PDF hosted at the Radboud Repository of the Radboud University Nijmegen

The following full text is a publisher's version.

For additional information about this publication click this link.
http://hdl.handle.net/2066/171333

Please be advised that this information was generated on 2019-02-09 and may be subject to change.
Randomised comparison of drug-eluting versus bare-metal stenting in patients with non-ST elevation myocardial infarction

Wouter S Remkes,1 Erik A Badings,2 Renicus S Hermanides,1 Saman Rasoul,3 Jan-Henk E Dambrink,1 Petra C Koopmans,1 Salem HK The,4 Jan Paul Ottervanger,1 A T Marcel Gosselink,1 Jan CA Hoornje,3 Harry Suryapranata,1,5 Arnoud WJ van ’t Hof1

ABSTRACT

Objective: The superiority of drug-eluting stents (DES) over bare-metal stents (BMS) in patients with ST elevation myocardial infarction (STEMI) is well studied; however, randomised data in patients with non-ST elevation myocardial infarction (NSTEMI) are lacking. The objective of this study was to investigate whether stenting with everolimus-eluting stents (EES) safely reduces restenosis in patients with NSTEMI as compared to BMS.

Methods: ELISA-3 patients were asked to participate in the angiographic substudy and were randomised to DE (Xience V) or BM (Vision) stenting (ELISA-3 group). The primary end point was minimal luminal diameter (MLD) at 9-month follow-up angiography. In addition, 296 randomised data in patients with NSTEMI who were excluded or did not want to participate in the ELISA-3 trial (RELI group) were randomised to DE or BM stenting and underwent clinical follow-up only (major adverse cardiac events (MACE), stent thrombosis (ST)). A pooled analysis was performed to assess an effect on clinical outcome.

Results: 178 of 540 ELISA-3 patients participated in the angiographic substudy. MLD at 9-month angiography was 2.37±0.63 mm (DES) versus 1.84±0.62 mm (BMS), p<0.001. Binary restenosis occurred in 1.9% in the DES group versus 16.7% in the BMS group (RR 0.11, 95% CI 0.02 to 0.84, p=0.007). In the pooled analysis, the incidence of MACE, target vessel revascularisation and ST at 2 years follow-up in the DES versus BMS group was 12.5% versus 16.0% (p=0.28), 4.0% versus 10.4% (p=0.009) and 1.3% versus 3.0% (p=0.34), respectively.

Conclusions: In patients with NSTEMI, use of EES is safe and decreases both angiographic and clinical restenosis as compared to BMS http://www.isrctn.com/search?q=39230163.

Trial registration number: 39230163; Post-results.

KEY QUESTIONS

What is already known about this subject?
■ The superiority of drug-eluting stents (DES) over bare-metal stents (BMS) in patients with ST elevation myocardial infarction (STEMI) is well studied.

What does this study add?
■ This trial provides randomised data, showing that also in non-STEMI (NSTEMI), everolimus-eluting stents are safe and decrease restenosis compared to BMS.

How might this impact on clinical practice?
■ Considering that randomised data on usage of second-generation DES in patients with NSTEMI are scarce, our study provides more evidence that our current clinical practice of treating patients with STEMI with DES is safer and more efficient than treating with BMS.

INTRODUCTION

Percutaneous coronary intervention with bare metal stent implantation is associated with high restenosis rates as compared to the first-generation drug-eluting stents (DES).1–4 The second-generation everolimus-eluting stent (EES) has shown a strong antiproliferative effect with a non-inferior efficacy profile compared to the first-generation DES but with an improved safety profile. While the effect of DE versus BM stenting in ST elevation myocardial infarction (STEMI) populations has been extensively evaluated, consistently showing that the second-generation DES are as safe as bare-metal stents (BMS) in terms of stent thrombosis while reducing restenosis rates,5–8 there are no randomised studies comparing DES versus its BMS counterpart in the setting of non-STEMI (NSTEMI). This subset of patients, however, comprises up to 50% of patients included in some stent trials, particularly those with an all-comer design. This evidence has translated into a class I, level of evidence a recommendation in current
clinical guidelines for the use of new-generation DES over BMS.9

Montalescot et al10 demonstrated that patients with STEMI and NSTEMI have similar in hospital and long-term prognoses as well as similar independent correlates of outcome, despite different in-hospital management and despite differences in lesion pathology. In STEMI, the culprit artery is usually occluded by a red thrombus, whereas in NSTEMI the culprit artery is usually patent with a non-occlusive white thrombus. Also, patient characteristics differ; the NSTEMI population is older, has a higher cardiovascular risk profile more often with diabetes and hypertension. Patients with NSTEMI have more extensive coronary artery disease than patients with STEMI and more often a personal history of coronary heart disease.11

In this randomised study, we focus on the effects of the use of an EES on the incidence of restenosis and on long-term safety in terms of MACE in this population with NSTEMI, treated with either DES or its bare metal counterpart.

METHODS
In this article, we describe the results of the ELISA-3 angiographic substudy and the ELISA prospective Registry (RELI).

The rationale, design and primary results of ELISA-3 have been previously described.12

Briefly, the ELISA-3 trial is a prospective multicentre randomised controlled trial, in which 542 patients, hospitalised with non-ST elevation acute coronary syndrome (NSTEMI, NSTE-ACS), were randomised to either an immediate (angiography and revascularisation if appropriate<12 hour) or a delayed invasive strategy (>48 hour after randomisation). This prespecified substudy investigates whether stenting with EES safely decreases the incidence of restenosis, compared to stenting with a BMS with the same stent frame design.

Patients were eligible if they were hospitalised with ischaemic chest pain or dyspnoea at rest, with the last episode occurring 24 hours or less before randomisation, and had at least two of three of the following high-risk characteristics: (1) evidence of extensive myocardial ischaemia on ECG (shown by new cumulative ST depression >5 mm or temporary ST segment elevation in two contiguous leads <30 min), (2) elevated biomarkers (troponin T >0.10 μg/L or myoglobin >150 μg/L) or elevated CKMB fraction (>6% of total CK), (3) age above 65 years. Exclusion criteria were persistent ST segment elevation, symptoms of ongoing myocardial ischaemia despite optimal medical therapy, contra-indication for diagnostic angiography, active bleeding, cardiogenic shock, acute posterior infarction and life expectancy <1 year.

During the same study period, patients with NSTEMI who did not want to participate in, or who did not meet the inclusion criteria for, high-risk NSTEMI of the ELISA-3 study, were recruited in the ELISA prospective registry.

Both patients in the ELISA-3 trial and in the ELISA registry, who underwent coronary angiography and were deemed appropriate for percutaneous coronary intervention (PCI) and stenting, underwent randomisation in the catheterisation laboratory to either EE or BM stenting. Patients with multiple lesions in need of more than one stent were treated with the same type of stent for all lesions.

Patients received dual antiplatelet therapy (acetylsalicylic acid and clopidogrel) for the duration of 1 year.

Between July 2007 and June 2012, 542 patients were randomised in the ELISA-3 trial. About 344 of these patients were eligible for PCI and 178 of these patients underwent a second randomisation to EES (n=87) and BMS (n=91). In the same period, 296 patients in the ELISA registry group were also randomised (EES n=147, BMS n=149). Patients in the ELISA-3 group were planned to undergo coronary angiography at 9 months, whereas patients in the prospective registry were followed for 2 years for clinical end points without planned follow-up angiography (figure 1).

The trial was conducted in six Dutch hospitals of which one had 24 hour facilities for (primary) PCI and coronary artery bypass graft (CABG) surgery. The study complied with the Declaration of Helsinki, was approved by the ethics committee of Isala, Zwolle, the Netherlands, and all patients gave written informed consent before entering the study or the registry. The study was registered in the ISRCTN Register (ISRCTN39290163).

Randomisation and treatment
Patients were randomised by a closed envelope system to blinded stent designs. Operators were blinded to the device used and the clinical end points were adjudicated by investigators blinded with regard to patients’ treatment allocation (flow chart: summary of the study design). Coronary angioplasty was performed according to the local standards of the intervention centre. All patients were treated according to the guidelines. Concomitant medication included a loading dose of aspirin (500 mg orally or intravenously), clopidogrel (600 mg orally) and 5000 IU unfractionated heparin intravenously as soon as possible after diagnosis. Tirofiban (bolus of 25 mg/kg followed by continuous infusion of 0.15 mg/min/kg), nitrates, β-blockers and calcium channel blockers were given at the discretion of the investigator.

Definitions
Procedure time was defined as the time interval between placement of the arterial sheath and removal of the guiding catheter. Clinical procedural success was defined as immediate angiographic success (defined as a diameter stenosis postprocedure of <50% (visual assessment) and TIMI 3 flow) without major in-hospital complication, including death, myocardial infarction (MI), stent thrombosis or emergency coronary artery bypass surgery. MI was defined by the presence of new
Q waves or creatine kinase level or MB fraction at least twice the upper limit of normal. Lesions were classified according to the definitions recommended by the American College of Cardiology/American Heart Association task force.

Stent thrombosis was defined as complete occlusion of the stented lesion at follow-up angiography or at recurrent angiography performed because of recurrent chest pain and signs of ischaemia.

End points
The primary end point of the ELISA-3 angiographic substudy was the extent of restenosis, expressed by the difference in minimal luminal diameter at 9-month follow-up angiography, as assessed by an independent core laboratory.

We conducted a pooled analysis of the ELISA-3 and the prospective ELISA registry patients, in which the incidence of definite stent thrombosis at 2 years follow-up was the key secondary and safety end point. The incidence of MACE at 2 years follow-up was an exploratory end point in this pooled analysis.

Qualitative and quantitative coronary analysis
Coronary angiograms were performed before angioplasty, immediately after angioplasty and at 9-month follow-up. Standard acquisition procedures were followed for qualitative and quantitative coronary angiography analysis. To improve the accuracy and reproducibility of measurements, intracoronary isosorbide-dinitrate (1–3 mg) was given before the initial and final post-stent placement angiograms. Angiographies were recorded on a CD-ROM. Matched orthogonal views were used for quantitative analysis at each control. Dye-filled guiding catheters were used for magnification calibration. Data collection included assessment of TIMI flow grade, lesion eccentricity, estimation of thrombus load and AHA/ACC classification. An independent laboratory (DIAGRAM, Zwolle, the Netherlands) performed routine quantitative coronary angiography measurements using the Coronary Angiography Analysis System (CAAS II System). Two orthogonal angiographic views with minimised vessel foreshortening were obtained, and the angiogram showing the most severe stenosis was selected for quantitative coronary analysis. Postprocedure and follow-up angiograms, which duplicate the initial orthogonal views, were obtained after the removal of the balloon and guidewire.

Follow-up
Coronary angiography was planned at 9 months in the ELISA-3 angiographic substudy patients. Coronary angiography could be prematurely performed on the basis of clinical indications; it was used as the follow-up angiogram in the case of restenosis or if performed after 4 months. When it was performed within 4 months’ time without evidence of restenosis, angiographic control was repeated at 9 months. All major clinical events including death, MI, readmission to hospital for unstable angina pectoris and the need for additional (ischaemia driven) revascularisation of the target vessel were monitored at the time of repeated angiography or by phone at 9 and 24 months for all patients and adjudicated by two independent physicians blinded to randomised treatment.

Statistical analysis
The study is designed to demonstrate superiority of EES based on the assumption that at follow-up angiography minimal luminal diameter (MLD) coated—MLD non-coated >0.20 mm (H0: MLD coated ≤ MLD non-coated —0.20, H1: MLD coated >MLD non-coated—0.20).

Previous studies have shown that it is reasonable to assume that the MLD measurement after angioplasty follows a normal distribution. It is expected that in all groups the mean will be ~1.9 mm and the SD will be ~0.5 mm. Allowing for a type I error of 5% and a dropout rate of 20%, a sample of 280 patients (140 per group) will give 85% power to prove superiority of
coated stenting compared to the use of a non-coated stent.

Data were analysed according to the intention-to-treat analysis. Continuous variables were expressed as means ±SD and were compared between the intervention groups using a Mann-Whitney U test. Categorical data were described by proportions and compared with the χ2 or Fisher’s exact test. Logistic regression was used to calculate the p value of the interaction between the effect of the intervention and the prespecified subgroups on the primary end point. All tests were two-sided and an α of 5% was used. Statistical analysis was performed with SPSS (V.20); SPSS, Chicago, Illinois, USA.

MACE survival Kaplan-Meier curves were obtained and compared by means of the log-rank test.

RESULTS

Baseline characteristics
Between July 2007 and June 2012, 178 ELISA-3 patients (87 EES, 91 BMS) and 296 ELISA registry patients (147 EES, 149 BMS) were randomised. Baseline characteristics in the ELISA-3 population were well balanced between the treatment groups (table 1). There was a significant difference in age between ELISA-3 and the ELISA registry group (68.0±10.9 vs 63.6±12.5 years, p<0.001); other baseline characteristics did not differ between Elisa-3 and the registry group (tables 2 and 3).

Angiographic outcome
Follow-up angiography was performed at 9 months in 124 (70%) of the ELISA-3 patients. Baseline characteristics of patients who declined follow-up angiography were similar to those of patients who had a follow-up angiography. The primary end point, the degree of restenosis (MLD), was significantly different when comparing DES to BMS (2.37±0.63 mm vs 1.84±0.62 mm, p<0.001) (table 4). The incidence of binary restenosis, defined as a diameter stenosis at 9 months follow-up of more than 50%, was 1.9% in the DES group vs 16.7% in the BMS group (RR 0.11, 95% CI (0.02 to 0.84), p=0.01).

Clinical outcome
In the ELISA-3 group, clinical follow-up at 24 months was complete in 173 (97%) patients. The rate of MACE was 10.7% (EES) versus 14.6% (BMS) p=0.442. Target vessel revascularisation was necessary in 4.8% (EES) versus 11.2% (BMS) p=0.119 and stent thrombosis occurred in 1.2% (EES) versus 3.4% (BMS) p=0.621.

Table 1 Characteristics and history (Elisa-3)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>EES</th>
<th>BMS</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male gender</td>
<td>136/178 (76.4%)</td>
<td>70/87 (80.5%)</td>
<td>66/91 (72.5%)</td>
<td>0.213</td>
</tr>
<tr>
<td>Hypertension</td>
<td>91/178 (51.1%)</td>
<td>44/87 (50.6%)</td>
<td>47/91 (51.6%)</td>
<td>0.886</td>
</tr>
<tr>
<td>Previous MI</td>
<td>28/178 (15.7%)</td>
<td>14/87 (16.1%)</td>
<td>14/91 (15.4%)</td>
<td>0.897</td>
</tr>
<tr>
<td>Previous CABG</td>
<td>22/178 (12.4%)</td>
<td>9/87 (10.3%)</td>
<td>13/91 (14.3%)</td>
<td>0.425</td>
</tr>
<tr>
<td>Previous PCI</td>
<td>30/178 (16.9%)</td>
<td>13/87 (14.9%)</td>
<td>17/91 (18.7%)</td>
<td>0.505</td>
</tr>
<tr>
<td>Previous stroke</td>
<td>6/178 (3.4%)</td>
<td>1/87 (1.1%)</td>
<td>5/91 (5.5%)</td>
<td>0.211</td>
</tr>
<tr>
<td>Previous TIA</td>
<td>8/178 (4.5%)</td>
<td>1/87 (1.1%)</td>
<td>7/91 (7.7%)</td>
<td>0.066</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>34/178 (19.1%)</td>
<td>17/87 (19.5%)</td>
<td>17/91 (18.7%)</td>
<td>0.884</td>
</tr>
<tr>
<td>Smoking</td>
<td>53/178 (29.8%)</td>
<td>28/87 (32.2%)</td>
<td>25/91 (27.5%)</td>
<td>0.492</td>
</tr>
<tr>
<td>Family history</td>
<td>72/178 (40.9%)</td>
<td>32/87 (37.6%)</td>
<td>40/91 (44.0%)</td>
<td>0.395</td>
</tr>
</tbody>
</table>

Table 2 Characteristics and history by study

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Elisa-3</th>
<th>Elisa registry</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randomisation everolimus</td>
<td>234/474 (49.4%)</td>
<td>87/178 (48.9%)</td>
<td>147/296 (49.7%)</td>
<td>0.868</td>
</tr>
<tr>
<td>Male gender</td>
<td>351/474 (74.1%)</td>
<td>136/178 (76.4%)</td>
<td>215/296 (72.6%)</td>
<td>0.365</td>
</tr>
<tr>
<td>Hypertension</td>
<td>226/474 (47.7%)</td>
<td>91/178 (51.1%)</td>
<td>135/296 (45.6%)</td>
<td>0.244</td>
</tr>
<tr>
<td>Previous MI</td>
<td>69/473 (14.6%)</td>
<td>28/178 (15.7%)</td>
<td>41/295 (13.9%)</td>
<td>0.584</td>
</tr>
<tr>
<td>Previous CABG</td>
<td>47/474 (9.9%)</td>
<td>22/178 (12.4%)</td>
<td>25/296 (8.4%)</td>
<td>0.167</td>
</tr>
<tr>
<td>Previous PCI</td>
<td>70/474 (14.8%)</td>
<td>30/178 (16.9%)</td>
<td>40/296 (13.5%)</td>
<td>0.321</td>
</tr>
<tr>
<td>Previous stroke</td>
<td>21/474 (4.4%)</td>
<td>6/178 (3.4%)</td>
<td>15/296 (5.1%)</td>
<td>0.385</td>
</tr>
<tr>
<td>Previous TIA</td>
<td>85/474 (17.9%)</td>
<td>34/178 (19.1%)</td>
<td>51/296 (17.2%)</td>
<td>0.607</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>167/473 (35.3%)</td>
<td>53/178 (29.8%)</td>
<td>114/296 (38.6%)</td>
<td>0.051</td>
</tr>
<tr>
<td>Smoking</td>
<td>200/472 (42.4%)</td>
<td>72/176 (40.9%)</td>
<td>128/296 (43.2%)</td>
<td>0.620</td>
</tr>
</tbody>
</table>

BMS, bare-metal stent; CABG, coronary artery bypass graft; EES, everolimus-eluting stent; MI, myocardial infarction; PCI, percutaneous coronary intervention; TIA, transient ischaemic attack.
In the registry group, clinical follow-up at 24 months was complete in 282 (95%) patients. The rate of MACE was 13.6% (EES) versus 16.9% (BMS) p=0.437. Target vessel revascularisation was necessary in 3.6% (EES) versus 9.9% (BMS) p=0.035 and stent thrombosis occurred in 1.4% (EES) versus 2.8% (BMS) p=0.684. The secondary end point, stent thrombosis, in the pooled population (1.3% (DES) versus 3.0% (BMS), p=0.339) did not differ significantly between the groups at 2 years follow-up. Neither did the exploratory end point MACE (12.5% (DES) versus 16.0% (BMS), p=0.284) (table 3), as also illustrated by the Kaplan-Meier event-free survival curves (figures 2 and 3). DE stenting, however, significantly reduced target vessel revascularisation as compared to BM stenting (4.0% vs 10.4%, p=0.009) (table 5).

**DISCUSSION**

The main finding of this study was that the use of an everolimus eluting second-generation DES is safe and decreased restenosis, angiographic as well as clinical, in patients with NSTEMI.
In STEMI, Laarman et al.\(^7\) found no significant benefit associated with the use of first-generation paclitaxel-eluting stents in primary PCI as compared with uncoated stents with the same design. Spaulding et al.\(^{13}\), however, found a significant reduction in the incidence of target-vessel failure at 1 year, using a sirolimus-eluting stent, compared with uncoated stents. Rates of stent thrombosis were similar in the coated and uncoated stent groups in both studies.

In the EXAMINATION trial, an allcomer trial in 1498 patients with STEMI comparing second-generation EES versus BMS, Sabate et al.\(^{14}\) showed that the rate of target lesion revascularisation and the rate of stent thrombosis were reduced in recipients of EES. The same result on stent thrombosis was found in a subgroup of patients with NSTE-ACS from the BASKET-PROVE trial; however, neither trial was sufficiently powered for this end point and the latter was a post hoc analysis.

### Table 4 Angiographic results preprocedural and postprocedural and at 9 months follow-up

<table>
<thead>
<tr>
<th></th>
<th>EES (n=85)</th>
<th>BMS (n=87)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-PCI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time from randomisation to PCI (hours)</td>
<td>26.4±40.2</td>
<td>41.7±67.3</td>
<td>0.075</td>
</tr>
<tr>
<td>MLD (mm)</td>
<td>0.81±0.42</td>
<td>0.81±0.40</td>
<td>0.928</td>
</tr>
<tr>
<td>Diameter stenosis (%)</td>
<td>69.73±15.28</td>
<td>69.00±14.92</td>
<td>0.711</td>
</tr>
<tr>
<td>Lesion length (mm)</td>
<td>14.43±6.63</td>
<td>13.39±7.03</td>
<td>0.234</td>
</tr>
<tr>
<td>Reference diameter pre-PCI (mm)</td>
<td>2.73±0.52</td>
<td>2.65±0.55</td>
<td>0.304</td>
</tr>
<tr>
<td><strong>Post-PCI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MLD (mm)</td>
<td>2.36±0.57</td>
<td>2.30±0.46</td>
<td>0.163</td>
</tr>
<tr>
<td>Diameter stenosis (%)</td>
<td>11.85±16.75</td>
<td>13.06±10.80</td>
<td>0.107</td>
</tr>
<tr>
<td>Lesion length (mm)</td>
<td>18.30±7.88</td>
<td>17.58±7.08</td>
<td>0.709</td>
</tr>
<tr>
<td>Stent placement</td>
<td>82/84 (97.6%)</td>
<td>87/89 (97.8%)</td>
<td>&gt;0.99</td>
</tr>
<tr>
<td>Direct stenting</td>
<td>27/82 (32.9%)</td>
<td>32/87 (36.8%)</td>
<td>0.599</td>
</tr>
<tr>
<td>Number of stents</td>
<td>1.26±0.49</td>
<td>1.15±0.39</td>
<td>0.114</td>
</tr>
<tr>
<td>Maximal stent diameter (mm)</td>
<td>3.14±0.43</td>
<td>3.13±0.45</td>
<td>0.660</td>
</tr>
<tr>
<td>Total stent length (mm)</td>
<td>22.57±10.74</td>
<td>21.47±7.72</td>
<td>0.825</td>
</tr>
<tr>
<td>Balloon size (mm)</td>
<td>2.82±0.45</td>
<td>2.69±0.45</td>
<td>0.084</td>
</tr>
<tr>
<td>Acute gain (mm)</td>
<td>1.53±0.50</td>
<td>1.50±0.52</td>
<td>0.498</td>
</tr>
<tr>
<td><strong>Nine-month follow-up</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time from randomisation to 9 months follow-up (months)</td>
<td>8.9±1.6</td>
<td>9.2±2.4</td>
<td>0.468</td>
</tr>
<tr>
<td>MLD (mm)</td>
<td>2.37±0.63</td>
<td>1.84±0.62</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Diameter stenosis (%)</td>
<td>11.25±18.03</td>
<td>31.13±18.65</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Binary restenosis*</td>
<td>1/54 (1.9%)</td>
<td>10/60 (16.7%)</td>
<td>0.007</td>
</tr>
<tr>
<td>Late loss (mm)</td>
<td>0.09±0.52</td>
<td>0.52±0.51</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Values are mean±SD or count/sample size (%).

* diameter stenosis at 9 months follow-up >50%.

Acute gain, MLD after stenting minus MLD at baseline; Late loss, MLD after stenting minus MLD at follow-up; MLD, minimal lumen diameter.

BMS, bare-metal stent; EES, everolimus-eluting stent; PCI, percutaneous coronary intervention.

### Figure 2 Kaplan-Meier curves showing freedom from MACE up to 720 days after the index procedure in the pooled population.

MACE, major adverse cardiac events (composite of death, myocardial infarction and target vessel revascularisation).
Although there is growing evidence that the cobalt-chromium (CoCr)-EES is safe, there is still debate about the relative safety of DES compared to BMS related to stent thrombosis. Pathological studies suggest that the permanent presence of polymers may result in chronic arterial inflammation, resulting in delayed endothelial healing and late thrombotic events.16

A large meta-analysis in 2007 comparing BMS and first-generation DES strengthened concerns about late and very late stent thrombosis with paclitaxel-eluting stents.17 Recently, however, it has been shown that second-generation polymers (ie, polyvinylidene fluoride-co-hexafluoropropene (PVDF-HFP)) used in current DES provide a more biocompatible surface than early-generation polymers18 and Kolandaivelu et al19 showed in a controlled model of early ST that drug-eluting polymer-coated stents are even consistently less, not more, thrombogenic than matched bare metal platforms.

Continuous refinement in stent design and the development of thinner stent struts has resulted in significantly lower rates of stent thrombosis; thus nowadays even larger sample sizes are required to accurately estimate differences between stents and as such many RCTs are presently underpowered for this endpoint. For this reason, Palmerini et al20 conducted a large network meta-analysis of RCTs comparing the risk of thrombosis between bare-metal, first-generation and second-generation DES. They reported a profound reduction of stent thrombosis with cobalt-chromium EES, compared with other DES as well as with BMS at 2-year follow-up. These findings were corroborated by the results of another meta-analysis of 4896 patients comparing the cobalt-chromium EES with its uncoated otherwise identical metallic counterpart, showing improvement in cardiovascular outcomes including cardiac survival, MI and overall stent thrombosis with the cobalt-chromium EES.21

The issue of restenosis is often thought of as trivial, not having any influence at clinical end points, but there is evidence that in ∼10% of cases, patients with in-stent restenosis present with reMI instead of just angina.22 In our study, restenosis rates were highly significantly lower in the EES group at 9 months angiographic follow-up, which is consistent with findings in previous trials.

Our study, however, is the first randomised trial to investigate the safety and efficacy of second-generation DES in a NSTEMI population. Patients with NSTEMI differ from those with STEMI. In STEMI, the culprit artery is usually occluded by a thrombus, whereas in NSTEMI the culprit artery is usually patent with a non-occlusive thrombus, but both conditions stem from the same pathophysiological process.10 23 24 Thereby, patients with STEMI are older and have more comorbidity as compared to patients with STEMI, reflecting their worse long-term clinical outcome. This study shows that

---

| Table 5 | MACE, TVR and ST at 2 years follow-up |
|------------------|------------------|------------------|------------------|
| Follow-up at 2 years | EES (%) | BMS (%) | p Value |
| Elisa-3 (n=173) | MACE | 10.7 | 14.6 | 0.442 |
| | TVR | 4.8 | 11.2 | 0.119 |
| | ST | 1.2 | 3.4 | 0.621 |
| Elisa Registry (n=282) | MACE | 13.6 | 16.9 | 0.437 |
| | TVR | 3.6 | 9.9 | 0.035 |
| | ST | 1.4 | 2.8 | 0.684 |
| Pooled Analysis (n=455) | MACE | 12.5 | 16.0 | 0.284 |
| | TVR | 4.0 | 10.4 | 0.009 |
| | ST | 1.3 | 3.0 | 0.339 |

BMS, bare-metal stent; EES, everolimus-eluting stent; MACE, major adverse cardiac events (composite of death, myocardial infarction and target vessel revascularisation); TVR, target vessel revascularisation; ST, stent thrombosis.

---

Figure 3  Kaplan-Meier curves showing freedom from stent thrombosis up to 720 days after the index procedure in the pooled population.
DE stenting in this patient population is safe and improves long-term target vessel revascularisation.

Limitations of the study
Several limitations of the present study should be acknowledged. Most important was the lower than expected inclusion rate in the ELISA-3 angiographic substudy. When inclusion in the main study was finished, of 344 eligible patients only 178 were randomised in this angiographic substudy, giving an ~78% power to prove superiority of the DES, while we anticipated to recruit 280 patients in our power calculations.

Furthermore, we encountered a higher than expected loss of angiographic follow-up at 9 months. We conducted a pooled analysis of the ELISA-3 and the ELISA Registry patients to have more power with regard to the safety of DE versus BM stenting in terms of clinical outcome; this study, however, was not powered to show differences in MACE.

Conclusion
In patients with NSTEMI, the use of an EES second-generation DES is safe and decreases both angiographic and clinical restenosis as compared to a cobalt chromium BMS.

Acknowledgements
The authors thank Vera Derks for excellent editorial assistance. The authors thank Vera Derks for excellent editorial assistance.

Contributors
WSR and AWJvH participated in design and concept of the current study and the Zwolle studies, data handling and preparation of the manuscript. JOAH and HS were involved in design and set-up of the Zwolle studies, critical comments and revision of the manuscript. PKC undertook statistical analysis. EAB, JPO, ATMG, SR, RSH and J-HED critically revised the manuscript.

Funding
Abbott (unrestricted research grant). The sponsor of the study had no role in the study design, data collection, data analysis, data interpretation or writing of the report.

Competing interests
EAB received consulting fees from Merck Sharp and Dohme and Sanofi-Aventis. AWJvH received speaker’s fees and research grants from Merck, Sanofi-Aventis, The Medicines Company, Iroko Cardio and AstraZeneca.

Ethics approval
The ethics committee of Isala, Zwolle.

Provenance and peer review
Not commissioned; externally peer reviewed.

Data sharing statement
No additional data are available.

Open Access
This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/

REFERENCES
Randomised comparison of drug-eluting versus bare-metal stenting in patients with non-ST elevation myocardial infarction

Wouter S Remkes, Erik A Badings, Renicus S Hermanides, Saman Rasoul, Jan-Henk E Dambrink, Petra C Koopmans, Salem HK The, Jan Paul Ottervanger, A T Marcel Gosselink, Jan CA Hoornije, Harry Suryapranata and Arnoud WJ van ’t Hof

*Open Heart* 2016 3:
doi: 10.1136/openhrt-2016-000455

Updated information and services can be found at:
http://openheart.bmj.com/content/3/2/e000455

These include:

**References**
This article cites 24 articles, 10 of which you can access for free at:
http://openheart.bmj.com/content/3/2/e000455#BIBL

**Open Access**
This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See:
http://creativecommons.org/licenses/by-nc/4.0/

**Email alerting service**
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Notes**

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/