNIS Executive Committee to address vital needs such as getting jobs out of training and developing future leadership of the SNIS and JNIS
- SNIS will be represented at upcoming FDA hearing on the future of the Gateway/Wingspan HDE



SNIS Update Summary

Healthy membership growth of this multi-discipline society

*Successful annual meetings and more involvement with CV
Section*

*Indexing of JNIS journal in Pub Med, and transition to bi-
monthly publication*



Brain Attack Coalition

Dr. Sander Connolly



Membership Update

Dr Gregory J. Zipfel



Membership Update

Gregory J. Zipfel, MD

CV Section Membership Update

Current Members

Active	360
International	67
Adjunct Associate	<u>42</u>
	469

Senior	98
Resident	1,119

Applications for vote

Active	13
International	0
Adjunct Associate	0

Members Lost

Suspended	1
Resigned	2
Deceased	<u>0</u>
	3



Initiatives to broaden membership

- E-blast to graduates requesting active membership
 - Sent September 12, 2011
- E-blast to complementary societies
 - NASBS E-blast – To be sent in October 2011
 - SNIS E-blast – To be sent in October 2011
- E-blast to CV Section Members to identify potential new members
 - Sent September 12, 2011

- These e-blasts will continue on annual basis



Issues to consider

- Many applications from non-neurosurgeons are “in progress” due to lack of sponsors
 - Should we respond to these potential members with a short list of willing sponsors with email addresses?
- Completed membership applications currently require approval by EC, which delays active membership by several months at times
 - Should we remove the EC approval from our process?



Membership Applications for Vote

<u>Applicant</u>	<u>Institution / Location</u>	<u>Category</u>
Pascal Jabbour	Thomas Jefferson	Active
Brian Jankowitz	University of Pittsburgh	Active
Alexander Coon	Johns Hopkins	Active
Chris Eddleman	UT Southwestern	Active
Gregory Fauthereee	Baton Rouge, LA	Active
Deanna Sasaki-Adams	SLU	Active
Albert Kim	Washington U / St. Louis	Active
Greg Velat	U of Florida	Active
Lucino Castillo		Active
Anil Nair	Albany Medical Center	Active
Kenneth Snyder	U of Buffalo	Active
Koji Ebersole	U of Miami	Active
Hosam Al-Jehani	Verdun, Quebec	Active

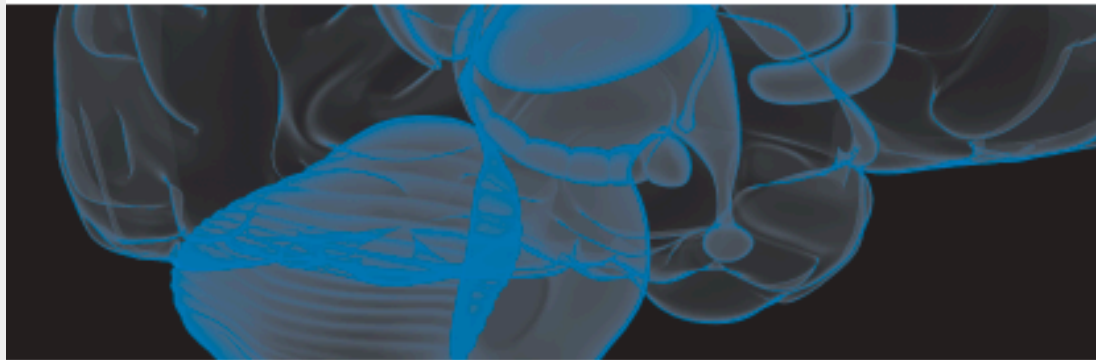
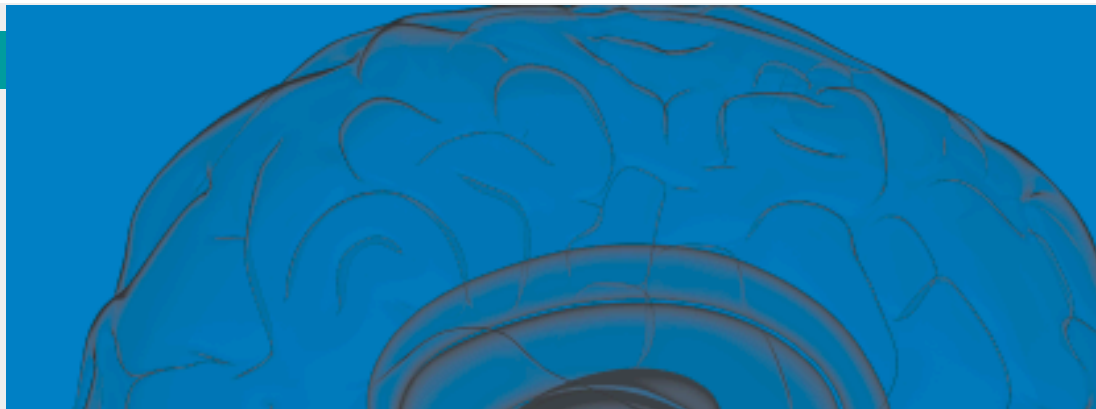


Fundraising Committee

Dr Brian Hoh

Dr Peter Rasmussen

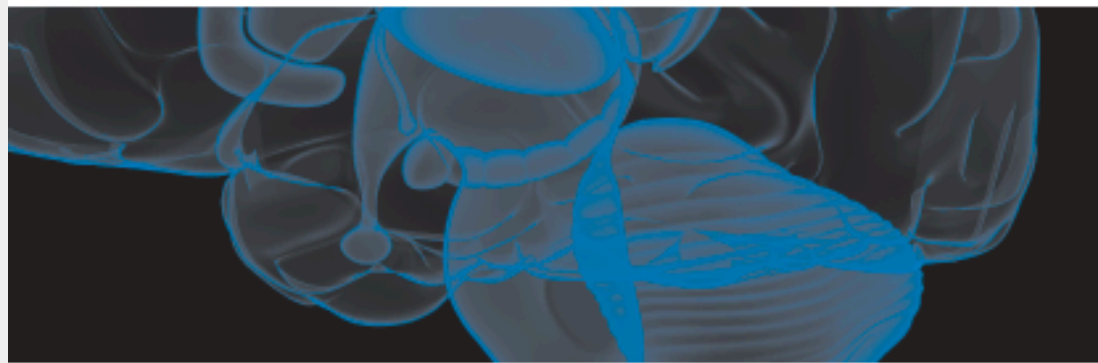
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- - **Action item: Send Prospectus out to CV Section Membership to initiate additional funding through personal relationships.**



AANS/CNS
CEREBROVASCULAR
SECTION
CORPORATE SUPPORT PROSPECTUS

Jointly sponsored by the AANS





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Research Fellowship Committee

Dr. Robert J. Dempsey

Dr. Peter Rasmussen



CV Research Award Update

Two \$15K Resident Research Awards for 2011:

- Dr Narlin Beaty, Maryland University: “ Involvement of myeloid relate protein 8/14 in aneurysmal subarchnoid hemorrhage”
- Dr Bartley Mitchell, Baylor College of Medicine: “Endovascular delivery of small-interfering RNA and molecular therapeutic strategies in CNS disorders”

Awards to be acknowledged at the 2012 AANS/CNS CV Section Meeting.

Renamed the “Robert J Dempsey MD Cerebrovascular Research Award” by the CV Section Exec Council

Cerebrovascular Research Award Update – 2011

As Chair of the Cerebrovascular Research Award, I am pleased to report the Cerebrovascular Section of the American Association of Neurological Surgeons and The Congress of Neurological Surgeons once again awarded two \$15,000 Resident Research Awards in Cerebrovascular Disease in 2011. Judged to be winners of this award for 2011 are:

Dr. Narlin Beaty from Maryland University for his study, “Involvement of Myeloid Related Protein 8/14 in Aneurysmal Subarachnoid Hemorrhage”, and Dr. Bartley Mitchell from Baylor College of Medicine for his study, “Endovascular Delivery of Small-Interfering RNA and Molecular Therapeutic Strategies in CNS Disorders”. Winners of this award will be acknowledged at the 2012 AANS/CNS Cerebrovascular Section Meeting.

At the last Joint Section Meeting, the Joint Section very kindly named the Cerebrovascular Research Award, “Robert J. Dempsey, MD, Cerebrovascular Research Award”, which is quite an honor. The Joint Section took on the responsibility of fundraising to establish ongoing funding. It will be important that ideas be considered regarding this assuring future funding. The reviewers for the past year were: Drs. Robert Dempsey, Robert Friedlander, Dandan Sun, and G. Edward Vates. We appreciate their help and hope they will be able to continue in the future. It may be appropriate for us to coordinate another basic scientist in the near future.

Assuming the funding will again be successful, information and applications for the 2012 award will be sent to program directors, neurosurgery journals, and appropriate websites in October and November, with applications due by March 1, 2012. We look forward to another year promoting resident research.

Sincerely,

Robert J. Dempsey, MD
Chairman and Manucher J. Javid
Professor of Neurological Surgery
Department of Neurological Surgery

RJD:lvb



Newsletter Committee

Dr. David

Dr. Bulsara

- 
- **Action Item: Check on e-blast distribution list.**

Website Committee

Dr. Gregory Zipfel

Dr. Bob Carter

Update

- Continuing with updates to existing website
- New website design in progress
 - RFP sent in Fall 2011
 - 4 Proposals ultimately received and reviewed
 - 2 Finalists
 - Formal interview at WashU
 - Proposals critiqued by WashU Director of Marketing
 - References contacted
 - Website committee recommendation = Vividsites

	VividSites	Comments
Development Cost	\$39,400	Negotiated 10% discount (\$35,460)
Modifications Cost	\$80-100/hr	Well within standard
Hosting Cost	\$55 per month	Well within standard
Timeline	12-16 weeks	Dependent on our ability to provide content
Content Management System	VS-CMS (proprietary) 3 hr of training provided / no personnel limit	Could ask for 3 rd party CMS (easier to switch to different web design company in future)
Mobile functionality	Not specified	Will be added at no extra cost
Past Work	<ul style="list-style-type: none"> • In business since 1989 • Visually very appealing • Significant healthcare experience (Ortho, OB-GYN) 	<ul style="list-style-type: none"> • Proven track record • Highly recommended by Ortho and OB-GYN at WashU



Review of previously raised issues

■ Development cost – HIGH!!

- Reduce scope of RFP in attempt to reduce cost

 - Not very feasible

- Approach other vendors hoping for lower estimate

 - Very similar costs (all in the high \$30K's)

- Approach industry to assist with cost

 - Provide Corporate Partners page with listing of companies that provided support – should we proceed?

■ Hosting costs – LOW

 - Manageable by section



Next steps

- Pursue formal contract with Vividsites if approved by CV section EC



Curriculum Development & Education Committee

Dr. Bernard Bendok



CONGRESS OF NEUROLOGICAL SURGEONS
UNIVERSITY OF NEUROSURGERY
VASCULAR WEBINAR SERIES

**Thursday, April 28, 2011,
7:00 – 8:00 PM EST**

Evolving Approaches To ICH

Moderators:

E. Sander Connolly, Jr., Brian L. Hoh

Speakers:

Issam A. Awad, Daniel F. Hanley

Objectives:

- 1-Review the epidemiology, pathophysiology and natural history of intracerebral hemorrhage.
- 2- Review minimally invasive options for ICH.
- 3- Update on clinical trials results

**Thursday, May 12, 2011,
7:00 – 8:00 PM EST**

Carotid Disease

Moderators:

Andrew J. Ringer, John A. Wilson

Speakers:

Jose Biller, Robert E. Harbaugh,
L. Nelson Hopkins, III

Objectives:

- 1- Review the role of atherosclerosis in stroke.
- 2- Review treatment options and decision making for carotid stenosis
- 3- Review recent data comparing carotid endarterectomy and carotid stenting.

**Thursday, June 09, 2011,
7:00 – 8:00 PM EST**

Moyamoya Disease

Moderators:

Christopher S. Ogilvy, Gregory J. Zipfel

Speakers:

Colin Derdeyn, R. Michael Scott, Gary K.
Steinberg

Objectives:

- 1- Review the pathophysiology, epidemiology, and natural history of pediatric and adult Moyamoya disease.
- 2- Review the clinical evaluation and imaging findings of Moyamoya disease.
- 3- Understand modern surgical options for Moyamoya disease.

<http://w3.cns.org/university/webinar/index2.asp#vascular>



Bylaws/Rules & Regulations Committee

Dr. Charles Prestigiacomo

- 
- **Action item: 2 new proposals approved at the CNS meeting Executive Council Meeting.**


Nominating Committee

Dr. John Wilson

Dr. Murat Gunel

The image features a modern, abstract background. On the left side, there is a vertical stack of overlapping teal squares of varying shades, creating a stepped effect. The rest of the background is a light grey gradient. A solid teal horizontal bar spans across the middle of the image, containing the text "Old Business" in a dark, sans-serif font.

Old Business



Junior Resident / Fellow
Endovascular Course

Dr Mocco

CV Section “Hands On” Resident Course



Directors:

J Mocco

Bernard Bendok



CV Section “Hands On” Resident Course

Goal:

Generate interest in Endovascular among Neurosurgery residents

- Target junior residents who may or may not be interested
- Provide Hands-On exposure through simulators/flow models
- Foster Mentorship opportunities for residents with
Endo Faculty
- Provide “Gateway” to the CV Meeting to potentially increase attendance

CV Section “Hands On” Resident Course

Brief Rundown:

45 residents attended

27 fellows attended

28 faculty

45 Hands-On Stations

13 Simulators

Current dollar estimate:

\$123,500 from industry

\$96,451 operating costs





Neuropoint Alliance

Dr Kevin Cockroft

3C meeting

Dr Elad Levy

Dr Adnan Siddiqui

"Mistakes are the portals of discovery."
– James Joyce



FOURTH ANNUAL
**CEREBROVASCULAR
COMPLICATIONS
CONFERENCE**

JUNE 23-26, 2011

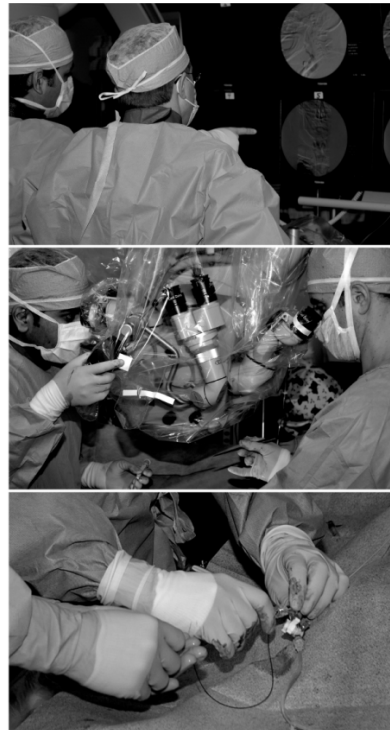
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Visit our website for conference details and online registration.

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THIS CONFERENCE IS DESIGNED FOR

- NEUROSURGEONS
- INTERVENTIONAL NEURORADIOLOGISTS
- NEUROLOGISTS
- SCIENTISTS
- ALL PRACTITIONERS INVOLVED IN INTERVENTIONAL PROCEDURES





Joint Meeting – Cerebrovascular Society of India

Dr Saleem Abdulrauf



Cerebrovascular Society of India Combined meeting

- CV Surgery Society of India – Mumbai
- Sept 22-23, 2012.



Brain Aneurysm Foundation

Dr Carlos David



BAF Update

- September established by the U.S. Senate as National Brain Aneurysm Awareness Month.
- First lobbying initiative with a day on Capitol Hill in May 8-9, 2012
- Developing a medical educational lecture to be delivered via PRI-MED conferences targeting primary care professionals and nurses. The lecture will be CME accredited. Boston, MA on Nov 15-18 2012
- Awarded 8 grants this year totaling \$160,000.
- Finished the year at \$800K+
- Research grant symposium will be in St. Louis on September 20, 2012
- Moving forward with a BAF non-charitable status in Canada




New Business



COSS Trial

Dr. Hanjani)



EC-IC Bypass for Stroke – is this the end of the line or a bump in the road?

Sepideh Amin-Hanjani, Fred G. Barker II, Fady T. Charbel, E. Sander Connolly Jr,
Jacques J. Morcos, B. Gregory Thompson

On behalf of the Cerebrovascular Section of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS)

The results of the recently published Carotid Occlusion Surgery Study (COSS) trial¹ have already been touted by some as the final death knell for bypass surgery in ischemic cerebrovascular disease². As with all influential clinical trials, however, it is important to scratch beneath the surface, in order to examine the design and execution of the study carefully before trying to decide what the results of the trial should mean for every day clinical practice.

COSS – the background

The historical context of the COSS trial dates back to the negative results of the much discussed EC-IC bypass trial published in 1985³. That study failed to show a benefit for superficial temporal artery (STA) – middle cerebral artery (MCA) bypass in over a thousand patients with symptomatic internal carotid or middle cerebral atherosclerotic disease not amenable to carotid endarterectomy; most were patients with carotid occlusion. The study was hotly debated, and criticized for several reasons⁴⁻⁶ including the large number of subjects operated on outside the study, raising concerns of selection bias. Another frequently cited concern was the lack of hemodynamic selection criteria. Over the next two decades, a number of studies emerged focused on evaluating the importance of hemodynamic impairment in stroke risk. The most relevant in terms of the subsequent COSS study, was the prospective blinded observational St Louis Carotid Occlusion Study (STLCOS) which utilized quantitative positron emission tomographic (PET) imaging to identify misery perfusion, defined as increased oxygen extraction fraction (OEF)⁷. Eighty one symptomatic patients with symptomatic carotid occlusion were enrolled and those with misery perfusion (n= 39) were found to have a significantly higher risk of ipsilateral stroke, 26.5 % vs. 5.3% at 2 years. Post-hoc retrospective subgroup analysis of the STLCOS data was then used to identify a higher risk subset for inclusion into a trial, and further post-hoc analysis was used to identify a ‘more specific’ OEF threshold, to define a very high risk cohort for COSS^{8,9}.

COSS – the results

COSS was undeniably a gargantuan effort led by a team of dedicated investigators who had examined their own existing preliminary data from the STLCOS closely. The study recruited patients in a 2 step process; potential participants with TIA or ischemic stroke in the hemispheric territory of an occluded carotid artery within the preceding 120 days were eligible to undergo PET at COSS-approved sites. Patients with ipsilateral-to-contralateral hemispheric ratios of mean regional OEF >0.13 were randomized to either medical management or surgical intervention with STA-MCA bypass. The primary outcome was defined as all stroke and death within 30 days after surgery and ipsilateral ischemic stroke within 2 years. Based on STLCOS, and the surgical cohort of the EC-IC bypass trial, the investigators had projected primary outcome rates of 40% for the medical group and 24% in the surgical group, with a sample size estimate of 372 patients. The study was prematurely halted after enrollment of 195 randomized patients based on an interim futility analysis. The main results from the analysis of randomized patients were as follows:

1. The 2 year primary outcome rates were not significantly different at 21% in the surgical group and 22.7% in the medical group
2. The 30 day (peri-operative) event rate in the surgical group was 15%
3. Mean OEF ratio in the surgical group improved from baseline at time of 30-60 day follow-up PET; repeat PET imaging was not performed in the medical group.

Although the primary analysis of COSS was by intent-to-treat, most patients received the treatment to which they were randomized and there was little cross-over. Other strengths of the study were the remarkably good follow-up rates (99%), blinded adjudication of endpoints, and standardized follow-up. Nonetheless several aspects of the study warrant further discussion.

The medical group – unexpectedly low stroke rate

Although the overall stroke rate in the surgical group was not significantly different than initially estimated (the relatively high peri-operative morbidity was counteracted by the low 6% stroke rate thereafter), the medically treated group had a substantially lower risk of stroke than originally hypothesized, 22.7% vs 40%. Much focus has been placed on the notion that improvements in medical therapy, particularly statins, are responsible for this difference in projected stroke rates¹. It is undeniable that improvements in medical management are leading to reduction in stroke incidence compared to historical controls; in the recent SAMMPRIS trial, for example, an aggressive medical management strategy, including LDL target below 70 mg/dl, as well as vigilant targeting of blood pressure, diabetes, smoking, excessive weight and inactivity, resulted in substantially lower stroke rates in patients with intracranial stenosis¹⁰. However these measures were far beyond the standard therapies employed in the COSS trial, and the attribution of a 17% absolute risk difference and almost 50% relative risk reduction to standard measures, such as higher utilization of statins, seems to credit medical therapies with a benefit larger than previously demonstrated. In the large scale SPARCL study, for example, statins showed a clear benefit, but only an absolute risk reduction of about 5% and relative risk reduction in the range of 25% for large vessel disease¹¹.

It is, therefore, worth examining other potential reasons for the lower observed stroke rate in the medical group, reasons which may indicate that the COSS criteria for identifying the very high risk patients failed to do so.

1. Firstly, concerns have been raised about the specific PET methodology employed for patient selection in the trial¹². Understanding these concerns requires some discussion of the nuances of PET imaging. The original STLCOS study defined high OEF based on the ratio of left-right hemispheric quantitative OEF values outside the normal range; this methodology differed from the absolute (as opposed to ratio) threshold utilized in some other studies^{13,14}. Regardless, the quantitative technique requires repeated arterial sampling during scanning. Subsequent post-hoc analysis of the STLCOS data was performed to demonstrate


that a simpler, but semi-quantitative, count-based ratio technique for OEF determination showed similar results in terms of predictive value¹⁵. Further post-hoc analysis was then used to identify a new threshold for OEF using this modified technique⁸. Thereafter COSS also made concessions to expand recruitment, such as allowing patients with contralateral carotid stenosis to be eligible (which could impact hemispheric ratios). Subsequent examination by others of the PET methodology and threshold used in COSS suggests that the hemispheric ratio count-based method of COSS identifies a different set of patients as flow compromised compared to those identified by quantitative PET, the previous gold standard¹². The implication would be that the COSS PET criteria failed, ultimately, to identify the truly hemodynamically high risk cohort.

2. Secondly, COSS relied on retrospective subgroup analysis of the STLCOS cohort, using features of clinical presentation, to help define the clinical criteria for selecting a high risk-group^{8,9}. However, there are intrinsic weaknesses concerning the use of retrospective post hoc analysis to evaluate prognostic factors¹⁶. Defining optimal cutpoints for risk stratification in this manner is known to predispose to overestimation of the true difference in event rates between groups^{17,18}.

Taking these concerns in aggregate, the efforts to select the highest risk group for inclusion in COSS may have failed due to reliance on posthoc analysis, and the specific thresholds used to define impaired hemodynamics.

Peri-operative morbidity – is this the best we can do?


As with many interventional trials, COSS included a certification process for the surgeons. Operator experience is well recognized as an important element in studies examining new techniques or technologies, as evidenced by fairly rigorous certification processes mandated by recent trials such as CREST and SAMMPRIS^{10, 19}; although STA-MCA bypass has been described and performed since the 1960s, the volume of the procedure dropped precipitously following the publication of the EC-IC bypass trial and the subsequent CMS (Center for Medicare and Medicaid Services) decision to withdraw reimbursement for the procedure. At first glance, it may appear that COSS took measures to ensure that experienced operators were engaged in the study. However, closer examination reveals that this process included such options as a 2 day training course, or allowing surgeons with less than 10 prior case experience to perform the case under supervision. Presumably these concessions were driven by the desire to expand the number of centers and enhance recruitment, but raise some concerns regarding surgeon experience. Although the investigators point out that the perioperative stroke rate was not found to be correlated with the certification method, the sample size of 93 patients, operated by 30 different surgeons, is likely too small to detect differences. The volume-outcome effect in many facets of cerebrovascular surgery, including bypass surgery, has been well illustrated based on larger regional and national databases²⁰⁻²³. An analysis of 558 EC-IC bypass admissions from the Nationwide Inpatient Sample (NIS) hospital discharge database found a clear association between volume and improved discharge outcome, with an OR of 0.45 for a 10-fold increase in caseload²⁰.



Although the high patency rates in the COSS trial may be considered an indicator of overall technical success and operator experience, the volume-outcome association in the NIS study was actually most evident when considering hospital volume, rather than individual surgeon caseload; this emphasizes the potential influence of hospital related factors such as specialized neuroanesthesia, dedicated neuro-intensive care units, and specialized nursing in the outcome of the patients, beyond only the technical aspect of the surgery. Although the observed 15% postoperative event rate is within the range anticipated from the original EC-IC bypass trial, with improvements in anesthetic technique, critical care, and overall peri-operative management, most surgeons would have expected some improvement in peri-operative morbidity compared to 25 years ago. Recognizing the tendency for publication bias, published reports from experienced centers would still suggest that a 15% perioperative stroke rate in patients with occlusive disease, even hemodynamically brittle patients with potentially higher surgical risks of surgery, is not the best that can be achieved²⁴⁻²⁷. Ultimately, for a similarly sized trial with identical post 30 day stroke rates to demonstrate benefit would require peri-operative stroke risk to be less than half of what was actually achieved in COSS.

Crossing curves- did we wait long enough?

COSS does provide us with the insight that, after the peri-operative period, bypass patients appeared to experience a clear reduction in subsequent event rate. This is in line with the interim results of the Japanese EC-IC bypass Trial (JET), which indicate similar reduction in stroke rates post bypass. In that study, an apparent zero percent stroke rate in the peri-operative period leads to a conclusion in favor of bypass^{28, 29}, although the final results have not been subjected to peer review and publication. COSS has also demonstrated well the concept of improved hemodynamics post bypass with follow-up PET studies in the operated patients. These data affirm the conceptual basis of revascularization with EC-IC bypass, and suggest that if perioperative stroke rates could be curbed, benefit is likely. Even with the existing event rates, is it possible that a sustained effect of bypass beyond the 2 year endpoint would ultimately outweigh the immediate perioperative down-side? Although the Kaplan Meier curves at 2 years are not significantly different, a continuation of the curves could result in a crossover benefiting surgery. In fact, if all patients enrolled completed additional follow-up, the study would have adequate power to demonstrate a significant benefit of surgery by 5 years. This projection presumes an ongoing steady stroke rate in both groups beyond 2 years, an assumption which, admittedly, may not be entirely justifiable. Spontaneous improvement in hemodynamics without surgery, presumably due to development of collaterals, has been reported in small scale observational studies; however, discrepant results have emerged from different reports as to whether continued improvement occurs with longer follow-up³⁰, or changes occur only in the first few months of observation³¹ and would not affect longer term stroke risk thereafter. Unfortunately, follow-up PET imaging was not performed for the medical group in COSS, and longer term follow-up is not currently available to elucidate the apparent eventuality of 'crossing curves' in the outcome analysis.



It should also be noted that the study was halted due to futility analysis, based on the improbability of demonstrating the effect size that had originally be hypothesized (24% surgical vs 40% medical at 2 years); however, a risk difference of 10% in favor of surgery was still viable, but would have required a substantial increase in sample size to 986 patients; this was not felt to be feasible, due to the cost and resources required to expand the study. The practicalities of performing such large scale studies notwithstanding, a 10% absolute reduction in stroke risk would still be a clinically important and meaningful outcome which was not addressed by the trial.

What about the 'hot' patient?

Recurrently symptomatic patients, especially those with severe clinically hemodynamic disease who become ischemic with postural or blood pressure variations, represent a potentially important subgroup that is not well addressed by COSS. The study allowed enrollment up to 120 days after most recent event, and by design, required patients to be clinically stable enough to be sent for PET scan (sometimes even requiring air travel to a PET center) to determine final eligibility. Prior studies of cerebrovascular atherosclerotic disease have repeatedly demonstrated that the highest risk for recurrent events tends to be in the early period after initial symptoms³²⁻³⁴, generally within a 2 week timeframe, and declining thereafter. Given that the mean time from symptoms to enrollment in COSS was about 72 days, the enrollees were potentially pre-selected to be the inherently more stable patients. The fact that no strokes occurred in the median 6 day period from randomization until surgery further suggests that these patients were not in their most acute period of risk. Additionally, COSS only required patients to have suffered a single ischemic event in order to be eligible for the trial. Critics of this approach may argue that a single incident event at the time of carotid occlusion is likely to represent a single embolic event unlikely to recur under medical therapy; on the other hand, the approach in COSS may seem reasonable as final eligibility was ultimately determined by hemodynamic criteria. Nonetheless, it also seems feasible that some proportion of such presumed hemodynamic patients would plateau quickly in their stroke curves as collaterals develop, whereas others would remain high risk, and would declare themselves with recurrent ischemic events as failures of medical therapy. Information regarding the ischemic history of enrolled patients are not currently published, but it seems that recurrently ischemic patients with hemodynamic impairment may not be well represented in COSS, and may still be the ones to target for revascularization.

Is stroke the only endpoint that matters?


Even as COSS has halted, the ancillary study, Randomized Evaluation of Carotid Occlusion and Neurocognition (RECON) continues to follow patients for cognitive outcomes. With small numbers, the study is likely not powered to definitively address the impact of revascularization on cognitive function, but may still provide further data to support the notion that increased cerebral blood flow has direct clinical benefits aside from reducing stroke risk. Improvement in cognitive function after bypass, and even after carotid endarterectomy in flow-impaired patients, have been reported³⁵⁻³⁸. Furthermore preliminary study in patients with fixed neurological deficits has shown electrophysiological and clinical evidence of improvement post bypass³⁹, and the intriguing potential of increased brain volume after bypass for ischemic states has been documented in small studies^{40, 41}.

The bottom line

Despite the efforts of the COSS investigators, the trial was ultimately underpowered to detect a benefit of surgery, primarily due to the overestimation of expected event rate in


the selected population. The PET methodology utilized was less rigorous than previously used, and the posthoc 'optimal' selection criteria may have contributed to a failure in identifying the true high risk group. Ultimately, in the years since the negative 1985 EC-IC bypass trial, surgical revascularization for carotid occlusion has become increasingly restricted to a small, very select population of patients who experience refractory symptoms despite maximal medical therapy^{26, 42}. Although COSS has been unable to provide any evidence that we should expand those indications, at the same time, we still have reason to believe that a select population may in fact benefit in long-term stroke risk from the surgery at specialized centers which can offer the procedure with sufficiently low peri-operative morbidity. Looking beyond stroke risk reduction, cognitive or functional benefits are also an area of future investigation which should not be ignored. Careful selection and limited application with an eye to future developments, rather than complete abandonment, is warranted.


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MedCAC Voting on Carotid Atherosclerosis

Dr. John Wilson



NINDS Update


Dr. Robert Friedlander

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- **Action item: Dr Friedlander to provide a list of the current programs**




Senior Society Matrix/ Milestones and Modules

Dr. Sander Connolly



Massimo Collice award for cerebrovascular malformations

Dr. Giovanni Broggi



The Massimo Collice Foundation for Neuroscience announces an annual international prize of 10,000 euros for experimental or clinical research on Cerebral vascular malformations.

This is an award sponsored by his widow, and is aimed at the best published paper in the preceding year by a first author less than 40 years of age.

Bob Spetzler will run the selection committee along with a number of others

The prize is intended to deepen training of the applicant in any specialized neurosurgical area, and will be delivered at the 2012 Annual meeting of the AANS during the Cerebrovascular Section.

Participants younger than 40 years old on December 31, 2011 are eligible to apply and should be the lead author of the work.

The study must have been published in a peer-reviewed journal in 2011 and may not have already received another award.

The deadline for submission is January 31, 2012. www.massimocolliceonlus.com



Meri Institute/CV Sect Resident & Fellows Courses

Dr Adam Arthur

Dr Erol Veznedaroglu

Dr. J Mocco

Dr. Brian Ho



SVIN Liaison

Dr. J Mocco

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- **Action item: Bylaws change to have reciprocal representation with the SVIN.**

The background features a teal and grey color scheme. On the left side, there is a vertical strip of teal with a grid of squares in various shades of teal and grey. The rest of the background is a solid light grey.

Thank you!