

The logo for LINC (Leipzig Interventional Course) features the letters 'LINC' in a white, sans-serif font. To the right of the text is a stylized graphic consisting of two overlapping, curved shapes in red and orange, resembling a flame or a dynamic motion. The entire logo is set against a dark blue background with a subtle, larger-scale brushstroke pattern.

LINC

Leipzig Interventional Course
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Drug coated balloons vs. BMS for the treatment of femoropopliteal lesions

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Disclosure

Speaker name: Hans Krankenberg

I do not have any potential conflict of interest

2017 ESC Guidelines

Revascularization of femoro-popliteal lesions

Recommendations on revascularization of femoro-popliteal occlusive lesions^c

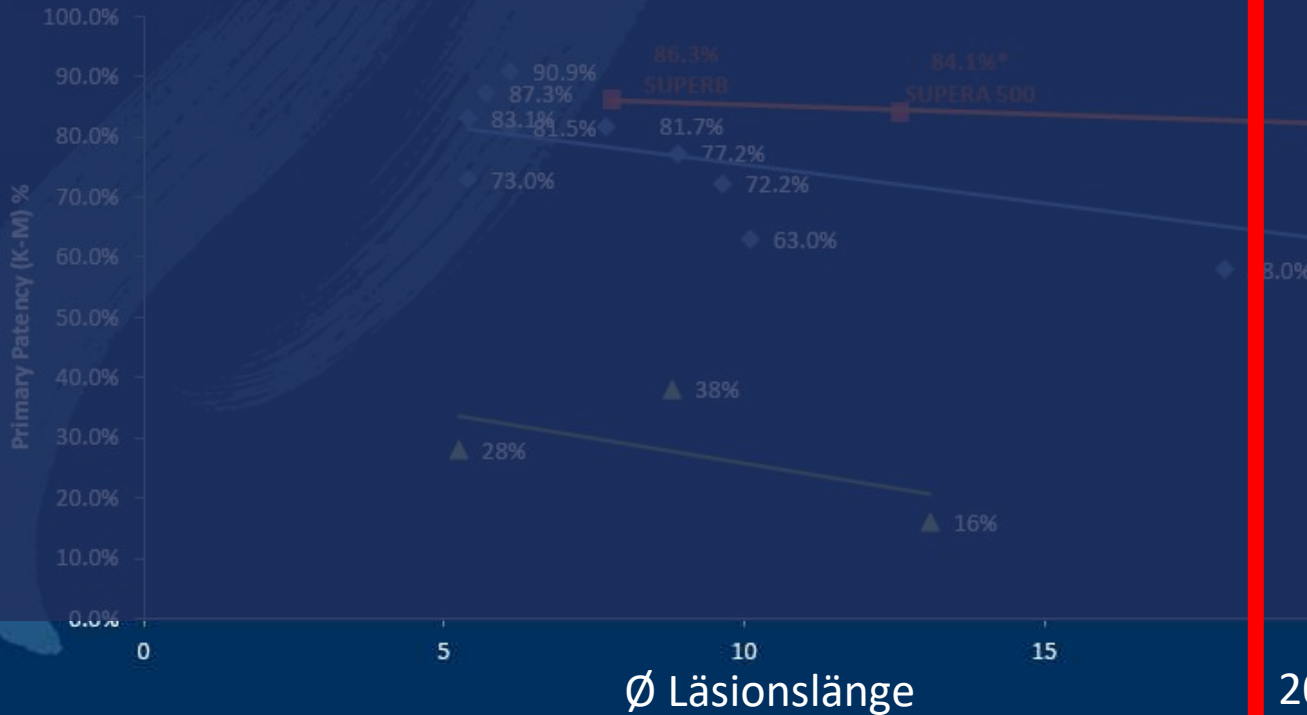
An endovascular-first strategy is recommended in short (i.e. <25 cm) lesions. ³⁰	I	
Primary stent implantation should be considered in short (i.e. <25 cm) lesions.	IIa	
Drug-eluting balloons may be considered in short (i.e. <25 cm) lesions. ^{77,306-3}	IIb	
Drug-eluting stents may be considered for short (i.e. <25 cm) lesions. ^{302,303,31}	IIb	
The autologous saphenous vein is the conduit of choice for femoro-popliteal bypass. ^{284,315}	I	A
When above-the-knee bypass is indicated, the use of a prosthetic conduit should be considered in the absence of any autologous saphenous vein. ²⁸⁴	IIa	A
In patients unfit for surgery, endovascular therapy may be considered in long (i.e. ≥25 cm) femoro-popliteal lesions. ³¹²	IIb	C

Primary Patency

12 months

Long lesions

12 Month Data Across SFA trials by Lesion Length



SUPERA 500
Long Lesions (N=172)
SUPERA Nitinolstent
82%

ZILVER PTX
Long lesions (N=126)
77%

Nitinolstent
Long lesions (N=100 / 58 / 204)
65% DURABILITY
66% STELLA
49% MARIS

20 cm 25 cm

2017 ESC Guidelines

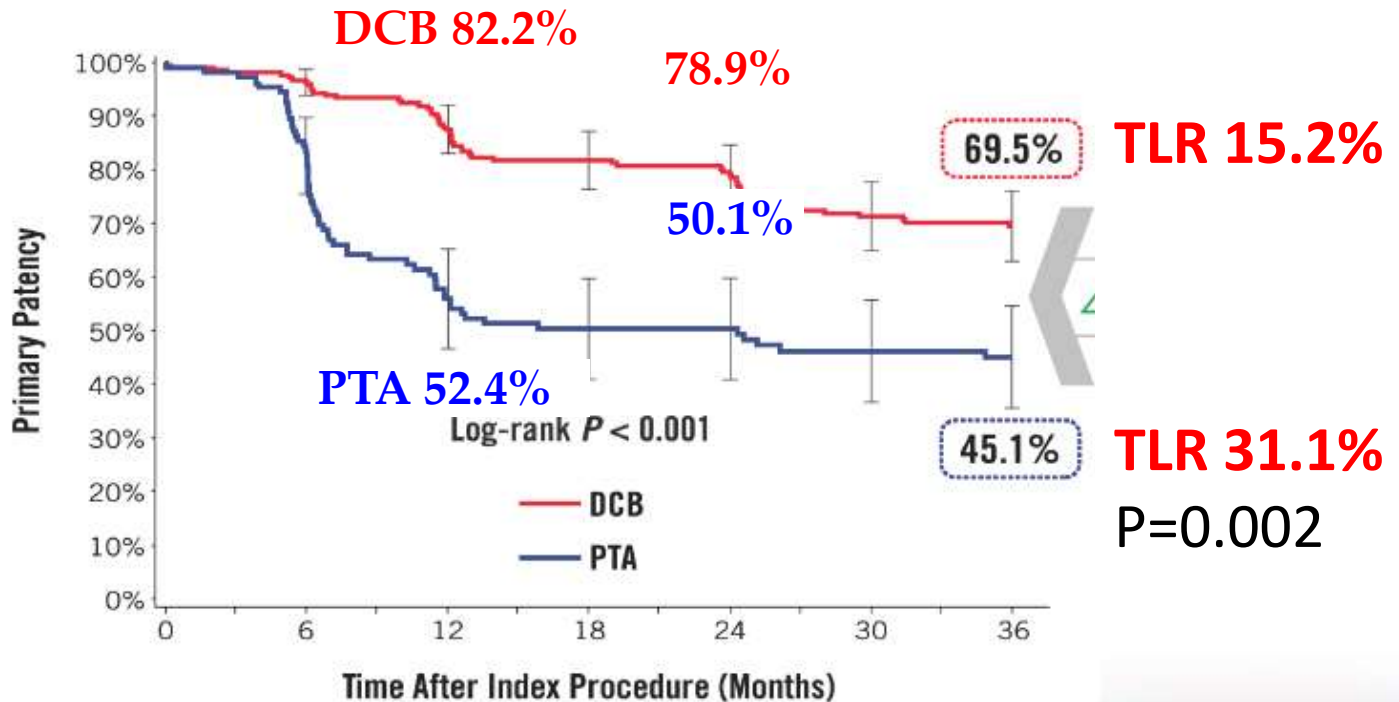
Revascularization of femoro-popliteal lesions

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Primary patency

IN.PACT SFA Trial (n=331, Ø Lesion length 9 cm)

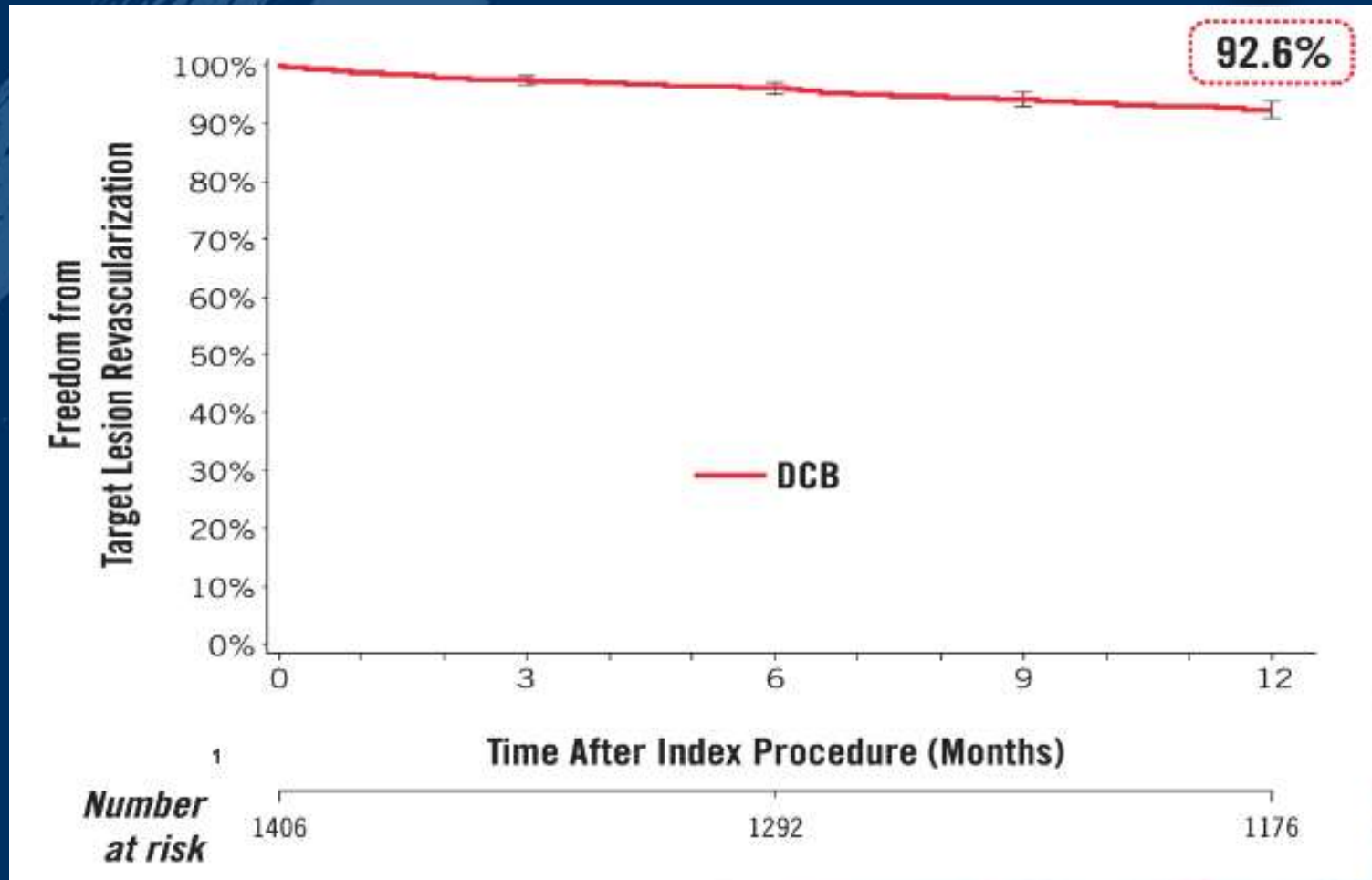
Primary Patency¹ Through 3 Years



Number²	DCB	220	213	192	149	121
at risk	PTA	111	108	69	52	41

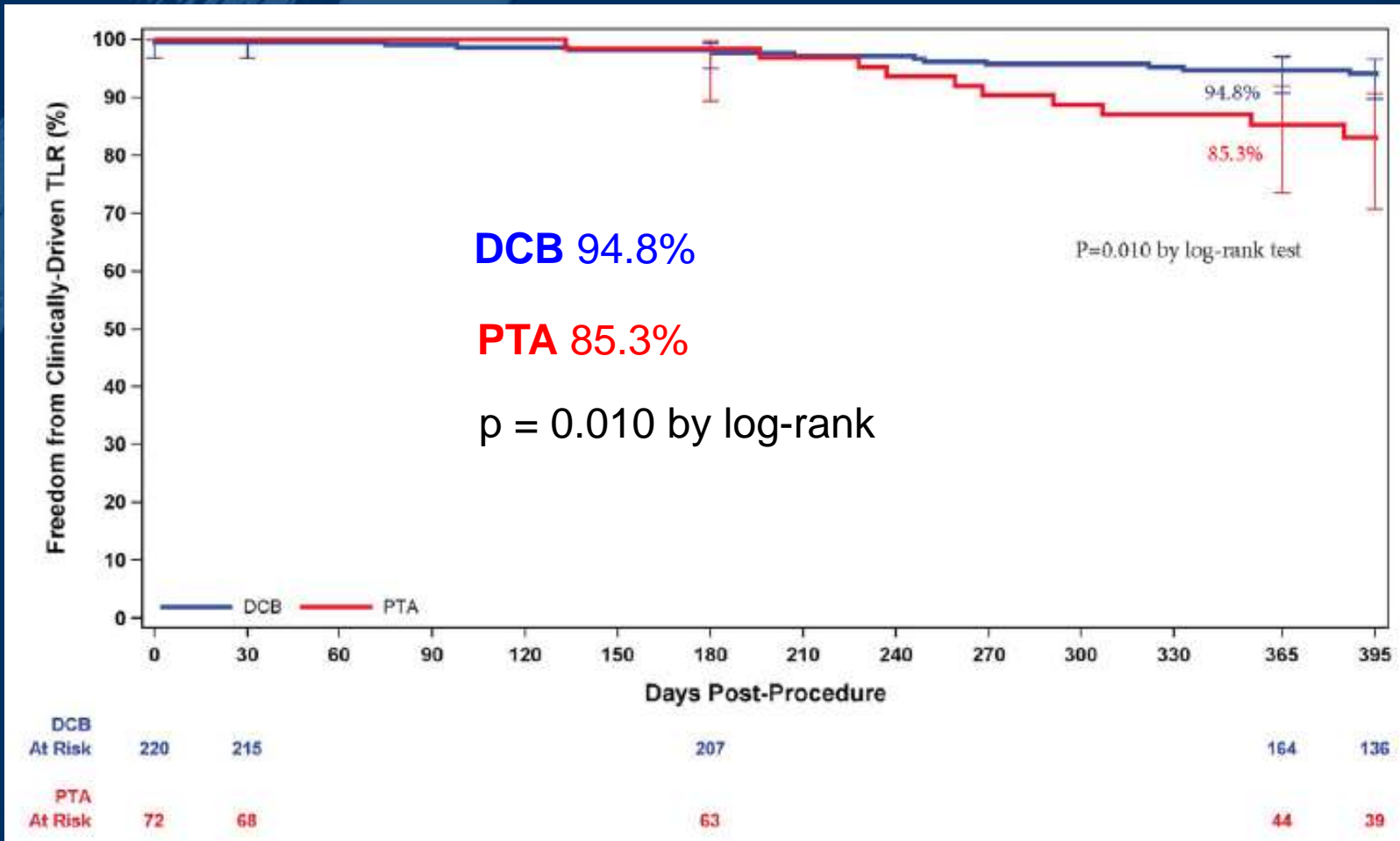
Freedom from cdTLR

IN.PACT Global (n=1406, \emptyset Lesion length 12 cm)



Freedom from cdTLR

ILLUMENATE European RCT (n=222, \emptyset Lesion length 7 cm)



Authors' conclusions

„...there is evidence of an advantage for DEBs compared with uncoated balloon angioplasty in several anatomic endpoints such as

- primary vessel patency (high-quality evidence),
- binary restenosis rate (moderate quality evidence),
- and target lesion revascularization (low-quality evidence)

for up to 12 months.“

Authors' conclusions

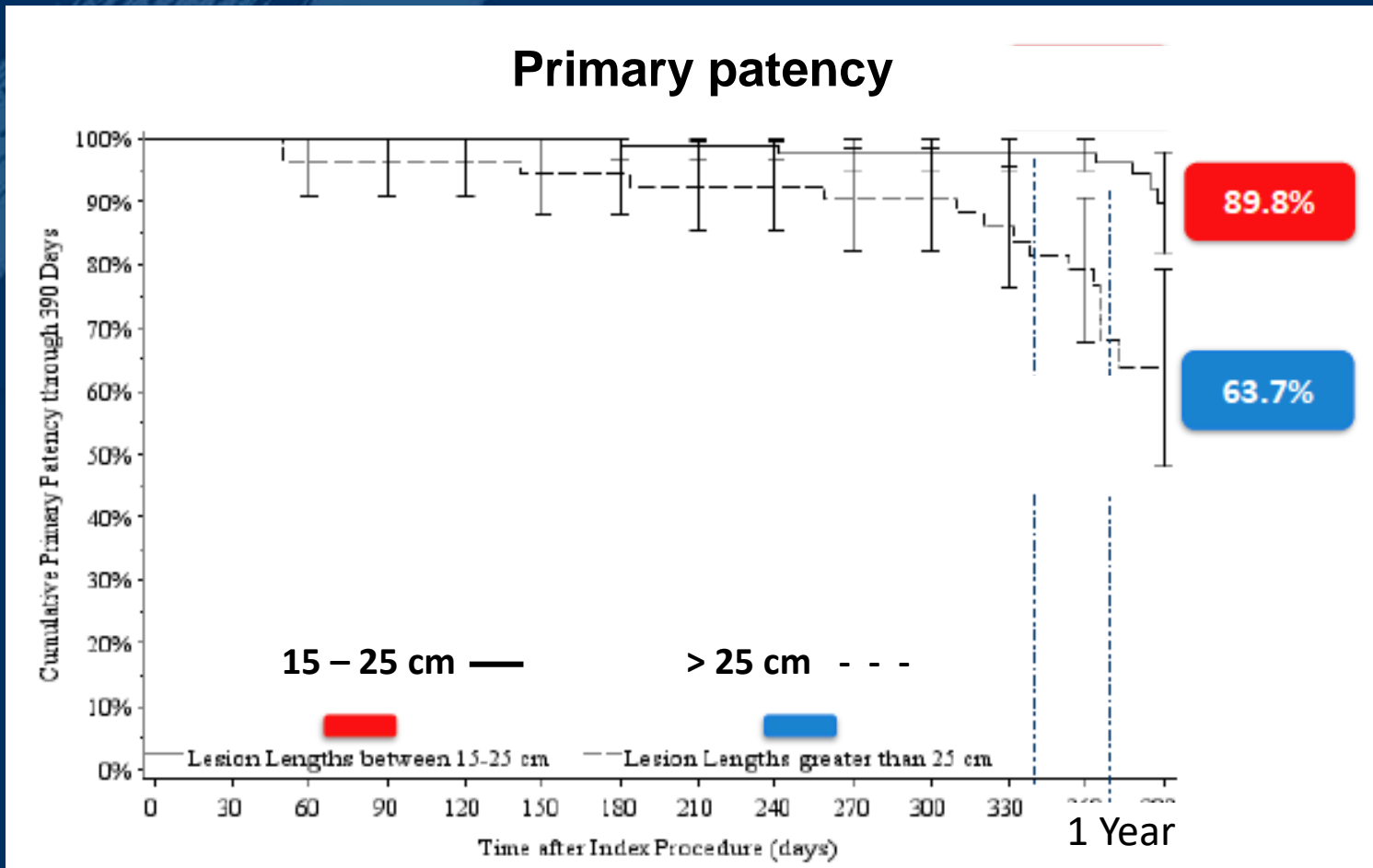
„...Conversely, there is no evidence of an advantage for DEBs in clinical endpoints such as

- amputation,
- death,
- or change in ABI, or change in Rutherford category

during 12 months' follow-up.“

DCB – Long lesions

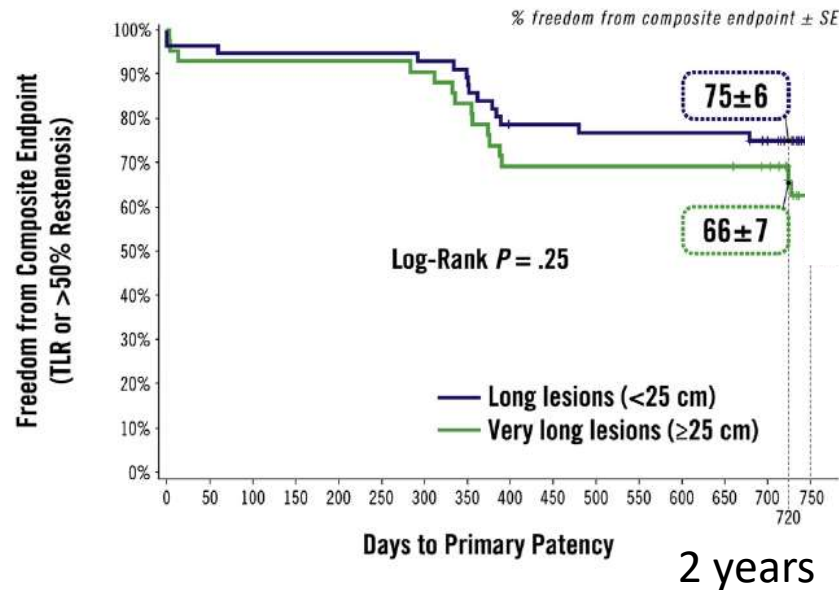
IN.PACT Global (Long lesions n=157/655)



DCB – Long lesions

SFA-Long Study / Real World Registry

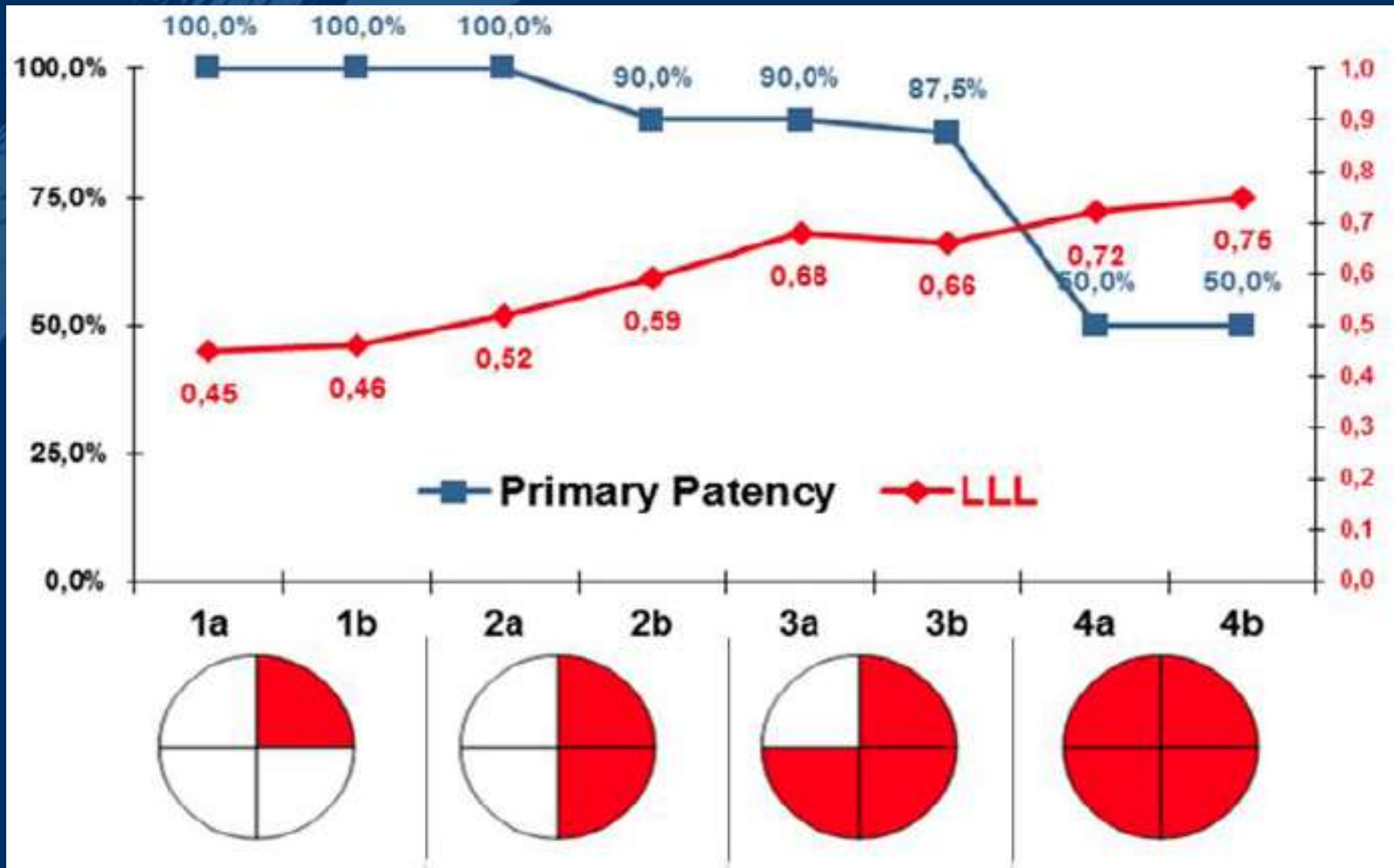
SFA-Long Study (N=105)¹



¹ Micari A et al. J Am Coll Cardiol Intv 2017;10:728-34, ² Schmidt A et al. J Am Coll Cardiol Intv 2016;9:715-24

DCB – Calcified lesions

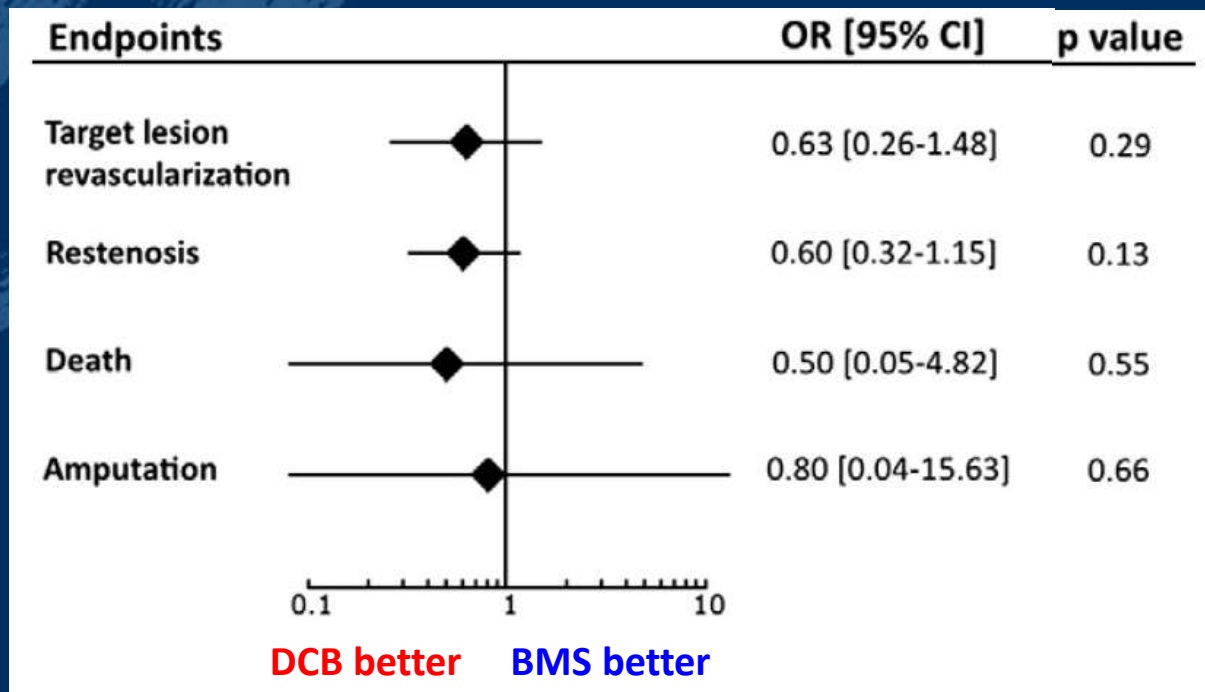
n=60, de novo lesion 3-30 cm, 1 year



DCB vs. BMS

Indirect comparison (11 RCTs)

DCB vs. PTA (n=441), **BMS** vs. PTA (n=1023)



* **DEB vs. PTA:** THUNDER, FemPac, LEVANT I, PACIFIER, BIOLUX
BMS vs. PTA: ABSOLUTE, ASTRON, ETAP, FAST, RESILIENT, SUPER

Conclusion

- BMS and DCB are effective in femoropopliteal lesions.
- A direct comparison is still lacking.
- Limitations: very long and calcified lesions
- Possible treatment strategy:
 - Spot-stenting + optional DCB
 - DCB + optional BMS

The logo for LINC, featuring a stylized red and orange flame or ribbon shape above the letters LINC.

LINC

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