

TCT@ACC-i2: Invasive and Interventional Cardiology

IMPACT OF POSITIVE AND NEGATIVE CORONARY REMODELING ON CULPRIT LESION MORPHOMETRY: THE ADAPT-DES IVUS SUBSTUDY

Poster Contributions

Poster Sessions, Expo North

Sunday, March 10, 2013, 9:45 a.m.-10:30 a.m.

Session Title: Intravascular Imaging: IVUS and OCT

Abstract Category: 38. TCT@ACC-i2: Intravascular Imaging and Physiology

Presentation Number: 2108-246

Authors: *Shinji Inaba, Gary Mintz, Bernhard Witzembichler, Christopher Metzger, Michael Rinaldi, Ernest Mazzaferri, Peter Duffy, Giora Weisz, Thomas Stuckey, Bruce Brodie, Ke Xu, Roxana Mehran, Gregg Stone, Akiko Maehara, Cardiovascular Research Foundation, New York, NY, USA*

Background: The relationship between vessel remodeling and plaque characteristics is incompletely understood.

Methods: ADAPT-DES was a prospective, multicenter observational study of 8,583 consecutive pts undergoing PCI with DES. A pre-specified intravascular ultrasound (IVUS) substudy enrolled 2670 pts; 831 culprit and 768 non-culprit lesions in 913 pts were evaluated by grayscale and virtual histology (VH)- IVUS pre-PCI. Receiver operating curve analysis identified 2 separate cut-off points that differentiated culprit from non-culprit lesions: Remodeling index (RI=lesion/reference arterial area)=0.85 and RI=1.09 [AUC; 0.66 (0.64-0.68)]. We then defined negative remodeling as RI \leq 0.85, intermediate remodeling as 0.85 < RI \leq 1.09, and positive remodeling as RI >1.09.

Results: Lesions with either positive or negative remodeling were longer, had a smaller MLA and a larger plaque burden, and more often contained a VH-TCFA (thin-cap fibroatheroma) compared to intermediate remodeled lesions. However, plaque rupture was observed far more frequently in positive remodeled lesions, while a calcified nodules were observed more frequently in negatively remodeled lesions (Table).

Conclusions: Both negative and positive remodeling are associated with clinically active coronary lesions (larger plaque burden, smaller MLA, more common VH-TCFA, plaque rupture, and calcified nodules) indicating that it is the magnitude of remodeling and not just the direction (inward or outward) that is important.

	Negative remodeling (n=469)	Intermediate remodeling (n=779)	Positive remodeling (n=351)	P value
Culprit lesions	60.6% (284)	35.4% (276)	77.2% (271)	<0.0001
Remodeling index	0.71 [0.70, 0.72]	0.97 [0.96, 0.97]	1.35 [1.31, 1.39]	<0.0001
MLA, mm ²	3.89 [3.69, 4.08]	5.43 [5.20, 5.67]	3.49 [3.23, 3.74]	<0.0001
Plaque burden at MLA, %	64.8 [63.5, 66.0]	63.0 [62.1, 63.9]	75.1 [73.8, 76.4]	<0.0001
Area stenosis	0.75 [0.74, 0.76]	0.64 [0.63, 0.65]	0.68 [0.66, 0.69]	<0.0001
Lesion length, mm	24.0 [22.6, 25.5]	15.0 [14.2, 15.9]	24.2 [22.4, 25.9]	<0.0001
VH-TCFA	61.2% (287)	51.6% (402)	60.1% (211)	0.0003
TCFA length, mm	7.5 [6.7, 8.3]	6.3 [5.7, 6.9]	8.2 [7.1, 9.2]	0.004
Plaque rupture	13.9% (65)	14.0% (109)	35.6% (125)	<0.0001
Calcified nodule	17.9% (84)	8.5% (66)	10.5% (37)	<0.0001