Pipeline embolization device versus coiling for the treatment of large and giant unruptured intracranial aneurysms: a cost-effectiveness analysis

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OBJECTIVE Rupture of large or giant intracranial aneurysms leads to significant morbidity, mortality, and health care costs. Both coiling and the Pipeline embolization device (PED) have been shown to be safe and clinically effective for the treatment of unruptured large and giant intracranial aneurysms; however, the relative cost-to-outcome ratio is unknown. The authors present the first cost-effectiveness analysis to compare the economic impact of the PED compared with coiling or no treatment for the endovascular management of large or giant intracranial aneurysms.

METHODS A Markov model was constructed to simulate a 60-year-old woman with a large or giant intracranial aneurysm considering a PED, endovascular coiling, or no treatment in terms of neurological outcome, angiographic outcome, retreatment rates, procedural and rehabilitation costs, and rupture rates. Transition probabilities were derived from prior literature reporting outcomes and costs of PED, coiling, and no treatment for the management of aneurysms. Cost-effectiveness was defined, with the incremental cost-effectiveness ratios (ICERs) defined as difference in costs divided by the difference in quality-adjusted life years (QALYs). The ICERs < $50,000/QALY gained were considered cost-effective. To study parameter uncertainty, 1-way, 2-way, and probabilistic sensitivity analyses were performed.

RESULTS The base-case model demonstrated lifetime QALYs of 12.72 for patients in the PED cohort, 12.89 for the endovascular coiling cohort, and 9.7 for patients in the no-treatment cohort. Lifetime rehabilitation and treatment costs were $59,837.52 for PED, $79,025.42 for endovascular coiling, and $193,531.29 in the no-treatment cohort. Patients who did not undergo elective treatment were subject to increased rates of aneurysm rupture and high treatment and rehabilitation costs. One-way sensitivity analysis demonstrated that the model was most sensitive to assumptions about the costs and mortality risks for PED and coiling. Probabilistic sampling demonstrated that PED was the cost-effective strategy in 58.4% of iterations, coiling was the cost-effective strategy in 41.4% of iterations, and the no-treatment option was the cost-effective strategy in only 0.2% of iterations.

CONCLUSIONS The authors’ cost-effective model demonstrated that elective endovascular techniques such as PED and endovascular coiling are cost-effective strategies for improving health outcomes and lifetime quality of life measures in patients with large or giant unruptured intracranial aneurysm.

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efficacy of PED versus endovascular coiling, the standard endovascular technique to treat aneurysms, has demonstrated comparable neurological outcomes in patients.\(^6\) Importantly, PED use in giant intracranial aneurysms may be associated with lower overall procedural cost and higher rates of complete angiographic occlusion.\(^9\)

Although the comparative efficacy and procedural costs of these emerging endovascular techniques have been described, a cost-effectiveness analysis to demonstrate the lifetime health utility and economic impact of endovascular techniques compared with no treatment has not yet been conducted. We present the first cost-effectiveness model to directly compare PED, endovascular coiling, and no treatment to determine the cost-effectiveness of each strategy to manage large or giant intracranial aneurysms. Incremental cost-effectiveness ratios (ICERs) were used to assess the strategies. This model highlights the economic and quality of life (QOL) outcome of these novel endovascular treatment techniques.

**Methods**

**Treatment Strategies**

Our decision model captures the choice for a patient with an identified, nonsurgically resectable, large or giant intracranial aneurysm who is deciding between PED, coiling, and no treatment. We chose a nonsurgically resectable aneurysm to best evaluate the cost-effectiveness of endovascular aneurysm treatments. The treatment choices for a large, unruptured intracranial aneurysm were as follows: Strategy 1 was PED treatment; Strategy 2, endovascular coiling; and Strategy 3, no endovascular treatment.

**Decision Model**

A decision-analysis Markov model was constructed to assess the cost-effectiveness of PED, endovascular coiling, and no treatment in patients with a confirmed large or giant intracranial aneurysm that was not amenable to resection. The decision-analytical model incorporated patient QOL, survival, and costs associated with each treatment. The base-case model simulates outcomes for a 60-year-old woman with a large or giant intracranial aneurysm (> 10 mm).\(^2\) The Markov model was constructed with an annual cycle length, and it was run over a 50-year time horizon to capture the long-term implications of these 3 treatment strategies. Our model assumed a risk of death from the treatments, and a risk of aneurysm rupture (described further below), and it also assumed an underlying age-specific risk of death from other causes that was derived from the Centers for Disease Control and Prevention mortality data.\(^1\) A simplified decision analysis model is illustrated in Fig. 1.

**Model Inputs**

**Neurological Outcomes**

The modified Rankin scale (mRS) represents the primary tool to measure neurological outcomes associated with the different treatment strategies. We converted the reported mRS values into health utility scores by using
techniques described elsewhere. Distributions of mRS outcomes for each endovascular treatment option including emergency coiling for a ruptured aneurysm were obtained from the current literature. The individual mRS outcomes for patients were grouped into good outcome (mRS Score 0–2), poor outcome (mRS Score 3–5), and death (mRS Score 6) based on reported conventions for outcome after aneurysm treatment by Chalouhi et al.6 Postoperative complications such as procedural stroke, aneurysm rupture, or hemorrhage that caused permanent deficits were incorporated into our model if they caused long-term neurological deficits resulting in either poor mRS outcome or death. To model the proportions of patients who had a unique mRS score within the good and poor outcome groups, a negative binomial distribution was constructed to model the proportions of patients who had a unique mRS score, a 92% probability of achieving a good mRS score, a 5.4% probability of achieving a poor mRS score, and a 2.6% probability of death at 8-month follow-up. These findings were comparable to a larger prospective study by Becske et al. that assessed outcome rates at 3-year follow-up of PED management for large intracranial aneurysms in which 92% had good outcome, 3.5% had a poor outcome, and 4.5% died. Given the comparable rates between these 2 studies, our model used the mRS outcomes from Chalouhi et al. as a similar study population to compare with the endovascular coiling group. For endovascular management, which included conventional coiling, stent-assisted coiling, and balloon-assisted coiling, Chalouhi et al. reported 94% of patients with a good outcome (mRS Score 0–2), 6% with a poor outcome (mRS Score 3–5), and 0 deaths at 15-month follow-up.9 Other studies reported a 1.25% mortality rate associated with coiling for unruptured aneurysms.29 To account for some probability of death within the model, we assumed that the final distribution of mRS scores after treatment with endovascular coiling was 94% with a good outcome, 4.75% with a poor outcome, and 1.25% with death.

Neurological outcome after spontaneous rupture of aneurysms that underwent subsequent emergency treatment was derived from the landmark International Subarachnoid Aneurysm Trial (ISAT), in which 76.5% of patients had mRS scores of 0–2, 15.5% had mRS scores of 3–5, and 8% died.31 Although the ISAT did not emphasize the emergency treatment of large or giant aneurysms specifically, these outcome values are similar to the existing reports in the literature that describe mRS outcome at 1-year follow-up after rupture of a large or giant intracranial aneurysm with endovascular treatment, and thus are used within our model.11,12,16,17,19 The probabilities of good outcome, poor outcome, and death after rupture of a previously treated aneurysm were also based on outcomes from the ISAT.20,21 Our model assumed that patients with major disability (mRS Score 3–5) after initial treatment who had a subsequent aneurysm rupture either still had a poor outcome (mRS Score 3–5) or died—these patients had a 66% chance of remaining at mRS Score 3–5 and a 34% chance of death following rupture.20,27

### Angiographic Outcomes by Type of Treatment

Chalouhi et al. reported that within the 1st year of treatment with either PED or endovascular coiling, 2.8% of those undergoing PED required additional treatment with coiling, whereas 37% of patients initially treated with coiling required subsequent recoiling.6 Chalouhi et al. reported that 86% of patients treated with PED had complete angiographic occlusion at 7 months. Given that occlusion rates after PED treatment increased over time28 and that the angiographic outcome reported by Chalouhi et al. was similar to complete occlusion rates at a follow-up of > 1 year, these values were included within our model.3 Chalouhi et al. report that, following endovascular coiling, 41% of patients attained complete occlusion at 12-month follow-up. Patients who had incomplete angiographic occlusion of their aneurysm were subject to an annual rupture risk of 4.3%.3 Our model assumed that patients who had aneurysmal rupture and emergency endovascular coiling were subject to the same retreatment and angiographic occlusion.

### TABLE 1. Neurological outcome (mRS score) by health utility score (QALYs) in reports of patients with large or giant unruptured aneurysms

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Health Utility</th>
<th>SD</th>
<th>Distribution</th>
<th>Authors &amp; Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>mRS Score 0–2, PED/coil</td>
<td>0.851</td>
<td>0.18</td>
<td>Beta</td>
<td>Rivero-Arias et al., 2010; Chalouhi et al., 2013</td>
</tr>
<tr>
<td>mRS Score 3–5, PED/coil</td>
<td>0.478</td>
<td>0.24</td>
<td>Beta</td>
<td>Rivero-Arias et al., 2010; Chalouhi et al., 2013</td>
</tr>
<tr>
<td>mRS Score 0–2, emergency treatment</td>
<td>0.81</td>
<td>0.21</td>
<td>Beta</td>
<td>Molyneux et al., 2005</td>
</tr>
<tr>
<td>mRS Score 3–5, emergency treatment</td>
<td>0.41</td>
<td>0.32</td>
<td>Beta</td>
<td>Molyneux et al., 2005</td>
</tr>
</tbody>
</table>
sion rates as with elective coiling. Our model also assumed complete angiographic occlusion after emergency retraction of a previously treated aneurysm. All probabilities, angiographic outcomes, rupture rates, and retraction rates are detailed in Table 2.

Treatment Costs

The costs of endovascular coiling (which averaged the costs of stent-assisted coiling, balloon-assisted coiling, and conventional coiling) and the costs for PED were derived from published literature describing the treatment of large or giant intracranial aneurysms. The costs of PED and coiling were consistent with previously reported findings in the literature demonstrating that the overall procedural costs of PED were lower relative to elective coiling. Costs of emergency coiling and associated hospitalization fees were derived from a prior cost-effectiveness study assessing the role of endovascular coiling in treating ruptured aneurysms. The cost of endovascular reination after initial intervention was equivalent to the entire procedure cost associated with endovascular coiling. All interventional costs also consisted of additional procedural costs of intraoperative and postoperative angiograms. Indirect costs to account for the management of functional disability were derived from a prior cost-effectiveness study on rehabilitation and special nursing facility costs associated with each mRS score. All retrospectively obtained costs from the literature were converted to 2016 US dollars to account for inflation (https://data.bls.gov/cgi-bin/cpicalc.pl). All costs in the model are detailed in Table 3.

Cost-Effectiveness Analysis

TreeAge Pro 2016 (TreeAge Software) was used to construct the decision analysis model. Our model discounted utilities and costs by 3% annually. Cost-effectiveness between the different treatments was assessed using the ICER, which represents the difference in costs divided by the difference in quality-adjusted life years (QALYs) between the treatment arms. Results were considered cost-effective if the ICER was less than a willingness-to-pay cutoff of $50,000/QALY—a convention used in cost-effectiveness analyses. A strategy was considered dominant within this analysis if both the costs were more and the health utility outcomes were less than a competing strategy. The cost-effectiveness results are presented from a societal viewpoint.

The base-case analysis represents the cost-effectiveness analysis using our best estimation of all parameters in the model. In addition to the base-case analysis we conducted 1-way, 2-way, and probabilistic sensitivity analyses. The 1-way sensitivity analyses were performed on all variables in the model, although we present only variables that the model was most sensitive to, including changes in patient age, probability of spontaneous rupture, cost of PED, and cost of coiling. Probabilistic sensitivity analysis consisted of a Monte Carlo simulation that included 100,000 iterations, which sampled from model parameters to fit individual probability distributions. In the probabilistic sensitivity analysis, age was modeled as a binomial distribution, costs were modeled by gamma distributions (constrained between 0 and infinity), and probabilities and
health utilities were modeled as beta distributions (constrained between 0 and 1). When possible, the standard deviation of each modeled variable was obtained from the literature, although when unavailable the standard deviation was assumed to be 20% of the mean value.

**Results**

**Base-Case Analysis**

Our base-case cost-effectiveness model demonstrated that elective PED and endovascular coiling were more effective than no treatment, yielding 12.72 QALYs in the PED group and 12.89 QALYs in the endovascular coiling group. Lifetime treatment and rehabilitation costs in the base-case scenario were $59,800 for PED and $79,000 for endovascular coiling. Patients who did not undergo elective treatment had an effectiveness of 9.7 QALYs, and costs of $193,500. Our cost-effectiveness analysis showed that although endovascular coiling provided more QALYs over a lifetime, the increased costs incurred to achieve those QALYs yielded an ICER of $123,600 per QALY gained.

**One-Way Sensitivity Analysis**

One-way sensitivity analysis demonstrated that the cost-effectiveness comparing PED and coiling was most sensitive to changes in cost of PED, cost of coiling, and probability of spontaneous death after PED (Table 4). As the initial cost of PED exceeded $40,100, coiling became the more cost-effective option at a willingness-to-pay threshold of $50,000 per QALY gained.

**Two-Way Sensitivity Analysis**

A 2-way sensitivity analysis was constructed to illustrate how the cost-effective strategy between PED and coiling transitioned across initial treatment costs ranging from $5,000 to $50,000 for either PED or coiling (Fig. 3). At a PED cost of < $11,200, PED remained the cost-effective strategy compared with the cost of coiling ranging up to $50,000. At a cost of endovascular coiling > $44,900, PED was the cost-effective strategy ranging up to $50,000.

**Probabilistic Sensitivity Analysis**

Figure 4 demonstrates the results of the Monte Carlo probabilistic sensitivity analysis. This analysis found that the no-treatment option was unlikely to be cost-effective across a range of willingness-to-pay thresholds compared with the 2 treatment options. When comparing PED and coiling, the probabilistic sensitivity analysis demonstrated a moderate degree of uncertainty with regard to which treatment arm was more cost-effective. At a willingness-to-pay threshold of $50,000/QALY, the PED was the cost-effective strategy in 58.4% of iterations, coiling was the cost-effective strategy in 41.4% of iterations, and the no-treatment option was the cost-effective strategy in 0.2% of iterations.

**Discussion**

As novel endovascular techniques emerge and become increasingly prevalent in the elective management of unruptured large or giant intracranial aneurysms, it is imperative for health care decision makers and patients to be informed on the cost-effectiveness of these treatment techniques. Patients who have large or giant intracranial aneurysms are at a very high risk of rupture, ranging from 7% to 43% annually, which results in expensive emergency treatment, a high mortality rate, and a high potential for severe neurological disability.
Whereas prior cost-effectiveness models have assessed neurosurgical clipping compared with endovascular coiling for emergency treatment of ruptured aneurysms, the present work is the first cost-effectiveness study to examine the elective endovascular management of large or giant intracranial aneurysms. Our model demonstrates that both elective PED and endovascular coiling are efficacious in dramatically improving lifetime QALYs, resulting in lifetime QALYs of 12.72 and 12.89, respectively, compared with QALYs of 9.7 in the no-treatment cohort. Although not undergoing treatment may be cost saving initially due to avoiding procedural costs, the high annual rupture rate associated with large or giant aneurysms and the subsequent ramifications, including higher costs of emergency intervention, lifetime rehabilitation, and severe neurological disability as well as elevated risk of death argue decisively in favor of aneurysm treatment provided using endovascular techniques.

Our model was sensitive to changes in the cost of PED and coiling, respectively. Chalouhi et al. reported a large variance in the cost of PED ($24,995.46 ± $12,531.70) and endovascular coiling ($31,906.29 ± $24,861.65). The costs of PED and endovascular coiling vary depending on the characteristics of the aneurysm, such as its size. Our model demonstrated that the more cost-effective endovascular treatment strategy between PED and coiling depended on the price of each procedure across a comparable range of costs. Using the mean procedural costs in the literature, our model indicated that PED may be slightly more cost-effective than coiling over a lifetime, possibly due to the decreased incidence of retreatment and higher rates of angiographic occlusion.

Notably, endovascular coiling generated 0.15 more QALYs over a lifetime compared with the PED, which would largely be ascribed to the higher initial mortality of 2.6% with the PED compared with a procedural mortality of 1.25% with endovascular coiling. Complications associated with the PED, including parent vessel thrombosis, still only represent a small fraction of patients, and the incidence of morbidity and mortality associated with the PED may decrease as technical skill and management of these patients continue to improve. Moreover, the probabilistic sensitivity analysis demonstrated that the PED was the dominant strategy in 58% of 100,000 iterations of our model compared with endovascular coiling dominating in 41% of iterations. These rates are similar due to the comparable neurological outcomes associated with both treatment techniques. The probabilistic sensitivity analysis demonstrates slight favorability of PED over coiling given the trend toward lower procedural costs, decreased need for retreatment, and improved angiographic outcomes. The no-treatment strategy was cost-effective in only 0.2% of iterations, demonstrating the urgent and important need to electively treat an identified large or giant

FIG. 2. Graph showing cost-effectiveness analysis demonstrating the cost and overall QALY for the competing strategies. The no-treatment strategy (yellow, highlighted in green) is shown to be dominated by elective PED and coiling treatment. The PED and coiling treatment demonstrated 12.72 QALYs and 12.89 QALYs, respectively, with an ICER of $123,600 per QALY gained, indicating that PED was the more cost-effective strategy.
Aneurysm to improve both QOL and decrease health care costs across a lifetime.

This model has several limitations—the primary outcomes of this study are based on the assumptions of prior studies. Given that large or giant intracranial aneurysms may not always be amenable to surgical clipping, vessel sacrifice, and bypass, surgical options were not included in this model and were beyond the scope of this analysis. Most

### TABLE 4. One-way sensitivity analysis demonstrating changes in ICER in patients with large or giant unruptured aneurysms

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value Used for Sensitivity Analysis</th>
<th>ICER for PED</th>
<th>ICER for Coiling</th>
<th>ICER for No Treatment</th>
<th>Dominant Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial procedural cost of PED</td>
<td>$5,000</td>
<td>$286,194.57</td>
<td>$224,866.85</td>
<td>Dominated PED</td>
<td>PED</td>
</tr>
<tr>
<td></td>
<td>$14,000</td>
<td>$286,194.57</td>
<td>$224,866.85</td>
<td>Dominated PED</td>
<td>PED</td>
</tr>
<tr>
<td></td>
<td>$23,000</td>
<td>$286,194.57</td>
<td>$224,866.85</td>
<td>Dominated PED</td>
<td>PED</td>
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<tr>
<td></td>
<td>$32,000</td>
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<td>Dominated PED</td>
<td>PED</td>
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<td>$41,000</td>
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<td>PED</td>
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<td></td>
<td>$50,000</td>
<td>$286,194.57</td>
<td>$224,866.85</td>
<td>Dominated Coil</td>
<td>Coil</td>
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<tr>
<td>Initial procedural cost of endovascular coiling</td>
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<td>$14,000</td>
<td>Dominated Coiling</td>
<td>Coiling</td>
</tr>
<tr>
<td></td>
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<td>Dominated</td>
<td>$23,000</td>
<td>Dominated PED</td>
<td>PED</td>
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<tr>
<td></td>
<td>$23,000</td>
<td>Dominated</td>
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<td>Dominated PED</td>
<td>PED</td>
</tr>
<tr>
<td></td>
<td>$41,000</td>
<td>Dominated</td>
<td>$50,000</td>
<td>Dominated PED</td>
<td>PED</td>
</tr>
<tr>
<td>Probability of initial death after PED treatment</td>
<td>0%</td>
<td>Dominated</td>
<td>$286,194.57</td>
<td>Dominated PED</td>
<td>PED</td>
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<td></td>
<td>1%</td>
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</tr>
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</table>

*An ICER corresponding to 0 refers to a nondominated base value. An ICER is dominated if another treatment option can provide more QALYs at lower cost. Nondominated ICERs < $50,000 were deemed cost-effective. Boldface type indicates cost-effectiveness.*

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**FIG. 3.** Graph showing 2-way sensitivity analysis for the base-case scenario of PED treatment versus endovascular coiling versus no treatment as management plan for large or giant unruptured intracranial aneurysm.
of the model inputs were data obtained from retrospective single-center studies, due to the lack of randomized prospective data comparing the different endovascular techniques. The procedural costs in this model were derived from a single-center study and may not reflect costs in different clinical settings. However, our model addressed this limitation using 1- and 2-way sensitivity analyses to adjust procedural costs from $5000 to $50,000, and aggregated the costs of endovascular coiling with balloon-assisted coiling and stent-assisted coiling. Probabilities of technical success may also differ across surgeons and centers; we also addressed this using a 1-way sensitivity analysis. Our model does not include additional costs associated with endovascular complications, such as femoral hematoma, vessel vasospasm related to catheter procedures, or thromboembolic stroke. However, to address this limitation, our model captured complications as affecting QOL if they caused long-term disability or death. Although our model derived all neurological outcome probabilities and costs from the single existing comparative study assessing PED and endovascular coiling for large or giant aneurysm, these variables were consistent with those in larger, prospective studies comparing the efficacy of these techniques individually. Future cost-effectiveness studies comparing endovascular techniques may benefit from additional data on procedural costs, neurological and angiographic outcomes, and complication and retreatment rates from larger, prospective multicenter settings.

Despite these limitations, our model is the first cost-effectiveness analysis that directly compares the elective endovascular management of large or giant intracranial aneurysms and provides an important perspective on the impact of aneurysm treatment on cost and health utilities. These findings should be considered in the setting of competing procedural options for a patient with a large or unruptured intracranial aneurysm to guide an informed decision that optimizes QOL and minimizes costs of intervention and rehabilitation.

Conclusions

Large or giant intracranial aneurysms pose a high risk of rupture—leading to expensive emergency treatments, reduction in QOL due to neurological disability, and a higher risk of death. Our cost-effectiveness model demonstrates that elective endovascular techniques such as PED and endovascular coiling are cost-effective strategies for improving health outcomes and lifetime QOL measures in patients with large or giant unruptured intracranial aneurysm.

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References

Cost-effectiveness of Pipeline versus coiling


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Disclosures
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