IS STENTING OF THE FEMORAL ARTERY AS GOOD AS BYPASS SURGERY?

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Disclosure

Speaker name: Jonas Eiberg

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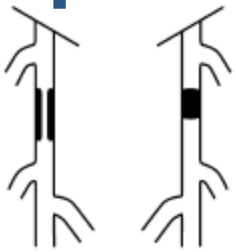
I have the following potential conflicts of interest to report:

- ☐ Consulting
- ☐ Employment in industry
- ☐ Stockholder of a healthcare company
- ☐ Owner of a healthcare company
- ☐ Other(s)
- ☑ I do not have any potential conflict of interest

Research question

A



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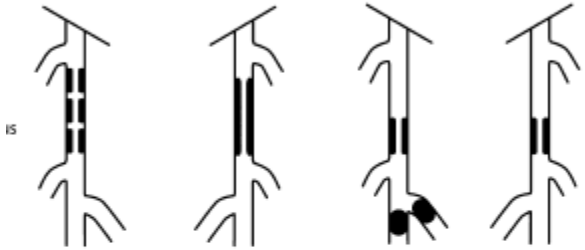

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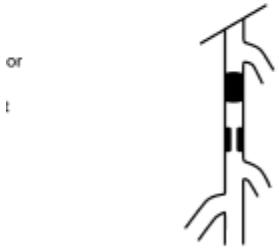

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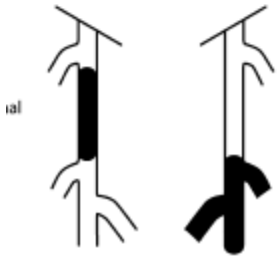

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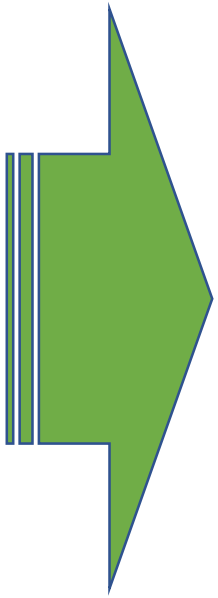

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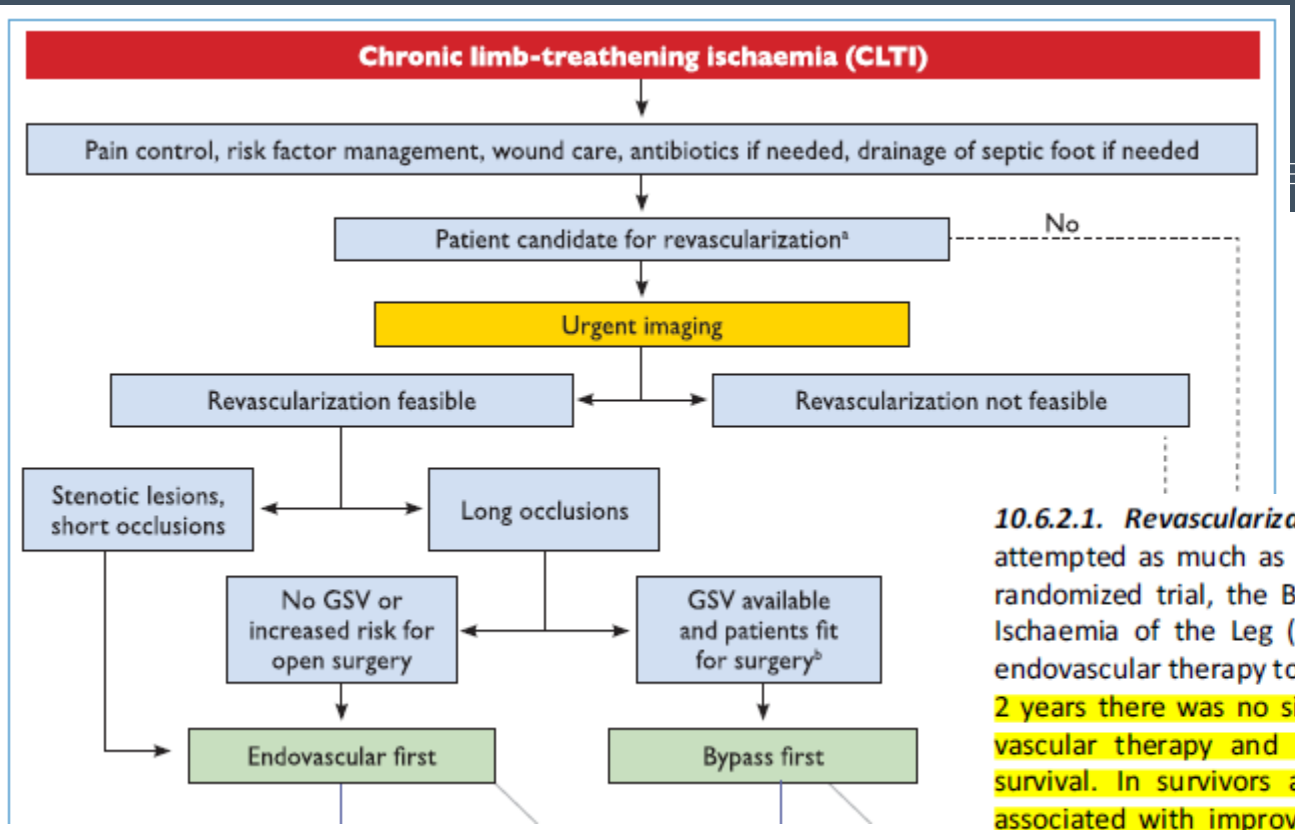
BYPASS



10.6.2.1. Revascularization. Revascularization should be attempted as much as possible.[246,320–322] So far, only one randomized trial, the Bypass versus Angioplasty in Severe Ischaemia of the Leg (BASIL) trial, has directly compared endovascular therapy to open surgery in CLTI patients.[323] At 2 years there was no significant difference between endovascular therapy and surgery regarding amputation-free survival. In survivors after 2 years, bypass surgery was associated with improved survival (on average 7 months, $P = 0.02$) and amputation-free survival (6 months, $P = 0.06$).[314] These data are challenged by more recent endovascular therapy techniques. So far, drug-eluting bal-

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Editor's Choice — 2017 ESC Guidelines on the Diagnosis and Treatment of Peripheral Arterial Diseases, in collaboration with the European Society for Vascular Surgery (ESVS)

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Endorsed by: the European Stroke Organization (ESO)

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Research question

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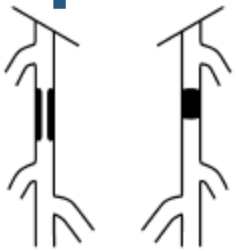

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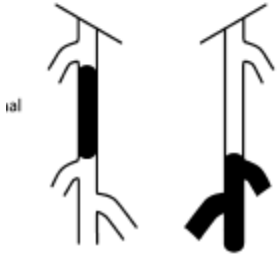


BYPASS

Method

- 2011-2015 (5y)
- Danish Vascular Registry + Death registry
- Patient records and PACS

INCLUSION

- Critical ischemia (Fontaine 3+4)
- Femoropopliteal lesions
- Revascularization of SFA with PTA or Bypass surgery

EXCLUSION

- Bilateral treatment
- Lost to follow up
- Adjunctive treatment, other than central and periferal PTA, and CFA TEA

Limitations

- Patient records and PACS was retrospectively reviewed
- Bias – unfit for surgery referred for PTA?
- Cohort size - legal (5y), no power analysis
- Follow-up – no systematic US surveillance of PTA in Cph
- 18% had endo without stenting

End Points

Amputation free survival

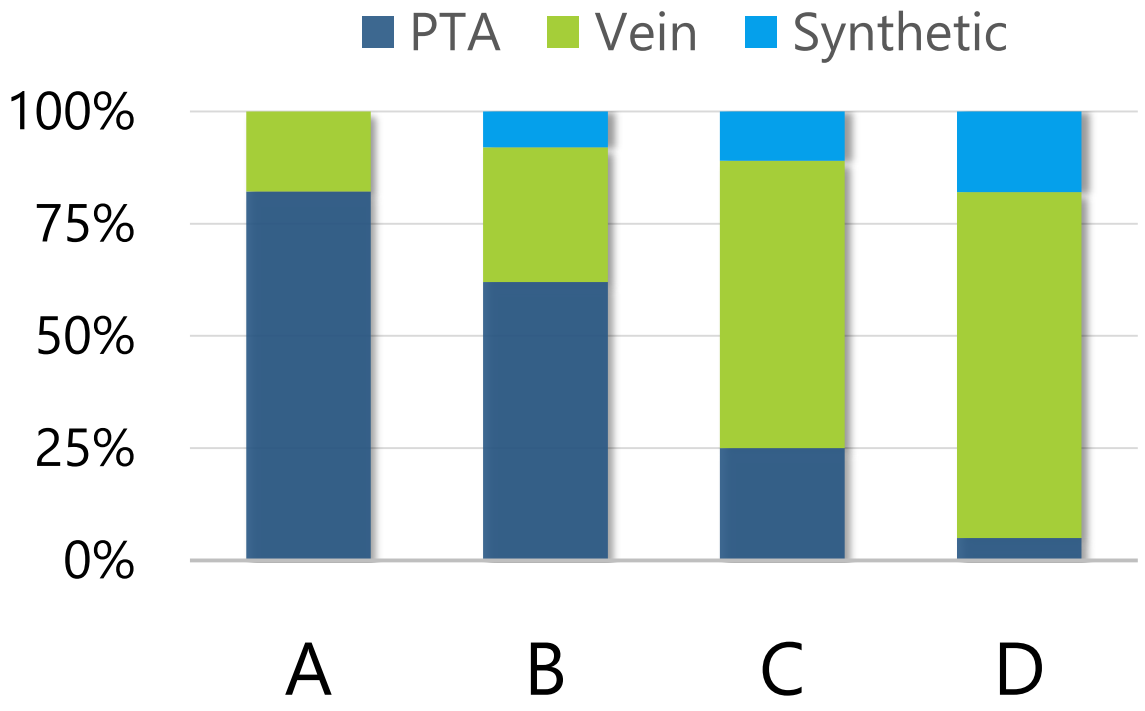
All-cause mortality

RESULTS- Baseline

	PTA	Vein	Synthetic	P
Number treated, n	239	357	76	
	In total 672 patient			
Demography				
Sex, man	55%	66%	61%	0.023
Age, mean (95% CI)	74 (73-76)	70 (69-71)	73 (70-76)	

RESULTS- Baseline

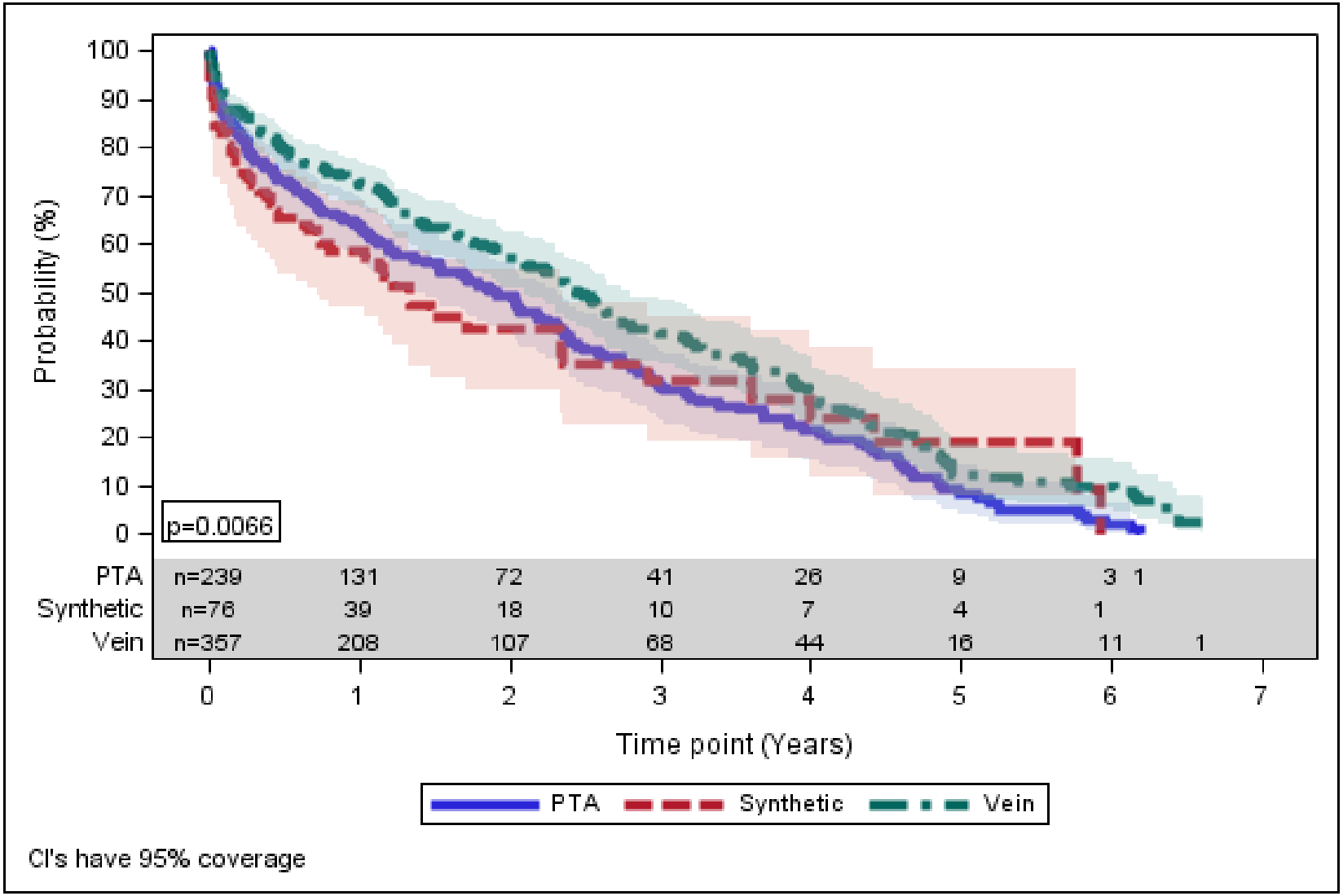
TASC II



Runoff

	PTA	Vein	Synthetic
0	13% (31)	14% (52)	5% (4)
1	40% (96)	38% (139)	53% (40)
2	33% (79)	31% (114)	32% (24)
3	13% (32)	16% (57)	9% (7)

Amputation Free Survival



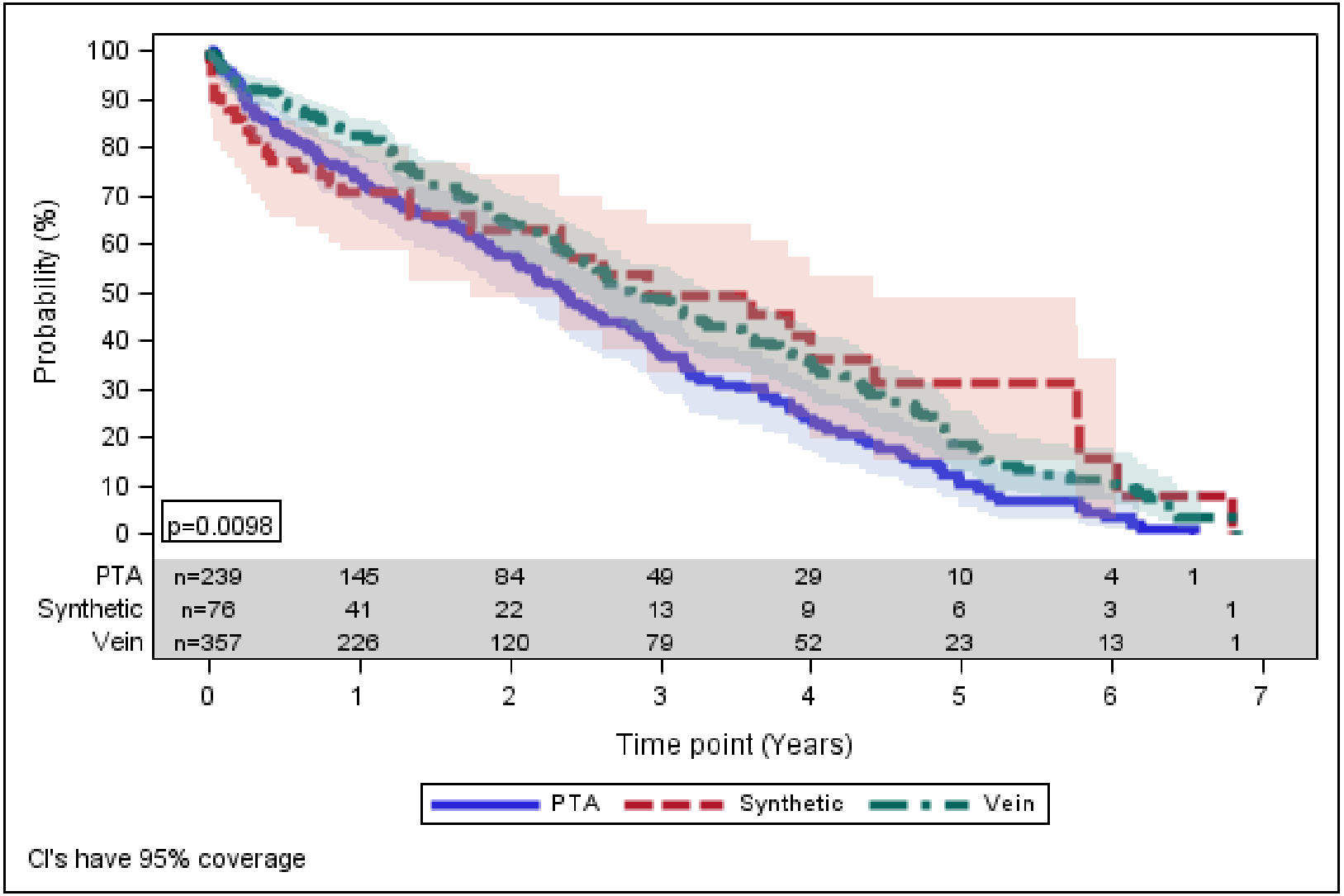
Risc Of Amp. Or Death, Hazard Ratio

	HR, Un-adjusted	HR, Adjusted for co-morb	HR, Adjusted for co-morb and TASC
PTA vs. Vein	1.36 (p=0.004)	1.29 (p=0.019)	1.56 (p=0.001)
Synthetic vs. Vein	1.40 (p=.004)	1.26 (p=0.204)	1.25 (p=0.211)
Synthetic vs. PTA	1.03 (p=.865)	0.98 (p=0.895)	0.80 (p=0.277)

Co-morb. And Risc Of Amp Or Death

	Hazard Ratio	P
Low renal function	1.39	0.005
Congestive heartfailure	1.55	0.001
Atrial fibrillation	1.33	0.025
Ischemic heart disease	1.02	0.858
Stroke	1.10	0.484
Hypertension	1.19	0.115
Diabetes	1.10	0.364
Lung disease	1.11	0.437
Smoking	1.04	0.682
Alcohol, above recom.	1.10	0.449
TASC II, B	1.19	0.408
TASC II, C	1.30	0.238
TASC II, D	1.81	0.015
No Run-off	1.37	0.034

Freedom from mortality



Conclusion

01 30% - 50% higher risc of amputation or death in the PTA group, compared to vein bypass.

02 Increased lenght of hospital stay and more wound complications in bypass group

03 Severity of lesion (TASC) is an important cofactor

04 Overall mortality is high in all groups.