were in the range of those after balloon dilatation followed by DES – stenting (8.3 %). At one year plain balloon dilatation (13.4 %) had a similar rate of re - restenosis as cutting balloon dilatation (13.4%) and balloon dilatation followed by implantation of a BMS (15.4%).

Conclusion: The reported rate of re - restenosis in ISR was generally low but differ largely according to the applied therapy.

TCT-196
Restenosis Pattern of Drug-Eluting Stent : Impact of Stent Type and Timing
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Background: Recently, late restenosis after drug-eluting stent (DES) has been reported. However, the impact of DES types and timing remains unclear. Thus, we evaluated the restenosis pattern of three different drug-eluting stent; sirolimus-eluting stent (SES), paclitaxel-eluting stent (PES), and zotarolimus eluting stent (ZES) in midterm (8 months) and laterterm (20 months).

Methods: From November 2002 to October 2009, 4368 consecutive patients (7546 lesions) were treated with SES and PES and ZES (SES, 5924 lesions; PES, 1405 lesions; ZES, 217 lesions) and performed midterm follow-up coronary angiography (f/u CAG) at 6 to 8 months after implantation (f/u rate, 81.6% [6156/7546]). Of these, 4610 lesions without restenosis underwent late f/u CAG at 12 months after early f/u (f/u rate, 86.2%). Early restenosis was defined as restenosis at midterm f/u and late restenosis (f/u CAG) at 12 months after implantation (f/u rate, 81.6% [6156/7546]). Of these, 4610 lesions without restenosis underwent late f/u CAG at 12 months after early f/u (f/u rate, 86.2%). Early restenosis was defined as restenosis at midterm f/u and late restenosis as restenosis at late f/u without early restenosis. Restenosis types are classified into 1 focal pattern with 4 types and 3 diffuse patterns: pattern I (focal: type IA, gap; type IB, edge; type IC, body; type ID, multifocal), pattern II (diffuse in-stent), pattern III (diffuse proliferative), and pattern IV (total occlusion).

Results: Data are shown in the table.

<table>
<thead>
<tr>
<th>Restenosis pattern with Mehran Classification of SES and PES</th>
<th>ZES</th>
<th>p-value</th>
<th>p-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>SES/PES</td>
<td>SES</td>
<td>ZES</td>
<td>p-value</td>
<td>p-value</td>
</tr>
<tr>
<td>Early f/u</td>
<td>55.5% (1503)</td>
<td>55.5% (1503)</td>
<td>55.5% (1503)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>diffuse</td>
<td>14.6% (419)</td>
<td>14.6% (419)</td>
<td>14.6% (419)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>late f/u</td>
<td>33.9% (971)</td>
<td>33.9% (971)</td>
<td>33.9% (971)</td>
<td>0.42</td>
</tr>
</tbody>
</table>

Conclusion: Restenosis pattern of drug-eluting stent could be depend on stent type and timing of restenosis.

TCT-197
Multi Center, Prospective, Randomized, Single Blind, Consecutive Enrollment Evaluation of the Elixir DESynTM BD Novolimus-Eluting Coronary Stent System with Bioabsorbable Polymer Compared to the Endeavor Zotarolimus-Eluting Coronary Stent System: 6- Month Clinical Angiographic and IVUS

Results: The EXCELLA BD Study
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Background: To evaluate the safety and effectiveness of the Elixir DESynTM BD Novolimus-Eluting Coronary Stent System (CSS) with a Bioabsorbable polymer compared to the Endeavor Zotarolimus-Eluting Coronary Stent System through the assessment of clinical, angiographic, and IVUS endpoints.

Methods: 149 patients, were randomized 3:1 to receive either the Elixir DESyn BD Novolimus-eluting CSS loaded with 5mcg per mm of stent length of Novolimus, a sirolimus metabolite, eluted via a bioabsorbable polylactide-based polymer, or to Endeavor Zotarolimus-eluting CSS loaded with 10mcg per mm of stent length of Zotarolimus eluted via a durable phosphoryl choline polymer. All patients were analyzed for the primary endpoint of in-stent late lumen loss assessed by QCA at 6 months. Moreover, all patients underwent evaluation for the secondary endpoints which include Device-oriented Composite Endpoint (DoCE) defined as: cardiac death, MI not clearly attributable to a non-intervention vessel, and clinically-induced target lesion revascularization at 1, 6, 9, and 12 months and annually through 5 years, clinically-induced Target Lesion Revascularization (TLR), and Clinically-induced Target Vessel Revascularization (TVR). Lesions were also evaluated for angiographic endpoints at 6 months including: in-lesion late lumen loss, percent diameter stenosis, minimal lumen diameter post procedure and at 6 months, angiographic binary restenosis (≥50%), and stent thrombosis. A subset of patients underwent intravascular ultrasound (IVUS) evaluation including in-stent volumetric neointimal burden and percent (%) neointimal thickening at 6 months.

Results: Clinical results through 6 months, as well as the primary endpoint of in-stent late lumen loss by QCA at 6 months with additional angiographic and IVUS results, will be presented.

Conclusion: Clinical results through 6 months, as well as the primary endpoint of in-stent late lumen loss by QCA at 6 months with additional angiographic and IVUS results will be presented.

TCT-198
The Impact of XIENCE V® Everolimus-Eluting Coronary Stents on Health Status in COURAGE-Like Patients
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Methods: This was a prospective, multi-center, unrestricted, real-world study of consecutively-enrolled patients (n=4797) who had a least 1 valid Seattle Angina Questionnaire score at baseline. Quality of Life (QoL) scores were analyzed using Two-Way ANOVA (Mixed Model-Repeated Measures) with group (COURAGE-like matched for symptom class, coronary anatomy, EF and BP vs. a more complex non-COURAGE-like) and visit (baseline, 180 days, 365 days) as fixed factors and group by visit as an interaction effect.

Results: See Table.
Conclusion: This represents the first time that patient-reported outcomes have been reported in both COURAGE-like and non COURAGE-like patients exclusively receiving a DES. Although there were no differences in clinical outcomes, marked improvements occurring early, being sustained for 1 year and most notable when angina burdens were greatest. These data extend patient's perspectives on the benefits of PCI.

Results: One hundred and eighty seven patients underwent PCI with DES while 276 underwent MIDCAB. Patients in PCI group were older (63.6 ± 10,2 y.o.; p<0,05), more often female (32 vs. 21%; p<0,01) had higher CCS class (2,53 ± 0,9 vs. 2 ± 0,3; p<0,01), higher Euroscore (4 vs. 2,2; p<0,01) and more often presented with peripheral artery disease (8 vs. 2%; p<0,01). At 30 day follow up there was no death in both groups. There were also no differences in the occurrence of major adverse cardiovascular and cerebral events (MACCE) defined as death, stroke, myocardial infarction or repeated revascularization between PCI and MIDCAB groups (0% vs. 0,7%;p=0,22). However there were less serious adverse events (SAE) defined as atrial fibrillation, wound infection, low output syndrome or serious bleeding in patients who underwent MIDCAB (0 vs. 5%; p<0,01). After adjustment at 5 year follow up there were no differences in survival (93,5 vs. 95,7%; p=0,56), MACCE free survival (64,9 vs. 74,4%, p=0,12) and MI – free survival (94,9 vs. 95.8%; p=0,46) between PCI and MIDCAB respectively. There was significantly higher freedom from repeated revascularization in patients who underwent MIDCAB (86,4 vs. 64,1%; p<0,01).

Conclusion: Both procedures show exceptional safety, with no deaths and only minor adverse events rate at perioperative period. At long term PCI with DES is non inferior to MIDCAB with regard to safety endpoints. The rate of repeated revascularizations remained higher in the PCI group.