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Bare-nitinol stent versus paclitaxel-coated balloon for femoro-popliteal revascularization. An adjusted indirect comparison meta-analysis of randomized trials
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Background: In femoro-popliteal artery (FPA) disease, Bare-Nitinol Stent (BNS) and Paclitaxel-coated balloon (PCB) improved outcomes as compared to Uncoated Balloon (UCB) angioplasty. Nevertheless, the relative efficacy of BNS vs. PCB remains unknown, due to the lack of head-to-head comparisons. We performed an adjusted indirect comparison meta-analysis of randomized trials to evaluate outcomes of BNS versus PCB in FPA disease.

Methods: A systematic literature search (PubMed, EMBASE, the Cochrane Central Register of Controlled Trials, scientific abstracts and relevant websites) through December 2011 was performed. Selected search words were: superficial-femoral artery, popliteal artery, angioplasty, self-expanding stent, nitinol-stent, bare-stent, drug-eluting balloon, paclitaxel-coated balloon, and randomized trial. Inclusion criteria were: randomized trial design, intent to treat analysis, ≥6-month follow-up (FU). Exclusion criteria were: other arterial segments treated than FPA, comparison other than BNS/PCB vs. UCB, irretrievable, duplicate or incomplete data. Odds ratio (OR [95% confidence intervals]) and z scores (z), with corresponding p values, were used as summary statistics. Main outcomes were target lesion revascularization (TLR), binary restenosis and all cause mortality.

Results: We identified 8 eligible trials, enrolling a total of 1,008 patients randomized to BNS/PCB or UCB angioplasty (BNS n=342, PCB n=186, UCB n=480). Median FU was 11.5 months. Angioplasty with BNS was found inferior to PCB with respect to TLR (OR = 2.60 [1.27–5.32], z = 2.63, p = 0.008), with a trend toward higher binary restenosis (OR = 2.03 [0.99–4.18], z = 1.93, p = 0.052). No significance in mortality was evident among study groups (OR = 1.79 [0.37–8.55], z = 0.73, p = 0.46; BNS vs. PCB comparison).

Conclusions: In diseases of femoro-popliteal artery, PCB offers superior freedom from repeat revascularization as compared to BNS. Both revascularization strategies appeared safe. Adequately powered, randomized, head-to-head comparisons are needed.

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EPIC Nitinol Stent Treatment of Iliac Artery Lesions: 12-Month Outcomes in the ORION Study
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Background: ORION is a prospective, multicenter, single-arm, long-term safety and efficacy study of the Epic™ vascular self-expanding stent for the treatment of iliac artery lesions.

Methods: Eligible patients had chronic, symptomatic iliac disease and received ≤2 stents for de novo/restenotic lesions in the common or external iliac arteries. Lesions were ≤15 cm in length with diameter stenosis ≥50%. Clinical, functional, hemodynamic, and duplex ultrasound follow-up was performed at 30 days and 9 and 12 months. Key endpoints evaluated at one year include primary, primary-assisted, and secondary patency, target lesion revascularization (TLR), stent thrombosis, amputation, assessment of the walking impairment questionnaire and ankle-brachial index (ABI). All deaths, revascularization, myocardial infarctions, amputations, and stent thromboses were adjudicated by an independent clinical events committee (CEC).

Results: A total of 125 patients were enrolled in the study. Through 12 months, primary patency, primary-assisted patency, and secondary patency was achieved in 94.4% (119/126), 96.0% (121/126), and 97.6% (122/125) of treated lesions and 95.4% of patients remained free from TLR. Improvement in ABI was 12.8% in AC, 18.1% in AT, 22.4% in T and 35% in A group, respectively (p<0.0001). Cumulative incidence of major amputation was 12.8% in AC, 18.1% in AT, 22.4% in T and 35% in A group, respectively (p=0.0003).

Conclusions: The combination of aspirin and cilostazol associated with better outcome for CLI due to isolated infrapopliteal lesions. Further studies are warranted to investigate which antiplatelet regimen could be a optimal option in CLI patients.

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Recanalization of infrapopliteal chronic total occlusions in critical limb ischemia.
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Background: Infrapopliteal (IP) chronic total occlusions (CTOs) are common in diabetics and patients presenting with critical limb ischemia (CLI). As endovascular procedures for CLI evolve, IP CTO recanalization is being attempted with increasing frequency. We analyzed the clinical and procedural outcomes following endovascular intervention for IP CTO at our institution.

Methods: Between March 2004 and October 2010, 1057 limbs from 884 patients with CLI due to isolated infrapopliteal lesions were retrospectively analyzed. In hospital death cases (n=22) and patients who did not taking aspirin (n=216) were excluded. Primary endpoint is freedom-from MALE (major adverse limb event defined as major amputation or any reintervention) and assessed out to 2 years by the KaplanMeier methods.

Results: Study population were divide into 4 groups due to antiplatelet status. Baseline characteristics was not different except for coronary artery disease. Freedom-from MALE at 2 years were 54% in aspirin and cilostazol (AC) group, 44% in triple antiplatelet therapy (T) group, 36% in aspirin alone (A) group and 35% in aspirin and thienopyridine (AT) group, respectively (p=0.0006). Cumulative incidence of major amputation was 12.8% in AC, 18.1% in AT, 22.4% in T and 35% in A group, respectively (p=0.0003).

Conclusions: The combination of aspirin and cilostazol associated with better outcome for CLI due to isolated infrapopliteal lesions. Further studies are warranted to investigate which antiplatelet regimen could be a optimal option in CLI patients.

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Optimal Antiplatelet Regimen for Critical Limb Ischemia due to Pure Isolated Infrapopliteal Lesions
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Background: Angioplasty for patients with critical limb ischemia (CLI) is effective to avoid major amputation. Although optimal antiplatelet therapy to improve the long term outcome following the angioplasty remains to be elucidated.

Methods: We identified 8 eligible trials, enrolling a total of 1,008 patients randomized to BNS/PCB or UCB angioplasty (BNS n=342, PCB n=186, UCB n=480). Median FU was 11.5 months. Angioplasty with BNS was found inferior to PCB with respect to TLR (OR = 2.60 [1.27–5.32], z = 2.63, p<0.0001), with a trend toward higher binary restenosis (OR = 2.03 [0.99–4.18], z = 1.93, p = 0.052). No significance in mortality was evident among study groups (OR = 1.79 [0.37–8.55], z = 0.73, p = 0.46; BNS vs. PCB comparison).

Conclusions: In diseases of femoro-popliteal artery, PCB offers superior freedom from repeat revascularization as compared to BNS. Both revascularization strategies appeared safe. Adequately powered, randomized, head-to-head comparisons are needed.