Influence of Thrombus Composition on Thrombectomy: ADAPT vs. Balloon Guide Catheter and Stent Retriever in a Flow Model

Einfluss der Thrombus-Zusammensetzung auf die Thrombekтомie: ADAPT gegen Balloon-Guide-Catheter und Stent-Retriever in einem Flussmodell

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ZUSAMMENFASSUNG


Schlussfolgerung Diese experimentelle Studie zeigt, dass die Effektivität der Thrombektomie-Technik von der Thrombus-Komposition abhängen könnte. Die Identifizierung der richtigen Technik für einen bestimmten Thrombus könnte die Rekanalisationsergebnisse optimieren. Im klinischen Kontext könnte die Morphologie des Thrombus in der dünnschichtigen nativen CT einen Marker für die Auswahl der Technik darstellen.

Kernaussagen:
- Die Effektivität der Thrombektomie-Technik scheint von der Thrombus-Komposition abzuhängen.
- Die alleinige Aspiration scheint effektiver für rote Thromben zu sein.
- Stent-Retriever und Ballon-Führungskatheter scheinen effektiver für weiße Thromben zu sein.
**Purpose**

In ischemic stroke caused by large-vessel occlusion, mechanical thrombectomy with stent retrievers (SR) is the standard therapy, in addition to systemic lysis [1–5]. The different SRs seem to perform equally well [6–9]. Additional aspiration is thought to improve the effectiveness of thrombectomy [6, 9, 10]. Aspiration can be performed distally using an intermediate catheter or proximally using a balloon guide catheter (BGC). Moreover, new intermediate catheters (i.e., SOFIA [Microvention, USA], ACE [Penumbra, USA]) have shown promising results in a direct aspiration, first-pass technique (ADAPT) [11, 12]. The ASTER trial showed that ADAPT was not superior to stent thrombectomy. The clinical results did not show any significant differences [13].

Experimental studies on ADAPT and BGC under standardized conditions with a transparent flow model may help to provide more objective results, while a special focus should be placed on the influence of the clot composition and the interaction between the vessel and the devices during each thrombectomy maneuver.

**Materials and Methods**

**Thrombus models**

Two different clot models were used for the experimental studies [14–16]:

1. An erythrocyte-rich (red) clot: fresh human blood was put in a Chandler loop system to create a thrombus under dynamic conditions. The clots were cut into pieces 10 × 3.5 mm in size.
2. A fibrin-rich (white) clot: citrated human blood was stored standing for 24 h. The plasma, the Buffy coat, and a few erythrocytes were aspirated. The sample was recalcified and incubated for a further 72 h. The clots were cut into pieces 10 × 3.5 mm in size.

**Flow model**

The experiments were performed under standardized and physiological hemodynamic conditions. The flow model consists of a custom-made, transparent silicon phantom (Elastrat, Switzerland) of the right anterior circulation (common carotid artery, internal carotid artery, external carotid artery, middle cerebral artery, and anterior cerebral artery), which has a physiological curvature and inner diameters, including the proximal M2 and A2 segments. To decrease friction, the inside of the phantom was coated with Slippery-Liquid (Elastrat Sarl, Switzerland) before each use.
Glycerol-saline solution was used to mimic blood (60/40 by volume saline/glycerin; 37 °C). A precise, programmable piston pump (CompuFlow 1000, Shelley Medical Imaging Technologies, Canada) produced a physiological flow velocity and flow profile, which was monitored by Doppler sonography (carotid profile, velocity of 100 cm/s, pulse 60/min). Interposed resistances guaranteed physiological pressure, which was monitored invasively (middle pressure 100 mmHg). The clots were injected into the model and flowed into the M1 segment of the MCA. All thrombectomy procedures were recorded on video (Full High Definition, 60 frames per second, Panasonic HC-V250, Japan). Simultaneously, the video signal was broadcast live to a monitor simulating an angio-suite-like setup.

**Advanced Thrombectomy Techniques**

The following recanalization techniques were used:

1. **ADAPT**: An intermediate aspiration catheter (SOFIA 5F, Microvention, USA) was placed directly proximal to the occlusion site and continuous machine aspiration was performed (Penumbra Aspiration Pump, USA). If the tip was blocked by the clot, the intermediate catheter was pulled back into the long sheath (Arrow-Flex 6F, 90 cm, Teleflex, Ireland) in the ICA. While withdrawing the distal catheter, we performed an additional aspiration via the sheath using a 20-ml Luer-Lock syringe. If necessary, subsequent passes followed.

2. **An SR with proximal flow arrest and aspiration (SR+BGC)**: A SR (4 × 20 mm Trevo ProVue, Stryker, USA) was placed at the occlusion site over a microcatheter (Trevo 0.021, Stryker, USA) such that the clot was in the proximal part of the working zone. A BGC (Cello 7F, Covidien, USA) was placed in the subpetrous part of the ICA. Just before retrieving the clot, the balloon of the BGC was inflated, creating complete proximal flow arrest. Proximal machine aspiration was performed simultaneously (Penumbra Aspiration Pump, USA) when the SR was retracted into the BGC. After the SR was pulled out of the BGC, the balloon was deflated. If necessary, subsequent passes followed.

**Analysis**

The videos of the thrombectomy procedures were analyzed after the experiments. The number of passes and the occurrence of distal emboli and emboli in new territories were documented. Distal emboli and emboli in the anterior cerebral artery were counted on the videos.

**Results**

Both the red clots and the white clots were successfully produced as described above. **Fig. 1** shows two specimens of the different clots.

**Table 1** Summary of the results.

<table>
<thead>
<tr>
<th>clot model</th>
<th>technique</th>
<th>median and interquartile range number of passes</th>
<th>rate of distal emboli</th>
<th>total number of distal emboli</th>
<th>rate of embolism in new territories</th>
</tr>
</thead>
<tbody>
<tr>
<td>red (erythrocyte-rich)</td>
<td>BGC+SR</td>
<td>1 (1–1.75)</td>
<td>4/6</td>
<td>5</td>
<td>1/6</td>
</tr>
<tr>
<td></td>
<td>ADAPT</td>
<td>1.5 (1–2)</td>
<td>2/6</td>
<td>2</td>
<td>1/6</td>
</tr>
<tr>
<td>white (fibrin-rich)</td>
<td>BGC+SR</td>
<td>1 (1–1)</td>
<td>1/6</td>
<td>1</td>
<td>0/6</td>
</tr>
<tr>
<td></td>
<td>ADAPT</td>
<td>1 (1–1)</td>
<td>3/6</td>
<td>6</td>
<td>0/6</td>
</tr>
</tbody>
</table>

ADAPT = a direct aspiration, first-pass technique; BGC = balloon guide catheter; SR = stent retriever.

ADAPT = direkte Aspirationstechnik; BGC = Ballon-Führungskatheter; SR = Stent-Retriever.
Six experiments were conducted per clot model and thrombectomy technique, resulting in a total of \( n = 24 \) experiments. ▶ Table 1 shows a summary of the results.

▶ Fig. 2-4 show the interaction between the techniques and the thrombus in consecutive pictures of live videos. The size of distal emboli and emboli in new territories was max. 3 mm.

Thrombectomy in white clots

For white clots, BGC and SR showed a lower risk of distal emboli than ADAPT (BGC 1/6, \( n = 1 \); statistically not significant). Using ADAPT, white clots could not be aspirated entirely (▶ Fig. 2) because the catheter was clogged every time and had to be retracted into the sheath, pulling the clot behind. Thus, the distal part of the clots loosened, causing distal emboli (ADAPT 3/6, \( n = 6 \)). The stent-thrombus interaction in the BGC group was rather superficial. The thrombus rolled between the retriever and the vessel wall distally, eventually losing the clot shortly before entering the BGC every time. With additional flow arrest, the lost clot could be saved in the petrous ICA and finally aspirated in the BGC before the balloon was deflated.

There were no emboli in the ACA. In both groups just one pass was necessary for full recanalization.

Thrombectomy in red clots

For red clots, ADAPT produced fewer distal emboli than BGC. The aspiration catheter was able to retrieve the clot just at the occlusion site without becoming clogged in 4 of 6 cases (▶ Fig. 3). As soon as the clogged aspiration catheter had to be retracted, distal emboli developed (ADAPT 2/6, \( n = 2 \); not statistically significant).

The rolling clot phenomenon occurred with red clots as it did in white clots also when using the BGC (▶ Fig. 4). The red clot was more fragile than the white clot, which caused clot fragmentation by the stent retriever in a more distal location (already in the M1 segment or the carotid T). Due to the distal location of the fragmentation, those fragments could not be caught by aspiration via the BGC and caused distal emboli (BGC 4/6, \( n = 5 \)). In both groups emboli developed in the ACA (1/6, respectively). A maximum of two passes was necessary in both techniques, thus showing no relevant differences.

Discussion

In this in vitro study, a difference in the effectiveness of thrombectomy could be found depending on the clot composition. RBC-rich thrombi were removed more effectively by ADAPT, and fibrin-rich thrombi by SR/BGC.

Constant physiological vessel architecture, hemodynamics, and thrombus composition were considered important factors to achieve realistic results. However, the lack of endothelium, coagulation factors, and blood cells apart from the thrombus represent limitations in this study. We deliberately selected a transparent vessel and blood model to visualize the thrombectomy procedure throughout all stages. We chose to film the experiments and analyze the direct interaction between the thrombus and the given technique. Chueh et al. published a similar study in 2016 [17], but performed the experiments under fluoroscopic control. However, like in a clinical setting under fluoroscopy, what is happening mechanically during the thrombectomy maneuver is not visible. Liebeskind et al. [14] described that retrieved clots mainly consisted of fibrin and red blood cells (RBC). They categorized thrombmi as fibrin-dominant (“white”) and RBC-dominant (“red”). Nevertheless, the clots were highly heterogeneous even within those groups, with smooth transitions from one to the other. In this study, we chose representative fibrin-rich and RBC-rich clots made of human blood. Artificial additives such as barium were not used to keep the thrombus as natural as possible, in contrast to other studies [10, 17]. We are aware that not all possible clot compositions were investigated in our experimental study. However, using more extreme clot compositions, we expected to find differences in the effectiveness of the given thrombectomy techniques. Beyond that, there is a major issue concerning clot composition. The composition of acute clots in ischemic stroke remains unclear because existing histopathological analyses have mostly dealt with retrieved, processed clots. Indeed, it is only possible to approximately determine the actual composition.

Using machine aspiration, a continuous vacuum could be maintained throughout the whole procedure. Chueh et al. used a 20-ml syringe, which makes changing or emptying of the syringe necessary and a loss of vacuum possible and probable [17]. The ADAPT technique can hardly be applied without a good vacuum. In contrast, the stent retriever technique is probably more robust with respect to less effective aspiration.

A higher rate of distal emboli was considered negative in this study. The actual biological effect of those emboli cannot be simulated in a flow model. Nor is it clear how to interpret the size of distal emboli, e.g., very small emboli (< 100 µm) might be harmful because the occluded microcirculation probably has no collaterals, or harmless because they are more prone to react to medical or intrinsic lysis. Finally, it is not possible to predict whether a certain embolus will produce an infarction, which depends on the collateral flow. Nevertheless, a reduction in the number of emboli is very likely to reduce the probability of infarctions.

The results of our in vitro study are in line with other recently published clinical thrombectomy studies. Brinjikji et al. [18] suggested that BGC use during mechanical thrombectomy for acute ischemic stroke is associated with superior clinical and angiographic outcomes. Teleb [19] concluded that the use of BGC was associated with a good first-pass effect and an overall recanalization of TiCl 2b/3 of 94%. Maegerlein et al. [20] and Turk et al. [21] concluded that ADAPT is a very successful approach to revascularization and shows advantages in comparison to the SR with respect to procedure time and safety, at a similar clinical outcome. In the PROMISE study [22], the ACE68 / ACE64 catheters for aspiration thrombectomy were found to be safe and showed similar efficacy to randomized trials using other revascularization techniques.

The ASTER study [13] showed very similar results with respect to both recanalization rate and clinical outcome comparing ADAPT and SR combined with BGC. Since a randomized patient population was treated and thus an average clot was retrieved, those results do not contradict the findings in our study. Overall
Fig. 2 Direct aspiration in white clot. The 5F aspiration catheter is not capable of aspirating the whole clot. The proximal part of the clot is stuck at the tip of the aspiration catheter. The catheter has to be retracted, while the major part of the thrombus is unprotected (black arrow).

Abb. 2 Direkte Aspiration bei weißem Thrombus. Der 5F-Aspirationskatheter ist nicht in der Lage, den gesamten Thrombus einzu saugen. Der proximale Anteil des Thrombus verstopft die Spitze des Aspirationskatheters. Der Katheter muss so zurückgezogen werden, während der Großteil des Thrombus ungeschützt ist (schwarzer Pfeil).

Fig. 3 Direct aspiration in red clot. The thrombus is aspirated directly at the occlusion site, no clogging of the aspiration catheter.

Abb. 3 Direkte Aspiration bei rotem Thrombus. Der Thrombus wird direkt an der Okklusionsstelle aspiriert, kein Verstopfen des Aspirationskatheters.
both techniques performed well in the flow model and in the clinical setting.

In this study the occurrence of distal emboli using ADAPT depended strictly on whether the aspiration catheter was clogged. If the catheter was clogged, the distal part of the clot was pulled back into the guide catheter in the ICA with no protection and parts of the thrombus were more likely to be lost. In a clinical setting, the clogging can be easily recognized, checking whether there is any backflow during the aspiration, and the results (occurrence of distal emboli) could be checked by post-treatment MRI.

An important observation in the SR+BGC group was that the clot always rolled between the SR and the vessel wall. The longer the distance over which the thrombus had to be retracted, the more the clot moved towards the tip of the SR and was eventually lost in many cases. These findings were already described in two previous independent studies by Madjidyar et al. [6] and Machi et al. [23]. To prevent distal embolization and to increase the number of successful first-pass recanalizations, an advanced thrombectomy technique with proximal flow arrest or an additional aspiration seems to be crucial.

Conclusion

Although many physiological aspects were incorporated in the model, the experiments were still performed in an artificial environment. This limitation must be considered when interpreting our results. Nevertheless, this study sheds some light on the blind side of mechanical thrombectomy, especially on device-thrombus interaction. Knowing what happens between pre- and postintervention angiograms might reveal how thrombectomy could be taken to a higher level. The selection of the device and technique might depend on the thrombus composition. Thus, preinterventional clot imaging and categorization could become a key for choosing the right recanalization technique. For the moment the clot attenuation on non-enhanced CT (NECT) is promising. There is a link between the density of the clot and the histological composition [24, 25]. Since almost every patient undergoes NECT, the workflow would not be significantly affected and no delay of therapy would occur. Aspiration catheters or balloon guide catheters with larger lumina might increase the effectiveness.

Conflict of Interest

The authors declare that they have no conflict of interest.

References


