Clinical outcomes of State-of-the-Art percutaneous coronary revascularisation in patients with de novo three vessel disease.

Results of the SYNTAX II Trial.

Javier Escaned MD, PhD, FESC
Hospital Clínico San Carlos / Madrid / Spain
on behalf of the SYNTAX II Investigators.
Potential conflicts of interest

Speaker's name: Javier Escaned

I have the following potential conflicts of interest to report:

Speaker at educational events and consultancies: Abbott, AstraZeneca, Biosensors, Boston Scientific, Medtronic, OrbusNeich, Philips Healthcare

The SYNTAX II study was funded through unrestricted grants from Boston Scientific and Philips Volcano.
The management of patients with 3-vessel disease (3VD) according to ESC guidelines is largely influenced by the results of the pivotal SYNTAX trial. However, since the completion of that trial major technical and procedural advances, influencing PCI outcomes, have taken place:

- New risk stratification tools.
- 2nd generation DES.
- Physiology- and imaging PCI guidance.
- Improved CTO PCI techniques.

### Extent of CAD

<table>
<thead>
<tr>
<th>Extent of CAD</th>
<th>PCI</th>
<th>CABG</th>
</tr>
</thead>
<tbody>
<tr>
<td>3VD with a SYNTAX Score &gt;32</td>
<td>I A</td>
<td>I B</td>
</tr>
<tr>
<td>3VD with a SYNTAX Score 23-32</td>
<td>I A</td>
<td>III B</td>
</tr>
<tr>
<td>3VD with a SYNTAX Score &gt;32</td>
<td>I A</td>
<td>III B</td>
</tr>
</tbody>
</table>

Windecker S et al. EHJ 2014;35:2541-619
Objective of the SYNTAX II study

To investigate if recent technical and procedural developments in PCI (incorporated to form the SYNTAX II strategy) significantly influence outcomes in appropriately selected patients with three-vessel (3VD) coronary artery disease.
Components of the SYNTAX II strategy

- SYNTAX Score II (incorporating clinical and anatomical variables) to guide Heart Team decisions on myocardial revascularisation.
- Physiology-based revascularisation (hybrid use of iFR and FFR).
- Second generation DES (thin strut, biodegradable polymer, everolimus-eluting Synergy™ stent [EES]).
- IVUS-guided optimisation of stent deployment (modified MUSIC criteria).
- Contemporary CTO revascularization techniques.
- Guideline-directed medical therapy.

Design and eligibility

- Multicenter, prospective, single-arm, open-label trial of patients with *de-novo* 3VD without left-main stem involvement

- Inclusion if the SYNTAX score II recommends either CABG or PCI (equipoise in 4-year mortality) or PCI, irrespective of anatomic SYNTAX score.

- Sample size: 450 patients (90% power to show superiority in terms of use of 2\textsuperscript{nd} generation EES over PES + attrition).

- Control group: Matched patients with 3VD from the SYNTAX I trial with a SYNTAX Score II showing equipoise between PCI and CABG.

Participating sites

- Belfast Health & Social Care Trust, UK
- Hospital Clínico San Carlos IDISSC, Spain
- John Radcliffe Hospital, Oxford, UK
- Hospital Clinic I Provincial de Barcelona, Spain
- Imperial College Healthcare NHS Trust, UK
- Szpital Kliniczny, Poland
- Hospital Universitario La Paz, Spain
- Hospital Clínico Salamanca, Spain
- Papworth Hospital, UK
- Academisch Medisch Centrum, The Netherlands
- Liverpool Heart and Chest Hospital, UK
- Manchester Royal Infirmary, UK
- Freeman Hospital Newcastle, UK
- Erasmus MC, The Netherlands
- The Royal Infirmary of Edinburgh, UK
- Hospital Universitario Marqués de Valdecilla, Spain
- American Heart of Poland (PAK), Poland
- Hospital Meixoeiro, Spain
- Hospital Puerta de Hierro, Spain
- Brighton & Sussex University Hospitals NHS Trust, UK
- Gornoslaskie Centrum Medycyne, Poland
- St Raphael Hospital, Poland

454 patients enrolled in 22 European centres

* Centers listed by number of enrolled patients
Principal Investigators and Study Chairmen

Javier Escaned MD PhD
Hospital Clínico San Carlos IDISCC
Madrid, Spain
Principal Investigator

Adrian Banning MBBS MD
John Radcliffe Hospital, Oxford University Hospitals, United Kingdom
Principal Investigator

Patrick W. Serruys MD PhD
Imperial College London
London, United Kingdom
Chairman

Vasim Farooq MB ChB PhD
Manchester Royal Infirmary
Manchester, United Kingdom
Deputy Chairman
Study flowchart: patient inclusion

Screening with SYNTAX Scores (SS) I & II

- SS II favours PCI
- SS II shows equipoise for PCI or CABG
- SS II favours CABG

Heart Team Discussion
Equivalent anatomic revascularisation achievable?

- Yes
  - Patient “signed off” by Heart Team for PCI

- No
  - Informed Consent
  - Patient included in the study

CABG registry
Study flowchart: PCI procedure

Patient included in the SYNTAX II study

iFR in all intended to treat stenoses

iFR < 0.86

iFR 0.86 – 0.93

iFR > 0.93

FFR ≤ 0.80

FFR > 0.80

Stenosis treated with SYNERGY™ EES

Stenosis not treated

IVUS optimization

Optimal medical therapy with strict LDL control (≤ 1.8 mmol/L)
Primary endpoint: comparison with PCI

- **Primary endpoint**: Composite of major adverse cardiac and cerebrovascular events (MACCE) at one-year follow-up.

- **Comparator**: Predefined PCI cohort (n=315) from the original SYNTAX-I trial selected on the basis of equipoise 4-year mortality between CABG and PCI.
Exploratory endpoint: comparison with CABG

- **Exploratory endpoint:** Composite of major adverse cardiac and cerebrovascular events (MACCE) at one-year follow-up.

- **Comparator:** Predefined CABG cohort (n=334) from the original SYNTAX-I trial selected on the basis of equipoise 4-year mortality between CABG and PCI.
## Baseline characteristics

<table>
<thead>
<tr>
<th></th>
<th>SYNTAX II (n=454)</th>
<th>SYNTAX I PCI arm (n=315)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>66.7 ± 9.7</td>
<td>66.7 ± 9.1</td>
<td>0.99</td>
</tr>
<tr>
<td>Male</td>
<td>93.2%</td>
<td>93.0%</td>
<td>0.93</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>28.9 ± 4.7</td>
<td>28.2 ± 4.4</td>
<td>0.032</td>
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<tr>
<td>DM</td>
<td>30.3%</td>
<td>29.2%</td>
<td>0.75</td>
</tr>
<tr>
<td>Current Smoker</td>
<td>14.7%</td>
<td>17.8%</td>
<td>0.26</td>
</tr>
<tr>
<td>Previous MI</td>
<td>12.5%</td>
<td>28.7%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Previous Stroke</td>
<td>5.6%</td>
<td>1.9%</td>
<td>0.010</td>
</tr>
<tr>
<td>Hypertension</td>
<td>77.0%</td>
<td>73.4%</td>
<td>0.26</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>77.3%</td>
<td>74.4%</td>
<td>0.35</td>
</tr>
<tr>
<td>Clinical Presentation</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Silent Ischemia</td>
<td>5.5%</td>
<td>13.3%</td>
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</tr>
<tr>
<td>Stable angina</td>
<td>68.8%</td>
<td>61.6%</td>
<td></td>
</tr>
<tr>
<td>Unstable angina</td>
<td>25.6%</td>
<td>25.1%</td>
<td></td>
</tr>
</tbody>
</table>
## SYNTAX Score II

<table>
<thead>
<tr>
<th>Components of the SYNTAX Score II</th>
<th>SYNTAX II</th>
<th>SYNTAX I PCI arm</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>66.7 ± 9.7</td>
<td>66.7 ± 9.1</td>
<td>0.99</td>
</tr>
<tr>
<td>Gender (Male)</td>
<td>93.2%</td>
<td>93.0%</td>
<td>0.93</td>
</tr>
<tr>
<td>Cr Clearance (ml/min)</td>
<td>82.0 ± 26.9</td>
<td>87.3 ± 28.5</td>
<td>0.008</td>
</tr>
<tr>
<td>Ejection Fraction (%)</td>
<td>58.1 ± 8.3</td>
<td>61.8 ± 11.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>7.7%</td>
<td>9.5%</td>
<td>0.37</td>
</tr>
<tr>
<td>COPD</td>
<td>10.8%</td>
<td>12.7%</td>
<td>0.42</td>
</tr>
<tr>
<td>Anatomic SYNTAX Score</td>
<td>20.3 ± 6.4</td>
<td>22.8 ± 8.7</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

| SYNTAX Score II PCI               | 30.2 ± 8.6 | 30.6 ± 8.7       | 0.528   |
| Predicted 4-yr mortality PCI (%)  | 8.9 ± 8.8% | 9.2 ± 8.7%       | 0.640   |

| SYNTAX Score II CABG              | 29.1 ± 10.4 | 29.1 ± 9.6      | 1.0     |
| Predicted 4-yr mortality CABG (%) | 9.0 ± 9.3   | 8.5 ± 8.1       | 0.440   |
Physiological stenosis interrogation

Anatomic target lesions (n=1559) (3.49 lesions/patient)

- iFR performed (n=1150; 73.8%)
- Only FFR performed (n=27; 1.7%)

Lesions not assessed with physiology (n=382; 24.5%)

- Pressure wire crossing not attempted/indicated*: 221
- Unable to cross the lesion with a pressure wire**: 127
- Other reasons: 26

*Use of pressure guidewire in CTOs was not indicated.
**Physiological interrogation was prompted irrespective of angiographic lesion severity.
Physiological stenosis interrogation

Anatomic target lesions (n=1559) (3.49 lesions/patient)

iFR performed (n=1150)

- iFR < 0.86 (n = 603; 52%)
  - FFR 16 (2.6%)
  - Treated (n=600; 99.5%)

- iFR 0.86-0.93 (n = 264; 23%)
  - FFR 252 (95.4%)
  - Treated (n=179; 67.8%)

- iFR > 0.93 (n = 283; 25%)
  - FFR 41 (14.4%)
  - Deferred (n=262; 92.6%)

Only FFR performed (n=27)

- FFR 16 (2.6%)
- FFR 252 (95.4%)
- FFR 41 (14.4%)

Treated (n=600; 99.5%)
Deferred (n=262; 92.6%)
Impact of intracoronary physiology on PCI

Lesion treatment after iFR/FFR interrogation (n=1177)

- PCI deferred: 31%
- PCI performed: 69%

Lesions treated per patient (n) in SYNTAX II and SYNTAX I

- SYNTAX II: 2.64
- SYNTAX I: 4.02
- P < 0.001

Cases of three-vessel PCI (%) in SYNTAX II and SYNTAX I

- SYNTAX II: 37.2%
- SYNTAX I: 83.3%
- P < 0.001
Treatment of chronic total occlusions (CTO)

CTO PCI procedural success rate in SYNTAX II: 87%

- Success: 87% (n=94)
- Failed: 14% (n=14)

CTO revascularisation in SYNTAX II and SYNTAX I:

- SYNTAX II: 87%  (p<0.0001)
- SYNTAX I: 53%
Use of intravascular ultrasound (IVUS)

Post-implantation IVUS led to further optimisation of the stented lesion in 30.2%.
One year follow up results

Comparison with PCI
Primary endpoint: MACCE

HR 0.58 (95% CI 0.39-0.85), p=0.006
All-cause death

HR 0.69 (95% CI 0.27-1.73), p=0.43
Myocardial infarction

HR 0.27 (95% CI 0.11-0.70), p=0.007
Stroke

HR 0.69 (95% CI 0.10-4.89), p=0.71
Any repeat revascularisation

HR 0.57 (95% CI 0.37-0.90), p=0.015
Definite stent thrombosis

HR 0.26 (95% CI 0.7-0.97), \( p = 0.045 \)
One year follow up results

Comparison with CABG
Exploratory End-Point: MACCE PCI vs. CABG

HR 0.91 (95% CI 0.59-1.41), p=0.684
P <0.001 for non-inferiority*

*Non-inferiority margin of 5% with a one-sided alpha of 5%
MACCE SYNTAX II and SYNTAX I PCI / CABG

<table>
<thead>
<tr>
<th>Days</th>
<th>SYNTAX I PCI</th>
<th>SYNTAX II</th>
<th>SYNTAX I CABG</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>315</td>
<td>450</td>
<td>334</td>
</tr>
<tr>
<td>30</td>
<td>298</td>
<td>441</td>
<td>313</td>
</tr>
<tr>
<td>60</td>
<td>292</td>
<td>437</td>
<td>304</td>
</tr>
<tr>
<td>90</td>
<td>288</td>
<td>433</td>
<td>295</td>
</tr>
<tr>
<td>120</td>
<td>280</td>
<td>429</td>
<td>293</td>
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<tr>
<td>150</td>
<td>278</td>
<td>427</td>
<td>291</td>
</tr>
<tr>
<td>180</td>
<td>274</td>
<td>421</td>
<td>289</td>
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<tr>
<td>210</td>
<td>269</td>
<td>417</td>
<td>288</td>
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<td>240</td>
<td>266</td>
<td>411</td>
<td>287</td>
</tr>
<tr>
<td>270</td>
<td>262</td>
<td>405</td>
<td>279</td>
</tr>
<tr>
<td>300</td>
<td>259</td>
<td>404</td>
<td>278</td>
</tr>
<tr>
<td>330</td>
<td>258</td>
<td>400</td>
<td>277</td>
</tr>
<tr>
<td>360</td>
<td>256</td>
<td>398</td>
<td>277</td>
</tr>
</tbody>
</table>

- Vs. PCI Hazard ratio: 0.58 (95% CI 0.39-0.85) p-value = 0.006
One year follow up results
Influence of anatomic SS on MACCE
SYNTAX II MACCE in SS I ≤22 and >22

SYNTAX II patients only

SYNTAX SCORE >22

SYNTAX SCORE ≤22

Days

Patients (%)
Conclusions (I)

- In patients with 3VD the use of the SYNTAX-II strategy was associated with improved clinical outcomes at one year, compared to matched patients treated percutaneously in the original SYNTAX-I trial.

- The one-year exploratory comparison between SYNTAX II and matched CABG patients from the original SYNTAX-I trial suggests non-inferiority of PCI when the SYNTAX-II strategy is followed.
Conclusions (II)

• Compared to SYNTAX I, contemporary state-of-art PCI in SYNTAX II led to significantly fewer lesions treated with PCI, and significantly higher success rates in CTO revascularisation.

• One-year outcomes of patients with SYNTAX score $>22$, treated with PCI using the SYNTAX score II risk stratification, were similar to those observed in patients with low anatomical risk (SYNTAX score $\leq 22$).
# SYNTAX II trial organisation

## Principal Investigators

- **PIs:** A Banning, J Escaned  
- **Study Chairman:** PW Serruys  
- **Deputy Chairman:** V Farooq  
- **Co-PIs:** AP Kappetein, D Taggart (Surgeons)

## Steering Committee

- A Banning, J Escaned, V Farooq, AP Kappetein, PW Serruys, D Taggart, GA van Es

## Sponsor

- ECRI - European Cardiovascular Research Institute

## Grant givers

- Volcano and Boston Scientific

## Data & Safety Monitoring Board

- FW Mohr, K Oldroyd, J Tijssen

## Clinical Events Committee

- JP Herrman, E McFadden, V Thijs, P Vranckx

## Clinical Research Organization

- Cardialysis BV, Rotterdam, The Netherlands  
- **Trial Manager:** S. Leeflang  
- **Statistics:** T de Vries, C. Collet, R. Cavalcante

## Core Laboratory

- **Coronary physiology:** N. Ryan  
- **IVUS:** G. De Maria  
- **Coronary CTA:** C. Collet, Y. Miyazaki
Interventional cardiology

Clinical outcomes of state-of-the-art percutaneous coronary revascularization in patients with de novo three vessel disease: 1-year results of the SYNTAX II study

Javier Escaned1, Carlos Colle2, Nicola Ryan3, Giovanni Luigi De Maria3, Simon Walsh4, Manel Sabate5, Justin Davies6, Maciej Lesiak7, Raul Moreno8, Ignacio Cruz-Gonzalez9, Stephan P. Hoole10, Nick Ej West10, J. J. Pick2, Azfar Zaman11, Farzin Fath-Ordoubadi12, Rodney H. Stables13, Clare Appleby13, Nicolas van Mieghem14, Robert Jm. van Geuns14, Neal Uren15, Javier Zueco16, Pawel Buszman17, Andres Iniguez18, Javier Goicolea19, David Hildick-Smith20, Andrzeij Ochala21, Dariusz Dudek22, Colm Hanratty22, Rafael Cavalcante22, Arie Pieter Kappetein24, David P. Taggart22, Gerrit-Anne van ES23,24, Marie-Angèle Morel23, Ton de Vries22, Yoshinobu Onuma24,25, Vasim Farooq22, Patrick W. Serruys6,26, and Adrian P. Banning2

1HospitalClinicSanCarlos (ISCIII) and UniversidadComplutense de Madrid, Madrid, Spain; 2CatholicUniversity of Leuven, Leuven, Belgium; 3AcademicMedicalCenter Amsterdam, Amsterdam, the Netherlands; 4University of Oxford, Oxford, UK; 5University Hospital, Bordeaux, France; 6University of Antwerp, Antwerp, Belgium; 7Cleveland Clinic Foundation, Cleveland, OH, USA; 8University Hospitals, Leuven, Belgium; 9St. Bartholomew’s Hospital, London, UK; 10Royal Brompton Hospital, London, UK; 11University Hospital, Leuven, Belgium; 12Cleveland Clinic, Cleveland, OH, USA; 13Royal Brompton Hospital, London, UK; 14University Hospitals, Leuven, Belgium; 15University Hospital, Leuven, Belgium; 16University Hospital, Leuven, Belgium; 17Catholic University of Leuven, Leuven, Belgium; 18University of Oxford, Oxford, UK; 19University Hospital, Bordeaux, France; 20University of Oxford, Oxford, UK; 21University of Antwerp, Antwerp, Belgium; 22Cleveland Clinic Foundation, Cleveland, OH, USA; 23Cleveland Clinic, Cleveland, OH, USA; 24Catholic University of Leuven, Leuven, Belgium; 25University of Leiden, Leiden, The Netherlands; 26Catholic University of Leuven, Leuven, Belgium.
Back up slides
<table>
<thead>
<tr>
<th>Centre</th>
<th>Investigators</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belfast Health &amp; Social Care Trust</td>
<td>Simon Walsh</td>
<td>70</td>
</tr>
<tr>
<td>Hospital Clinico San Carlos</td>
<td>Javier Escaned</td>
<td>50</td>
</tr>
<tr>
<td>John Radcliffe Hospital</td>
<td>Adrian Banning</td>
<td>35</td>
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<tr>
<td>Hospital Clinic I Provincial</td>
<td>Manel Sabaté</td>
<td>32</td>
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<tr>
<td>Imperial College Healthcare</td>
<td>Justin Davies</td>
<td>27</td>
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<tr>
<td>Holy Transfiguration Hospital</td>
<td>Maciej Lesiak</td>
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<td>Hospital Universitario La Paz</td>
<td>Raul Moreno</td>
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<td>Hospital Clinico Salamanca</td>
<td>Ignacio Cruz</td>
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<td>Papworth Hospital</td>
<td>Nick West</td>
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<td>Academisch Medisch Centrum</td>
<td>Jan Piek</td>
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<tr>
<td>Liverpool Heart and Chest Hospital</td>
<td>Clare Appleby &amp; Rod Stables</td>
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<td>Manchester Royal Infirmary</td>
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<td>Freeman Hospital Newcastle</td>
<td>Azfar Zaman</td>
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<tr>
<td>Erasmus Medical Center</td>
<td>Nicolas van Mieghem</td>
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<td>The Royal Infirmary of Edinburgh</td>
<td>Neal Uren</td>
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<td>Hospital Universitario Valdecilla</td>
<td>Javier Zueco</td>
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<td>American Heart of Poland (PAK), Pawel Buszman</td>
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<td>Hospital Meixoeiro</td>
<td>Andres Iñiguez</td>
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<td>Hospital Puerta de Hierro</td>
<td>Javier Goicolea</td>
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<tr>
<td>Brighton &amp; Sussex University Hospitals</td>
<td>David Hildick-Smith</td>
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<td>Gornoslaskie Centrum Medycnze, Andrzej Ochala</td>
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<tr>
<td>St Raphael Hospital</td>
<td>Dariusz Dudek</td>
<td>3</td>
</tr>
</tbody>
</table>
Definitions

- **MACCE:** All-cause death, stroke, any myocardial infarction (MI) or any revascularisation.

- **Periprocedural MI:** CK-MB ≥5xULN (or Tn ≥35 ULN if CK-MB not available) and new pathological Q-waves in the ECG within 7 days post PCI.

- **Spontaneous MI:** New Q-waves or one plasma level of CK-MB 5x ULN (or Tn ≥35 ULN if CK-MB not available) in the context of clinical syndrome consistent with ACS.

- **Stent Thrombosis:** According to the Academic Research Consortium.
## Medical therapy

<table>
<thead>
<tr>
<th>Medical therapy</th>
<th>SYNTAX II</th>
<th>SYNTAX I PCI arm</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aspirin</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At discharge</td>
<td>99.8% (448/449)</td>
<td>96.2% (302/314)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>At 1 Year</td>
<td>95.6% (413/432)</td>
<td>92.1% (278/302)</td>
<td>0.046</td>
</tr>
<tr>
<td><strong>P2Y12 inhibitor</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At discharge</td>
<td>99.3% (446/449)</td>
<td>98.4% (309/314)</td>
<td>0.234</td>
</tr>
<tr>
<td>Clopidogrel</td>
<td>66.8% (298/446)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Prasugrel</td>
<td>4.5% (20/446)</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Ticagrelor</td>
<td>28.7% (128/446)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>At 1 Year</td>
<td>61.8% (267/432)</td>
<td>72.2% (218/302)</td>
<td>0.0034</td>
</tr>
<tr>
<td><strong>Beta-blocker at discharge</strong></td>
<td>75.7% (339/448)</td>
<td>77.1% (242/314)</td>
<td>0.6550</td>
</tr>
<tr>
<td><strong>Statin at discharge</strong></td>
<td>97.3% (437/449)</td>
<td>85.4% (268/314)</td>
<td>&lt;0.001</td>
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</tbody>
</table>
## Use of coronary stents

<table>
<thead>
<tr>
<th></th>
<th>SYNTAX II</th>
<th>SYNTAX I PCI arm</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stents per patient</td>
<td>3.78±1.92 (440)</td>
<td>5.19±2.04 (308)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Stents per lesion</td>
<td>1.43±0.76 (1165)</td>
<td>1.28±0.65 (1251)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mean stent length (per stent, mm)</td>
<td>24.43±9.18 (1663)</td>
<td>18.82±7.04 (1599)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Total stent length (per patient, mm)</td>
<td>92.32±52.78 (440)</td>
<td>97.71±43.66 (308)</td>
<td>0.13</td>
</tr>
</tbody>
</table>
Selection of the SYNTAX I PCI Reference Arm

SYNTAX Trial
903 patients randomised to PCI

546 patients with 3VD
SYNTAX Score II calculated

315 patients
SYNTAX-I PCI reference arm

357 patients with Left Main Disease excluded

231 patients excluded:
SYNTAX Score II did not show equipoise for CABG and PCI
**Selection of the SYNTAX I CABG Reference Arm**

SYNTAX Trial
897 patients randomised to CABG

549 patients with 3VD
SYNTAX Score II calculated

334 patients
SYNTAX-I CABG reference arm

348 patients with Left Main Disease excluded

215 patients excluded:
SYNTAX Score II did not show equipoise for CABG and PCI