When should we use DCBs?
Why?

Gunnar Tepe MD
Dep. of Radiology, RoMed Rosenheim
Disclosure

Speaker name:
Gunnar Tepe

I have the following potential conflicts of interest to report:

Study support by BART, Biotronic, Bayer, Biotronic, Gore, Medtronic, Verian
In TASC A/B lesions

1. Always better than POBA
2. ...and in the meantime even more DCBs with positive results are available
3. ...but what about long-term?
In TASC A/B lesions – long term

1. 2/3 would have been also ok with POBA but
2. 1/3 with either sustained benefit or delayed restenosis
In TASC C/D lesions

>140 mm, mean 200 mm
In TASC C/D lesions

But: As longer the lesion as more stents needed

Open question: What is the better concept?

DCB + Spot Stent OR direct DES: The SPORTs Study will tell us!
In TASC calcified lesions

DCB in Calcification:
An Assessment of Complex Lesions (Long Lesions, Chronic Occlusions + Severe Calcium) from the IN.PACT Global Study

Fabrizio Fanelli, MD, EBIR
“Sapienza” University of Rome
In TASC calcified lesions

**IN.PACT GLOBAL (LL&CTO) + SEVERE CALCIUM**

**PRIMARY PATENCY**

**IN.PACT GLOBAL (LL&CTO) + SEVERE CALCIUM**

**FREEDOM FROM CD-TLR THROUGH 1 YEAR**

**IN.PACT GLOBAL (LL&CTO) + SEVERE CALCIUM**

**SUMMARY**

- Largest real-world study of DCB in patients with symptomatic femoropopliteal PAD, with independent clinical events committee and core-lab adjudication of outcomes in pre-specified imaging subgroups.
- Results from this post-hoc analysis of patients with complex lesions including severe calcium demonstrate strong patency rate of 88.8% and CD-TLR of 8.5%, with adjunctive stenting.
In In-Stent RS

FAIR and PACUBA (DCB)

FAIR 6 mo RS rate

PACUBA 6 and 12 mo

Length: 8.1 cm

Length: 17.9 cm

Good results after 6 months but nothing beyond!
In In-Stent RS

Debate ISR 3 Y
Grotti et al., JETT, 2016; 23: 52-57

Results, TLR 2y

Delayed RS compared to POBA
Alternative treatments (DES or Viabahn): no comparative studies, no data up to 3y with the other technologies in comparison to POBA
In RS after DCB
This is the next frontier!

How shall we proceed in case of restenosis after DCB?

My approach

1. Try to identify the reason for DCB failure and solve the problem
   (e.g. in case of calcium: vessel prep
    – in case of reststenosis and dissection: stent)

2. Do not repeat the same procedure which lead to restenosis
   (e.g. do vessel prep, increase dose, use stents)
Conclusion

DCB = As primary treatment strategy in most of the SFA cases
When should we use DCBs? Why?

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