

Coil embolisation of unruptured intracranial aneurysms

HealthTech guidance
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www.nice.org.uk/guidance/htg63

Your responsibility

This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account, and specifically any special arrangements relating to the introduction of new interventional procedures. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties. Providers should ensure that governance structures are in place to review, authorise and monitor the introduction of new devices and procedures.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guidance replaces IPG105.

1 Recommendations

- 1.1 Current evidence suggests that coil embolisation is efficacious in obliterating unruptured intracranial aneurysms and that its safety is similar to that of surgical treatment.
- 1.2 The annual risk of haemorrhage from unruptured intracranial aneurysms varies widely, depending on their site and size; and the lifetime risk depends on life expectancy and other factors. The decision to treat unruptured intracranial aneurysms by coil embolisation therefore requires judgement of the risks for each patient, and recognition of the importance of patient choice. Clinicians wishing to undertake this procedure should ensure that:
 - normal arrangements are in place for audit and clinical governance
 - patients understand the relative risks of coil embolisation and surgery compared to the risk of having no treatment when giving their consent for this treatment. Use of NICE's information for the public is recommended.
- 1.3 The procedure should only be performed in specialist units with expertise in the endovascular treatment of intracranial aneurysms.

2 The procedure

2.1 Indications

- 2.1.1 Intracranial aneurysms are small balloon-like dilated portions of blood vessels that may occasionally rupture, causing haemorrhage, stroke or death. Usually, the cause is unknown, but people with genetic causes of weak blood vessels are more likely to develop aneurysms.
- 2.1.2 The traditional treatment for ruptured or unruptured aneurysms involves open surgery to clip the abnormal blood vessels inside the skull.

2.2 Outline of the procedure

- 2.2.1 The coil technique involves approaching the aneurysm from inside the diseased blood vessel, thereby avoiding the need to open the skull. A thin tube containing the coil on a guidewire is inserted into a large artery, usually in the groin, and passed up into the skull under radiological guidance. The coil is placed inside the aneurysm and detached from the guidewire. Once in position, it causes clotting and stops blood from entering the aneurysm. Multiple coils may be inserted into the aneurysm through the same tube until the aneurysm is filled with coils.
- 2.2.2 The coil technique is mainly carried out on ruptured aneurysms but may also be used to treat unruptured aneurysms.

2.3 Efficacy

- 2.3.1 In a large observational study, it was reported that overall morbidity and mortality associated with endovascular repair was 9% (41/451) at 1 year after having the procedure, compared with 12% (233/1917) for surgery. Similar results were reported in smaller studies comparing the two techniques. However, these comparisons are difficult because patient characteristics differed between the

two groups; for example, those who underwent endovascular repair were often older than those who had surgery.

2.3.2 For the patients undergoing endovascular repair by coil embolisation in the International Study of Unruptured Intracranial Aneurysms, obliteration was complete in 55% (207/379) of patients, incomplete in 24% (91/379), unsuccessful in 18% (67/379), and unknown in 3% (12/379) of patients. At 1 year after the procedure, less than 1% of patients (4/451) had a moderate or severe disability, as measured by the Rankin score. In other studies on this procedure, the rate of permanent complications ranged from 5% (6/116) to 8% (3/38). For more details, see the [overview](#).

2.3.3 The Specialist Advisors considered that the main uncertainty related to the long-term durability of the procedure.

2.4 Safety

2.4.1 In a retrospective study of 62 patients, the procedure-related complication rate was 23% (14/62) after coil embolisation. Major complications resulting in reduced functional status were reported in five patients (8%) and minor complications causing prolonged hospitalisation were reported in nine patients (15%). Adverse events during initial and follow-up hospitalisation included intra- or postoperative rupture (6%, 4/62 patients) and cranial neuropathy (11%, 7/62 patients). For more details, see the [overview](#).

2.4.2 In the large observational study, perioperative haemorrhage was noted in 2% (10/451) and cerebral infarction in 6% (26/451) of patients who underwent endovascular repair.

2.4.3 The Specialist Advisors considered that this was a safe procedure. One Advisor noted that complications during the procedure include rupture of the aneurysm or thrombo-embolic occlusion of intracranial vessels, but these complications are uncommon. There is also a small risk of delayed haemorrhage from the aneurysm.

3 Further information

Sources of evidence

The evidence considered by the committee is in the [overview](#).

Information for patients

NICE has produced [information on this procedure for patients and carers](#). It explains the nature of the procedure and the guidance issued by NICE, and has been written with patient consent in mind.

Update information

Minor changes since publication

January 2026: Interventional procedures guidance 105 has been migrated to HealthTech guidance 63. The recommendations and accompanying content remain unchanged.

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Endorsing organisation

This guidance has been endorsed by Healthcare Improvement Scotland.