Left Ventricular Support Systems for High-Risk Percutaneous Coronary Interventions
How Can We Improve Outcomes for Rare Procedures?

John P. Vavalle, MD, MHS; E. Magnus Ohman, MD

The opinions expressed in this article are not necessarily those of the editors or of the American Heart Association.

From the Division of Cardiovascular Medicine and Duke Clinical Research Institute, Duke University, Durham, NC.

Correspondence to E. Magnus Ohman, MD, Duke University Medical Center, 8676A HAFS Building, Box 3126 DUMC, Durham, NC 27710. E-mail ohman001@mc.duke.edu

(Circulation. 2013;127:162-164)
© 2012 American Heart Association, Inc.

Circulation is available at http://circ.ahajournals.org
DOI: 10.1161/CIRCULATIONAHA.112.152785

High-risk percutaneous coronary interventions (PCI) are becoming more prevalent as the ability to perform complex coronary interventions continues to improve. Patients for whom high-risk interventions are considered generally have severe diffuse coronary artery disease, a single last patent conduit, or significant left main disease with large territories of myocardial ischemia. In addition, these patients also typically have reduced left ventricular function (ejection fraction <25%–35%) with comorbidities that make them high risk for standard coronary artery bypass grafting. Thus, PCI is increasingly used as a viable alternative for coronary revascularization, but it too is associated with a high degree of morbidity and mortality.

Article see p 207

Coronary ischemia can transiently worsen during PCI through repeated balloon inflations, stent manipulations, and contrast injections that result in a negative inotropic effect.1 In patients with left ventricular dysfunction and large territories of ischemia who have little reserve, this can lead to reductions in blood pressure that make it hard to complete the revascularization. Hemodynamic support during the conduct of the PCI, such as that provided by intra-aortic balloon pump (IABP) counterpulsation or Impella, may therefore maintain perfusion pressure throughout the procedure to reduce the risk associated with these complex interventions.

Kahn and colleagues reported the first use of intra-aortic balloon pumps to support high-risk PCI in 1990 among 28 patients with severe LV dysfunction undergoing PCI for 3-vessel or left main coronary artery disease.2 This study established that IABP support in this setting was safe and allowed the PCI to be completed without untoward risk. IABP use for this indication has continued to grow since that time and now is one of the more common reasons for IABP use in the cardiac catheterization laboratory, reflective of the growing number of high-risk PCIs being performed by interventional cardiologists.3

In an analysis by Brennan and colleagues from the National Cardiovascular Data Registry evaluating the use of PCI as a revascularization strategy for unprotected left main coronary artery stenosis in the United States, they demonstrated that this was being performed in almost 5% of patients with unprotected left main coronary artery stenosis, accounting for almost 6000 PCIs during the interval studied (2004–2008).4 Furthermore, the proportion of patients with unprotected left main coronary artery stenosis treated with PCI was increasing during that time. Among the patients included in the National Cardiovascular Data Registry, 95% of those who had unprotected left main coronary artery stenting survived to hospital discharge. However, by 30 months, >40% of these patients had died, indicating the high-risk nature of these interventions and the need for long-term follow-up.

The Balloon Pump-Assisted Coronary Intervention Study (BCIS-1) was the first randomized controlled study to assess the efficacy of elective intra-aortic balloon pump use in patients undergoing elective high-risk PCI.5 In this study, >300 patients with severe left ventricular systolic dysfunction and extensive coronary disease were randomized to IABP or no IABP before elective high-risk PCI. In general, these patients were older, with severe left ventricular dysfunction (mean left ventricular ejection fraction of 24%), and more than half had class III or IV heart failure symptoms. The primary end point for this study was major adverse cardiac and cardiovascular events defined as death, acute myocardial infarction, cerebrovascular event, or further revascularization before hospital discharge, capped at 28 days.

In the BCIS-1 study, major adverse cardiac and cardiovascular events at hospital discharge was 15.2% in the elective IABP group versus 16.0% in the control arm and was not statistically significantly different (odds ratio, 0.94; 95% confidence interval [CI], 0.51–1.76; P=0.85). Prophylactic IABP use was associated with more minor bleeding (15.9% versus 7.3%; odds ratio, 2.39; 95% CI, 1.07–5.61; P=0.02) and vascular access site complications (3.3% versus 0%; P=0.06). However, procedural complications were significantly more common in the no IABP group (10.7% versus 1.3%; odds ratio, 0.11; P<0.001), driven mostly by episodes of prolonged procedural hypotension in the control group. It is also important to note that in this study there was significant crossover from no IABP to placement of an IABP, which occurred in 18 of the 150 patients (12%) assigned to the control arm, usually because of profound hypotension. In the initial publication, the secondary end point of all-cause mortality at 6 months was reported. This showed a trend toward improved 6-month all-cause mortality in the IABP group at 4.6% versus 7.4% in the control group (odds ratio, 0.61; 95% CI, 0.24–1.62; P=0.32). The Kaplan–Meier cumulative mortality estimates for the 2
arms in the study showed that this trend is not evident until at least 2 months after the PCI, and at 6 months, the Kaplan–Meier mortality curves still appear to be diverging.

In this issue of *Circulation*, we now learn of the 5-year mortality outcomes of the BCIS-1 trial. Strikingly, it shows a significant reduction in all-cause mortality among those randomized to prophylactic IABP with a relative reduction in all-cause mortality of 34% (hazard ratio, 0.66; 95% CI, 0.44–0.98; *P*=0.039). The Kaplan–Meier curves for survival not only demonstrate a significant difference at 5 years, but also that the Kaplan–Meier curves appear to be continuing to diverge even at 5 years.

The use of a central national database to determine vital status led to the remarkable achievement of 100% long-term follow-up. Because of the nature of the data collected, the cause of death for these patients is unknown, and our ability to understand the mechanisms behind the improved survival 5 years after IABP use is hindered. The authors conclude that the effect on mortality may be attributable to reductions in procedural ischemia and myocardial infarction or from more aggressive revascularization in the setting of prophylactic IABP use in high-risk PCI.

The results of BCIS-1 parallel those seen in the recently published PROTECT II study, which randomized patients undergoing elective high-risk PCI to either hemodynamic support with the Impella 2.5™ device or IABP. Although the primary end point in PROTECT II of 30-day major adverse events was not different between the 2 groups, the 90-day per protocol analysis demonstrated improved outcomes with the Impella device over IABP (relative risk, 0.79; 95% CI, 0.64–0.97; *P*=0.023). Examination of the Kaplan–Meier event rates demonstrates that with longer follow-up there appears to be a growing difference in the event rates that seems to be still diverging at the end of follow-up (90 days). Again, the reasons for the improved outcomes with more hemodynamic support over less support that becomes increasingly apparent with longer-term follow-up are not entirely clear. Reductions in myocardial ischemia and necrosis, as well as more aggressive revascularization with improved hemodynamic support, are possible contributing factors. The authors of PROTECT II suggest that 30-day follow-up was insufficient in this study to fully demonstrate the differences between the groups and that out-of-hospital events that occur beyond 30 days have important safety and cost implications and should be captured in future studies like this.

What are the implications for intervention cardiologists that are about to perform a high-risk PCI in a patient with severe left ventricular function and left main disease that the Heart Team has suggested should be best managed with PCI because of the comorbidity? On the surface, the primary end points of both BCIS-1 and PROTECT-II were neutral, suggesting that these devices did not offer any additional benefit when examined at 30 days. In fact, both devices offer very good hemodynamic support, with the advantage to the Impella device that allows higher cardiac output and greater support at a price of larger canulae and the potential for more vascular access issues. However, both studies suggest a possible later effect. The later outcomes data with IABP (at 5 years) and Impella (at 90 days) suggest that when more complete revascularization is desirable, these devices will offer the potential to improve outcomes with high-risk PCI.

The question that remains is how can we better ascertain the long-term outcomes with relatively rare high-risk procedures like this? The U.S. Food and Drug Administration has suggested that longer-term safety data are desirable for approved medical devices. In September of 2012, the U.S. Food and Drug Administration released its vision for postmarket surveillance for medical devices. Although the primary objective of these postmarket surveillance systems is to assess for long-term safety, these systems can and should be used to also assess efficacy. It has already been demonstrated that automated safety surveillance of clinical registries for approved cardiovascular devices can provide early warnings regarding the safety of approved cardiovascular devices in clinical practice. It is our belief that similar to what was carried out in the BCIS-I study, long-term follow-up using a death index would allow safety information such as mortality to be collected prospectively without holding up an approval process. This would be of particular value for high-risk interventions where long-term mortality data are not usually available.

We need to acknowledge that revascularization with PCI is an iterative science where gradual changes to procedures such as the use of left ventricular support devices in high-risk PCI can offer new avenues for us to treat the most complex patients. Although the use of prophylactic IABP or Impella can improve outcomes compared with a more stand-by approach, we must recognize that newer support devices may be on the horizon. We need to approach them with a more mature process for data-collection so that we can truly understand major outcomes, such as mortality, without holding up the process of moving the science of improving patient outcomes forward. The data from BCIS-I and PROTECT-II that demonstrate more robust differences in the treatment arms with longer follow-up should be a call to investigators that future studies of hemodynamic support devices must include long-term follow-up.

**Disclosures**

Dr Ohman reports the following conflicts: research grants from Daiichi Sankyo, Lilly, and Gilead Sciences; consulting fees from AstraZeneca, Boehringer Ingelheim, Bristol-Myers Squibb, Gilead, Janssen Pharmaceuticals, LipoScience, Merck, Pozen, Roche, Sanofi-Aventis, The Medicines Company, and Web MD; lecture fees from Boehringer Ingelheim and Gilead. Dr Vavalle reports no conflicts.

**References**


**Key Words:** Editorials ■ percutaneous coronary intervention
Left Ventricular Support Systems for High-Risk Percutaneous Coronary Interventions: How Can We Improve Outcomes for Rare Procedures?
John P. Vavalle and E. Magnus Ohman

Circulation. 2013;127:162-164; originally published online December 6, 2012;
doi: 10.1161/CIRCULATIONAHA.112.152785

Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2012 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/127/2/162

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation is online at:
http://circ.ahajournals.org/subscriptions/