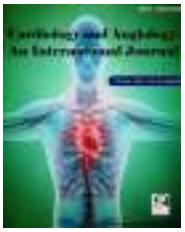

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Are Biodegradable Third Generation Drug Eluting Stents the Answer to Instent Restenosis?

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Review Article

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ABSTRACT

The third generation biodegradable Drug Eluting Stent (DES) are being evaluated and being introduced in clinical practice. They have been DESigned to overcome limitations associated with durable polymer and a persistent metallic stent scaffold which could be related to late target lesion revascularization (TLR) and very late stent thrombosis (VLST). Although a recent pooled data analysis found that biodegradable polymer stents were superior for TLR and VLST compared with first generation Sirolimus Eluting Stent (SES), superiority has not been demonstrated against second generation Everolimus eluting stents (EES) and is yet to be conclusively proven in randomized trials. This paper reviews the key features, recent trial data, and future directions of the third generation of DES technology including stents with fully biodegradable scaffolds, stents with biodegradable polymer, and polymer free stents.

Keywords: Biodegradable; coronary; stents.

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ABBREVIATIONS

PLLA, poly-L-lactic acid; PDLLA, poly-D,L-lactide; PLGA, polylactic-co-glycolic acid; PLA-polylactide derivative; BR- binary restenosis; DD- non-polymeric dual DES; FIM- first-in-man; LLL- in-stent late lumen loss (mm); MACE- major adverse cardiovascular events; NP-non-polymeric DES;ST- definite/probable stent thrombosis; TLF-target lesion failure; PP-permanent polymer; BP-biodegradable polymer; SD-standard dose; NS-not significant; PLA,poly-L-lactide; PLC, 75:25 poly-L-lactide-co-caprolactone; PLGA, 50:50 poly-D,L-lactide-co-glycolide; PLLA, poly-L-lactic acid; PVP, polyvinyl pyrrolidone; USS- uncovered stent struts; NS-not significant; RCT-randomized control trial.

1. INTRODUCTION

Interventional cardiology is currently in the process of refining the third generation of DES technology. It incorporates a broad mix of technologies ranging from incremental improvements in existing stent scaffolds, antiproliferative coats, polymer free, biodegradable polymer coated scaffolds, fully biodegradable scaffolds, newer nano-material coatings and stem cell therapy.

Compared with first generation DES, the second generation stents have advantages like having thinner struts and increased flexibility, more biocompatible polymers and new generation antiproliferative agents [1,2]. Even the second generation DES are not free from disadvantages as the persistent presence of a stent scaffold or polymer beyond its short-term function is related to late target lesion revascularisation (TLR) and very late stent thrombosis (ST). The two year pooled results from the SPIRIT II, III, IV and compare trials prove that everolimus eluting stents (EES) have a superior safety and efficacy profile compared with first generation paclitaxel eluting stents (PES) because of lower rates of myocardial infarction (MI) (RR, 0.57; 95% ci, 0.45–0.73), st (RR, 0.35; 95% ci, 0.21–0.60) and ischemia driven TLR(RR, 0.59;95%ci, 0.47–0.73) [3-5]. Neither EES nor zotarolimus eluting stents (ZES) have demonstrated superior clinical outcomes to first generation sirolimus eluting stents (SES) [6-9].

Major concern with second generation DES is very late stent thrombosis (VLST) rates beyond one year. The pathogenesis of late restenosis and stent thrombosis in second generation DES include neointimal hyperplasia, persistent inflammation of the vessel wall, in-stent neoatherosclerosis, uncovered struts and/or polymers with secondary stent malapposition and stent fracture [10-13].

The bern-rotterdam cohort followed 4212 patients treated with EES for four years and reported a definite or probable st rate of 6.3% and a VLST rate of 2.0%. Although the 2% VLST rate is stastically significant and lower than the corresponding VLST rate for first generation PES (4.0%, $p<0.0001$) and SES (2.8%, $p=0.02$), it represents an ongoing 0.67% annual risk of st after one year [14]. The HORIZONS-AMI [15] trial at three years, LEADERS [16] and syntax [17,18] trials at four years and the sirtax late [19] trial at five years demonstrated similar annual VLST rates of 0.6–0.85% for PES and SES.

Long term efficacy in terms of repeat revascularization rates, TLR incidence rate and late lumen loss (LLL) are other major limitations of second generation DES. Four year repeat revascularization rates of up to 28.8% have been reported for first generation PES in high risk patients undergoing PCI for left main stem and triple vessel disease [17]. Five year

SPIRIT III data of 669 low risk patients treated with EES revealed an annual TLR incidence rate of 1.3% beyond one year with TLR increasing from 3.5% at one year to 8.6% at five years [20]. Second generation DES are also associated with a persistent increase in late lumen loss (LLL). In SPIRIT II EES cohort the mean in-stent LLL increased from 0.17±0.32mmto 0.33±0.37mm [21] while in the ISAR-4 EES cohort [22,23] it increased from 0.14±0.41mm to 0.29±0.51mm between six and 24 months interval. Additional limitations with current generation DES include restrictions to non-invasive imaging with CT and MRI, difficulties with future surgical and transcatheter revascularization, long term disruption of native vascular fluid dynamics and vasoreactivity, chronic inflammation, delayed endothelialization and the need for six or more months of dual antiplatelet therapy (DAPT) [24-29].

The ultimate dream would be to develop a stent system which has best combination of metallic alloys and/or polymers with all DESirable properties favourable combination-drug eluting capabilities. This paper reviews the key features, recent trial data, and future directions of the third generation of DES technology including stents with fully biodegradable scaffolds, stents with biodegradable polymer, and polymer free stents.

2. FULLY BIODEGRADABLE SCAFFOLDS

Fully biodegradable scaffolds aim to combine the advantages of the first and second generation of DES while additionally targeting their disadvantages and limitations. They provide a stable vascular scaffold in the short term, thereby minimizing constrictive remodeling, preventing restenosis due to vascular recoil, and loose intimal dissection flaps [30-32]. The fully biodegradable scaffolds score over the older generation stents by reducing the limitations including but not limited to long-term in-stent restenosis and stent thrombosis associated with a permanent metallic scaffold.

they have been associated with the development of a homogenously thickened neointima, suggestive of a thicker, more stable fibrous cap [12], potential for expansive arterial remodeling and a return of normal vasomotion [33], theoretical decrease in paradoxical peri-stent vasoconstriction[34], facilitating improved non-invasive CT and MRI imaging, wider future transcatheter and/or surgical revascularization options, FREEDOM from jail branch obstruction, less impediment to vascular growth in the pediatric population and limit the need for prolonged DAPT [33,35,46].

Metallic biodegradable scaffolds can be magnesium or iron based. Magnesium has a shorter degradation period of four to twelve months compared with four or more years for iron [38,39]. A polymer coat is used to contain and control the release of an antiproliferative agent. These are DESigned to biodegrade by krebs cycle into carbon dioxide and water over six to 24 months, after the antiproliferative agent has been fully released [34,37].

3. ABSORB BVS

3.1 ABSORB A and ABSORB B

The bioabsorbable everolimus-eluting stent system ABSORB B*VS* (Abbot Vascular, Santa Clara, CA, USA). The ABSORB BVS stent is based on a poly-l-lactic acid (PLLA) scaffold with a poly-d,l-lactide (PDLLA), everolimus impregnated polymer coat. The device has been assessed in two small single arm industry sponsored non-randomized trials, ABSORB a and

ABSORB B. Both studies were restricted to lesions with a rvd of 2.5–3mm and length less than 14mm. Patients received a minimum of six months DAPT post stent insertion.

Five year data from the ABSORB A trial, a 30 patient study using the first iteration BVS 1.0 [35,40,41], revealed a MACE rate of 3.4%, representing a single non-Q wave MI at 46 days, and TLR and ST rates of 0%. LLL increased to 0.48±0.28mm at 24 months. Mean in-stent LLL was 0.43±0.37mm at six months which was largely attributed to scaffold recoil.

Optical coherence tomography (OCT) at 24 months showed a smooth endoluminal lining appearance with virtually indiscernible struts suggested almost complete stent biodegradation.

Intravascular ultrasound (IVUS) results suggested expansile arterial remodeling with the minimum lumen area (MLA) increasing from 3.92±0.98mm2 to 4.34±1.74mm2 from six to 24 months. There was evidence of a return of normal arterial vasomotion at two years with five of nine patients demonstrating arterial vasodilatation on acetylcholine administration [42].

ABSORB B trial assessed the b*vs* 1.1 stent, a revision of the b*vs* 1.0 DESigned to improve radial support beyond six months and allow stent storage at room temperature in 100 patients [37]. The 24 month MACE rate was 9%, comprising a TLR rate of 6% and non-q-wave mi rate of 3%. There were no st events [41]. LLL increased from 0.19±0.18mm at six months to 0.27±0.25mm at 12 months and was stable at 0.27±0.20mm out to 24 months [43]. Between six and 24 months, mean lumen area by IVUS increased from 6.36mm2 to 6.85mm2 with a small increase in MLA from 5.12mm2 to 5.13mm2. Vasoreactivity was demonstrated at 12 months on administration of methylergonovine and acetylcholine [41].

3.2 ABSORB Extend and ABSORB II

Two larger trials with less restrictive inclusion criteria are currently enrolling patients. ABSORB extend is a 1000 patient multinational single arm trial and ABSORB II is a 500 patient RCT comparing the ABSORB B*VS* against the second generation DES, xience prime (Abbot Vascular, Santa Clara, CA, USA) [44,45]. Six month data from the first 200 patients enrolled in the ABSORB extend trial revealed a MACE rate of 2.5% comprising an mi rate of 2% and TLR rate of 0.5% [46].

DESpite significant recent interest in biodegradable scaffolds, clinical and trial experience is limited. Only two devices, the bioabsorbable everolimus-eluting stent system ABSORB B*VS* (Abbot Vascular, Santa Clara, CA, USA) and the igaki-tamai stent (Kyoto Medical Planning Co., Kyoto, Japan) have had trial results published in peer reviewed journals. Both of these stents have the European C.E. mark although the Igaki-Tamai is currently only used in peripheral arteries. There is no randomized data and trials have less restrictive inclusion criteria with respect to reference vessel diameter (RVD) and lesion length. Complex lesions including left main coronary artery (LMCA), left main stem, ostial lesions, saphenous vein graft disease and bifurcations have been excluded [33,35,47-50].

3.2.1 Igaki-Tamai stent

The Igaki-Tamai stent was the first ever fully biodegradable stent. The device was also based on a PLLA polymer scaffold but required contrasts heated to 80℃ to self expand. It was first implanted in 1999 and 10 year data for 50 patients was reported in 2012 [1,47]. The study was non-randomised and industry sponsored. At 10 years, rates of TLR, ST and MI

were 28%, 4% and 8% respectively. Mean in-stent LLL reduced from 0.91±0.69mm at six months to 0.59±0.50mm at three years while MLA increased from 3.64±1.68mm2 to 5.18±2.09mm2 over the same period, suggestive of expansile arterial remodeling. At three years, IVUS echogenicity had returned to Pre-stent levels, indicating complete stent degradation [47].

3.2.2 Rezolve stent

(Reva medical, San Diego, CA, USA): The ReZolve device is based on a tyrosine polycarbonate rather than PLLA scaffold and has the advantage of being radio-opaque [34]. It elutes sirolimus and is being assessed in the restore single arm clinical trial which is currently enrolling a target cohort of 50 patients [50]. An earlier iteration of the stent was assessed in 27 patients in the 2008 resorb trial which reported a six month TLR rate of 67% and 30 day Q-wave-MI rate of 7% [1,36].

3.2.3 DESolve stent

(Elixir Medical Corporation, Sunnyvale, CA, USA): DESOLVE has a PLLA scaffold with a Myolimus eluting PLA coat. Six month clinical data of a 16 patient fim trial revealed a TLR rate of 7%, MI and cardiac death rate of 0% and LLL of 0.19±0.19mm [48]. A larger trial with the DESOLVE NX Novolimus eluting stent is underway with a target enrolment of 120 patients [51].

3.2.3 ART bioresorbable stent

(Arterial Remodelling Technologies, Paris, France): the ART non-drug eluting bioresorbable stent is based on a PLA scaffold and has recently started enrolling patients in the ARTDIVA FIM trial [52].

3.2.4 DREAMS drug eluting absorbable metal stent

(BIOTRONIK, Berlin, Germany) is the only metal biodegradable stent currently undergoing trial assessment. It comprises a magnesium alloy scaffold with a paclitaxel impregnated PLGA coat. It was evaluated in the BIOSOLVE-1 46 patient FIM trial which reported a 12 month TLR rate of 4.7%, MI rate of 2.3% and no ST events. Mean LLL was 0.64±0.50mmat six months and 0.52±0.39 at 12 months [49].

Biodegradable polymeric scaffolds have a number of limitations including but not limited to thicker struts with an increased crossing profile, limited post-dilatation options which mandates quantitative vessel sizing, radio-lucency with more challenging angiographic visualization.

There is also a scarcity of trials testing complex anatomy and challenging lesion subsets including ostial, bifurcation and heavy calcified disease [25]. Potential risk like strut fracture secondary to post-dilatation was observed in one patient at 46 days post stent insertion in the ABSORB A trial. It was hypothesized that fracture resulted from the 3.0mm×12mm stent being over expanded post dilation with a 3.5mm×9mmballoon [53].

Biodegradable polymer DES have demonstrated non-inferiority to both first and second generation DES for safety and efficacy. Although a recent pooled analysis of the ISAR-TEST 3, ISAR-TEST 4 and LEADERS trial data found that biodegradable polymer stents were

superior for TLR and VLST compared with first generation SES, superiority has not been demonstrated against second generation EES and is yet to be proven in any single substantial randomized trial [54].

3.2.5 Non-polymeric drug eluting metallic stents

Non-polymeric DES comprises of a metal alloy scaffold directly impregnated with an anti-proliferative agent. The absence of a polymer coat offers a theoretical basis to minimize the duration of DAPT in patients with a high bleeding risk to one month or less based on the BMS guidelines [28] while still providing the established late safety of a BMS and the antiproliferative effects comparable to polymer based DES. Table 1 gives a brief outline of non-polymeric drug eluting metallic stents.

3.2.5.1 LEADERS-FREE trial

LEADERS-FREE trial is comparing the BioFreedom with the gazelle BMS in 2500 randomized patients at high risk of bleeding with the primary endpoints of non-inferiority for MACE and superiority for clinically driven TLR. importantly, patients will be treated with only one month of DAPT [55].

Yukon SES (translumina, hechingen, Germany) has been examined in two independently funded, assessor blinded, randomized trials, the ISAR-TEST and ISAR-TEST 3. The ISAR-TEST trial included 450 patients across two centers and reported non-inferiority of the yukon SES compared with the durable polymer-based taxus PES [56] for six month in-stent LLL (0.48±0.61mm *vs* 0.48±0.58mm, *p*=0.98) and death & mi (4.4% *vs* 4.0% , *p*=0.81). DESpite the encouraging early results, it performed poorly in the subsequent three-arm ISAR-TEST 3 study, failing to demonstrate non-inferiority with the first generation cypher stent in 650 patients for the primary endpoint of in-stent LLL at six to eight months (0.47±0.56mm *vs* 0.17±0.45mm *vs* 0.23±0.46mm, *p*=0.94) [57]. At two years, however, there was no difference for a composite endpoint of death or mi (7.0% *vs* 6.9% *vs* 6.4% *p*=0.97); for TLR (13.9% *vs* 8.4%*vs* 10.4 *p*=0.19); or for st (1.0% *vs* 0.5% *vs* 1.0%, *p*=0.82) [58].

A non-polymeric dual-DES utilises the yukon stent platform, but incorporates a second antiproliferative agent – probucol, a potent liposoluble antioxidant which reduces neointimal hyperplasia. The stent has been examined in the independently funded, assessor blinded, multicentre randomized ISAR-TEST 2 and ISAR-TEST 5 trials.

3.2.5.2 ISAR-TEST 2 trial

ISAR-TEST 2 trial compared this dual-DES (*n*=333) with the first generation cypher SES (*n*=335) and the second generation endeavour zotarolimus eluting stent (ZES) (*n*=339)(medtronic inc., santa rosa, ca, USA) [59] with promising results. The dual-DES was superior to the endeavour stent at six months for binary angiographic restenosis (dual-DES 11.0% *vs* ZES 12.0%, *p*=0.68 *vs* SES 19.3%, *p*=0.002), in-stent LLL 0.23±0.50mm *vs* 0.24±0.51 (*p*=0.78) *vs* 0.58±0.55mm, (*p*<0.001), and TLR (6.8% *vs* 7.2% (*p*=0.83) *vs* 13.6%, *p*=0.001)); its results were comparable with the cypher stent. At two years, there was no significant difference in clinical outcomes including cardiovascular death or MI (DUAL-DES 7.8% *vs* ZES 9.2% *vs* SES 10.2%, *p*=0.88); TLR 7.7% *vs* 10.7% *vs* 14.3% (*p*=0.009); br 13.9% *vs* 18.6% *vs* 20.9% (p=0.047) and LLL 0.30±0.54 *vs* 0.35±0.60 *vs* 0.57±0.57 (*p*<0.001) [60].

3.2.5.3 ISAR-TEST 5 trial

ISAR-TEST 5 trial compared the dual-DES (*n*=2002)with the resolute ZES *(n*=1000)(medtronic inc., santa rosa, ca, USA) and demonstrated the dual-DES to be non-inferior with regards to the br 13.3% *vs* 13.4% (*p*=0.95); LLL 0.31±0.58 *vs* 0.30±0.56 (*p* = 0.50) and primary endpoint of MACE at 12 months (13.1% *vs* 13.5%, *p*=0.74) and st 1.1% *vs* 1.2% (*p*=0.80) [61].

3.2.5.4 BioFreedom BES

BIOFREEDOM BES (Biosensors Europe SA, Morges, Switzerland) the Biolimus-A9 eluting bioFREEDOM stent is currently being assessed in a first in man (FIM) randomized, three arm trial of 182 patients [62]. It was shown to be non-inferior to the taxus liberte for mean in-stent LLL at 12 months (0.17±0.22mm *vs* 0.35±0.22mm, *p*=0.001) and for MACE at two years (6.8% *vs* 10.0%, *p*=not significant).

3.2.5.5 VESTASync SES

Vestasync SES (MIV Therapeutics, Atlanta, GA, USA): this SES is currently being assessed in the small, industry funded, double blinded, multicentre VESTASYNC II study (*n*=75; np *n*=50 *vs* BMS *n*=25). It has been shown to be non-inferior to the genx durable polymer stent (miv therapeutics, atlanta, ga, USA) with regards to in-stent late lumen loss at nine months (0.39±0.20mm *vs* 0.74±0.52mm, *p*=0.03) [63].

3.2.6 Biodegradable polymer drug eluting stents

Durable polymers of first and second generation DES remain within the coronary artery environment long after their purpose is fulfilled, and have deleterious effects by causing inflammation, delayed vascular healing, as well as providing a platform for accelerated neoatherosclerosis [1,64]. They are also considered to play a pivotal role in late stent thrombosis (ST) [10-13]

Biodegradable polymers have been the focus of active research and development. The scientists continue to be challenged by issues like composition, degradation time of the polymer, biocompatibility, interaction and pharmacokinetic profile of the antiproliferative agents. Table 2 gives a brief outline of biodegradable polymer DES.

3.2.6.1 BioMatrix (BIOSENSORS INC., Newport Beach, CA, USA)

Biolimus-A9 is a sirolimus analogue with extreme lipophilicity that enables targeted tissue uptake and minimiZES systemic exposure. It has been combined with an abluminal polylactic acid (PLA) polymer that biodegrades within six to nine months, eluting 45% of the antiproliferative agent within the first 30 days.

3.2.6.2 LEADERS study

LEADERS study was an industry funded, multicentre, non-inferiority powered randomized controlled trial (RCT) that examined the use of BioMatrix-Flex bes against the durable polymer first generation CYPHER SES (CORDIS, Miami Lakes, FL, USA) [16,65,66]. 1707 patients (BES *n*= 857 *vs* SES *n*= 850) were enrolled and 96.5% were followed to five years. Patients as well as assessors of angiographic films and staff involved with clinical follow-up

were blinded to the assigned stent. Operators involved with stent insertion were not blinded. Non-inferiority was demonstrated for the primary endpoint of major adverse cardiovascular events (MACE) at nine months (9.2% *vs* 10.5%, *p*=0.39) and at five years (22.3% *vs* 26.1%, *p*=0.071). The definite VLST at five years was also found to be significantly low (0.66% *vs* 2.5% *p*=0.003).

3.2.6.3 Comfortable AMI trial

Comfortable ami trial was an industry funded, assessor blinded, multicentre study of 1161 patients randomized to either the BioMatrix- flex or the gazelle BMS biosensors europe sa, morges, switzerland) (BES *n*=575 *vs* BMS *n*=582). It showed that BioMatrix- flex bes had lower rates of definite VLST from one to five years compared with the cypher SES (0.66% *vs* 2.5%, *p*=0.003) [66]. Its efficacy and safety has also been validated in primary PCI for acute st elevation myocardial infarction (STEMI) [67]. This showed superiority for MACE at 12 months in favor of the BES (4.3% *vs* 8.7%, *p*=0.004). There was no significant difference in the rate of definite or probable late st (2.5% *vs* 3.7%, *p*=0.25) at 12 months.

3.2.7 NOBORI (Terumo, Somerset, NJ, USA) stents

The NOBORI bes has also reported encouraging results in both the NOBORI 1 and NOBORI core trials [68,69] and more recently in the ongoing, large, industry funded, randomized, all-comers COMPARE II trial (BES *n*=1795 *vs* EES *n*=912) [70]. At 12 months, the stent was non-inferior for MACE compared with a durable polymer EES (5.2% *vs* 4.8%, *p*=0.69) and had very low but similar rates of definite or probable late st (0.8% *vs* 1.0%, *p*=0.58). Basket-prove ii completed recruitment of 2400 all-comer patients randomized to either the NOBORI bes, the xience prime EES, or the pro-kinetic BMS in 2012 [71]. They will be followed over five years for MACE and other clinical end points.

3.2.7.1 NOBORI 2 and eNOBORI

NOBORI 2 and eNOBORI are two large, prospective, single-arm, multicenter, registries that enrolled 3067 and 7750 patients respectively, out of which 248 and 703 were stemi patients. All adverse events were adjudicated by an independent clinical event committee in NOBORI 2, while adjudication in eNOBORI (including stent thrombosis) is ongoing. At 1-month, there were no mis observed. Total of 5 patients died because of cardiac reasons (0.9%) and one TLR (0.17%) and one *TVR* (0.4%) were found. The TLF rate was 1.0%. In the cohort of patients followed at 3-year, 2 patients suffered a cardiac death (0.8%), 10 had an MI (4.0%) and TLF rate was 6.1%. A total of 96% of the patients were angina free. Regarding stent thrombosis (ST), occurring up to 3 years, total of 4 cases have been detected (1.6%), out of which 3 cases were subacute (1.2%) and one case of late st (0.4%). There was no very late st detected at 3 years follow up. [72]

3.2.7.2 Supralimus (Sahajanand Medical)

Paint trial, an industry funded, multicentre, unblinded trial with 274 randomised patients to the supralimus stent, the infinnium bioabsorbable polymer PES (Sahajanand Medical Technologies Pt. Ltd., INDIA), or the millennium matrix BMS (Sahajanand Medical Technologies Pt. Ltd., INDIA) groups (SES *n*=106 *vs* PES *n*=111 *vs* BMS *n*=57) examined the supralimus stent [73,74]. The polymers included PLLA, PLGA, PLC and PVP. Clinical events were adjudicated by an independent committee. At nine months angiographic follow-up, the supralimus stent had significantly less instent LLL than the BMS (0.32±0.43mm *vs*

0.90±0.45mm, *p*<0.001) and the infinnium stent (0.32±0.43mm *vs* 0.54±0.44mm, *p*=0.001). The supralimus stent also had superior rates of MACE compared with the BMS at 12 months (8.6% *vs* 21.1%, *p*= 0.01) and three years (12.5% *vs* 33.3%, *p*< 0.01).

3.2.7.3 EXCEL (JW Medical System, Weihai, China)

The industry funded create study was a large single-arm, multicentre, prospective registry of 2077 patients implanted with the excel stent. It reported a MACE rate of 4.5% and definite or probable st in 1.0% of patients at three year follow- up, half of which occurred beyond one year [75,76].

3.2.7.4 SYNERGY (Boston Scientific)

Everolimus eluting stents as durable polymer EES have become the most widely used DES worldwide, it is not surprising that advancement continues in this direction through clinical investigation of the synergy stent (Boston Scientific Corp., Natick, MA, USA). Clinical experience with the stent is limited but the industry funded, assessor blinded evolve randomized trial recently demonstrated non-inferiority for its primary endpoint of in-stent late loss at six months when compared with the promus element durable polymer EES (Boston Scientific corp., natick, ma, USA)(0.10±0.25mm *vs* 0.15±0.34mm, *p*=0.19) [77]. MACE was also comparable between the stents.

4. PLATINUM STUDY

In this prospective single blind trial (NCT00823212) 1,530 patients undergoing PCI of 1 or 2 de novo native lesions were randomized at 132 worldwide sites to CoCr-EES (n = 762) or PtCr-EES (n = 768). It was found that novel PtCr-EES was noninferior to the predicate CoCr-EES for TLF, with nonsignificant differences in measures of safety and efficacy through 12-month follow-up after PCI. The 12 month TLF was 2.9% in CoCr-EES and 3.4% in PtCr-EES (p noninferiority =0.001, p superiority=0.60). By intention-to-treat, there were no significant differences between CoCr-EES and PtCr-EES in the 12-month rates of cardiac death or mi (2.5% *vs*. 2.0%, *p*=0.56), TLR (1.9% *vs*. 1.9%, *p*=0.96), TLF (3.2% *vs*. 3.5%, *p*=0.72), or academic research consortium definite or probable stent thrombosis (0.4% *vs*. 0.4%, *p*=1.00) [78].

4.1 The JACTAX Liberte Paclitaxel Eluting Stents (PES)

The JACTAX liberte paclitaxel eluting stents (PES) (Boston Scientific, Natick, MA, USA) is the effort to advance the initial success of the first generation taxus PES into a third generation bioabsorbable polymer DES. The industry funded, single centre OCTDESI pilot study examined 60 patients randomized to either a JACTAX high dose stent (*n*=20), a JACTAX low dose stent (*n*=21), or a taxus liberte stent (*n*=19), with percentage of strut coverage as the primary endpoint. Angiographic endpoints were assessed by an independent core laboratory. At six months, the results were comparable across the three stents for both percentage of uncovered struts (7.0±12.2% *vs* 4.6±7.3% *vs* 5.3±14.7%, *p*=0.81) and for in-stent late loss (0.25±0.32mm *vs* 0.39±0.43mm *vs* 0.24±0.44mm, *p*=0.39) [79].

4.2 Combo Stent (Orbusneich, Fort Lauderdale, FL, USA)

The combo stent is a novel biodegradable polymer SES that utiliZES endothelial progenitor cell (EPC) capture technology in addition to low-dose abluminal sirolimus. This EPC capture

technology is a luminal coating of immobile cd34 antibodies and aims to capture EPCs that differentiate into endothelial cells to form mature endothelial coverage of stent struts. Early data from the small, industry funded, non-randomized remedee trial showed non-inferiority for its primary angiographic endpoint of in-stent late loss at nine months when compared with the taxus liberte durable polymer PES (0.39±0.45mm *vs* 0.44±0.56mm, *p*=0.55) [80]

4.3 ISAR-TEST 4

ISAR-TEST 4 was an independently funded, assessor blinded trial that randomized 2603 patients from two centers to a novel, non-commercially available biodegradable polymer SES or a durable polymer DES, either the first generation cypher SES or the second generation xience EES [81]. Non-inferiority of the biodegradable polymer SES was demonstrated for the primary endpoint of MACE at 30 days (4.4% *vs* 4.5%, p=0.87) and at one year (13.8% *vs* 14.4%, p=0.66), as well as for definite or probable late st at one year (1.0% *vs* 1.5%, p=0.29).

4.4 Fourth Generation Stents

Wayne et al successfully modified a standard bioresorbable terpolymer with the covalent incorporation of lovastatin, as seen on nmr, into a backbone comprised of lactide, glycolide, e-caprolactone, and lovastatin (60:15:10:15 parts by weight), respectively. Thus a fourth-generation bioresorbable stent was produced that has the potential to deliver two drugs to the site of the procedure-related vessel lumen injury. [82]

4.5 Ongoing Clinical Trials

The database of the clinicaltrials.gov was searched for biodegradable coronary stents and 14 open trials were identified. Table 3 gives the brief outline of identifier number, design types, primary outcomes and current recruitment status of the “open studies”.

4.6 Duration of Dual Antiplatelet Therapy (DAPT)

Multiple studies have shown that early discontinuation of clopidogrel after the DES as one of the strong predictors for stent thrombosis [83,84] and hence prolonged dual antiplatelet therapy (DAPT) is historically recommended to prevent stent thrombosis [83,85]. However long term DAPT does not come without complications.there have been reports from several trials of the zotarolimus-eluting stent (endeavor [e-ZES], medtronic, santa rosa, california) that have shown beneficial efficacy and safety, despite a relatively short duration of DAPT [86-88]. Kim et al showed using optical coherence tomography that there is sufficient strut coverage following implantation with the e-ZES as early as 3 months post-procedure [89]. A recent registry study with 661 low-risk patients who received DAPT for 3 months following e-ZES implantation has shown favorable long-term clinical outcomes and lower incidence of stent thrombosis after cessation of clopidogrel 3 months post-intervention [90].

4.7 RESET Trial

RESET trial (NCT01145079) randomly assigned 2,117 patients with coronary artery stenosis into 2 groups according to DAPT duration and stent type: 3-month DAPT following endeavor zotarolimus-eluting stent (e-ZES) implantation (e-ZES+ 3-month DAPT, *n*=1,059) versus 12-month DAPT following the other DES implantation (standard therapy, *n*=1,058). E-ZES+3-month

Table 1. Non-polymeric drug eluting stents

Study (N) Current Status	Stent(Manufacturer)	Drug	ResulTS/Endpoints
ISAR-TEST [53] (NP *n*=225 *vs* PES *n*=225) Completed	Yukon (Translumina)	Sirolimus	9 MONTHS LLL 0.48±0.61 *vs* 0.48±0.58 (*p*=0.98) Death and MI 4.4% *vs* 4.0% (*p*=0.81)
ISAR-TEST 2 [56] (DD n = 333 *vs* SES *n*=335 *vs* ZES *n*=339) Completed	Dual DES	Sirolimus and Probucol	6–8 months BR 11.0% *vs* 12.0% (*p*=0.68) *vs* 19.3% (P=0.002)LLL0.23±0.50 *vs* 0.24±0.51 (*p*=0.78) *vs* 0.58±0.55 (P < 0.001) TLR 6.8% *vs* 7.2% (*p*=0.83) *vs* 13.6% (*p*=0.001) 2 years Death and MI 7.8% *vs* 10.2% *vs* 9.2% (*p*=0.61) TLR 7.7% *vs* 10.7% *vs* 14.3%(*p*=0.009) BR 13.9% *vs* 18.6% *vs* 20.9%(*p*=0.047) LLL 0.30±0.54 *vs* 0.35±0.60 *vs* 0.57±0.57 (*p*<0.001)
ISAR-TEST 3 [54] (NP *n*=201 *VS* BP *n*=202 *vs* PP *n*=202) Completed	Yukon (Translumina)	Sirolimus	6–8 months LLL 0.47±0.56 *vs* 0.17±0.45 *VS* 0.23±0.46 (*p*=0.94) 2 years TLR 13.9% *vs* 8.4% *vs* 10.4%(*p*=0.19) Death and MI 7.0% *vs* 6.9% *vs* 6.4% (*p*=0.97) ST 1.0% *vs* 0.5% *vs* 1.0% (*p*=0.82)

ISAR-TEST 5 [58] (DD *n*=2002 *vs* ZES *n*=1000) Completed	Dual DES	Sirolimus and Probucol	6–8 months BR 13.3% *vs* 13.4% (p=0.95)LLL 0.31±0.58 *vs* 0.30±0.56 (p=0.50) 1 year MACE 13.1% *vs* 13.5% (P=0.74) ST 1.1% *vs* 1.2% (p=0.80)
VESTASync II [59] (NP *n*=50 *vs* BMS *n*=25) Ongoing	VESTASync (MIV Therapeutics)	Sirolimus	9 months LLL 0.39±0.20 *vs* 0.74±0.52 (p=0.03)
FIM [60] (NP SD *n*=60 *vs* PES *n*=60) Ongoing	BioFREEDOM (Biosensors)	Biolimus A9	1 year LLL 0.17±0.22 *vs* 0.35±0.22 (p=0.001) 2 years MACE 6.8% *vs* 10.0% (p=NS)

BR-Binary Restenosis; DD-Non-Polymeric Dual DES; FIM-First-In-Man; LLL-*In-Stent Late Lumen Loss (MM);* MACE-*Major Adverse Cardiovascular Events; NP-Non-Polymeric DES; ST-Definite/Probable Stent Thrombosis;* TLF-*Target Lesion Failure; PP-Permanent Polymer; BP-Biodegradable Polymer; SD-Standard Dose; NS-Not Significant.*

Table 2. Biodegradable polymer drug eluting stents

Study (*n*) Current Status	Stent (Manufacturer)	Drug	Polymer type	Results/endpoints
LEADERS [38](BES *n*=857 *vs* SES *n*=850) Completed	BIOMATRIX (Biosensors)	Biolimus A9	Abluminal PLA	5 years MACE 22% *vs* 26% (p=0.07) Definite VLST 0.66% *vs*2.5% (p=0.003)
Comfortable AMI [39] (BES *n*=575 *vs* BMS *n*=582) Completed	BIOMATRIX (Biosensors)	Biolimus A9	Abluminal PLA	1 year MACE 4.3% *vs* 8.7% (p=0.004) ST 2.5% *vs* 3.7% (p=0.25)
Ongoing		Abluminal		MACE 5.2% *vs* 4.8% (*p*=0.69) ST 0.8% *vs* 1.0% (*p*=0.58)
BASKETPROVE- II [43] (Target *n*=2400,BES *vs* EES *vs* BMS) Recruiting	NOBORI (Terumo)	Biolimus A9 Abluminal	PLA	Primary endpoint of MACE at 2 years
Paint [47] (SES *n*=106 *VS* PES *n*=111 *VS* BMS *n* = 57) Completed	Supralimus (Sahajan and Medical)	Sirolimus	PLLA, PLGA, PLC, PVP	9 months LLL 0.32±0.43 *vs* 054±0.44 *vs* 0.90±0.45 (*p*<0.001) 3 years MACE 12.5% *vs* 16.6% *vs* 33.3% (*p*<0.01)
CREATE registry [46] (*n*=2077) Completed	Excel (JW Medical System)	Sirolimus	PLA	3 years MACE 4.5% ST 1.0%
REMEDEE [50] (SES *n*=124 *vs* PES *n*=59) Ongoing	Combo (Orbusneich)	Sirolimus + EPC	Abluminal	9 months LLL 0.39±0.45 *vs* 0.44±0.56 (*p*=0.55)

EVOLVE [44] (Synergy *n*=94 *vs* Synergy half-dose *n*=99 *vs* Promus Element *n*=98) Completed	Synergy (Boston Scientific)	Everolimus	PLGA Rollcoat Abluminal	6 months LLL 0.10±0.25 *vs* 0.13±0.26 *vs* 0.15±0.34 (Paired *p*=NS) TLF 2.2% *vs* 4.1% *vs* 3.1% (*p*=NS) ST 0.0% *vs* 0.0% *vs* 0.0%
OCTDESI [51] (JACTAX *n*=20 *vs* JACTAX low-dose *n*=21 *vs* Taxus *n*=19) Ongoing	JACTAX Liberte (BOSTON SCIENTIFIC)	Paclitaxel	Juxtaposed Abluminal Coating Technology	6 months USS 7.0±12.2% *vs* 4.6±7.3% *vs* 5.3±14.7% (*p* = 0.81) LLL 0.25±0.32 *vs* 0.39±0.43 *vs* 0.24±0.44 (*p*=0.39)

LLL- *In-Stent Late Lumen Loss (MM);* MACE-*Major Adverse Cardiovascular Events;PLA-Poly-L-Lactide; PLC-75:25 Poly-L-Lactide-Co-Caprolactone;* PLGA-*50:50 Poly-D,L-Lactide-Co-Glycolide;* PLLA-*Poly-L-Lactic Acid; PVP- Polyvinyl Pyrrolidone;*
ST-Definite/Probable Stent Thrombosis; TLF- *Target Lesion Failure; USS- Uncovered STENT Struts; NS- Not Significant.*

Table 3. Ongoing clinical trials

Clinical Trial (NCT Identifier)	Official Title	Study Type	Primary Outcome Measures	Designed as Safety Issue	EstimateD Study Completion Date	Current Status
DESTINY Trial (Inspiron X BIOMATRIX) (NCT01856088)	Stents Coated with THE Biodegradable Polymer on Their Faces and Elution of Sirolimus Abluminais Versus Elution Biolimus for the Treatment of Coronary Lesions Again - Randomized DEStiny	Interventional Allocation: Randomized	Lumen Loss [Time Frame: 9 months after the Procedure]	Yes	February 2018	Recruiting Last Verified: May 2013
PONTINA (NCT01060306)	Prospective Optical Coherence Tomography Evaluation of Neointimal Coverage of a Biodegradable Polymer-based Drug-eluting Stent	Observational: Case Control Time PerspectivE: Prospective	Assessment of neointimal Coverage of the Biodegradable Polymer-based Biolimus A9-eluting Stent (BIOMATRIX Stent) After Full Drug Elution and Polymer BiodegradATIon [Time Frame: 6 months]	No	January 2011	Unknown Last Verified: January 2010
BESS (NCT01268371)	Comparison of Biolimus-Eluting Biodegradable Polymer, Everolimus-Eluting and Sirolimus-Eluting Coronary Stents	Interventional. Allocation: Randomized	MACE	Yes	July 2015	Recruiting Last Verified: April 2013
BIO-RESORT (NCT01674803)	Comparison of Biodegradable Polymer and Durable Polymer Drug-eluting Stents in an all Comers Population: Randomized MulticenteR Trial in an all Comers Population Treated within the Netherlands 3 (Twente 3)	Interventional. Allocation: randomized	Target Vessel FAILURE (TVF) [Time frame: 1 year]	Yes	November 2016	Not yet open for participant recruitment last verified: August 2012
EVOLUTION (NCT00825773)	A Randomized Study to Evaluate Safety and Efficacy of THE Exceltm Sirolimus Eluting STENT with a Biodegradable Polymer Versus	Interventional. Allocation: Randomized	Ischemia-driven Target Vessel Failure which is a composite of cardiac death, myocardial infarction (q and non-q wave) and target	Yes	April 2014	Recruiting Last Verified: January 2009

	Sirolimus Eluting Stent with Non-biodegradable Polymer in the Treatment OF Patients with Denovo Coronary Artery Lesions		vessel revascularization (*TVR*) at 12 months. [Time Frame: 12 months]			
OCTOBER(NCT01012583)	Optical Coherence Tomography Assessment of the Excel Drug-eluting Stent with Biodegradable Polymer *vs*. the Cypher DRUG-Eluting Stent with Permanent Polymer	Observational: Case Control Time Perspective: Prospective	To quantitate the presence of neointimal stent strut coverage at 6 month via optical coherence tomography follow-up. [Time Frame: 6 month]	Yes	October 2010	Unknown Last Verified: November 2009
PRO-HOPE (NCT01880879)	A Prospective Multicenter Trial Evaluating Helios Biodegradable Polymer Sirolimus-eluting Stent Safety and Effectiveness in Treatment of Coronary Artery Disease	Interventional Single Group Assignment	1 year incidence of target lesion [Time Frame: 1year]	No	January 2015	Recruiting Last Verified: January 2013
Evaluate Safety and Effectiveness OF the TIVOLI® DES and the FIREBIRD2® DES for Treatment Coronary Revascularization (NCT01681381)	A Prospective, Open Label, Randomized Study to Evaluate Safety and Effectiveness of the TIVOLI® Biodegradable Polymer Rapamycin-eluting Stent and the FIREBIRD2® Rapamycin-eluting Coronary CO-CR Stent for Treatment Coronary Revascularization	Interventional. Allocation: Randomized	Ischemia-driven Target Lesion Failure (TLF) which is a composite of cardiac death, myocardial infarction (q and non-q wave) and target lesion revascularization (TLR) at 12 months post-procedure. [time frame: 12 months]	Yes	September 2018	Recruiting Last Verified: November 2012
CREDIT-I (NCT01909869)	A Pilot First-in-Man Study to Evaluate Safety and Efficacy of the Excel-Ⅱ with Cobalt Chromium Alloys Sirolimus Eluting Biodegradable Polymer Stent in the Treatment of Patients with Denovo Coronary Artery Lesions(Credit-I)	Interventional Single Group Assignment	MACE	Yes	March 2018	Recruiting Last Verified: July 2013
DISCOVERY123 (NCT01844843)	Evaluation with OFDI of Strut Coverage OF Terumo New Drug Eluting Stent	Interventional Single Group Assignment	OFDI Assessed Percent Stent Strut Coverage [Time Frame: 3 months	No	December 2014	Recruiting Last Verified: April 2013

	(Development Code TCD-10023) with Biodegradable Polymer at 1, 2 and 3 months		Post Procedure.]			
OPTIMA (NCT01137019)	Optical Coherence Tomography Assessment of Intimal Tissue and Malapposition: a Randomized Comparison of the Biolimus A9-eluting and Everolimus-eluting Coronary Stents	Interventional. Allocation: Randomized	Rate of Stent Strut Malapposition [Time Frame: 0 DAYS]	No	October 2012	Unknown Last Verified: May 2010
FIREHAWK (NCT01412164)	A Prospective Multicenter Single-arm Observational Registry Study Assessing the Safety and Efficacy of Firehawk Biodegradable Polymer Target-release Rapamycin-eluting Stent for the Treatment of Coronary Artery Disease: Target II	Observational Non-randomized	Device related cardiovascular composite endpoint [Time Frame: 12 months]	YES	FEBRUARY 2013	NOT RECRUITING LAST VERIFIED: APRIL 2012
CREDIT -III	A Prospective Multicenter Single-arm Observational Registry Study to Assess the Safety and Efficacy of Excel-II With Sirolimus Eluting Stent for the Treatment of Patients with denovo Coronary Artery . (Credit-III TRIAL)	Observational [Patient Registry]	The target lesion failure(TLF) as the primary endpoint at 12-month [time frame: 12months]	Yes	June 2015	Recruiting Last Verified: January 2014

(WWW.CLINICALTRIALS.GOV; AS ACCESSED ON 2/4/2014)

DAPT was noninferior to the standard therapy with respect to the occurrence of the primary endpoint (difference: 0.0%; 95% confidence interval [CI]: -2.5 to 2.5; p 0.84; p < 0.001 for noninferiority). The composite rates of any death, myocardial infarction, or stent thrombosis were 0.8% and 1.3%, respectively (difference: -0.5%; 95% CI: -1.5 to 0.5; p 0.48). The rates of stent thrombosis were 0.2% and 0.3%, respectively (difference: -0.1%; 95% CI: -0.5 to 0.3; p 0.65) without its further occurrence after cessation of clopidogrel in the e-ZES+3-month DAPT group. The rates of target vessel revascularization were 3.9% and 3.7%, respectively (difference: 0.2%; 95% CI: -2.3 to 2.6; p = 0.70). (real safety and efficacy of a 3-month dual antiplatelet therapy following e-ZES implantation [RESET]. [91]

5. DISCUSSION

The field of interventional cardiology is experiencing a great deal of cutting edge research especially in order to reduce the disadvantages of second generation stents. Although the second generation stents have come a long way and offer significant benefits including a large evidence base, good deliverability and operator familiarity, long term definite or probable st rates of up to 0.67% per annum and TLR rates of 1.3% per annum suggest a scope for improvement.

Although a recent pooled analysis of the ISAR-TEST 3, ISAR-TEST 4 and LEADERS trial data found that biodegradable polymer stents were superior for TLR and VLST compared with first generation SES, superiority has not been demonstrated against second generation EES and is yet to be proven in any single substantial randomized trial [54]. Trials to date have been small, non- randomized and exclusively industry funded. Early trial data has shown the promise of longer term expansile remodeling and restoration of vasoreactivity but the clinical implication of this is uncertain and there is no large study to backup this hypothesis. Moreover, deliverability, expansion constraints together with an absence of data in complex lesions suggests the need for further research.

Two larger trials with broader inclusion criteria are currently underway and should provide a greater indication of performance of third generation stents. There is a need for developing a technology which can provide excellent efficacy and safety, deliverability in broad range of clinical settings, minimal limitations on non-invasive imaging and future revascularization procedures, and limit the need for prolonged DAPT.

CONCLUSION

Long term efficacy in terms of repeat revascularization rates, TLR incidence rate and late lumen loss (LLL) are the major limitations of second generation DES. Additional limitations with current generation DES include restrictions to non-invasive imaging with CT and MRI, difficulties with future surgical and transcatheter revascularization, long term disruption of native vascular fluid dynamics and vasoreactivity, chronic inflammation, delayed endothelialization and the need for six or more months of dual antiplatelet therapy (DAPT) [24-29].

There is a need for further research and RCT's to reach the ultimate goal of developing a stent system which has best combination of metallic alloys and/or polymers with all DESirable properties favorable combination-drug eluting capabilities.

CONSENT

Not applicable.

ETHICAL APPROVAL

Not applicable.

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COMPETING INTERESTS

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