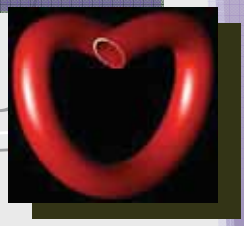
Intervention vs. Surgery in Unprotected Left Main Coronary Artery Disease



Toyohashi Heart Center

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Results of Elective Unprotected Left Main PCI

		No. Pts	Acute Mortality	Late Survival	Late Follow (yrs.)	Event Free Survival	IABP/ CPS	LVEF	% Stented
O'Keefe	1981-87	**33**	**9.1%**	**35%**	**2**	**18%**	**33%**	**<40% in 24%**	**0%**
Eldar	1985-90	**8**	**12.5%**	**75%**	**2**	**37%**	**25%**	**<30%**	**0%**
Chauhan	1991-95	**8**	**0%**	**75%**	**1.1**	**38%**	**N/A**	**N/A**	**100%**
Ellis	1994-86	**91**	**12.1%**	**71%**	**1**	**68%**	**68%**	*******	**50%**
Park	1996-97	**42**	**0%**	**98%**	**0.8**	**81%**	**0%**	**56%**	**100%**
Wong	1995-98	**55**	**0%**	**98%**	**2.2**	**82%**	**0%**	**55%**	**100%**
Kosuga	1986-00	**120**					**68%**		**14%**
	POBA	**29**	**0%**	**86.2%**	**1**	**42%**		**50%**	
	NewDevice	**91**	**3.3%**	**91.0%**	**1**	**78%**		**54%**	

Background

The present condition of PCI for unprotected left main coronary artery disease (ULM)

- **Increase of complicated cases:**
  - **Systemic diseases**
    - ✓ **Infectious disease**
    - ✓ **Cerebrovascular disease**
    - ✓ **Illness of Aorta and/or peripheral arteries**
  - **Ungraftable native coronary artery**
    - ✓ **Severe calcification, diffuse lesion (ex. HD pathents)**
- **Advent of new devices: Stents, DCA, Rotablator, etc.**
- **Improvement of operators' skill**

Background

- **Indication began to widely spread from high-risk to low-risk candidates;**
  - ✓ **with adequate consideration of indication**
  - ✓ **with proper device and procedures**
  - ✓ **by skilled operators with a lot of experiences**

Background

- **Advantages of PCI for ULM**
  - ✓ **Psychological matter of patients**
  - ✓ **Shorter admission**
  - ✓ **Repeatable**

PCI for Unprotected LMCA

Purpose

- **The purpose of present study is to evaluate the mid-term reliability of PCI for ULM comparing with those of CABG.**

Subjects

- ULM cases who underwent revascularization therapy between May 1999 and November 2002 in our institute:
  - 243 consecutive cases
    - ✓PCI: 104
    - ✓CABG: 139
  - Acute myocardial infarction containing both LAD and LCX occlusion was excluded.

Standars for CABG rather PCI

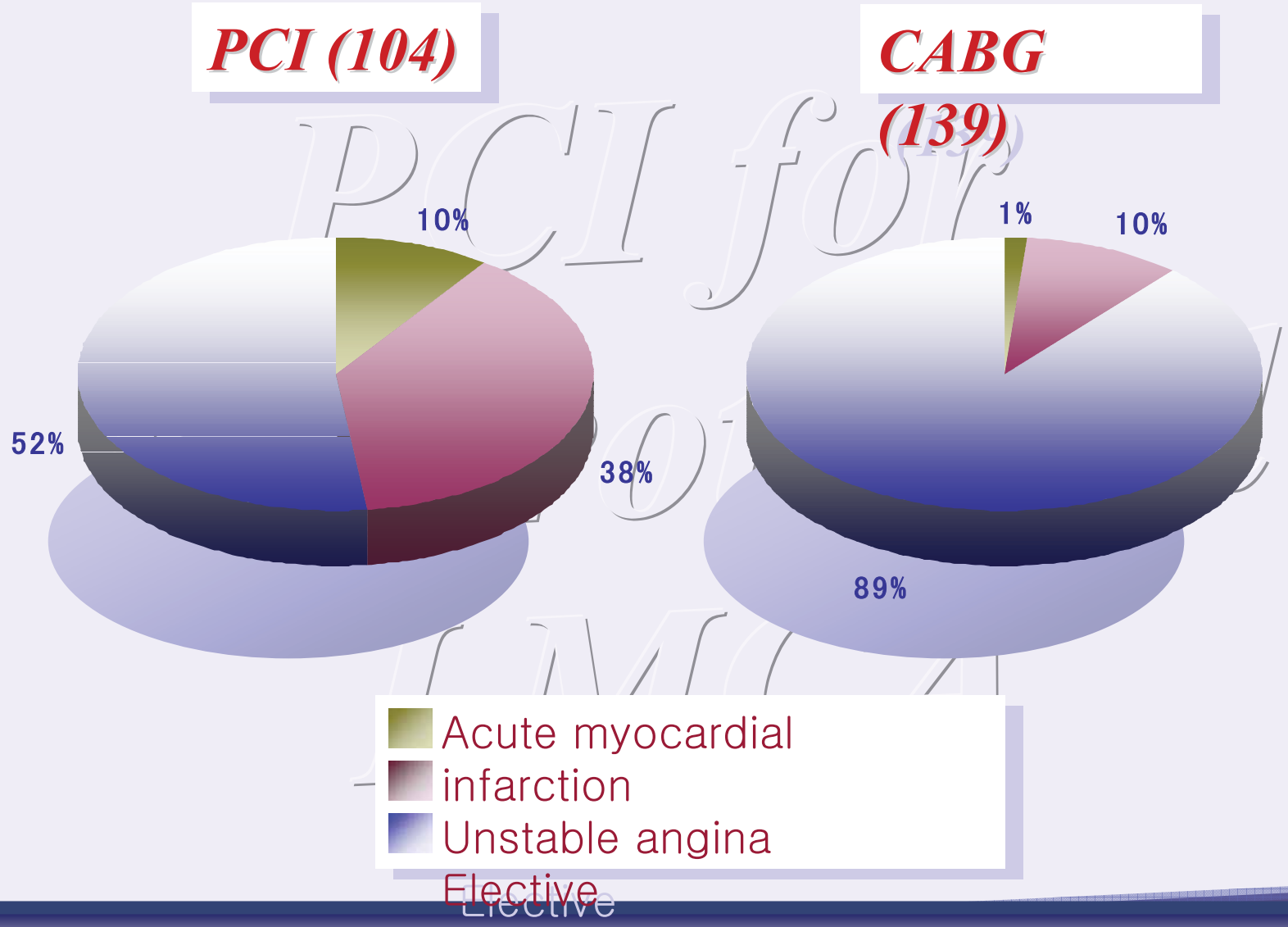
- Referral patient for surgery from other institutes
- Repeated PCI
- Inadequate morphology for PCI
  - ✓ Small left main (less than 3.5mm)
  - ✓ Triple vessel disease
  - ✓ Severely calcified lesion
  - ✓ Diffuse long lesion of LAD or LCX
  - ✓ Containing CTO
  - ✓ Severely bending

…not absolute criteria

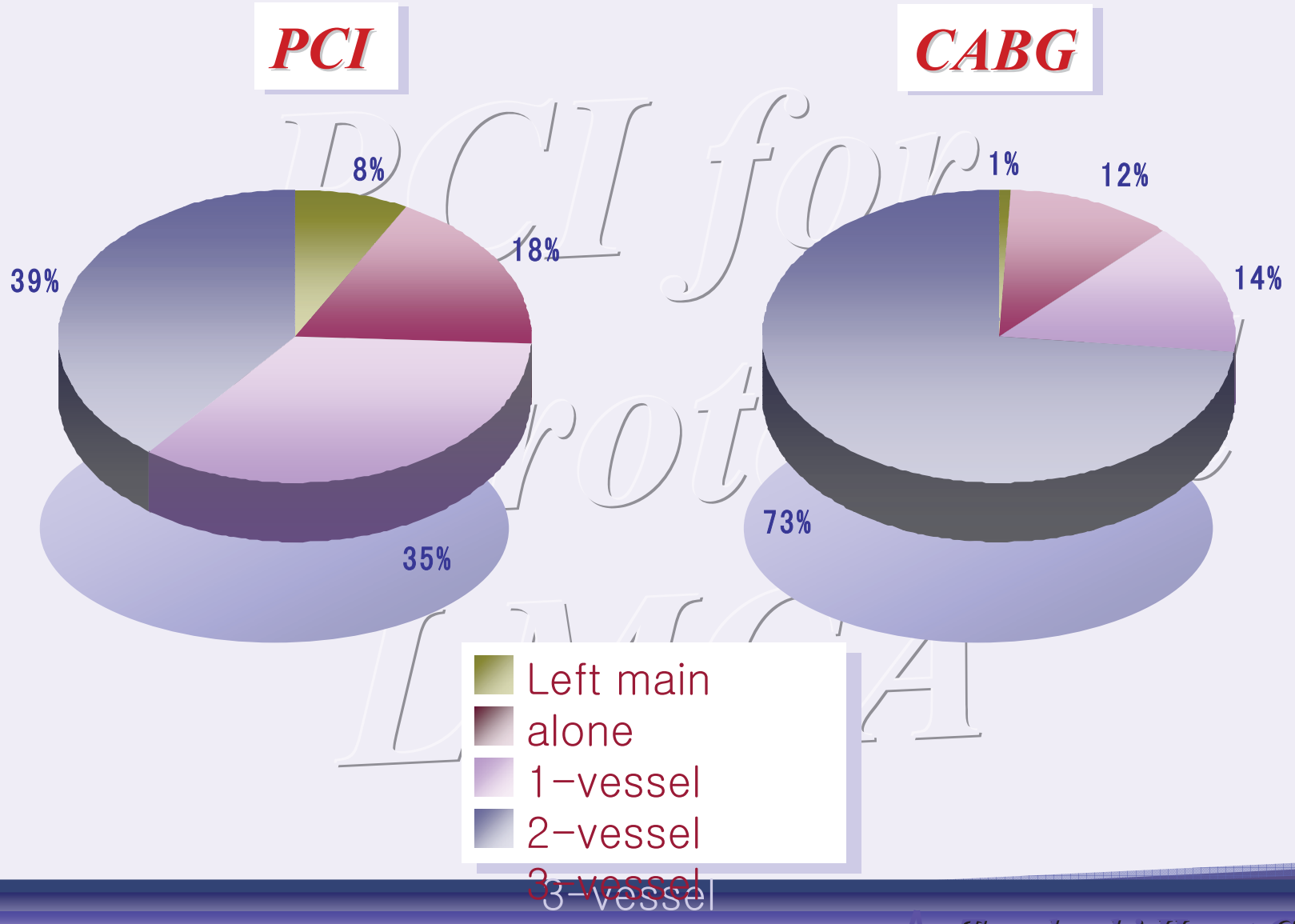
Baseline Characteristics

	PCI	CABG
Total No. , n	104	139
Age (yrs)	68.1±11.5	68.6±8.4
Male gender, n	81 (78%)	99 (71%)
DM, n	36 (35%)	26 (19%)
Cerebrovascular disease, n	7 (7%)	8 (6%)
Previous CABG, n	7 (7%)	-
Over 75 y.o., n	24 (23%)	25 (18%)
LVEF (%)	50.1±11.1	-
Clinical presentation at arrival		
AMI, n	10 (10%)	2 (1%)
UAP, n	40 (38%)	14 (10%)
Elective, n	54 (52%)	123 (89%)

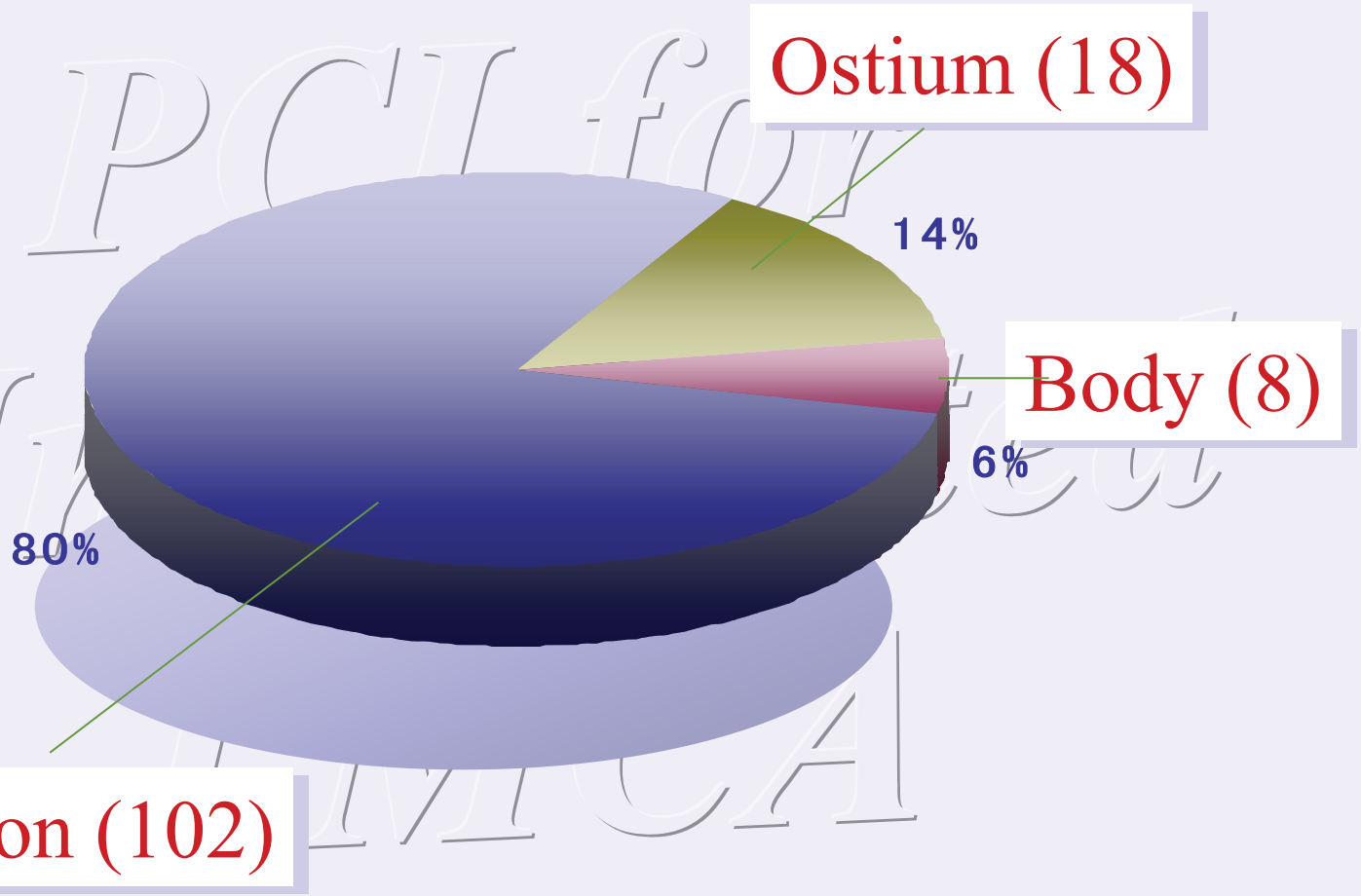
Status at arrival (PCI group)



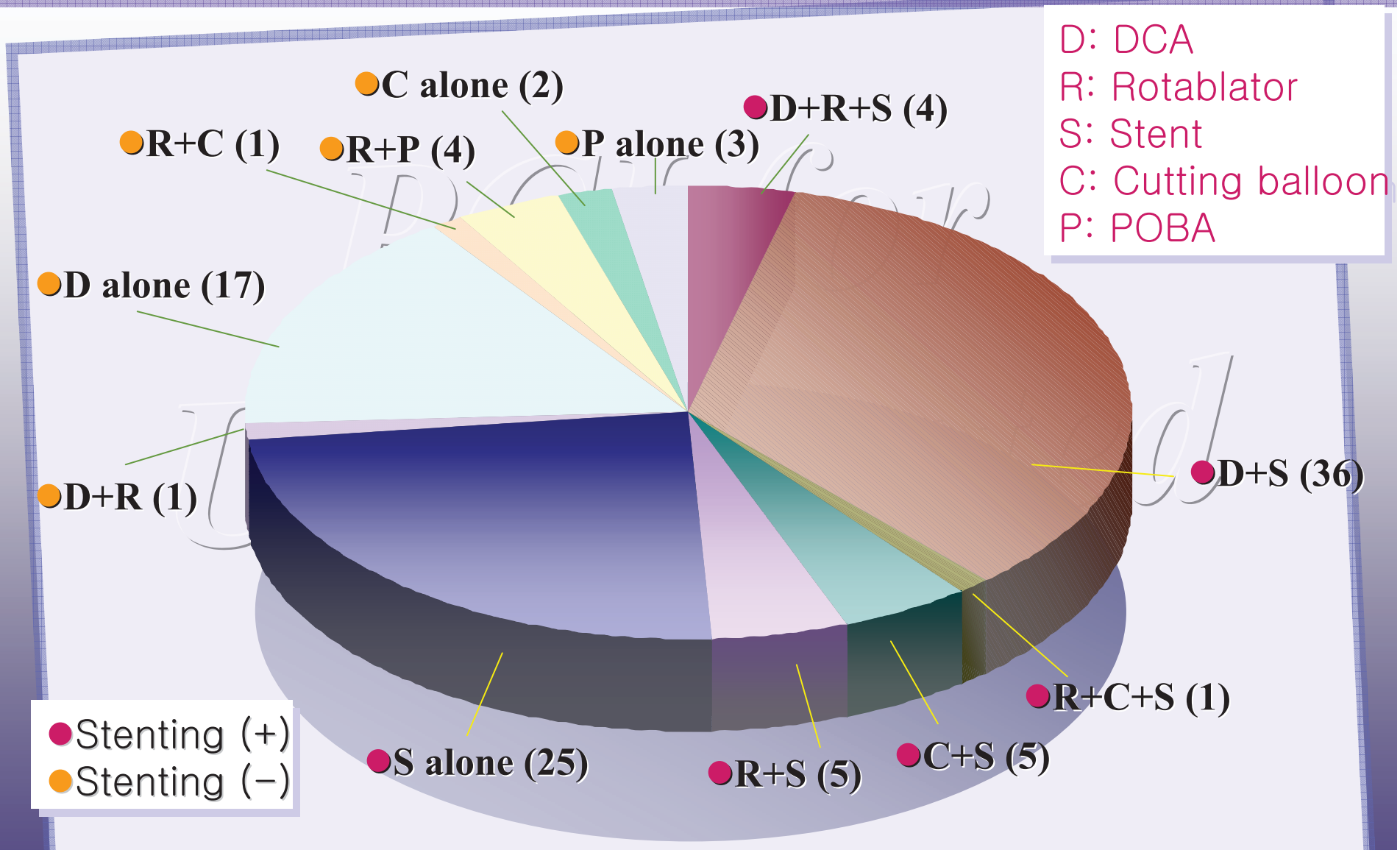
Number of Diseased Vessels



Lesion location (PCI group)



Procedure in PCI

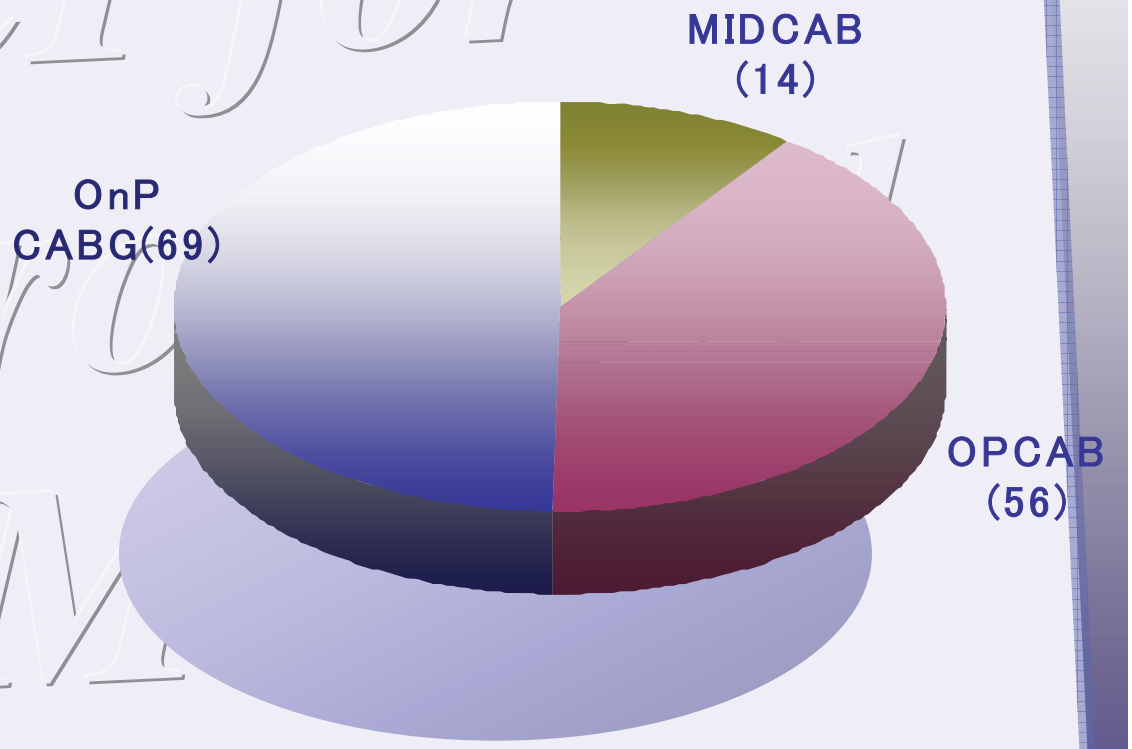


No. of Bypass and Procedure (CABG group)

No. of Bypass Grafts

Graft	n
1	15
2	48
3	46
4	22
5	8

Procedure



In-hospital Outcome

	PCI (n=104)	CABG (n=139)	p
Lesion success, n	104 (100%)	139 (100%)	ns.
Clinical success, n	102 (98%)	137 (99%)	ns.
Complications, n	2 (1.9%)	2 (1.4%)	ns.
Cardiac death, n	1 (1.0%) *	2 (1.4%) #	ns.
Non-cardiac death, n	1 (1.0%) **	0 (0%)	ns.
Q-myocardial infarction, n	0 (0%)	0 (0%)	ns.
Re-PCI or CABG, n	1 (1.0%) *	0 (0%)	ns.

*Low output syndrome with severe diffuse calcified lesion, rejected CABG.
**Peripheral hemorrhage.
#Both congestive heart failure.

Late Phase Outcome within 6 months

	PCI (n=104)	CABG (n=139)	p
Total death, n	4 (3.8%)	7 (5.0%)	ns.
Cardiac death, n	2 (1.9%)	5 (3.6%)	ns.
Non-cardiac death, n	2 (1.9%)	2 (1.4%)	ns.
Q-MI, n	0 (0%)	1 (0.7%)	ns.
TVR, n	17 (16.3%)	4 (2.9%)	0.0002

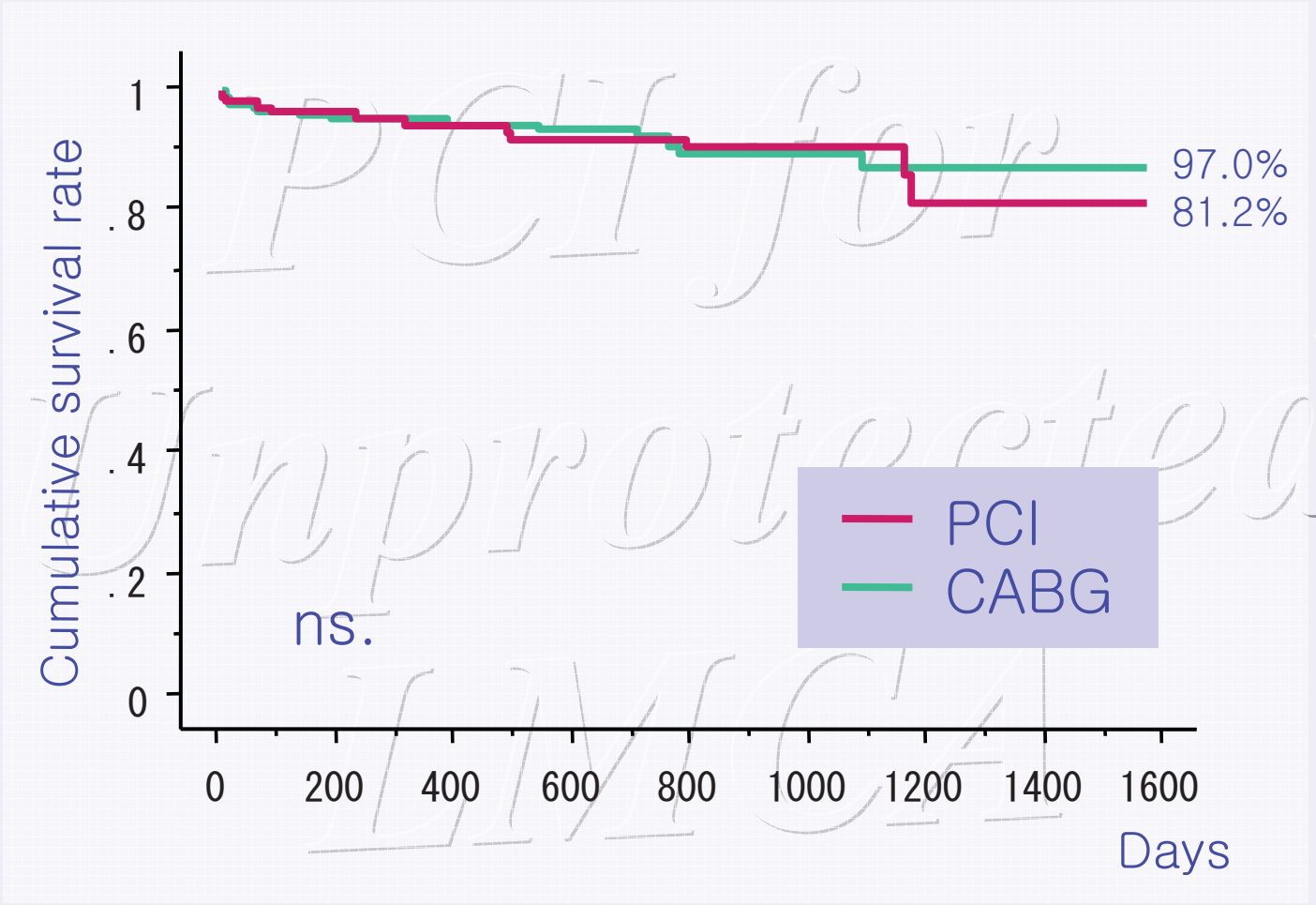
Latephase Outcome within 4 years

	PCI (n=104)	CABG (n=139)	p
Total death, n	10 (9.6%)	13 (9.4%)	ns.
Cardiac death, n	2 (1.9%)	5 (3.6%)	ns.
Cardiac death, MI and TVR, n	20 (19.2%)	19 (13.7%)	ns.
TVR, n	17 (16.3%)	7 (5.0%)	0.0024
Any revascularization, n	42 (40.4%)	14 (10.1%)	<0.0001

Cumulative Survival Rate

(Death-free for any reason)

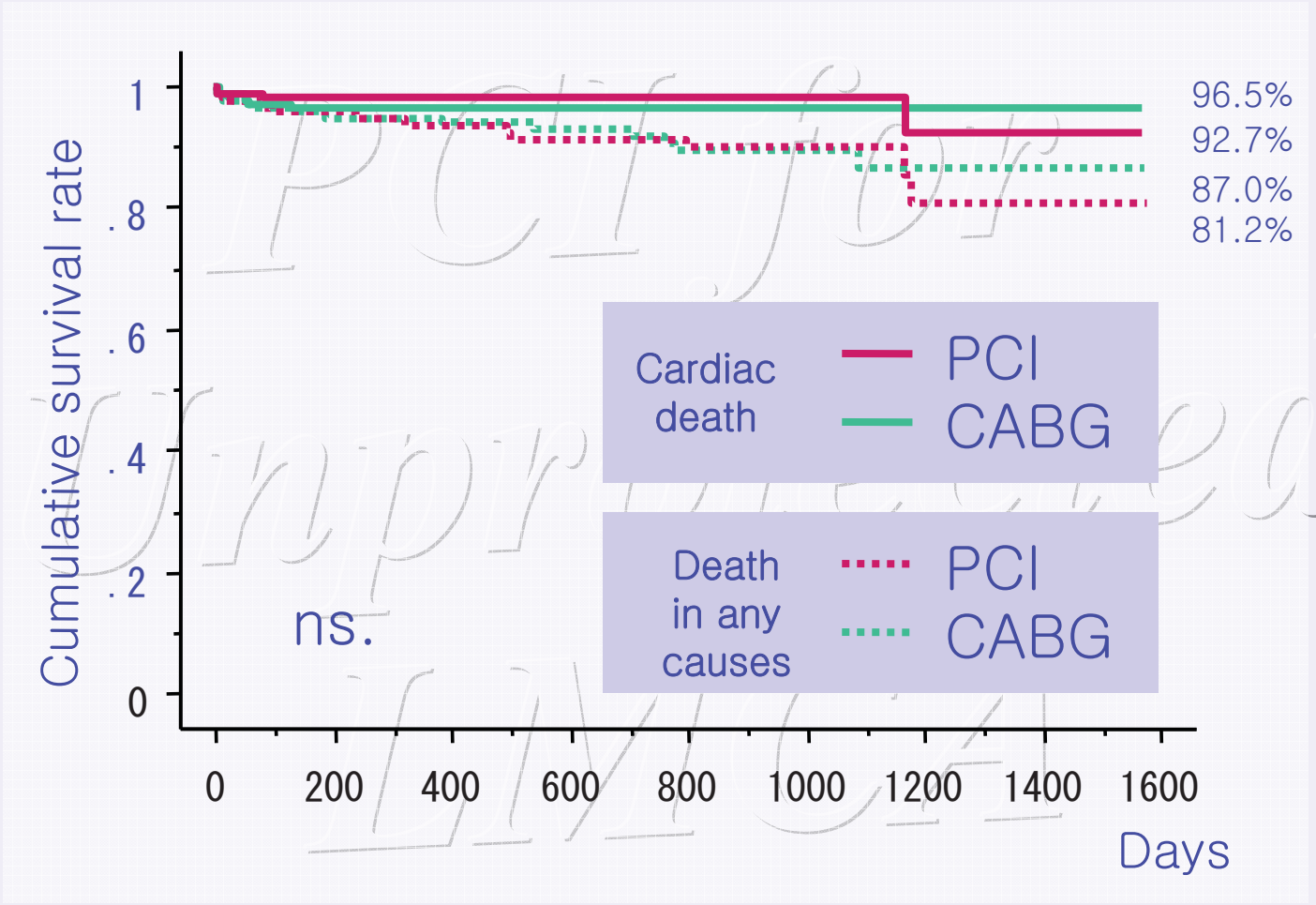
Kaplan-Meier method



Cumulative Survival Rate

(Cardiac death-free)

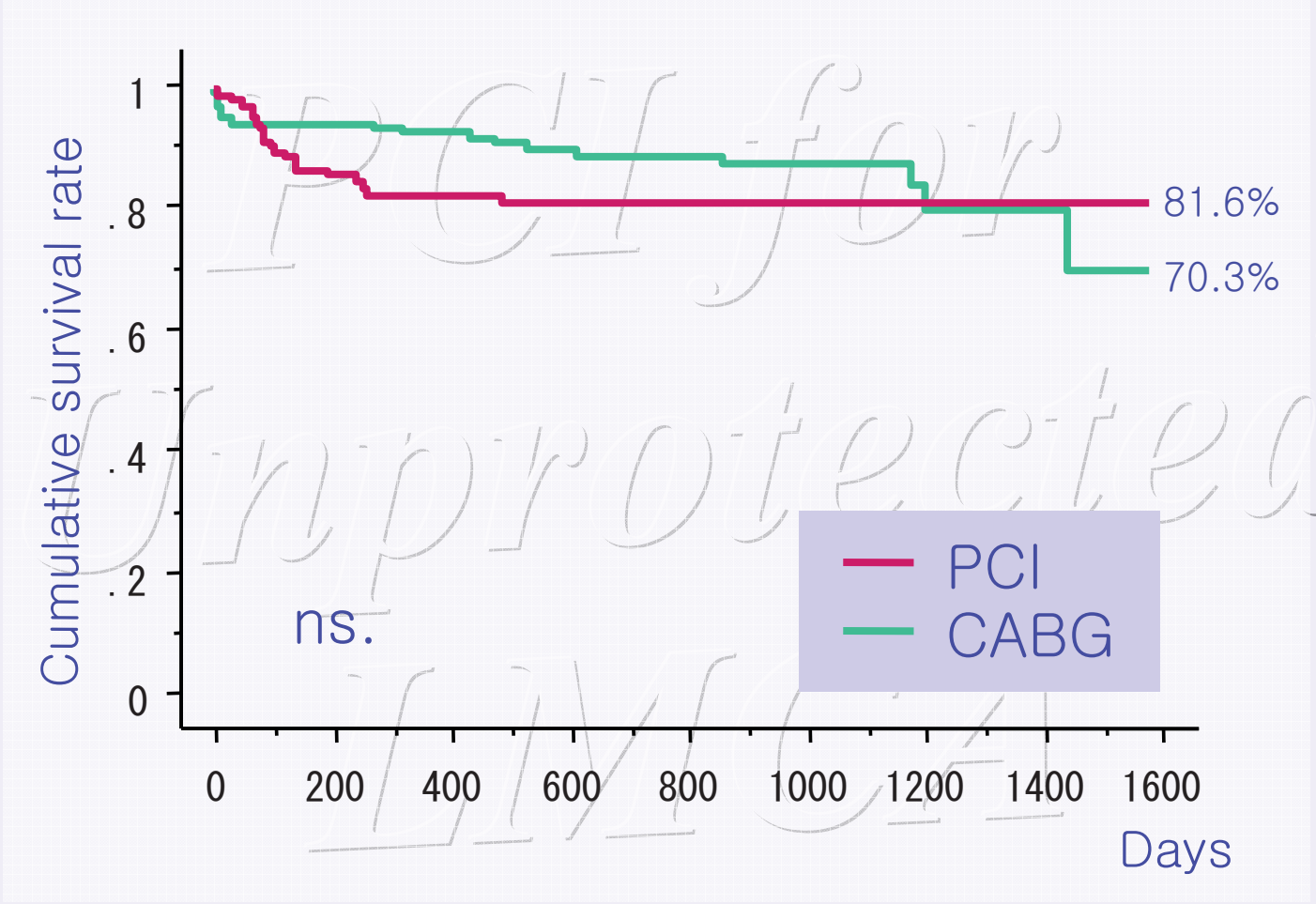
Kaplan-Meier method



Cumulative MACE-free Rate

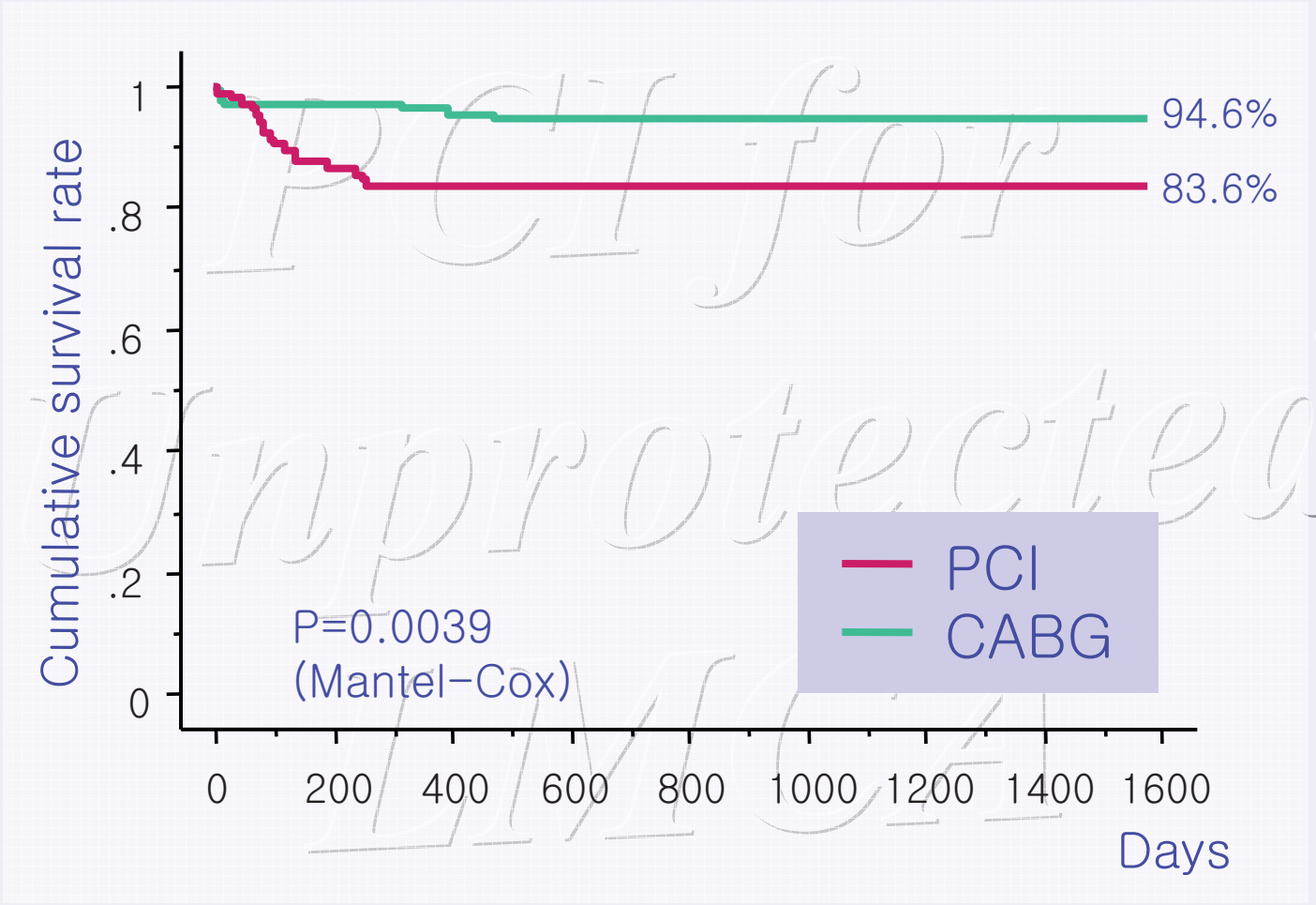
(MACE: Death, MI, TVR and CHF)

Kaplan-Meier method



Cumulative TVR-free Rate

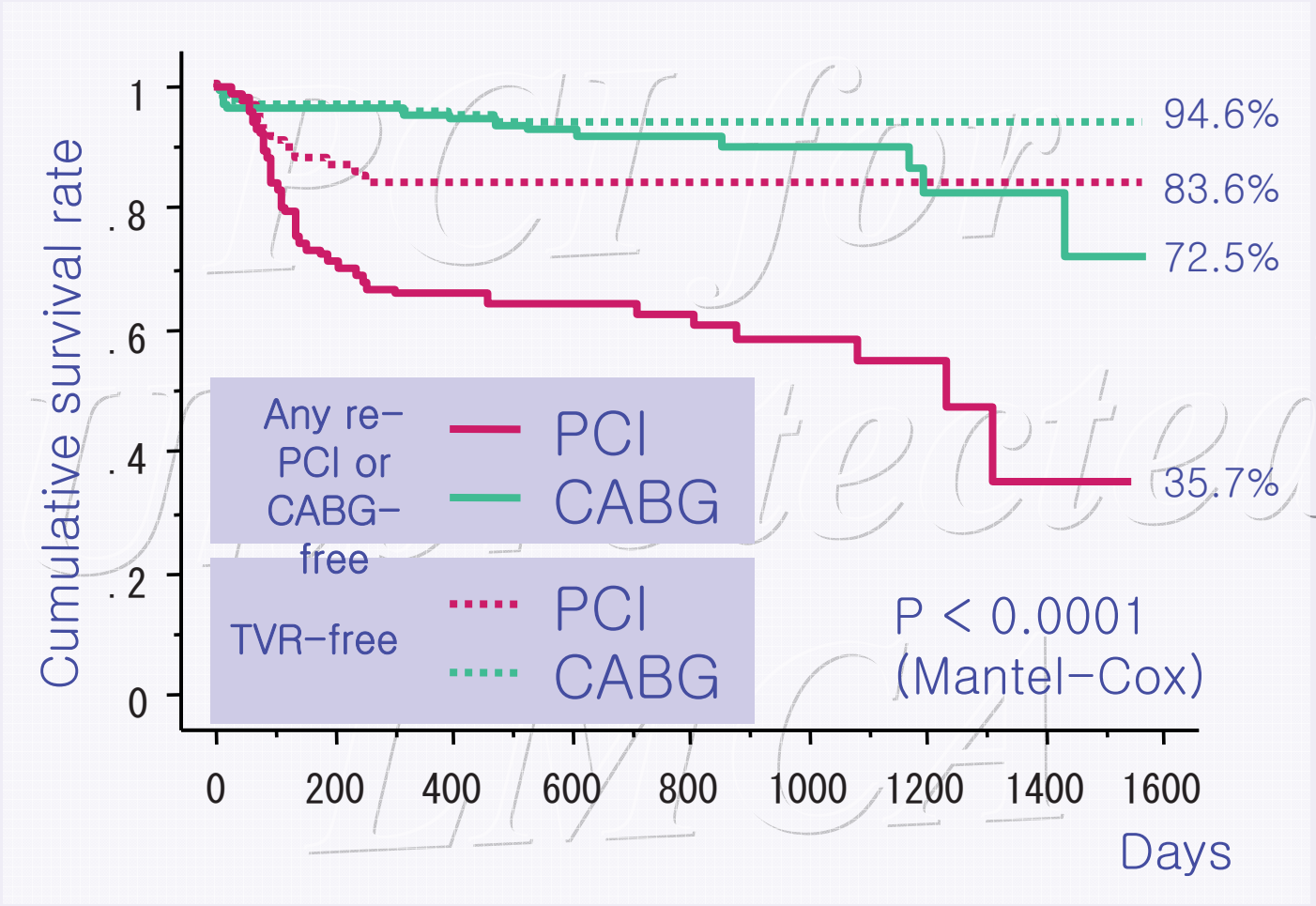
Kaplan-Meier method



Cumulative Any Revascularization-free Rate

(including progressive or restenosis lesion of non-target vessel)

Kaplan-Meier method



Change in Cardiac Death and TVR rate

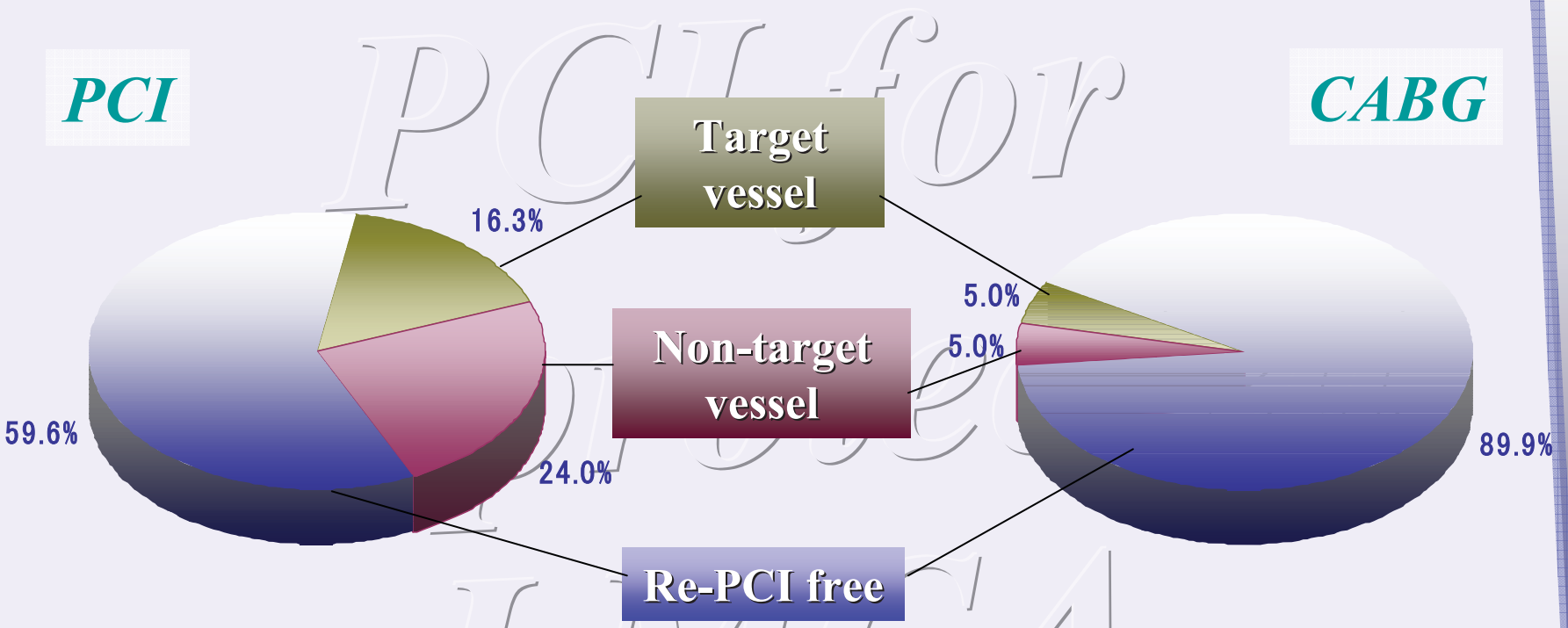
Change in Cardiac Death Rate

	PCI (n=104)	CABG (n=139)	p
In-hospital, n	1 (0.9%)	2 (1.4%)	ns.
6 months, n	2 (1.9%)	5 (3.6%)	ns.
4 years, n	2 (1.9%)	5 (3.6%)	ns.

Change in TVR Rate

	PCI (n=104)	CABG (n=139)	p
In-hospital, n	1 (1.0%)	0 (0%)	ns.
6 months, n	17 (16.3%)	4 (2.9%)	0.0002
4 years, n	17 (16.3%)	7 (5.0%)	0.0035

Contents of Revascularization within 4 years

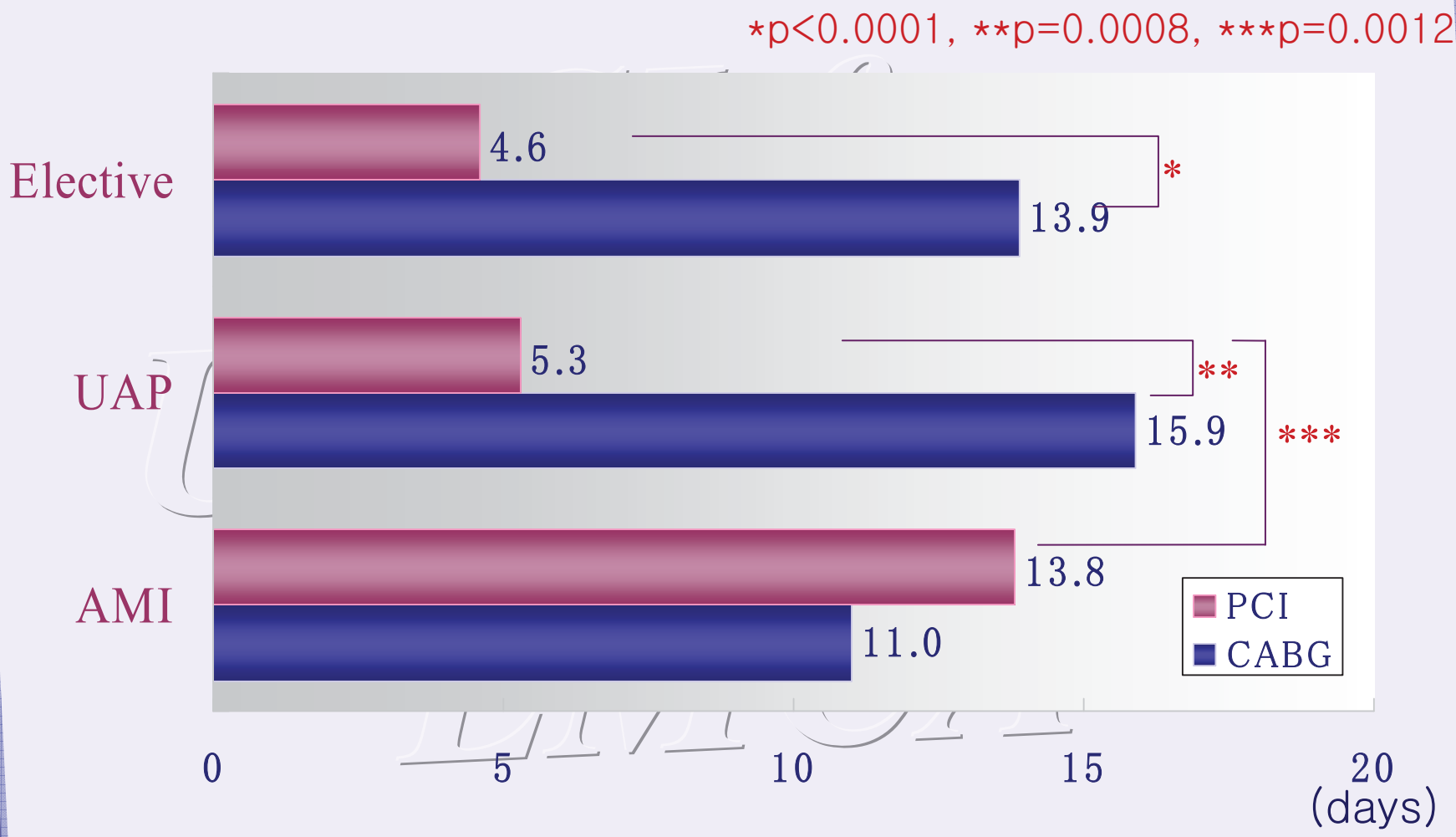


Contents of Target Lesion Revascularization

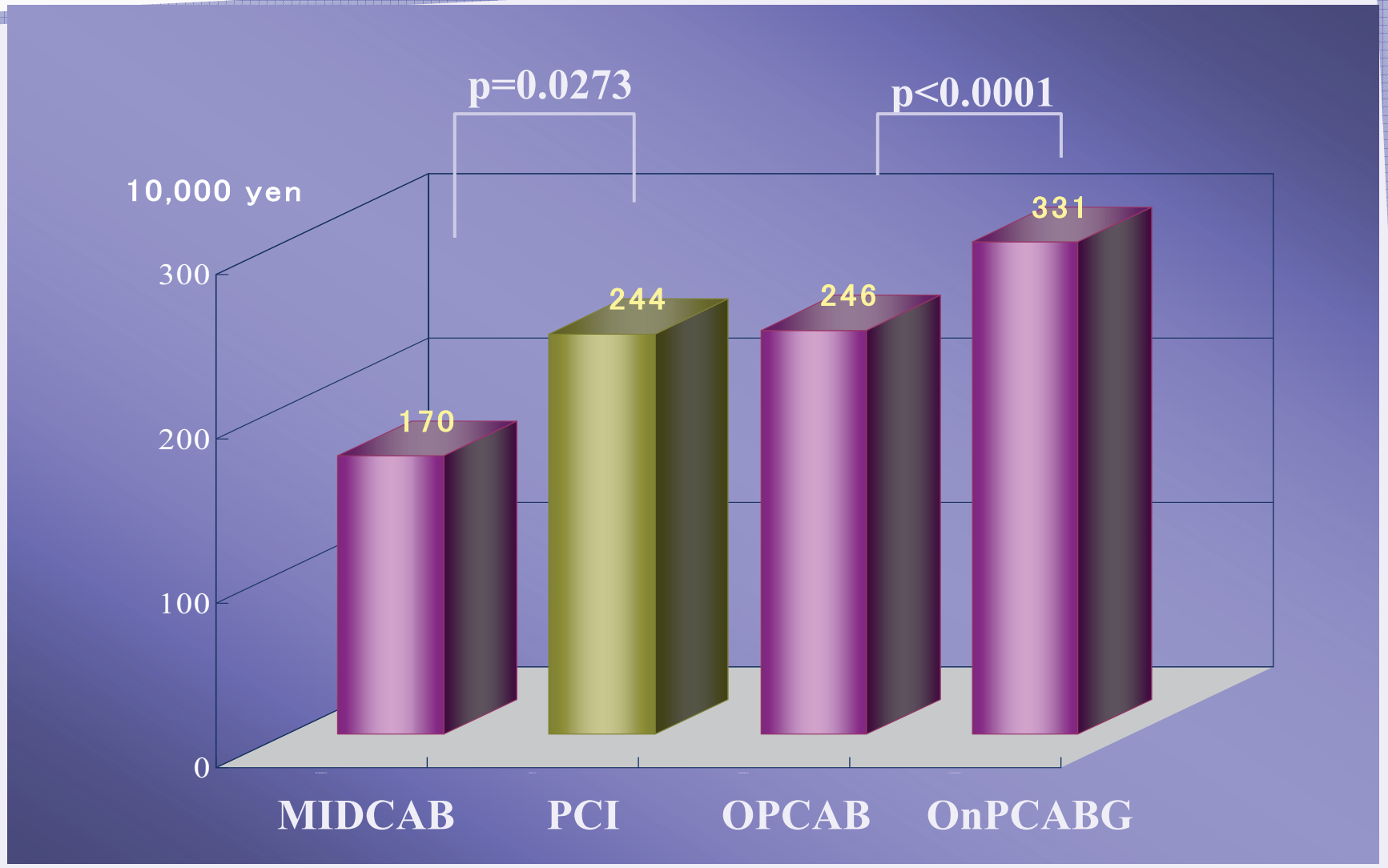
PCI cases (n = 17)

CABG	**11**
Stent	**2**
Cutting balloon	**2**
DCA	**1**
None (died in other institute	**1**

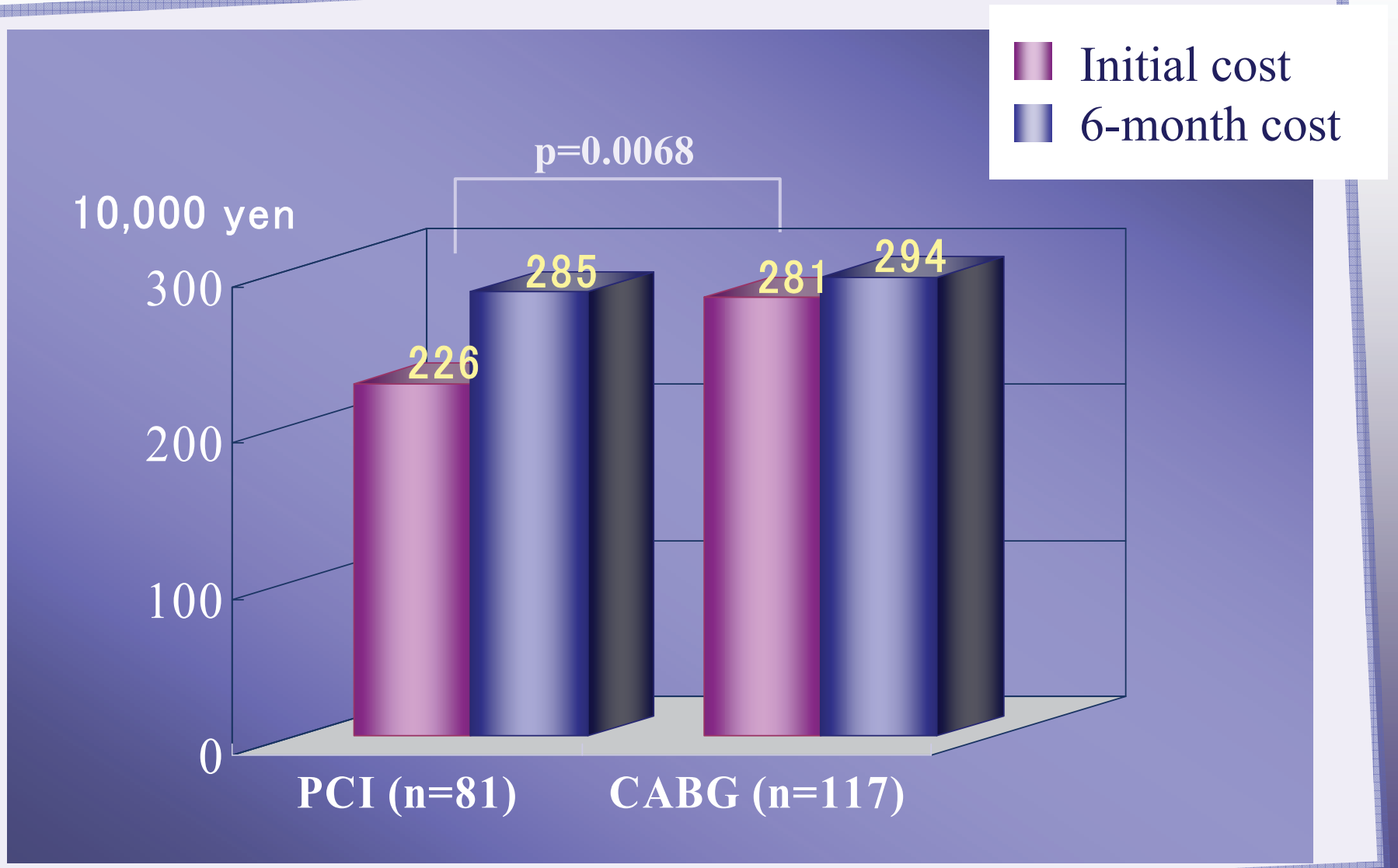
In-Hospital Days



Initial Costs



Initial and 6-months Cumulative Costs



Summary (1)

- Initial success rate was 100% in both groups. There were 1 and 2 in-hospital cardiac death in each group, respectively.
- Cardiac death rate at 6 months was 1.6% and 3.6% in each group (no significance). TVR rate at 6 months was significantly higher in PCI group (16.3% vs. 2.9%, p = 0.0002).

Summary (2)

- Cumulative cardiac death-free rate of both groups were quite similar (98.1% vs. 96.4%), although the rate of any adverse cardiac events was higher in CABG group (no significance).
- Cumulative TVR rate at 4 years was significantly lower in PCI group than CABG group (94.5% vs. 82.9%, p = 0.0032). Also, revascularization-free rate was significantly lower in PCI group (51.4% vs. 72.4%, p < 0.0001).

Conclusion

- PCI for ULM is acceptable in the aspect of safety and prognosis: mid-term survival rate and adverse events. Although, target lesion revascularization and total re-PCI is significantly more frequent than CABG. That is still an issue of PCI in general.
- Proper case selection (good systemic condition and cardiac function, large vessel size, simple lesion morphology, etc.) may improve the outcome.

Conclusion

- **Cumulative any revascularization-free rate was significantly lower in PCI group compared with CABG.**

  But this problem will be solved by using DES.

Thank you