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## Abstract

**Objectives:** The aim of this study was to identify themes that determine health-related quality of life (HRQoL) in patients with carotid artery stenosis and identify the patient-reported outcome measures that best cover the identified themes.

**Methods:** A systematic review of the main six databases from inception to September 2018 was undertaken to identify primary qualitative studies reporting on the HRQoL of patients with carotid artery stenosis. Quality of studies was assessed using the CASP criteria. Findings from the included studies were analysed using Framework Analysis methodology. The identified themes were mapped against the items/domains from the patient-reported outcome measures used previously in patients with carotid artery stenosis.

**Results:** The systematic review identified four papers that fulfilled the inclusion criteria. The included papers reported the views of sixty-two patients with symptomatic carotid artery stenosis; twenty-four of the patients were awaiting assessment for intervention, twenty-six had carotid endarterectomy and twelve were turned down for intervention and received best medical therapy. The overall quality of the included studies was good based on CASP criteria. Framework Analysis identified sixteen themes that were divided into six main domains: anxiety, impact on physical activity, effect on independence, impact on personal roles, psychological impact and symptoms. The best fit generic and disease specific PROMs were the Short-Form 36 (SF-36 ©) and the Carotid Stenosis Specific Outcome Measure (CSSOM) respectively. None of the PROMs covered all the themes identified in the qualitative systematic review.

**Conclusion:** The findings from the review identified the important themes that affect patients with carotid stenosis disease. The current generic and disease specific patient-reported outcome measures do not cover all themes that impact the HRQoL of patients suffering with this disease. The proposed themes can be used to develop a new disease specific PROMs to measure HRQoL.

## Key Points

**Carotid artery disease is the main cause of stroke; some patients with this disease can benefit from surgical intervention to reduce the risk of future stroke.**

**Understanding and measuring quality of life in these patients can guide intervention decisions.**

**This systematic review provides detailed overview of the impact of this disease on quality of life**

## Introduction

Carotid artery stenosis (CAS) is a major cause of stroke, accounting for about 20% of all cases **(1-2)**. It is caused by either carotid artery lesion thrombosis or embolism this lesion.

Patients with CAS can be asymptomatic or present with transient ischaemic attack (TIA) or stroke. Evidence shows that patients who present with disabling stroke with previous evidence of CAS can benefit from preventive procedures including carotid endarterectomy (CEA) and stenting **(3-10)**; however, these procedures are not risk free and can be complicated with perioperative stroke. The symptoms and the uncertainty of outcome can impact the daily living of patients with CAS. Therefore, several clinical studies that investigated the efficacy and safety of different preventative interventions used patient-reported outcome measures (PROMs) to investigate the impact of the disease and treatment on health-related quality of life (HRQoL). However, due to a lack of validated PROMs they either used generic PROMs **(11-14)** or developed and used questionnaires without validation **(14)**.

Patients presenting with symptomatic and asymptomatic CAS need support to choose the best treatment strategy to help reduce their risk of stroke and improve their HRQoL. Patients' experience of disease and impact of treatment is a major indicator of quality and it is only through better understanding of the impact of the disease on HRQoL that PROMs can be developed. It is argued that PROMs, when designed carefully (e.g. based on input from patients' experiences), can measure the issues of most importance to patients and any

changes to their HRQoL because of the disease or as consequence of the treatment they may have received **(15)**.

The aim of this study was to systematically review the qualitative evidence to identify the impact of CAS and treatment pathway on patients' HRQoL. The identified themes were then mapped against the items and domains from the generic and disease specific PROMs we had previously identified **(16,17)**. The mapping was done to find the PROMs that captured the most important issues to patients with CAS.

## **Method**

The systematic review aimed to identify all primary qualitative research studies that investigated the impact of CAS on HRQoL. The inclusion criteria included any patients with CAS and any studies with undefined population were excluded. For further information regarding the inclusion and exclusion criteria refer to **table 1**.

This systematic review was undertaken and reported in accordance with the general principles recommended in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement. In accordance with the study protocol **(18)**, searches were conducted from inception up to April 2017 and further updated to September 2018, in the following bibliographic databases; CINAHL via EBSCO, Medline and Medline in Process via Ovid, Embase via Ovid, PsycINFO via Ovid, Social Science Citation Index/ Science Citation Index via Web of Science (Thomson Reuters) and Proquest dissertations and theses. No language or date constraints were applied.

<b>Inclusion</b>	<b>Exclusion</b>
Patients' experience of living with carotid artery stenosis and its impact on their health-related quality of life.	Studies not in English
A defined population of participants with a diagnosis of carotid artery stenosis (CAS) who need, have had or are undergoing surgical treatment. Participants undergoing treatment for stroke or transient ischaemic attack (TIA) secondary to a diagnosis of CAS.	Studies with participants under 16 years of age Patients with Stroke or TIA not related to CAD
Studies that include semi-structured interviews, descriptions, focus groups either as stand-alone studies or embedded in a quantitative study. Must include both data collection and data analysis	Quantitative studies with no primary qualitative data reported
Published or unpublished; Full-text or structured abstract with all relevant information	Full-text or structured abstract with incomplete or unclear evidence

**Table 1: Summary of the inclusion and exclusion criteria**

The search strategy combined condition terms, terms for patient views and terms for qualitative studies (which augmented a qualitative study filter) **(19)**. Further details of the search strategy are provided in **Appendix 1** (supporting information).

### **Study selection**

The search results were uploaded into Endnote X8™ (Thomson Reuters, Philadelphia, USA), two reviewers (AA, AH) independently screened the titles for inclusion and exclusion in accordance with the set criteria in the protocol. All titles were examined, and any citations that clearly did not meet the inclusion criteria (for example mixed population, quantitative PROMs data) were excluded. For included titles, abstracts were read and for the included abstracts, full-text articles were obtained.

### **Quality assessment**

The Critical Appraisal Skills Program (CASP) qualitative checklist instrument was used to examine the methodological quality of the included studies **(20)**. This was selected for its appropriateness as it is commonly used in qualitative reviews of evidence **(21)**. Two of the authors (AA, AH) independently examined the quality of each study and any inconsistencies were resolved by discussion or involving a third author (GJ).

### **Data extraction and analysis**

The data on authors, year of publication, country of study, number of participants, research aims, methods of recruitment, method of data collection, key results and analysis were extracted and tabulated for all the included studies by the first author. The included papers were uploaded into the qualitative data analysis software NVivo10 (QSR International, Doncaster, Victoria, Australia) and the primary and secondary text (patient quotes reported in

the articles and themes), were analysed. The inductive process of framework analysis was used for the qualitative evidence synthesis. In another systematic review (17); the PROMs used for this condition were examined for their validity; their conceptual domains were used to give a basis for the qualitative data synthesis (22). The first stage of the framework analysis was reading all the included papers and identifying common themes from within and across the articles. The second stage involved establishing a thematic framework by creating a list of the main themes based on the domains of validated PROMs and common themes in the identified papers. In the third stage the thematic framework was applied to all the primary and secondary data. In the final stage themes were examined for their conceptual similarities and differences. The second author (AH) checked all the themes that were identified and differences in conceptualization were discussed and adjusted involving a third senior author (GJ).

### **Triangulation of PROMs items with qualitative themes**

A triangulation of evidence was performed to examine how the items within generic and disease specific PROMs corresponded to themes from the qualitative review (23,24). The items from generic and disease specific PROMs used in patients with CAS (17) were examined in detail. The items from these instruments were mapped against the themes identified, and two researchers (AA, AH) reviewed both the themes from the qualitative review and the items/ from each PROM to evaluate whether the concepts were the same (agreement), offered similar concepts (partial agreement) or were not present (silence). The aim was to identify whether any of the instruments covered the issues that are important to patients with carotid artery disease.

## **Results**

The database searches identified 1,095 citations; after removing duplicates, 859 titles were assessed and subsequently fifteen full-text papers were reviewed in detail. Finally, only four

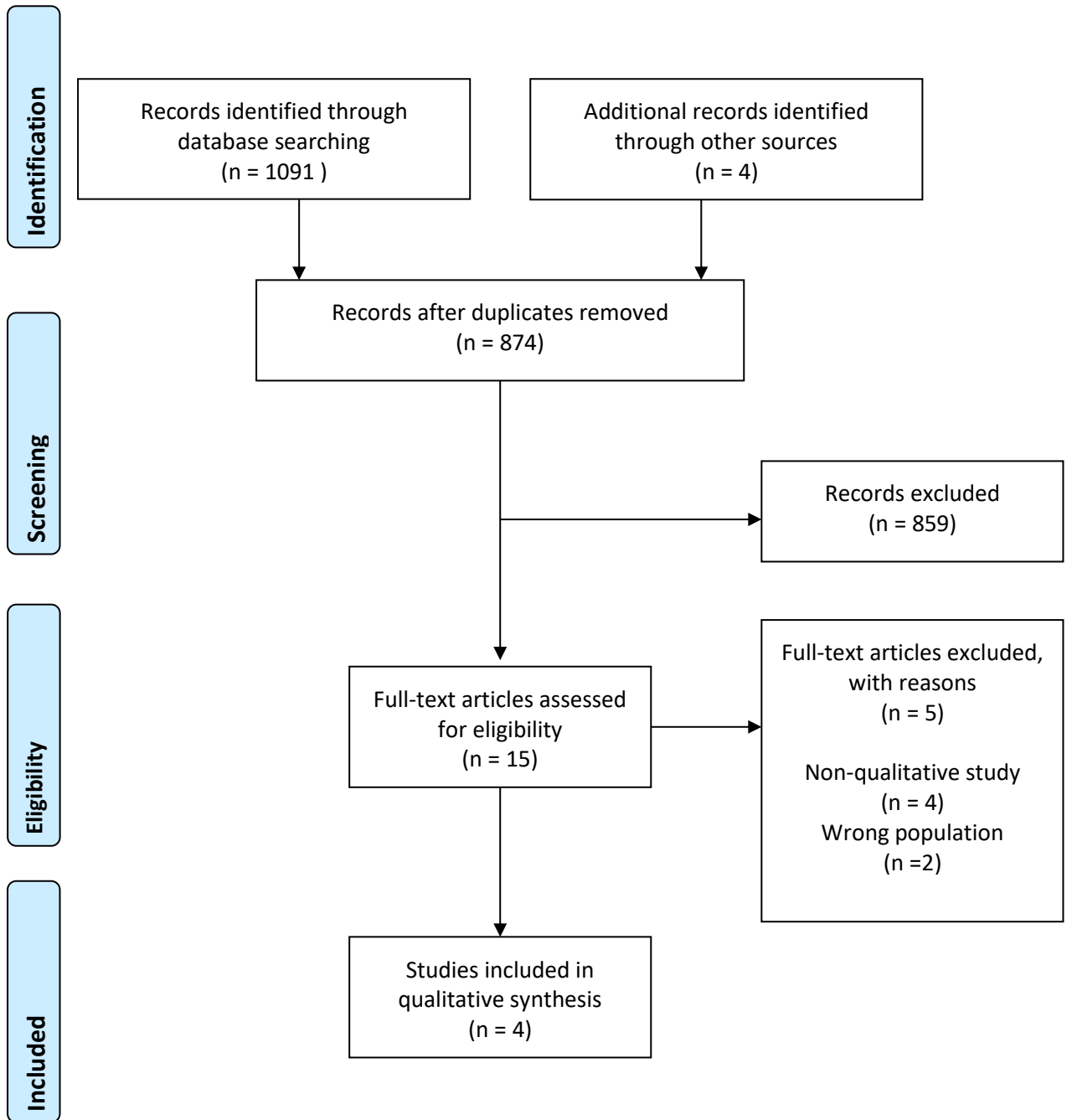


papers fulfilled the inclusion criteria and were included in the qualitative evidence synthesis (Please see PRISMA chart (Figure 1)). The studies included in the qualitative synthesis are summarized in table 2.

**Table 2. Qualitative studies exploring living with carotid artery stenosis**

Author (Year)	Country	Research Design	Method of Analysis	Age (years)	Sample	Diagnosis /Treatment	Study Aims and Objectives
Gibson (2002) <b>(25)</b>	UK	Qualitative semi-structured interviews	Grounded Theory	Age, mean 70.9 (50-79)	6 Participants Male (%): 50	Symptomatic carotid stenosis Medical management: 1 Post CEA: 5	Explore ways in which patients comprehend and live with risk of CEA or medical management only for carotid stenosis.
Halin et al. (2002) <b>(26)</b>	Sweden	Mixed methods including a qualitative component using semi-structured interviews	Thematic analysis	Age, mean 71 (56-80)	20 Participants Male (%): 60	Symptomatic carotid stenosis Medical management, no intervention: 1 Post CEA: 11 Pre-CEA or Stent: 8	Assess quality of life of patients with carotid artery stenosis
Gibson & Watkins (2012) <b>(27)</b>	UK	In-depth interviews	Grounded Theory	Age, Mean 71.6(50-80)	16 Participants Male (%): 65	Symptomatic carotid stenosis	Explore the lived experience of patients with TIA secondary of carotid stenosis
Gibson & Watkins (2013) <b>(28)</b>	UK	In-depth semi-structured interviews	Thematic analysis	Age, mean 70.2 (50-80)	20 Participants Male (%): 65	TIA/Recovered stroke Post CEA: 10 Medical management: 10	To examine the use of formal and informal knowledge by patients in making decisions about (CEA) and medical treatment after TIA/ recovered stroke caused by carotid stenosis
Abbreviations: Carotid revascularisation Enarterectomy (CEA), Transient ischaemic attack (TIA)							

Figure 1. PRISMA Diagram: CS Qualitative Systematic Review



Three of the included studies were from the UK (**25, 27-28**) and one from Sweden (**26**). The studies were published between 2002 and 2013; the age of patients with carotid artery disease in the included studies ranged from 50-80 years, and the percentage of male participants was 50-65%. The included studies reported the views of sixty-two patients with twenty-four of the patients awaiting assessment for surgery, twenty-six had surgery and twelve were turned down for intervention and received best medical therapy.

### **Quality assessment**

The quality of the included studies was assessed independently by two authors (AA, AH) using the CASP checklist (**10**) for qualitative studies, any disagreement on the final score was resolved through discussion and/or involving a third senior author (GJ). The overall quality of the included studies was good, and all the studies scored “yes” for almost all the criteria set in the CASP checklist; Only one study scored ‘can’t tell’ on the rigour of the data analysis (**25**). For detail on the quality of the included studies see table 3.

**Table 3: CASP checklist final score for included studies**

Paper	CASP Quality Appraisal									
	1. Was there a clear statement of the aims?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the project?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addresses the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?
Gibson 2002 (25)	✓	✓	✓	✓	✓	✓	✓	?	✓	✓
Hallin et al. 2002 (26)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gibson & Watkins 2012 (26)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gibson & Watkins 2013 (28)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

3 **Analysis**

4 The Framework Analysis of the primary and secondary data of the included papers identified  
 5 sixteen themes. These were divided into five main domains comprising; anxiety, impact on  
 6 personal roles, effect on independence, psychological impact and symptoms. Please see  
 7 Table 4 for further details.

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 9  
 10  
 11  
 12

**Table 4: Themes identified from qualitative research studies of patients with carotid artery stenosis.**

Themes ( <b>Domains in bold font</b> )	Gibson (2002)	Halin <i>et al.</i> (2002)	Gibson & Watkins (2012)	Gibson & Watkins (2013)
<b>Anxiety</b>				
Fear of stroke	√	√	√	√
Fear of becoming a burden	√	√	√	√
Fear of operation	√	√		√
Uncertainty about future	√	√	√	√
<b>Impact on personal roles &amp; activities</b>	√	√	√	√
<b>Effect on independence</b>	√	√	√	√
<b>Psychological impact</b>				
Happiness	√		√	√
Health perception	√			
<b>Symptoms</b>				
Weakness			√	
Numbness or loss of sensation			√	
Loss of ability to speak			√	
Loss of vision			√	
Cognitive function			√	
Duration of symptoms			√	
Neck stiffness	√		√	

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## 23 **Anxiety**

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25 The anxiety domain had several themes including fear of stroke, fear of becoming a burden,  
26 worry and uncertainty and fear from consequences of the operation. These four themes were  
27 grouped together because of overlapping. The impact of anxiety on daily living of patients  
28 suffering with CAS featured in all four studies. Patients experiencing symptoms of transient  
29 ischaemic attack (TIA) secondary to CAS expressed concern about fear of stroke, patients  
30 said:

31 "I'm afraid of having a stroke and then becoming paralysed" (Pre-operative patient,  
32 age not reported) **(26)**

33 "I'd be worrying a lot, yes, wondering when or where or how it (stroke) was going to  
34 happen...it would be in the back of my mind...which takes some of the pleasure out of life."  
35 (Patient experienced TIA –before CEA) **(27)**

36 "Well, I wouldn't like to be here and have one (stroke) on my own." (*Patient*  
37 *experienced TIA –before CEA*) **(25)**

38

39 Two of the major causes for worry from having symptomatic CAS that can cause stroke were  
40 uncertainty and fear of becoming a burden. Participants in the included studies reported  
41 feeling that their life was put on hold and many were worried that a disabling stroke may make  
42 them a burden on others including their family members.

43 "It's the unknown isn't it, that's what makes you fearful, you don't know what's going  
44 to happen." (patient after the CEA reflecting on experiences prior to the surgery) **(25)**

45 "I'm afraid of becoming dependent on care" (Pre-operative patient) **(26)**

46

47 The uncertainty about the future and fear of sudden stroke was affecting patients treated with  
48 best medical therapy when compared to patients treated with preventive procedures such as  
49 CEA or stenting **(27)**. Another source of anxiety was the worry from complications of surgery  
50 including death or stroke. Many patients' perceptions about the risk of stroke from the

51 preventive procedures were disproportionate **(25)**, some patients thought that their risk of  
52 stroke from the surgery was 50% and this higher than the 2% reported by clinical studies **(3,4)**.  
53 Furthermore, many patients had an inaccurate recall of the risks of treatment options offered  
54 to them **(25)**.

55 “if somebody tells you there’s a 50% chance of having a stroke (without surgery)  
56 that’s in your mind all the time” (patient after the CEA reflecting on experiences prior to the  
57 surgery) **(25)**

58

59 “You’re damned if you do and damned if you don’t, I mean I’d have a stroke if I didn’t  
60 have it, and I might have the stroke under the operation.” (Patient experienced TIA –before  
61 CEA) **(25)**

62

63 Patients with successful revascularisation reported improved psychological wellbeing and  
64 felt that they could move on with their lives compared to the time prior to their procedure  
65 when they felt that their daily livings were overshadowed by the worry associated with the  
66 CAS diagnosis and possible stroke **(25)**.

67 I’m a happier person, physically and emotionally.” (patient after the CEA reflecting on  
68 experiences prior to the surgery) **(25)**

### 69 **Impact on Personal Roles & Activities**

70

71 Some participants in the included studies described the onset of symptomatic CAS to have  
72 put a hold on their life and without the preventative surgery, they would have not been able  
73 to carry on with their personal roles and daily activities **(25)**. Some patients took many  
74 measures in their daily living to avoid activities that they perceived may increase their risk of  
75 further TIA or major stroke. For instance, some patients made changes to their diet **(26)**.

76 One patient said:

77

78 “I’d have been worried about having a stroke, it curtailed my activities” (Post-  
79 operative patient) **(26)**

80

81 The anxiety associated with further TIA or strokes as well as residual symptoms of strokes  
82 had an impact on the physical functioning of the patients **(25)**.Patients also suggested that

83 the symptomatic CAS causing TIA dramatically changed their perception about their physical  
84 health, Furthermore, attitude of family and friend reinforced this view of diminished physical  
85 function **(27)**.

86 "I've always kept my health...this has absolutely shattered me." (Patient experienced  
87 TIA) **(27)**

88 "you're not as fit as you thought you were, everybody's always telling me to be  
89 careful, and have a rest...people around me have sort of convinced me that I'm a bit  
90 fragile..." (Patient experienced TIA) **(27)**.

### 91 **Effect on Independence**

92

93 All the included studies reported that patients suffering with CAS felt that their social life and  
94 independence were compromised because of the disease and potential consequences.

95 Patients expressed concerns about the impact of the disease and possible consequences of  
96 on their independence.

97 "I'm afraid of becoming paralysed and dependent on care" (patient reporting after  
98 surgery) **(25)**  
99

100 "I'm enjoying life and I want it to go on, without having a stroke" (patient reporting  
101 after surgery) **(28)**

102

103

### 104 **Psychological Impact**

105

106 Patients suffered with issues related to their health perception; the diagnosis had adverse  
107 consequences for many patients; with some reporting that they felt their daily life is being  
108 shattered with the new diagnosis **(27)**.

109 Some patients developed low mood when they understood the risks associated with their  
110 disease, however, on the other hand, patients who had the operation and did not experience

111 any complications reported that they felt happier emotionally because of dealing with a  
112 potentially significant disease that made them felt unhappy **(25, 27-28)**. One patient

113 reported:



114 "I'm a happier person, physically and emotionally." (patient reporting after  
115 surgery) **(25)**  
116

## 117 **Symptoms**

118

119 The symptomatic outcomes that were reported by the patients could be divided broadly into  
120 two main groups: symptoms associated with TIA and post-intervention symptoms. Patients  
121 experiencing TIA reported classical symptoms including loss of sensation, weakness,  
122 temporary loss of ability to speak and loss of vision **(27)**.

123 "I couldn't pick anything up at all, I had great difficulty in using the knife and  
124 fork...and then suddenly it came back."(Patient reporting TIA symptoms) **(27)**

125 "I just thought a film had come over my eye." (Patient reporting TIA symptoms) **(27)**

126

127 Patients described symptoms of neck pain and discomfort at the site of operation to treat  
128 CAS following CEA **(25)**.

129 "...did feel better, apart from residual minor discomfort from surgical incision  
130 pain and neck stiffness." (patient reporting after surgery) **(25)**

131

132 Lastly, some patients described loss of cognitive function that was noticeable by their family  
133 and caused concern for the patient **(25)**.

134 "I have difficulties taking part in advanced discussions"(patient with carotid artery  
135 stenosis) **(25)**

## 136 **Triangulation**

137 The identified themes were compared to items from PROMs that were identified in a recent  
138 study **(17)**. These PROMs include the carotid artery disease quality of life questionnaire  
139 developed by the Carotid revascularisation Enarterectomy vs. Stenting Trial group (CREST  
140 Randomised controlled trial), Carotid Stenosis Specific Outcome Measure developed by  
141 Ivanova et al **(28)**, Dizziness Handicap Inventory (DHI), Hospital Anxiety and Depression  
142 Scale (HADS), EuroQoL-5D (EQ-5D), and the Short-Form 36 (SF-36®). Two reviewers (AA,

143 AH) examined the overlap between the themes in the qualitative review and items in the  
 144 PROMs. When there was complete overlap between the theme and an item in an instrument  
 145 an agreement score (+) was awarded; however, when the theme is covered in a  
 146 general question a partial agreement score was awarded (+/-).

147

148

149 **Table 5: Themes identified from the qualitative review mapped against items of**  
 150 **validated PROMs**

Themes	CREST trial PROMs	CSSOM	DHI	HADS	EQ-5D	SF-36
<b>Anxiety</b>	-	+	+/-	+	+	+
Fear of stroke	-	-	-	-	-	-
Fear of becoming a burden	-	+	-	-	-	-
Fear of operation	-	-	-	-	-	-
Uncertainty about future	-	-	-	-	-	-
<b>Impact on personal roles &amp; activities</b>	-	+	+	+/-	-	-
<b>Effect on Independence</b>	-	-	+/-	-	-	-
<b>Psychological impact</b>	-	+	+	+	+/-	+
Happiness	-	+	+	+	-	+
Health Perception	-	-	-	-	-	-
<b>Symptoms</b>	+/-	+	+	-	-	-
Weakness	-	+	+/-	-	-	-
Numbness or loss of sensation	-	+	-	-	-	-
Loss of ability to speak	-	-	-	-	-	-
Loss of vision	-	+	-	-	-	-
Cognitive function	-	+	-	-	-	-
Duration of symptoms	-	-	-	-	-	-
Neck Stiffness	+	+	-	-	-	-
<p><b>Abbreviations:</b> Carotid revascularisation Enarterectomy vs. Stenting Trial (<b>CREST Randomised controlled trial</b>), Dizziness Handicap Inventory (<b>DHI</b>), Hospital Anxiety and Depression Scale (<b>HADS</b>), EuroQoL-5D (<b>EQ-5D</b>), and Medical outcomes study 36-item short form (<b>SF-36</b>®), Carotid Stenosis Specific Outcome Measure (<b>CSSOM</b>).</p> <p><b>Scores:</b> -, silence; +/-, partial agreement; +, agreement.</p>						

151

152

153

154 None of the identified PROMs covered important HRQoL themes such as fear of stroke or fear  
155 from the operation as well as uncertainty about future caused by the diagnosis of the disease.  
156 Many of the symptoms described in the qualitative evidence synthesis of this study were not  
157 included in the PROMs used previously. The generic PROM that captured most of the  
158 important issues for patients with CAS was the SF-36 ® and the disease specific PROM was  
159 the PROMs for carotid artery disease developed by Ivanova *et al* **(28)**. However, both PROMs  
160 did not cover all the themes identified in this review. For further details on the results of  
161 triangulation see table 5.

162

## 163 Discussion

164

165 We identified six domains that impacted upon the HRQoL of patients with CAS throughout  
166 their care pathway. These include anxiety, impact of the disease on personal roles/ activities,  
167 impact on physical functioning, impact on social functioning, psychological impact, and  
168 symptoms associated with it.

169 The HRQoL of patients with CAS undergoing either revascularisation or best medical  
170 therapy have only been measured using generic PROMs, anxiety specific PROMs and  
171 questionnaires developed by clinicians with no validation (RCT) **(5-11)**. A single RCT  
172 attempted to develop a disease specific PROM for patients with CAS **(11)** however, the  
173 instrument was made of the six items suggested by clinicians and, more importantly, patients  
174 were not consulted. Furthermore, there was no further validation for this PROM.

175 Clinical outcomes such as 30-days mortality, stroke-free survival, and re-stenosis have been  
176 used to compare the efficacy of surgical, radiological and medical therapies for patients with  
177 CAS. These are important outcomes, however, HRQoL, when measured using a validated  
178 PROM can provide comprehensive data about the impact of different therapies. The themes  
179 from this review can be used to develop a more tailored PROM that can be used in routine

180 clinical practice both to inform discussion between patients and clinicians, as well as, a  
181 quality measure of the carotid revascularisation service.

182

183 One of the strengths of this study is that the qualitative review included patients at different  
184 stages of their care pathway including sixty-two patients with symptomatic carotid artery  
185 stenosis; twenty-four of the patients waiting for to meet a clinician to decide whether they are  
186 suitable for surgery or stenting, twenty-six patients had carotid endarterectomy with no  
187 complications and twelve patients turned down for surgical or interventional radiology  
188 procedures. This review used the evidence from an earlier systematic review **(11)** by the  
189 same group to evaluate the validity of PROMs used in patients with CAS. This earlier  
190 systematic review was performed to examine the psychometric validation evidence for  
191 PROMs used in patients with CAS. In the triangulation section of this study the themes from  
192 the qualitative review were mapped against the items from the generic and disease specific  
193 CAS PROMs that were identified.

194

195 The main limitation of this study is that it relies on the primary and secondary data of existing  
196 studies. The patients sampled in one of the studies only included patients with CAS waiting  
197 for operation (27); whereas, the other three studies included patients on best medical  
198 therapy for CAS as well as patients waiting for preventive surgery and patients following their  
199 operation. Furthermore, the included studies beside investigating aspects of HRQOL also  
200 examined issues such as decision making about management that were not related to  
201 HRQoL. Additionally, few patients who were treated with best medical therapy or turned  
202 down for revascularisation were included in any of the studies. The included papers did not  
203 distinguish clearly between patients with resolved stroke symptoms and TIA. Some papers  
204 mentioned important themes such as denial of diagnosis and depression but failed to report  
205 any primary evidence to support these themes **(27, 28)**.

206

207 Amongst some clinical academic circles HRQoL has confusingly come to be known as  
208 anything which is not clinical **(30)**. However, this study demonstrates that patients with CAS  
209 experience distress related to diagnosis and the risks associated with the intervention.  
210 These have an adverse impact on their wellbeing and should be taken into consideration by  
211 the clinician. The review identified anxiety to be an important domain that impacts the  
212 HRQoL of patients with CAS and this is related to fear of stroke, uncertainty about future,  
213 fear of becoming a burden on others and fear of operation. Carotid artery disease also had  
214 an impact of on the patient independence, the personal functioning and beyond anxiety had  
215 a further psychological effect on patients.  
216 This systematic review of the qualitative evidence combine all the relevant data concerning  
217 the impact of CAS and its treatments on the patients. One of the strongest finding of this  
218 study is that none of the generic and disease specific PROMs covered all the important  
219 issues for CAS patients revealed by this qualitative systematic review.

## 220 **Conclusions**

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222 The identified themes that impact the HRQoL of patients with CAS can be used to develop a  
223 disease-specific PROM. Our group designed this instrument and currently validating this  
224 PROM in an extensive survey of patients with CAS. The aim is to perform a factor analysis  
225 as well as further psychometric studies to ensure the PROM's validity, reliability, and  
226 responsiveness.

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## 228 **“Data Availability Statement”**

229 The analysis data cannot be shared since some of the papers included in the systematic  
230 review have copy rights and these prohibit publishing them in other journals but allow  
231 researchers to use them for secondary analysis. These papers were uploaded into the  
232 software in which we performed the analysis. Supplementary materials are included  
233 regarding the search strategy and analysis.

234 **Compliance with Ethical Standards**

235 **Acknowledgment**

236

237 Ahmed Aber contributed to the analysis and interpretation of data, drafting of the manuscript,  
238 and critical revision; Aoife Howard contributed to the analysis and interpretation of data and  
239 drafting of the manuscript; Helen Buckley Woods performed the searches for the systematic  
240 review and helped in drafting of the manuscript. Georgina Jones contributed to the study  
241 conception and design, analysis and interpretation of data, and drafting of the manuscript;  
242 and Jonathan Michaels contributed to the study conception and critical revision.

243

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249 **Conflict of interest**

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251 Ahmed Aber, Aoife Howard, Helen Buckley Woods, Georgina Jones, Jonathan Michaels  
252 have no conflicts of interest directly relevant to the content of this article.

253

254 **Abbreviations**

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256 CASP: Critical Appraisal Skills Program, CREST: Carotid revascularisation Endarterectomy  
257 vs. Stenting Trial, DHI: Dizziness Handicap Inventory, HADS: Hospital Anxiety and  
258 Depression Scale, EQ5D: EuroQoL-5D, SF-36®: Medical outcomes study 36-item short  
259 form, CAS: Carotid artery stenosis, CEA: carotid endarterectomy, PROMs: patient reported  
260 outcome measures, HRQOL: health-related quality of life, PRISMA: Preferred Reporting  
261 Items for Systematic Reviews and Meta-Analyses, TIA: transient ischaemic attack, Carotid  
262 Stenosis Specific Outcome Measure (CSSOM).

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## References:

- 1- Luengo-Fernandez R, Gray AM, Bull L, Welch S, Cuthbertson F, Rothwell PM. Quality of life after TIA and stroke: ten-year results of the Oxford Vascular Study. *Neurology* 2013; **81**(18):1588-1595.
- 2- British Health Foundation, Heart Matters. Focus on: Stroke and carotid artery disease. 2016. Available at: <https://www.bhf.org.uk/heart-matters-magazine/medical/stroke-and-carotid-artery-disease>. Accessed on 30 April 2018.
- 3- Barnett HJ, Taylor DW, Eliasziw M, Fox AJ, Ferguson GG, Haynes RB et al. Benefit of carotid endarterectomy in patients with symptomatic moderate or severe stenosis. North American Symptomatic Carotid Endarterectomy Trial Collaborators. *N Engl J Med* 1998; **339**(20):1415-1425.
- 4- Randomised trial of endarterectomy for recently symptomatic carotid stenosis: final results of the MRC European Carotid Surgery Trial (ECST). *Lancet* 1998; **351**(9113):1379-1387.
- 5- Halliday A, Mansfield A, Marro J, Peto C, Peto R, Potter J et al. Prevention of disabling and fatal strokes by successful carotid endarterectomy in patients without recent neurological symptoms: randomised controlled trial. *Lancet* 2004; **363**(9420):1491-1502.
- 6- Halliday A, Harrison M, Hayter E, Kong X, Mansfield A, Marro J et al. 10-year stroke prevention after successful carotid endarterectomy for asymptomatic stenosis (ACST-1): a multicentre randomised trial. *Lancet* 2010; **376**:1074-1084.
- 7- Ederle J, Dobson J, Featherstone RL, Bonati LH, Worp HB, Borst GJ et al. Carotid artery stenting compared with endarterectomy in patients with symptomatic carotid stenosis (International Carotid Stenting Study): an interim analysis of a randomised controlled trial. *Lancet* 2010; **375**:985-997.
- 8- Yadav JS, Wholey MH, Kuntz RE, Fayad P, Katzen BT, Mishkel GJ et al. Protected carotid-artery stenting versus endarterectomy in high-risk patients. *N Engl J Med* 2004; **351**(15):1493-1501.
- 9- Brott TG, Hobson RW, Howard G, Roubin GS, Clark WM, Brooks W et al. Stenting versus endarterectomy for treatment of carotid-artery stenosis. *N Engl J Med* 2010; **363**(1):11-23.
- 10- Bonati LH, Dobson J, Algra A, Branchereau A, Chatellier G, Fraedrich G et al. Short-term outcome after stenting versus endarterectomy for symptomatic carotid stenosis: a preplanned meta-analysis of individual patient data. *Lancet* 2010; **376**(9746):1062-1073.
- 11- Stolker JM, Mahoney EM, Safley DM, Pomposelli FB, Yadav JS, Cohen DJ. Health-related quality of life following carotid stenting versus endarterectomy: results from the SAPPHERE (Stenting and Angioplasty with Protection in Patients at High Risk for Endarterectomy) trial. *JACC Cardiovascular interventions* 2010; **3**:515-523.
- 12- Chabowski M, Grzebien A, Ziomek A, Dorobisz K, Lesniak M, Janczak D. Quality of life after carotid endarterectomy - a review of the literature. *Acta Neurol Belg* 2017; **117**(4):829-835
- 13- Hsu LC, Chang FC, Teng MMH, Chern CM, Wong WJ. Impact of carotid stenting in dizzy patients with carotid stenosis. *J Chin Med Assoc* 2014; **77**(8):403-408.
- 14- Cohen DJS. Health-related quality of life after carotid stenting versus carotid endarterectomy: Results from CREST (Carotid Revascularization Endarterectomy versus Stenting Trial). *J Am Coll Cardiol* 2011; **58**(15):1557-1565.
- 15- Black, N. Patient reported outcome measures could help transform healthcare. *BMJ* 2013; **346**:f167

- 308 16- Department of Health. Liberating the NHS: Transparency in outcomes- a framework for the  
309 NHS. July 2010. <http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=1280>  
310 (Accessed 30 April 2018)
- 311 17- Essat M, Aber A, Phillips P, Poku E, Woods HB, Howard A, Palfreyman S, Kaltenthaler E, Jones  
312 G, Michaels J. Patient-Reported Outcome Measures in Carotid Artery Revascularization:  
313 Systematic Review and Psychometric Analysis. *Ann Vasc Surg.* 2018;50:275-283  
314
- 315 18- Duncan R, Booth A, Woods HB, Essat M, Phillips P, Poku, E, Kaltenthaler E, Jones G, Michaels  
316 J. Understanding the experience and impact of living with a vascular condition from the  
317 patients' perspective: qualitative evidence synthesis protocol. HEDS discussion paper. May  
318 2016. [https://www.sheffield.ac.uk/polopoly\\_fs/1.552397!/file/DP\\_16\\_05.pdf](https://www.sheffield.ac.uk/polopoly_fs/1.552397!/file/DP_16_05.pdf) (Accessed 08  
319 June 2017)
- 320 19- Grant, M. J. (2004) How does your searching grow? A survey of search preferences and the  
321 use of optimal search strategies in the identification of qualitative research. *Health  
322 information and libraries journal.* *Health Info Libr J.* 2004;21(1):21-32  
323
- 324 20- Critical Appraisal Skills Program. 10 questions to help you make sense of qualitative  
325 research: CASP qualitative check list. 2006;1–6.  
326 [http://media.wix.com/ugd/dded87\\_951541699e9edc71ce66c9bac4734c69.pdf](http://media.wix.com/ugd/dded87_951541699e9edc71ce66c9bac4734c69.pdf). (Accessed  
327 30 April 2018)
- 328 21- Carroll C, Booth A. Quality assessment of qualitative evidence for systematic review and  
329 synthesis: is it meaningful, and if so, how should it be performed? *Res Synth Methods.*  
330 2015;6(2):149–54.
- 331 22- Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman G,  
332 Burgess A, editors. *Analysing qualitative data.* London: Routledge; 2015, fourth edition.  
333 Pages 169–91.
- 334 23- Farmer T, Robinson K, Elliott SJ, Eyles J. Developing and implementing a triangulation  
335 protocol for qualitative health research. *Qual Health Res.* 2006;16:377–94.
- 336 24- O’Cathain A, Murphy E, Nicholl J. Three techniques for integrating data in mixed methods  
337 studies. *BMJ.* 2010;341:c4587.
- 338 25- Gibson J. Use of qualitative research to analyze patient and clinician decision making in  
339 carotid endarterectomy. *J Vasc Nurs.* 2002;20(2):60-5
- 340 26- Hallin A, Bergqvist D, Fugl-Meyer K, Holmberg L. Areas of concern, quality of life and life  
341 satisfaction in patients with peripheral vascular disease. *Eur J Vasc Endovasc Surg.* 2002  
342 ;24(3):255-63.
- 343 27- Gibson J, Watkins C. People's experiences of the impact of transient ischaemic attack and its  
344 consequences: qualitative study. *J Adv Nurs.* 2012;68(8):1707-15.
- 345 28- Gibson J, Watkins C. The use of formal and informal knowledge sources in patients'  
346 treatment decisions in secondary stroke prevention: qualitative study. *Health Expect.*  
347 2013;16(3):e13-23.
- 348 29- Ivanova, P., Kikule, I., Zvirgzdins, V. et al, Quality of life assessment for asymptomatic high-  
349 grade carotid stenosis patients before and after carotid endarterectomy. *Gazz Med Ital Arch  
350 Sci Med.* 2015;174:33–42.
- 351 30- Bowling A. *Measuring health: a review of quality of life measurement scales.* Buckingham:  
352 Open University Press; 2017, Fourth edition.