Critical Appraisal of the Major Randomized Controlled Trials on the Management of Atherosclerotic Renovascular Disease (ARVD)

Rebeen R. Saeed*

General University Teaching Hospital of Sulaimania-Medical center, Zanko Street, Sulaimania, Kurdistan, Iraq

Abstract

Background: In this article, the author discusses critical appraisals of the major randomized controlled trials on the management of Atherosclerotic Renovascular Disease (ARVD). The article will also discuss the limitations of the published trials, while highlighting the crucial aspect of appropriate patient selection, the serious flaws noted, and the quality of the main studies. Also included are the six major randomized controlled trials that compared the difference between revascularization, either surgical or PTRA (Percutaneous Renal Angioplasty), with or without stent versus conservative management (medication). The author also discusses the recommended research for the management of atherosclerotic renovascular disease.

Methodology and search strategies to identify studies: A comprehensive search of PUBMED including Medical Subject Headings (MeSH) data base from 1990 to may 2012 and The Cochrane library was completed. Searching was only for relevant English papers related to the management of Atherosclerotic renovascular disease.. CASP questionnaire, Jadad scaling and (Oxford Centre for Evidence-based Medicine) levelling of evidence are used for the purpose of the critical appraisal.

Criteria for considering studies for this article: To be considered, clinical studies had to be randomized trials comparing intervention; balloon angioplasty or stenting or both or surgical revascularization versus medical treatment, or surgical versus balloon angioplasty with or without stenting in hypertensive patients who had atherosclerotic renal artery stenosis with a minimum of three months of follow up after treatment Only those studies included with adult patients (age >18 years) who had uncontrolled hypertension (diastolic blood pressure ≥ 95mmHg, treated or untreated) and moderate-to-severe (≥50%) unilateral or bilateral atherosclerotic renal artery stenosis. Studies which were not randomized or those related to fibromuscular dysplasia, meta-analysis, and diagnostic studies were excluded.

Objectives: Explaining a critical appraisal of six major randomized clinical trials which compared Revascularization (intervention) to medication (conservative treatment) which includes Angioplasty and Stenting for Renal Artery Lesions Trial (ASTRAL), Stent Placement in Patients With Atherosclerotic Renal Artery Stenosis and Impaired Renal Function Trial (STAR), Dutch Renal Artery Stenosis Intervention Cooperative (DRASTIC), Essai Multicentrique Medicaments vs. Angioplastie trial (EMMA), Scottish and Newcastle Renal Artery Stenosis Collaborative Group trial (SNRASCG), and Prospective randomized trial of operative vs. interventional treatment for renal artery ostial occlusive disease (RAOOD) trials. We also highlighted some points about the ongoing CORAL (Cardiovascular Outcomes in Renal Atherosclerotic Lesions) trial.

Conclusions: Correction of Astherosclerotic Renal Artery Stenosis (ARAS), either by surgical revascularization or percutaneous methods, including stenting, has not been shown to be beneficial in treating Atherosclerotic RAS over conservative treatment, although some of the studies showed blood pressure control benefit in intervention groups like EMMA, SNRASCG and post hoc analysis of DRASTIC studies. Consequently, it seems reasonable to consider interventional procedures to correct Renal artery stenosis in patients who do not respond to medical therapy or with poorly-controlled or resistant hypertension; recurrent flash pulmonary edema; dialysis dependent renal failure resulting from atherosclerotic renal artery stenosis; chronic kidney disease and bilateral renal artery stenosis; or Renal artery stenosis to a solitary functioning kidney and waiting for the next available research with less flaws and biases.

Keywords: Renal artery obstruction; Stenosis; Atherosclerosis; Therapy; Management; Revascularization; Intervention; Randomized; Control; Trial; Evidence based

Introduction

Renal Artery narrowing and progressive renal impairment caused by atherosclerotic renovascular disease is a clinical problem that it’s frequency increased in recent years [1-3]. There are many risk factors which may have roles in the development of atherosclerotic renovascular disease and they are the same as for other atheromatous vascular conditions like advanced age, smoking, hyperlipidemia, hypertension, renal failure, and diabetes [4]. There are various therapeutic options: a) Conservative or medical management with antihypertensive drugs including the general measures like smoking cessation, anti-lipid items, healthy diet and exercise b) Percutaneous angioplasty, usually with stent placement and c) Surgical revascularization [5,6].
What's wrong with the results of major randomized controlled trails?

In this section, a critical appraisal of the major trials within studies which compared revascularization, either angioplasty with stent or without stent and surgical versus medical or conservative approaches will be discussed. The quality of the trials as well as their implications on current practice will be critically evaluated.

1- ASTRAL trial [10] (Angioplasty and Stenting for Renal Artery Lesions trial)

ASTRAL authors' conclusions: "We found substantial risks but no evidence of a worthwhile clinical benefit from revascularization in patients with atherosclerotic renovascular disease" [10].

Astral was a randomized controlled trial, patients were randomly assigned either to undergo revascularization with medical therapy versus receiving medical therapy alone, in a 1:1 ratio with the use of a computerized minimized-randomization procedure. The results were precise in the sense of showing Confidence intervals and showing the P values of the primary and secondary outcomes. However, patients included in the trial did not have the same severity of renal artery stenosis and renal function in which the majority of patients had severe renal-artery stenosis (59% had stenosis of more than 70%) or clinically significant renal impairment (60% had a serum creatinine level of 150 μmol/l [1.7 mg/dl] or more or both. Jadad scoring [7] of the ASTRAL trail is 3/5 (Table 1) and good sample size thus the quality of the study was good and it's level Ib of evidence [9].

Major drawbacks of ASTRAL:

a) Normal renal function at baseline, 25% of patients in each group had normal renal function (eGFR > 50 ml/min/1.73 m2) at the entry of the trial.

b) No core laboratory were found in ASTRAL, some patients in the 50%–70% stenosis group (about 40% of patients entered) actually had a stenosis of less than 50%. Moreover, some patients in the group with stenosis greater than 70% had stenosis of less than 70% and 40% serum creatinine were less than 150 μmol/dl.

c) Possible selection bias, the physicians were aware that which patients selected would benefit from either revascularization or medications.

d) High complication rate: The major complication rate in the first 24 hours was 9%

e) The measurement of GFR was calculated by the Cockcroft–Gault method not MDRD.

f) Non-blinding: though it's difficult to blind treatments in such a trial, thus observer and selection bias is highly expected.

g) "Rate of cross-over" was 6% from medication to intervention group.

2- DRASTIC [11] (Dutch Renal Artery Stenosis Intervention Cooperative) trial

DRASTIC author's conclusion: "In the treatment of patients with hypertension and renal-artery stenosis, angioplasty has little advantage over antihypertensive-drug therapy" [11]. The study was a prospective randomized controlled trial, serious issues that was identified in DRASTIC trail;

a) The sample size was not sufficient to detect a significant difference between treatment groups. In other words, the chance of a type two statistical error is high. Balloon angioplasty without stenting was used as the method of revascularization. Experts

| Jadad Score Calculation | ASTRAL | STAR | DRASTIC | EMMA | SNRASC | RAODD |
|-------------------------|--------|------|---------|------|--------|-------|
| Was the study described as randomized (this includes words such as randomly, random, and randomization)? | 0/1 | 1 | 1 | 1 | 1 | 1 |
| Was the method used to generate the sequence of randomization described and appropriate (table of random numbers, computer-generated, etc)? | 0/1 | 1 | 1 | 1 | 0 | 0 |
| Was the study described as double blind? | 0/1 | 0 | 0 | 0 | 0 | 0 |
| Was the method of double blinding described and appropriate (identical placebo, active placebo, dummy, etc)? | 0/1 | 0 | 0 | 0 | 0 | 0 |
| Was there a description of withdrawals and dropouts? | 0/1 | 1 | 1 | 1 | 1 | 1 |
| Deduct one point if the method used to generate the sequence of randomization was described and it was inappropriate (patients were allocated alternately, or according to date of birth, hospital number, etc). | 0/-1 | 0 | 0 | 0 | 1 | 1 |
| Deduct one point if the study was described as double blind but the method of blinding was inappropriate (e.g., comparison of tablet vs. injection with no double dummy). | 0/-1 | 0 | 0 | 0 | 0 | 0 |
| Total score | 3 | 3 | 3 | 1 | 1 | 1 |

Table 1: Jadad scoring of the selected trials.
now recognize that stenting is required for renal artery intervention to have a durable result [12,13].
b) “High rate of cross over” Twenty-two of the 50 patients randomized to medical therapy crossed over to the angioplasty group because their blood pressure became difficult to control. In other words, 44% of the patients in the medical group underwent angioplasty, an astonishing percentage in an intention-to-treat analysis comparing one therapy with another.
c) Renal artery stenosis was defined as greater than 50% stenosis (allowing hemodynamically stable patient to enter the trial). Jadad Scoring for DRASTIC trial is 3/5 (Table 1), thus according to Jadad it's of good quality. Moreover, it's of level Ib of evidence and grade A of recommendation [8,9]. Furthermore, high rate of selection and observer bias was expected because of none blinding.

3-STAR [14] (Stent Placement in Patients with Atherosclerotic Renal Artery Stenosis and Impaired Renal Function trial)

**STAR author's conclusion:** “Stent placement with medical treatment had no clear effect on progression of impaired renal function but led to a small number of significant procedure-related complications” [14].

**The Serious draw-backs of the STAR trial:**

a) They included patients with mild renal artery stenosis; 33% of the patients in the trial had mild renal artery stenosis (50%-70%), and 12 (19%) of the 64 patients in the intervention group which supposed to receive stenting actually they had renal artery stenosis of less than 50%. Hence, it's really difficult to expect from this trial the benefit of stenting in patients who had mild (hemodynamically insignificant) renal artery stenosis.

b) This study was under-powered i.e. there was high chance of a type two statistical error. Moreover, four patients lost in follow up and 3% drop out (dilution of the power).

c) Not all “stent” group or patients received stents. In the medical group, all of the patients received medication without any crossovers. However, only 46 (72%) of the 64 patients subjected to stenting infact received a stent, while 18 (28%) did not.

d) More than half of the patients had unilateral disease. It seems logical that if one were to plan a study or a trial with change in renal function to be the primary end point, it is reasonable only patients with bilateral renal artery stenosis of more than 70% or with stenosis of more than 70% to a solitary functioning kidney should be included. It's not reasonable to expect that patients with stenosis of less than 70% or with unilateral disease would get any benefit from revascularization.

e) Complication rates were high. The complications during procedures and death rates were much higher than in many other reports on renal artery stenting. Four deaths were due to procedure and CV events and 11% due to hematoma. Jadad Scoring of STAR trial is 3/5 (Table 1), so the quality of the study is good but it was underpowered and it's of level Ib of evidence and Grade A recommendation [8,9].

4-EMMA [15] (Essai Multicentrique Medicaments vs. Angioplastie trial)

**EMMA author's conclusion:** “We found that angioplasty made BP control easier in the short term but was more frequently associated with complications than conservative management in patients with unilateral atherosclerotic RAS” [15].

**Like other trials, EMMA had some serious flaws including the following:**

a) Only unilateral renal artery disease was enrolled.

b) The groups were not well balanced, as there were 23 patients for angioplasty and 26 for control group at the entry point.

c) There are some differences that might have explained confounding and bias in the results like five patients in the control group and three in the angioplasty group were receiving no antihypertensive treatment, whereas all others were taking one to three antihypertensive agents.

d) “Cross-over” seven of the control-group got the intervention-group participants and not all participants outcomes were analyzed by the groups to which they were originally allocated (no intention-to-treat analysis).

e) High complication rate in angioplasty group which was about (6 of 23, or 26%). Another issue was one in three eligible patients declined inclusion, mostly because of the patient's (or referring physician's) preference for angioplasty.

f) Power issue of the study: initially they needed to enroll 52 patients to allow 90% power, yet 49 patients randomized finally.

g) No information about Patency rate: Moreover, the quality of study is poor as it's 1/5 on Jadad scaling (Table 2) and level Ib of evidence and grade A recommendation [8,9].

5- SNRASCG [16] (Scottish and Newcastle Renal Artery Stenosis Collaborative Group trial)

**SNRASCG author's conclusion:** In hypertensive patients with atheromatous renal artery stenosis, percutaneous renal angioplasty results in a modest improvement in systolic BP compared with medical therapy alone. This benefit was confined to patients with bilateral disease. No patient was 'cured', renal function did not improve, and intervention was accompanied by a significant complication rate” [16].

**The serious issues were the following:**

a) There were difference between intervention and medication group number at the entry point i.e. intervention group was 25 and medical therapy was 30 patients.

b) Power calculation description was unclear, thus we cannot decide if there was sufficient number of patients to predict significant outcome that may change practice. In 135 patients only 55 randomized.

c) The method of allocation and randomization were unclear.

d) No intention to treat analysis.

e) High complication rate: (9 out of 25 in intervention group) like stroke, bleeding from arterial site, severe pain, but no death reported. The quality of the study on Jadad Scale is 1/5 (Table 1) and it's of level II b of evidence and grade B of recommendation thus policy should not be changed as a result of this trial [8,9].
6-RAOOD [17] (Prospective randomized trial of operative vs. interventional treatment for renal artery ostial occlusive disease)

RAOOD author’s conclusion: “Both treatment modalities showed good early results concerning RVH, kidney function, and renal perfusion” [17].

The serious flaws of this study were the following:

a) Single center and Allocation concealment was unclear
b) The groups were not well balanced (PTRA+ stent group number = 22, Surgical group number = 27)
c) Power calculation was not mentioned, so it’s unclear whether the number of patients is sufficient or not to predict it’s outcome and hard to predict how meaningful it was, thus we cannot say the result is precise enough to make a decision.
d) There were confounders which might have affected the results, like the difference in preoperative serum creatinine among the two groups which was higher in interventional group as compared to surgical group. 27% diabetics in the interventional group, 11% in the operative group. Moreover, PAOD was 54% in the interventional group, 40% in the operative group.
e) Two patients crossed over to surgical treatment. The incidence of diabetes and Peripheral Arterial Occlusive Disease (PAOD) differed slightly; higher in interventional group. Serum creatinine as well as urea levels were slightly higher in the interventional group.
f) Complication rate was high, 18% in interventional group and 19% in surgical group though the author claimed that it was low as
compared to cohort studies. On Jadad Scoring its 1/5 (Table 1) and it's of level II of evidence and grade B of recommendation thus the quality of the study is poor. Moreover, policy should not be changed as a result of this trial [8,9].

Discussion

Nine main Randomized Controlled Trials (RCTs) have completed enrollment and reported results on the management of ARVD, their characteristics are summarized in Table 2. Four trials compared balloon angioplasty with medical management alone, one compared primary renal artery stenting with balloon angioplasty with stenting as needed, one compared stenting with medical therapy with medical therapy alone, two compared surgical revascularization with endovascular revascularization, and one compared surgical revascularization with medical management. In six of the nine trials, the primary end points were blood pressure control or renal artery patency. For this article we only criticized the major trials in which their methodological quality is summarized in Table 3 [18].

Not all of the five completed trials comparing angioplasty with medical management have demonstrated blood pressure, renal function, or survival results favouring renal artery angioplasty or stenting when the three of the study group was evaluated in an intention-to-treat analysis [10,11,14] and the other two were not [15,16]. The report by the Scottish Newcastle group demonstrated a significant benefit in blood pressure treatment for the subset of patients with bilateral ARVD [16]. Van Jaarsveld et al. [11] in DRASTIC trial, demonstrated significant reduction in blood pressure and medications in post hoc analyses of treatment received, without considering initial crossover status and treatment assignment. Only ASTRAL had sufficient number of patients, all of the other trials were relatively small and significantly underpowered to detect meaningful differences in solid outcomes such as survival rate, freedom from adverse cardiovascular events, and the development of dialysis-dependent renal failure. Furthermore, the studies excluded patients with severe baseline renal function impairment [11,16], suffered from obvious significant crossover between treatment groups [11,19], did not include renin-angiotensin-based antihypertensive medications into medical treatment [16], and used angioplasty without stenting for interventional approach or treatment [11,14,16,19]. Hence, it's impossible to generalize or apply the results from these trials to current endovascular treatment of Atherosclerotic Renal Artery disease because of the limitations we addressed. In a separate trial comparing primary renal artery stenting vs. angioplasty alone, Van de Ven et al. [20] evaluated disease recurrence at six months in patients with ostial renal artery stenosis randomized to angioplasty alone vs. Renal Artery Percutaneous Transluminal Angioplasty and Stent (RAPTAS). Superior technical success reported by the research group, they reported improved primary patency, and reduction in recurrent stenosis in the RA-PTAS group. These results contributed to widespread use of primary stent placement as a current standard endovascular management for ARVD. Three trials evaluating surgical renal artery revascularization have also been reported. In their comparison between angioplasty (without stenting) vs. surgical revascularization of ARVD, Weibull et al. [21] observed similar blood pressure responses between groups but low technical success and low primary patency rate with endovascular management. Balzer et al. [17] reported similar results in terms of patency, hypertension, and renal function responses. A single randomized comparison between surgical and medical management of ARVD has also been published. Uzzo et al. [19] randomized 52 patients to medical therapy vs. surgical intervention and evaluated a composite end point outcome that included blood pressure, renal function, cardiovascular morbidity, and

| Study (Reference) | Allocation Concealment | Method of Randomization | Blinding of Main Outcome | Intention-to-Treat Analysis | Number of Patients Withdrawn or Lost to Follow-up | Quality Assessment Score* (Jadad Scoring) |
|-------------------|------------------------|-------------------------|--------------------------|-----------------------------|-----------------------------------------------|----------------------------------------|
| ASTRAL 2008       | Adequate               | Computerized Minimized-randomization procedure | No                        | Yes                         | 38                                            | 3                                      |
| STAR 2009         | Adequate               | Computer generated      | No                        | Yes                         | 4                                             | 3                                      |
| DRASTIC 2000      | Adequate               | Computer generated      | No                        | Yes                         | 2                                             | 3                                      |
| EMMA 1998         | Unclear                | Sealed envelopes        | No, But objective measurement (24-hour ambulatory blood pressure) | No                           | 1                                             | 1                                      |
| SNRASCG 1998      | Unclear                | Not mentioned           | Yes                       | No                          | 6                                             | 1                                      |
| RAOOD 2008        | Unclear                | Unmarked envelope       | No                        | Yes                         | 11                                            | 1                                      |

Adapted from Nordmann AJ, Woo K, Parkes R, Logan AG. Balloon Angioplasty or Medical Therapy for Hypertensive Patients with Atherosclerotic Renal Artery Stenosis? A Meta-Analysis of Randomized Controlled Trials

Randomized Controlled Trials

*Range of 0 (low) to 5 (high).

ASTRAL Angioplasty and Stenting for Renal Artery Lesions trial

STAR, Stent Placement in Patients with Atherosclerotic Renal Artery Stenosis and Impaired Renal Function

DRASTIC, Dutch Renal Artery Stenosis Intervention Cooperative trial;

EMMA, Essai Multicentrique Medicaments vs. Angioplastie trial;

SNRASCG, Scottish and Newcastle Renal Artery Stenosis Collaborative Group trial

RAOOD trial, Renal Artery Ostial Occlusive Disease

Table 3: Methodological Quality of Included Trials that compared Angioplasty to medical management.
death. The authors did not find any significant difference in event-free survival between treatment groups at a median follow-up of 74 months, but they noted a trend towards reduced mortality in those patients with renal impairment managed surgically.

The methodological quality of all published randomized controlled trials comparing either PTA [11,15,16,19], with medical therapy, analyzed according to the method of Jadad [7] was low to moderate [18]. The risk of bias, defined according to the Cochrane Collaboration handbook [22] ranged from moderate to severe [23,24]. Major points of criticism are the non blinded analysis of the study results, the high rate of cross-over to angioplasty – in particular in the largest of the three PTA trials (DRASTIC: 44%) - and the long enrolment periods – especially in the DRASTIC trial (seven years for 106 patients), but also in the ASTRAL trial (eight years). Moreover, the most severe bias of all of the studies, including the ongoing CORAL trial, is the criteria for defining the severity of renal artery stenosis. They enrolled 1080 patients and the power of the study is 90% Lesion severity started with 50% [26]. None of the studies asked for proof of the hemodynamic relevance of the RAS before enrolment. Experimental studies have shown that a drop of post-stenotic flow lumen does not occur until a narrowing of the luminal diameter by ≥ 60% with 20 mmHg gradient or ≥ 80%, respectively, and even patients with systolic gradient of 20 mmHg with systolic gradient in ≥ 1 renal arteries of ≥ 3.5 in diameter and supplying at least 50% of the ipsilateral kidney will be eligible for randomization [25]. 30% of the patients included in the trials had RAS with a diameter stenosis of less than 70%; some even less than 50% [26]. None of the studies asked for proof of the hemodynamic relevance of the RAS before enrolment. Experimental studies have shown that a drop of post-stenotic flow lumen does not occur until the diameter reduction exceeding 70% [27,28]. Although the results of CORAL trial is not published yet officially, if we compare CORAL trial to ASTRAL, the power of study in CORAL is 90% and number of patients enrolled is 1080 compared to ASTRAL which is 80% and 806 patients. In the Coral trial they are using genesis stent. In Astral trial 25% of patients had normal and 15% near normal renal function. 41% has renal artery stenosis of less than 70%, so this had definitely made biases in the study. Furthermore, we could not find population data of the CORAL trial as the study has not published yet. Moreover, it seems reasonable to consider interventional procedures to correct Atherosclerotic Renal artery stenosis in patients who do not respond to medical therapy or with poorly-controlled or resistant hypertension; recurrent flash pulmonary edema; dialysis dependent renal failure resulting from atherosclerotic renal artery stenosis of more than 70%; chronic kidney disease and bilateral renal artery stenosis of more than 70%; or Renal artery stenosis to a solitary functioning kidney more than 70% or even less, though there is no solid evidence for supporting the above recommendation, but until the next available clinical trial will be available-CORAL probably answers some of the questions, it seems reasonable if revascularization tried for the above group.

**Recommended research or RCT in management of Atherosclerotic renal artery disease**

A long-term, multi-central (1:1) randomized controlled trial will be of great value in changing practice, focusing on comparison of the effect of medical treatment versus Percutaneous Transluminal Renal Angioplasty (PTRA) with stenting on controlling blood pressure, kidney disease progression, and cardiovascular morbidity and mortality. Such trial should aim to clarify and the research questions of who is the ideal candidate for interventional therapy, it should include patients with renal artery stenosis more than 70% narrowing, either bilateral or unilateral in equal numbers and both control group and intervention group should have the same number of patients at entry point. Hypertensive population should include African American, Hispanics, and Native Americans as well as Caucasians. The study should use MDRD formula, and minimizing selection, observer bias, clear method of allocation and blinding if possible.

**Conclusions**

Intervention in atherosclerotic renovascular disease including...
Balloon angioplasty, stenting or even surgical revascularization did not show any significant benefit over medication on improvement of renal function except with some of the trials showed slight improvement on blood pressure control in intervention group compared to control groups. Moreover some them are level Ib evidence and some are Ib and on Jadad Scoring their quality did not cross more than 3/5, high selection and observer bias in all of them, high complication and cross over in most of them. they did not include all races, they did not use MDRD in their calculation of eGFR and even some trials only used serum creatinine in the follow up, thus another trial will probably answer the questions, which should be of an excellent quality and level Ia evidence, using MDRD formula for renal function measurement and because of the fact that blinding is impossible thus getting level Ia evidence with excellent quality of 4-5/5 on Jadad scoring will be challenging. Moreover, we cannot conclude on current evidence that any kind of intervention is better than conservative treatment.

Acknowledgements

Special thanks for Professor Meguid El Nahas at the University of Sheffield and the University of Sheffield Libraries for the help in preparation of this paper.

References

1. Hansen KJ (1994) Prevalence of ischemic nephropathy in the atherosclerotic population. Am J Kidney Dis 24: 615-621.
2. Caps MT, Perissinotto C, Zierer RE, Polissar NL, Bergelin RO, et al. (1998) Prospective study of atherosclerotic progression in the renal artery. Circulation 98: 2866-2872.
3. Caps MT, Zierer RE, Polissar NL, Bergelin RO, Beach KW, et al. (1998) Risk of atrophy in kidneys with atherosclerotic renal artery stenosis. Kidney Int 53: 735-742.
4. Chrysoschou C, Kalra PA (2009) Epidemiology and Natural History of Atherosclerotic Renovascular Disease. Progress in Cardiovascular Diseases 52: 184-195.
5. Kaplan NM, Rose BD, Bakris GL, Sheridan AM (2011) Treatment of Bilateral renal artery stenosis. Last literature review version 16: 3. September 2009 | This topic last updated: Up-to-date.
6. Spinowitz BS (2011) Renal artery stenosis management http://emedicine.medscape.com/article/245023-overview
7. CASP questionnaire http://www.sph.nhs.uk/sph-files/casp-appraisal-tools/rcf%20appraisal%20tool.pdf
8. Jadad AR, Moore RA, Carroll D, Jenkinson C, Reynolds DJ, et al. (1996) Assessing the quality of reports of randomized controlled trials: is blinding necessary? Control Clin Trials17: 1-12.
9. http://www.cebm.net
10. ASTRAL Investigators, Wheatley K, Ives N, Gray R, Kalra PA, et al. (2009) Revascularization versus medical therapy for renal-artery stenosis. N Engl J Med 361: 1953-1962.
11. Van Jaarsveld BC, Krijnen P, Pieterman H, Derkx FH, Deinum J, et al. (2000) The effect of balloon angioplasty on hypertension in atherosclerotic renal-artery stenosis. Dutch Renal Artery Stenosis Intervention Cooperative Study Group. N Engl J Med 342: 1007-1014.
12. Hirsch AT, Haskal ZJ, Hertzler NR, Bakal CW, Creager MA, et al. (2006) ACC/ AHA 2005 guidelines for the management of patients with peripheral arterial disease (lower extremity, renal, mesenteric, and abdominal aortic): executive summary a collaborative report from the American Association for Vascular Surgery/Society for Vascular Surgery, Society for Cardiovascular Angiography and Interventions, Society for Vascular Medicine and Biology, Society of Interventional Radiology, and the ACC/AHA Task Force on Practice Guidelines (Writing Committee to Develop Guidelines for the Management of Patients With Peripheral Arterial Disease) endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation; National Heart, Lung, and Blood Institute; Society for Vascular Nursing; TransAtlantic Inter-Society Consensus; and Vascular Disease Foundation. J Am Coll Cardiol 47: 1239-1312.
13. White CJ, Olin JW (2009) Diagnosis and management of atherosclerotic renal artery stenosis: improving patient selection and outcomes. Nat Clin Pract Cardiovasc Med 6: 176-190.
14. Bax L, Woltzlez AJ, Kouwenberg HJ, Mali WP, Buskens E, et al. (2009) Stent placement in patients with atherosclerotic renal artery stenosis and impaired renal function: a randomized trial. Ann Intern Med 150: 840-848.
15. Plouin PF (2003) Stable patients with atherosclerotic renal artery stenosis should be treated first with medical management. Am J Kidney Dis 42: 851-857.
16. Webster J, Marshall F, Abdalla M, Dominiczak A, Edwards R, et al. (1998) Randomised comparison of percutaneous angioplasty vs. continued medical therapy for hypertensive patients with atheromatous renal artery stenosis. Scottish and Newcastle Renal Artery Stenosis Collaborative Group. J Hum Hypertens 12: 329-335.
17. Balzer KM, Pfeffer T, Rossbach S, Voiculescu A, Mödder U, et al. (2009) Prospective randomized trial of operative vs interventional treatment for renal artery ostial occlusive disease (RAOOD). J Vasc Surg 49: 667-674.
18. Nordmann AJ, Logan AG (2003) Balloon angioplasty versus medical therapy for hypertensive patients with renal artery obstruction. Cochrane Database Syst Rev CD002944.
19. Uzzo RG, Novick AC, Goormastic M, Mascha E, Pohl M (2002) Medical versus surgical management of atherosclerotic renal artery stenosis. Transplant Proc 34: 723-726.
20. Van de Ven PJ, Kaatee R, Beutler JJ, Beek FJ, Woltzlez AJ, et al. (1999) Arterial stenting and balloon angioplasty in ostial atherosclerotic renovascular disease: a randomized trial. Lancet 353: 282-286.
21. Weibull H, Bergqvist D, Bergentz SE, Jonsson K, Hultén L, et al. (1993) Percutaneous transluminal renal angioplasty versus surgical reconstruction of atherosclerotic renal artery stenosis: a prospective randomised study. J Vasc Surg 18: 841-850.
22. Mullow C, Oxmann A (1999) Cochrane Collaboration Handbook. The Cochrane Collaboration.
23. Dworkin LD, Jamerson KA (2007) Is renal artery stenting the correct treatment of renal artery stenosis? Case against angioplasty and stenting of atherosclerotic renal artery stenosis. Circulation 115: 271-276.
24. Shannon HM, Gillespie IN, Moss JG (1998) Salvage of the solitary kidney by insertion of renal artery stent. AJR Am J Roentgenol 171: 217-222.
25. Cooper CJ, Murphy TP, Matsumoto A, Steffes M, Cohen DJ, et al. (2006) Stent revascularization for the prevention of cardiovascular and renal events among patients with renal artery stenosis and systolic hypertension: rationale and design of the CORAL trial. Am Heart J 152: 59-66.
26. Uwe S, Thomas Z (2009) Renal Artery Stenting – Developments in Practice. Interventional Cardiology 4: 104-108.
27. May AG, De Weese JA, Rob CG (1963) Haemodynamic effects of arterial stenosis. Surgery 53: 513-524.
28. Schoenberg SO, Bock M, Kallnowski F, Just A (2000) Correlation of hemodynamic impact and morphologic degree of renal artery stenosis in a canine model. J Am Soc Nephrol 11: 2190-2198.

Submit your next manuscript and get advantages of OMICS Group submissions

Unique features:
User friendly/feasible website-translation of your paper in 30 world's leading languages
Audit Version of published paper
Digital articles to share and explore
Special features:
200 Open Access Journals
15,000 editorial team
21 days rapid review process
Quality and quick editorial, review and publication processing
Indexing at PubMed (partial), Scopus, DOAJ, EBSCO, Index Copernicus and Google Scholar etc
Sharing Option: Social Networking Enabled
Authors, Reviewers and Editors rewarded with online Scientific Credits
Better discount for your subsequent articles
Submit your manuscript at: http://www.omicsonline.org/submission