

FFR pullbacks to guide PCI

the ongoing PPG Global registry

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Disclosure Statement of Financial Interest

Within the past 12+ months, Nils Johnson has had a financial interest/arrangement or affiliation with the organization(s) listed below.

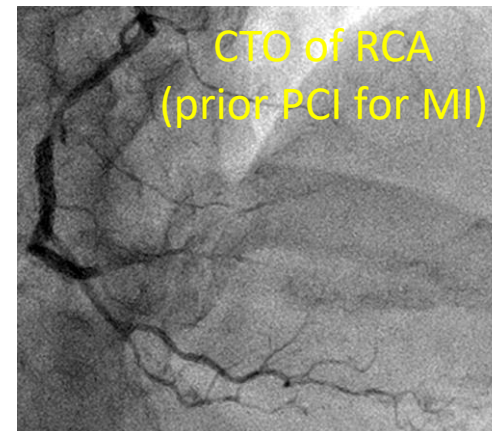
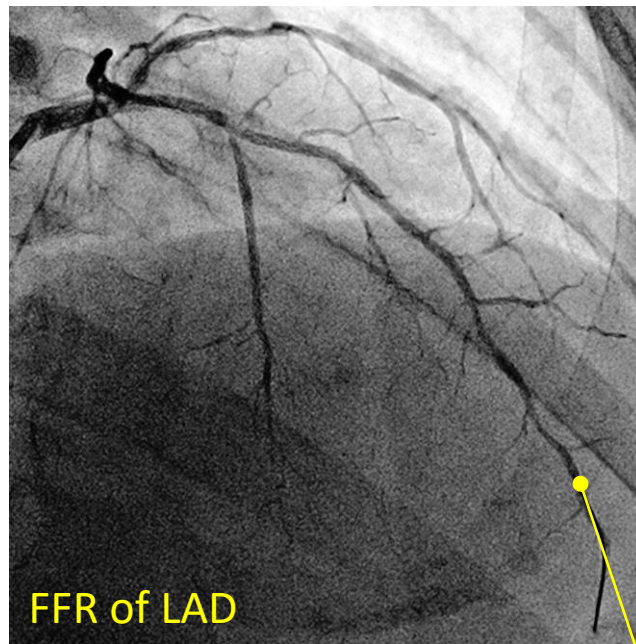
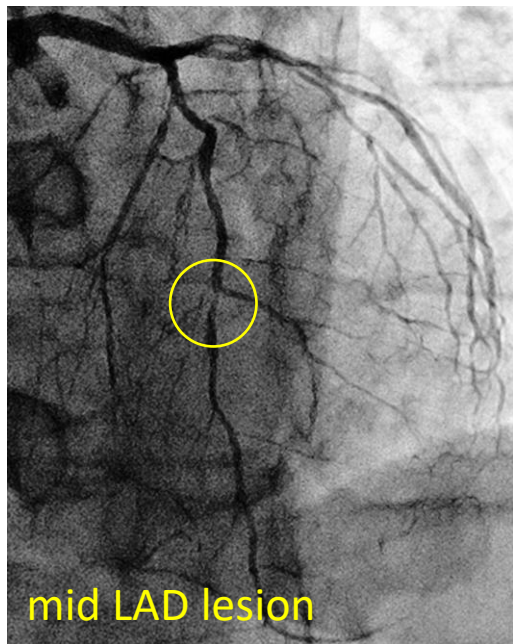
Affiliation/Financial Relationship

- Grant/research support (to institution)
- Licensing and associated consulting (to institution)
- Support for educational meetings/training (honoraria/fees donated to institution)
- PET software 510(k) from FDA (application by Lance Gould, to institution)
- Patents filed (USPTO serial numbers 62/597,134 + 62/907,174)

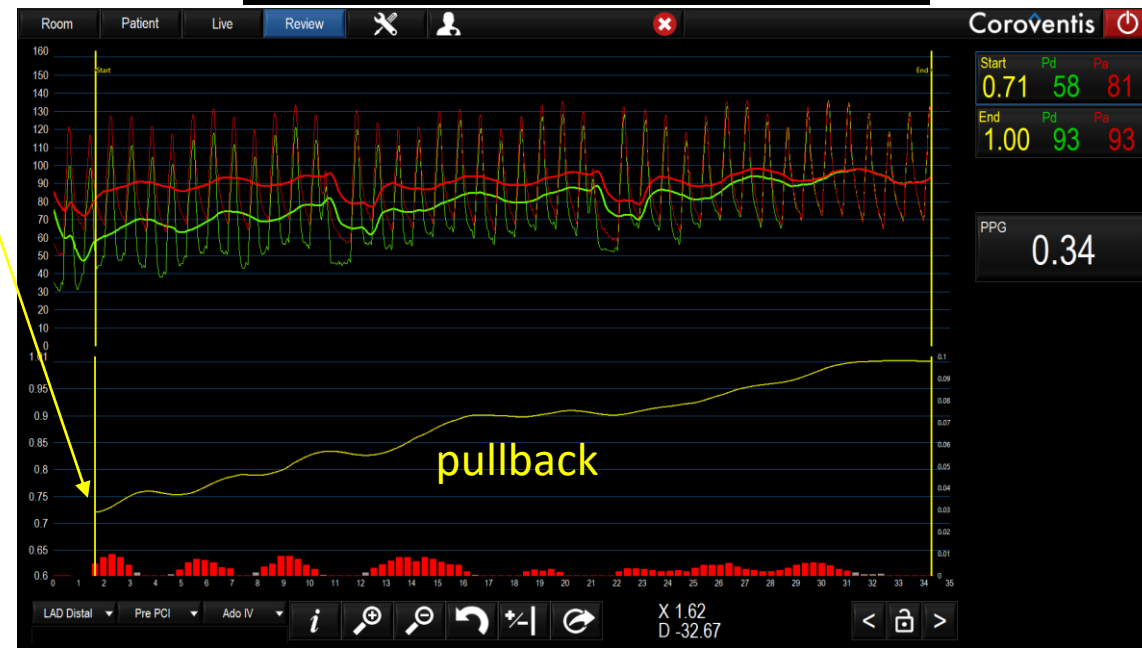
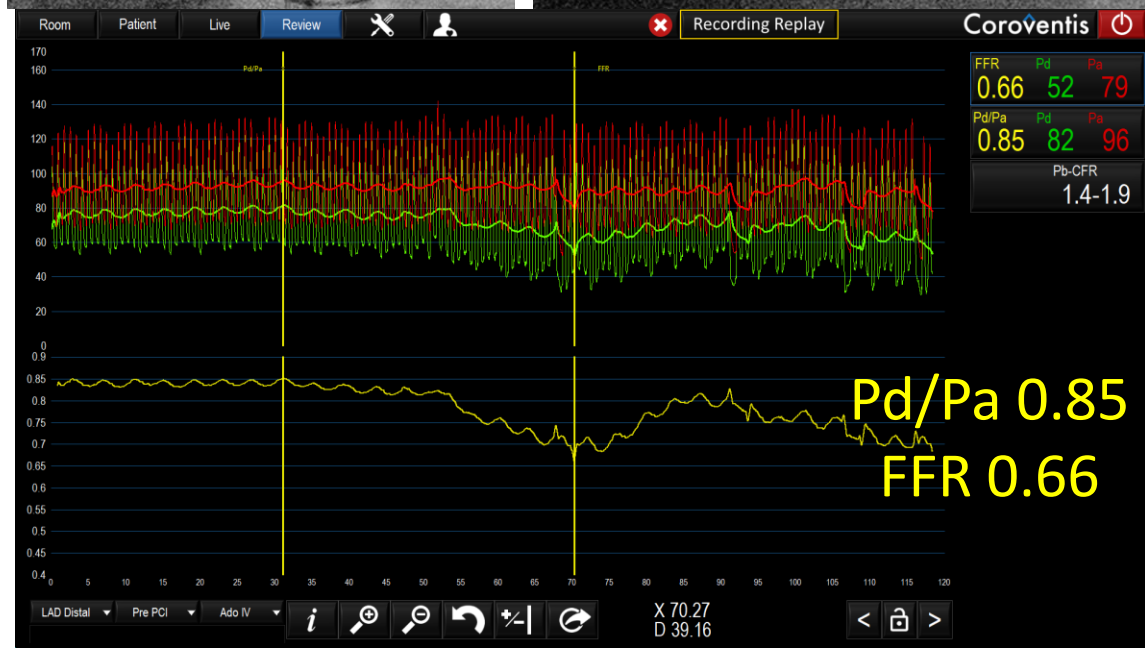
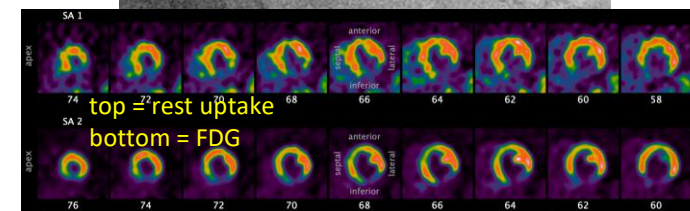
Organizations (chronologic)

- St Jude Medical (CONTRAST, NCT02184117)
- Volcano/Philips (DEFINE-FLOW, NCT02328820)
- CoreAalst (PPG registry, NCT04789317)
- Abiomed (local “DPTI” study)
- Boston Scientific (smart-minimum FFR, 510(k) K191008)
- Various, including academic and industry
- K113754 (cfrQuant, 2011)
- K143664 (HeartSee, 2014)
- K171303 (HeartSee update, 2017)
- K202679 (HeartSee update, 2020)
- SAVI and $\Delta P/Q$ methods
- Correction of fluid-filled catheter signal

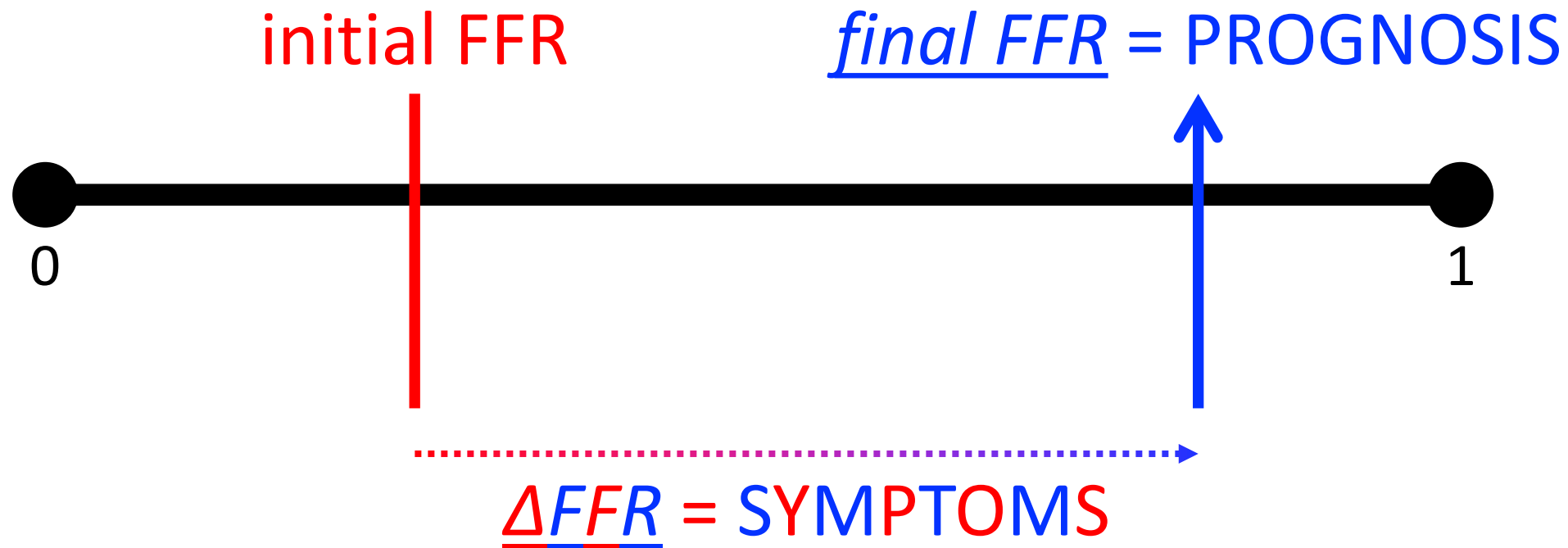
52 year-old woman with dyspnea



no RCA viability
("matched")



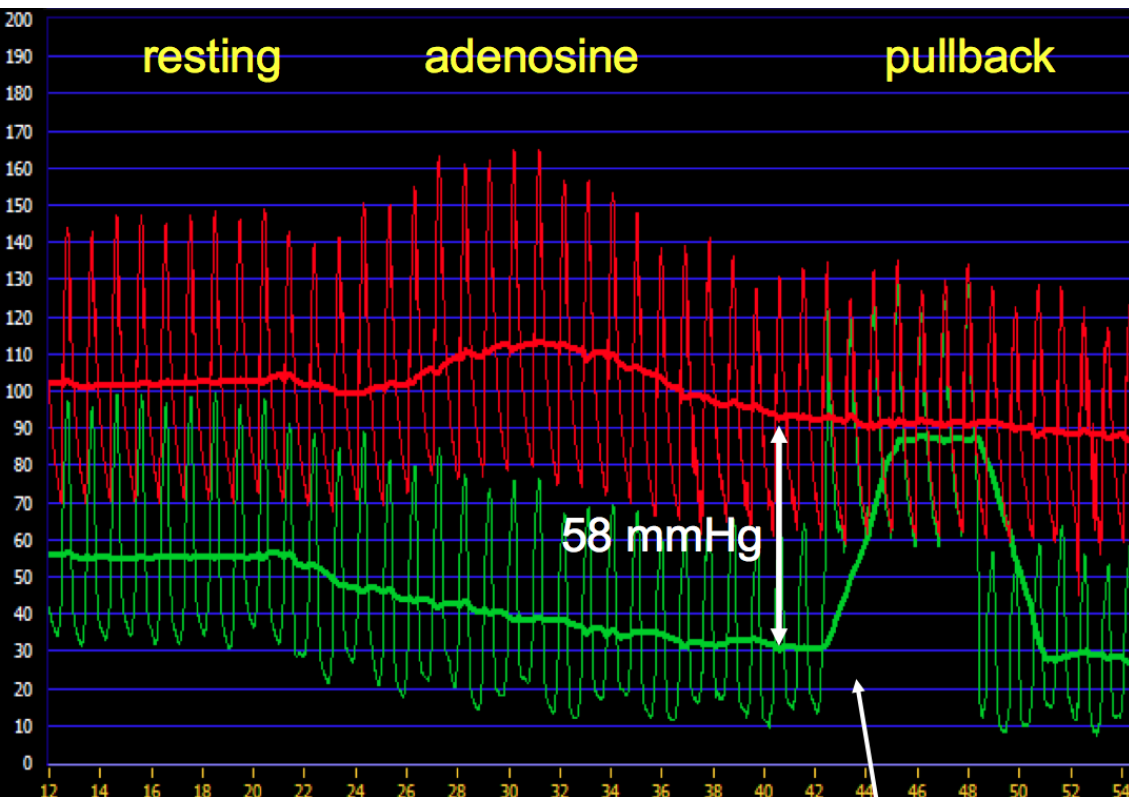
Key concept: final FFR + Δ FFR



Final + Δ FFR

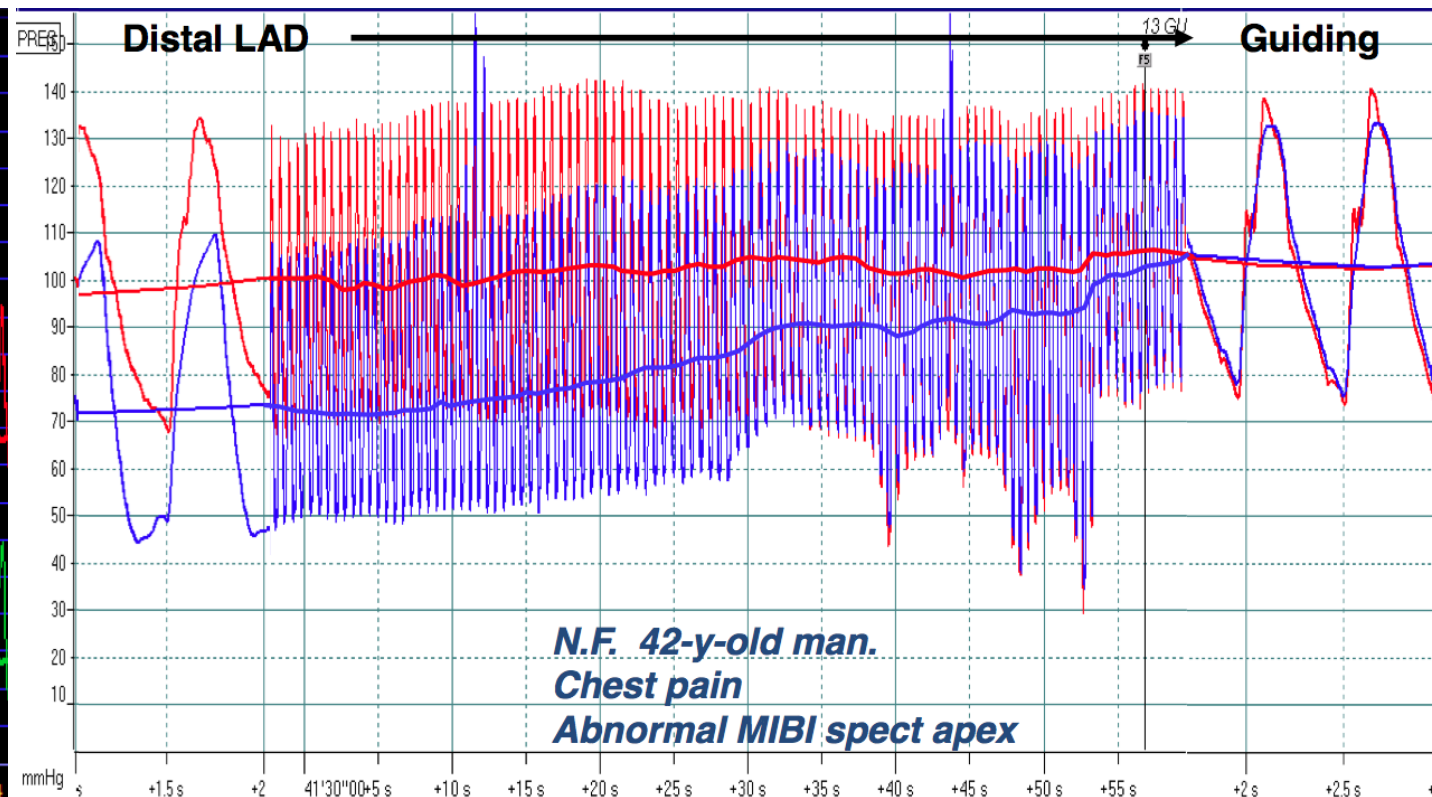
can we predict?

Pullback pattern: focal vs diffuse?



FOCAL

BEST target for PCI/CABG

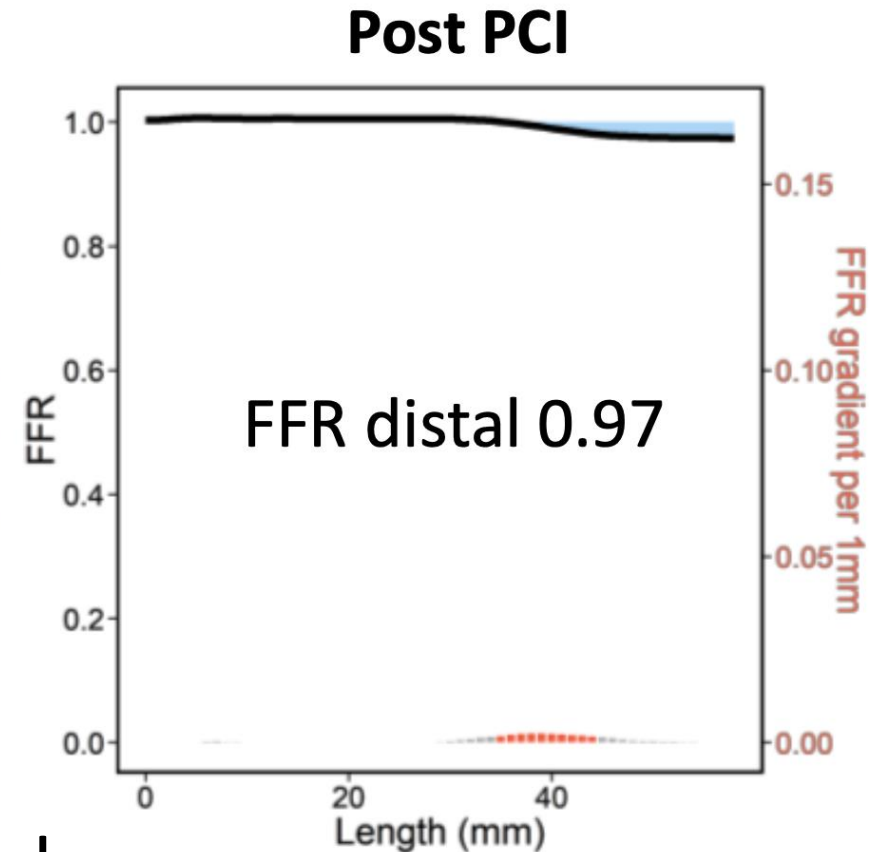
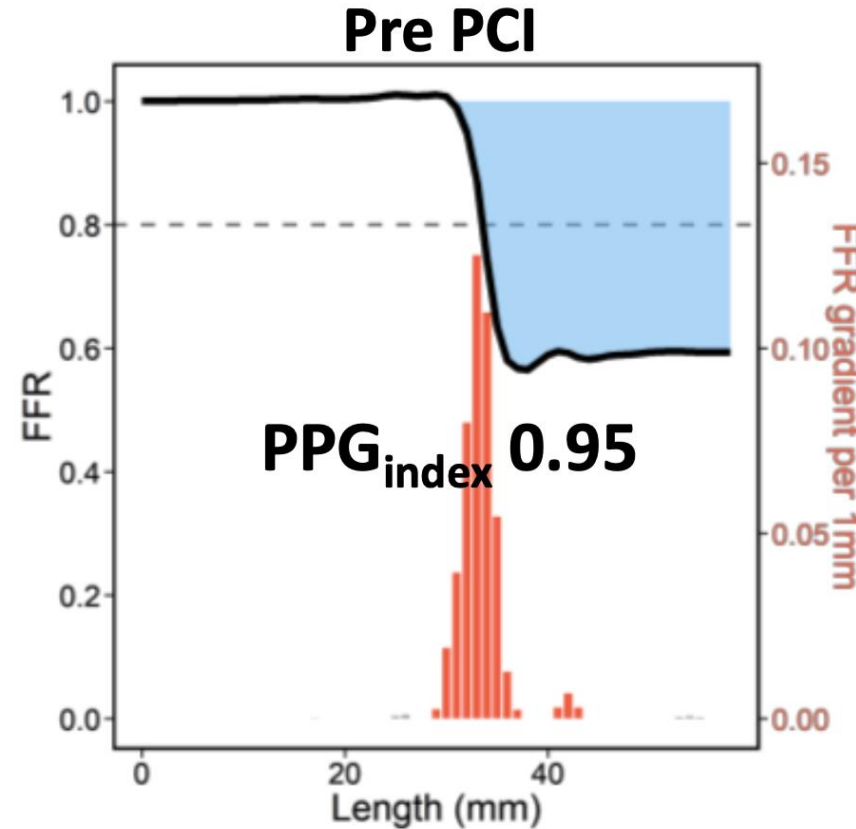
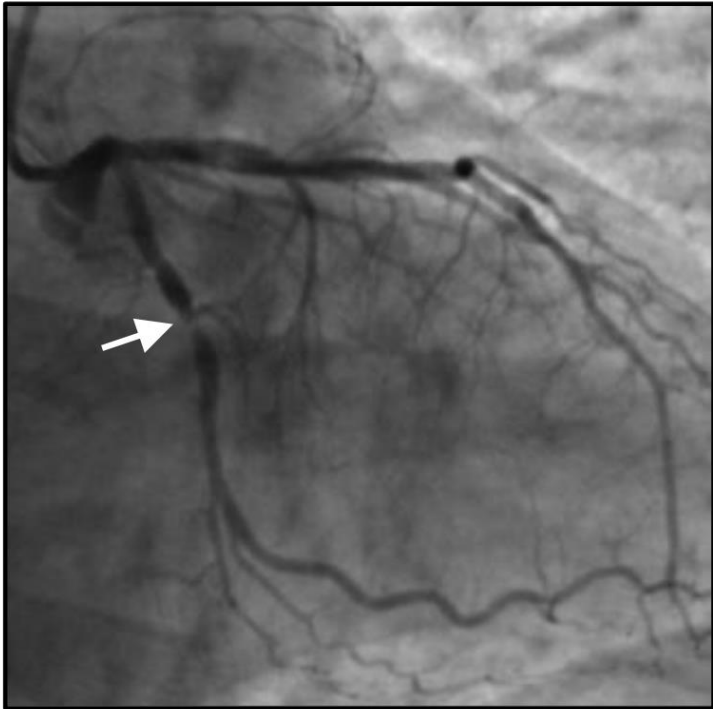


DIFFUSE

POOR target for PCI/CABG

Focal disease = higher final FFR + large Δ

Functional Focal CAD



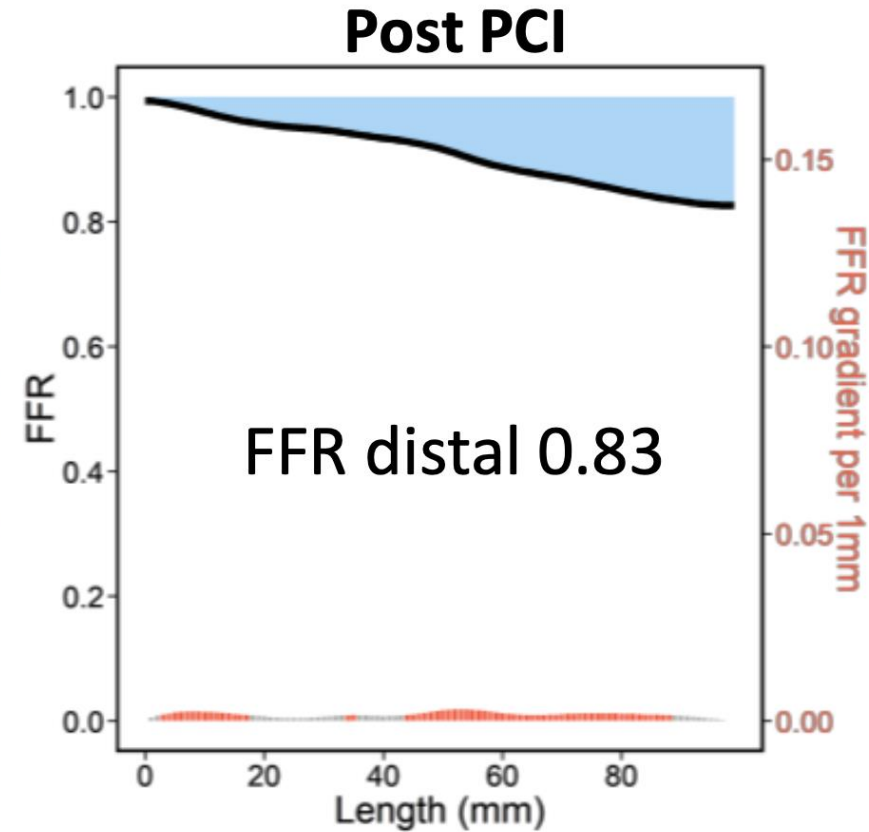
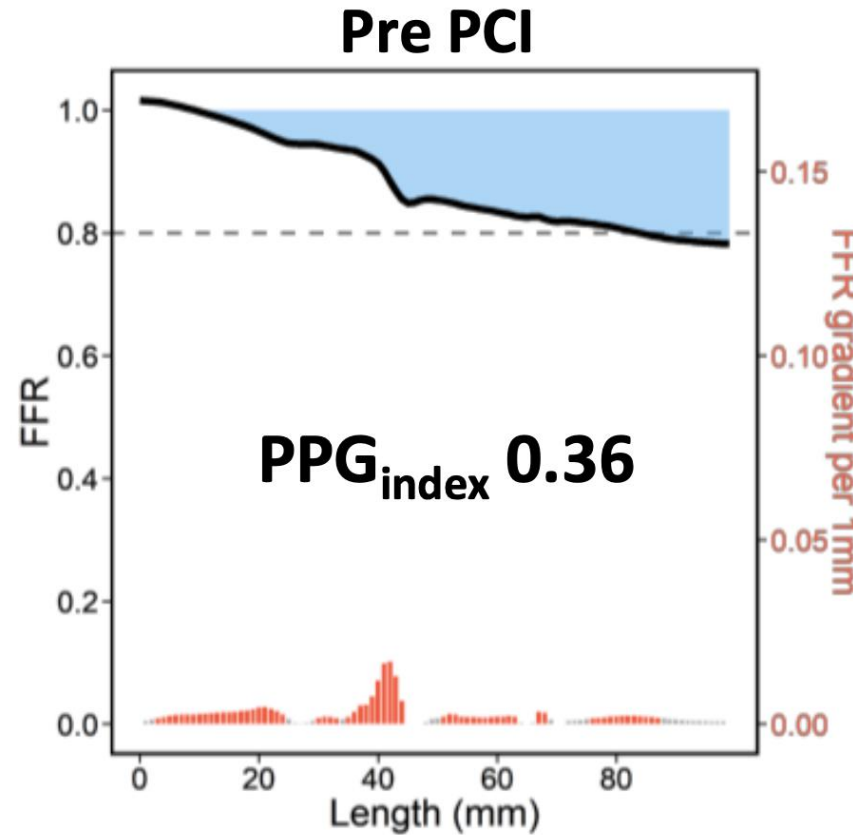
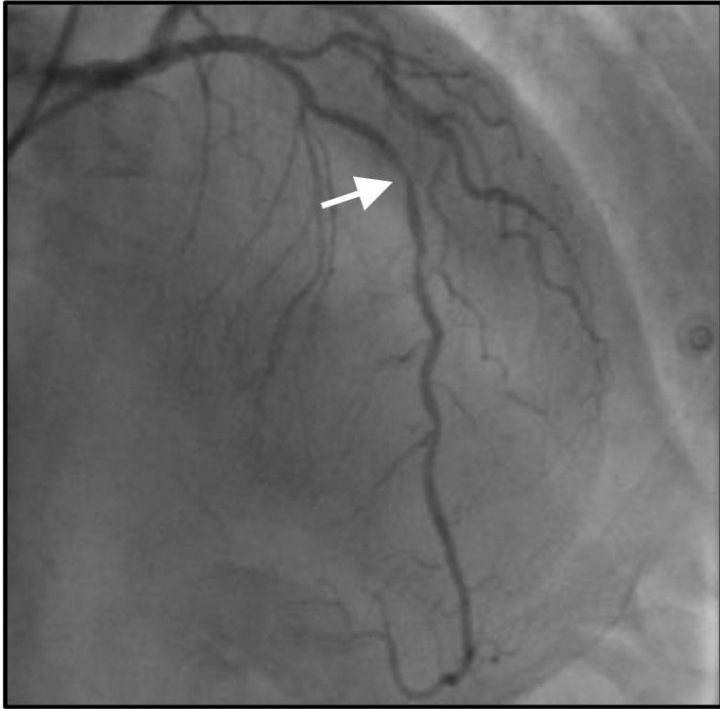
FFR distal

- before 0.59
- after 0.97

FFR Δ +0.38

Diffuse disease = lower final FFR and small Δ

Functional Diffuse CAD



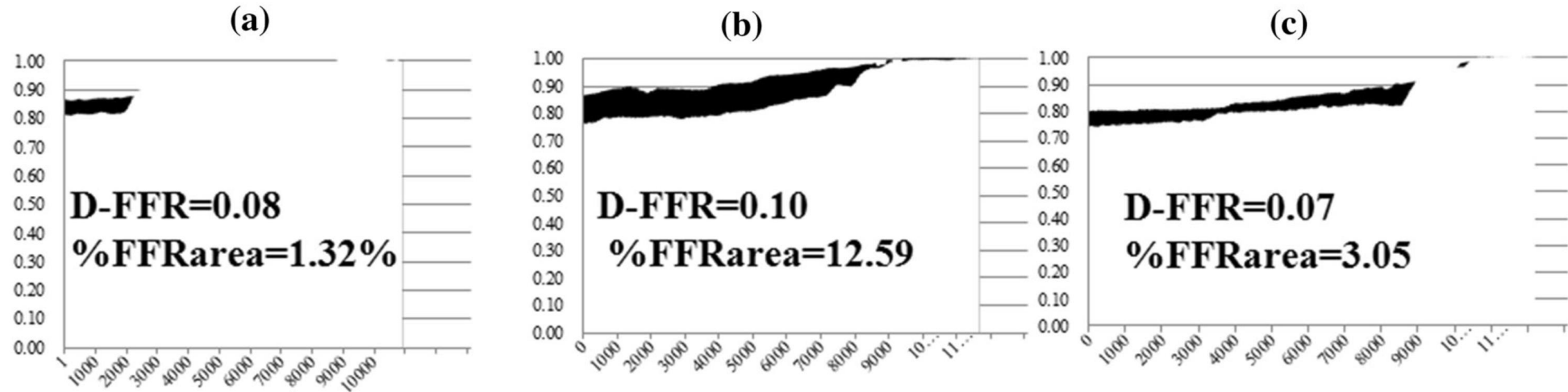
FFR distal

- before 0.78
- after 0.83

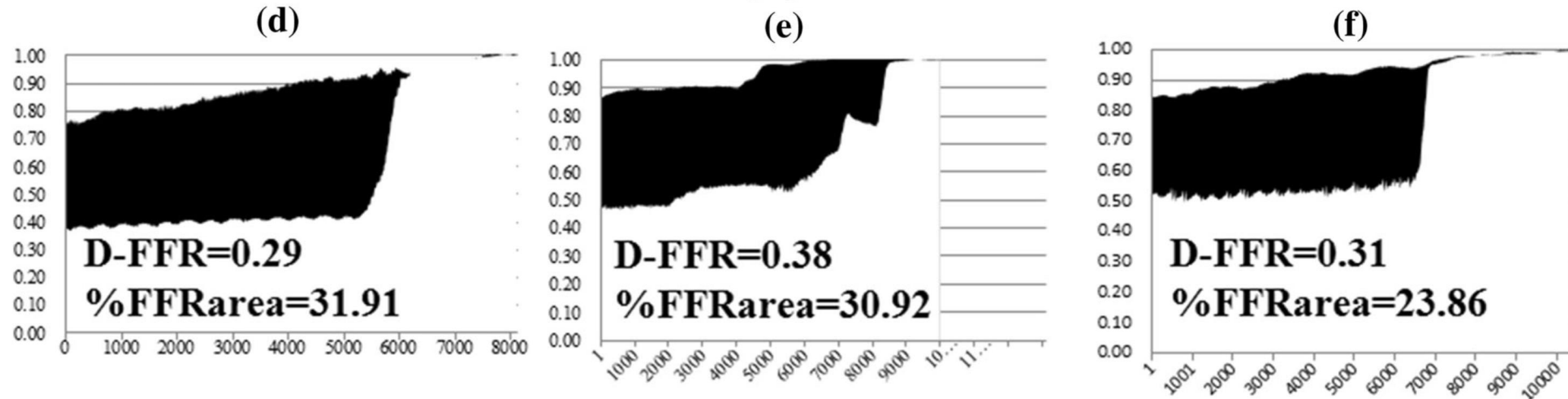
FFR Δ +0.05

Pullback curve -> anticipate

Gradual pattern



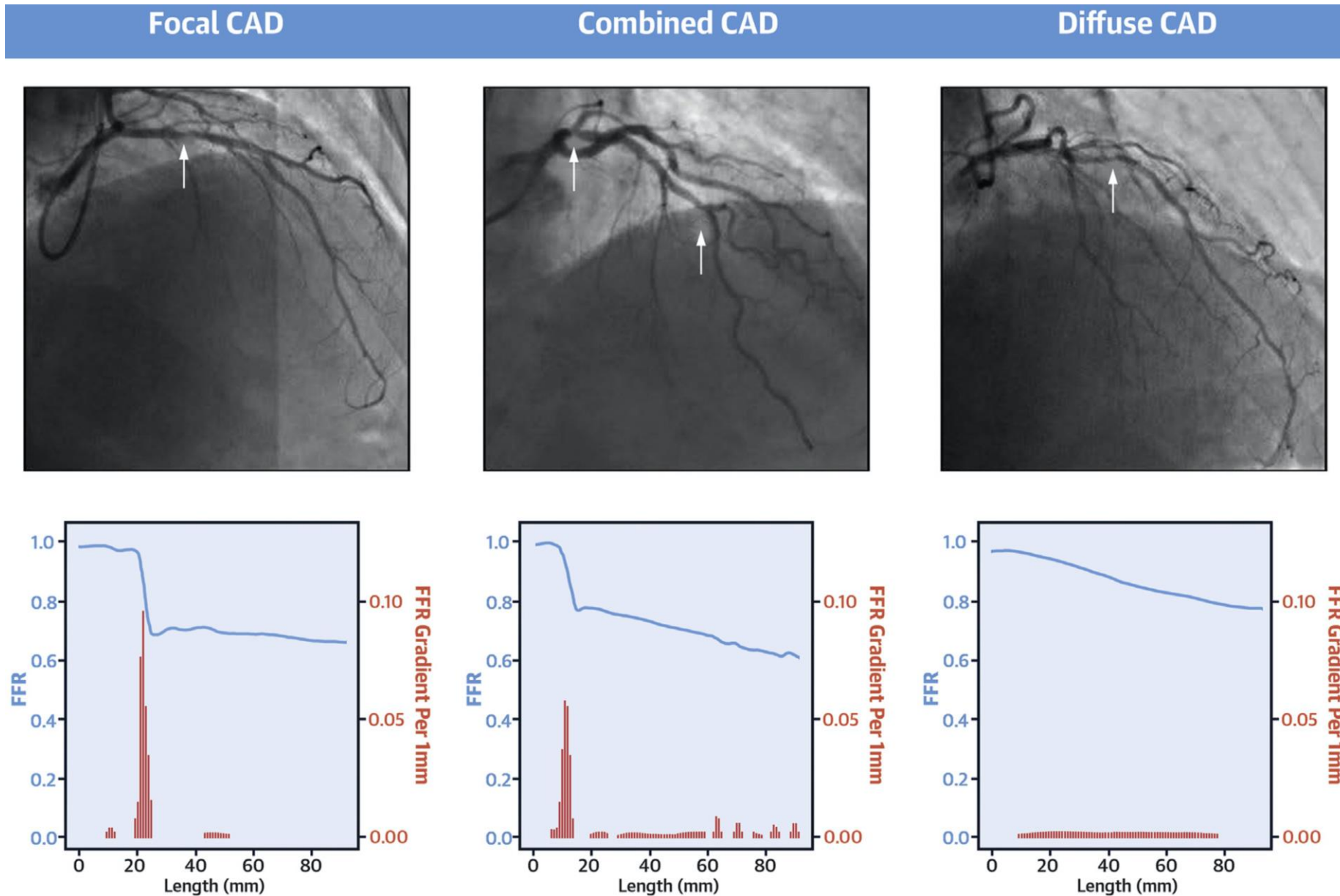
Abrupt pattern



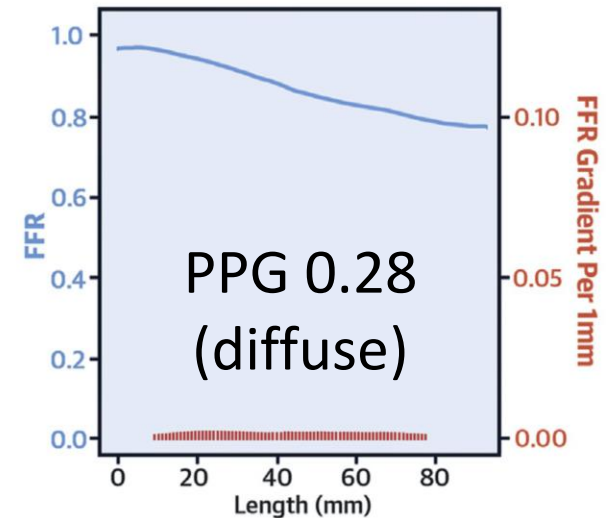
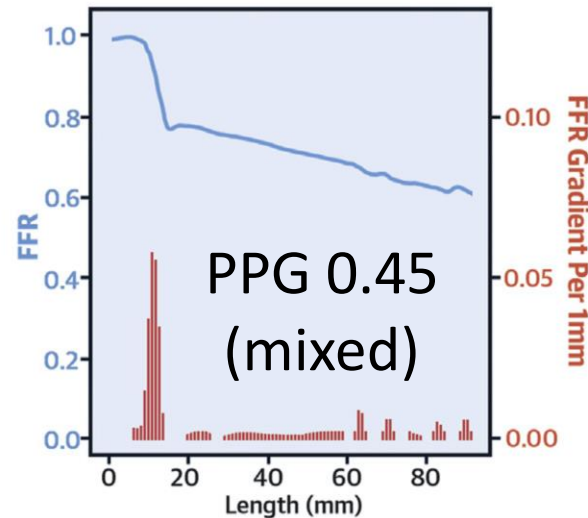
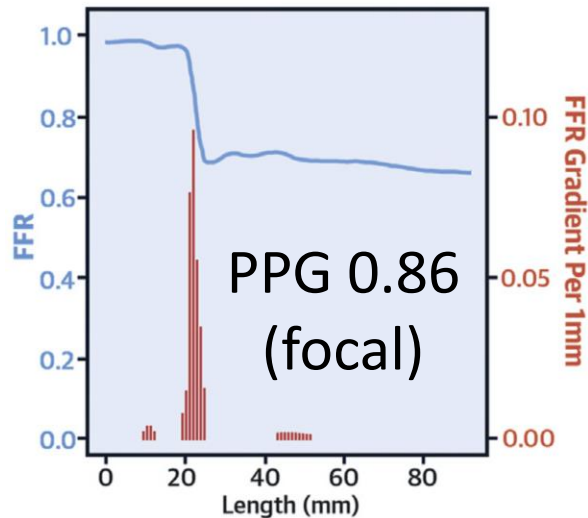
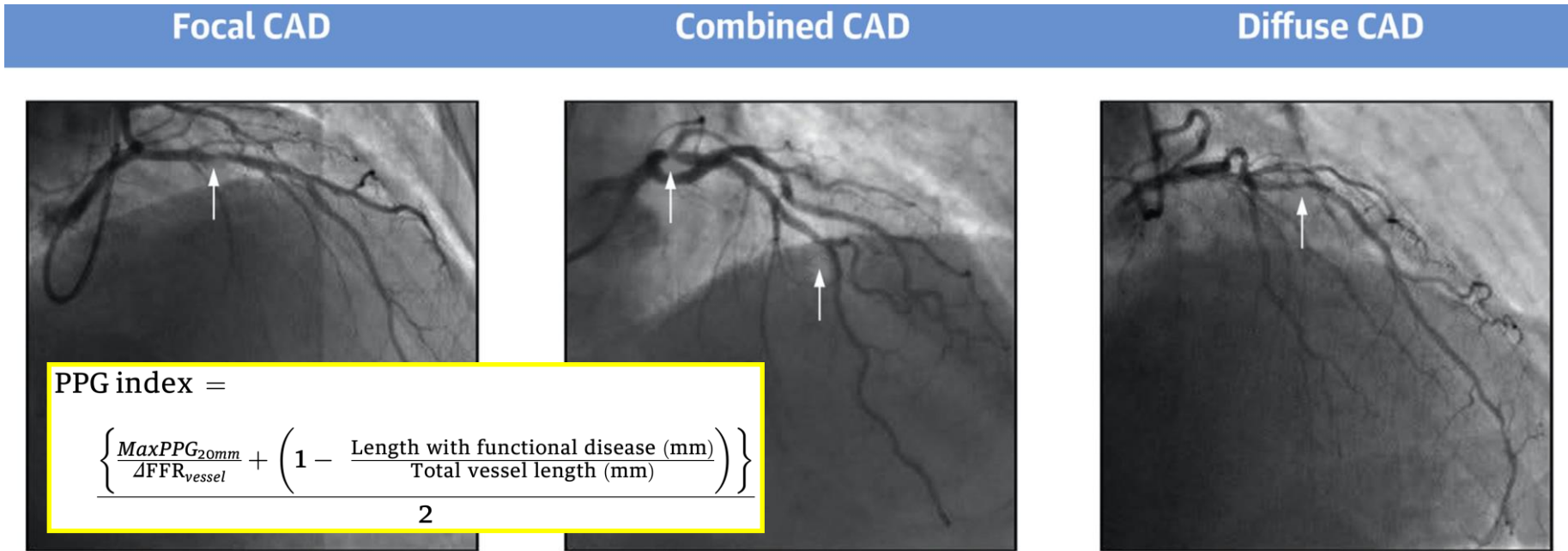
How exactly?

PPG

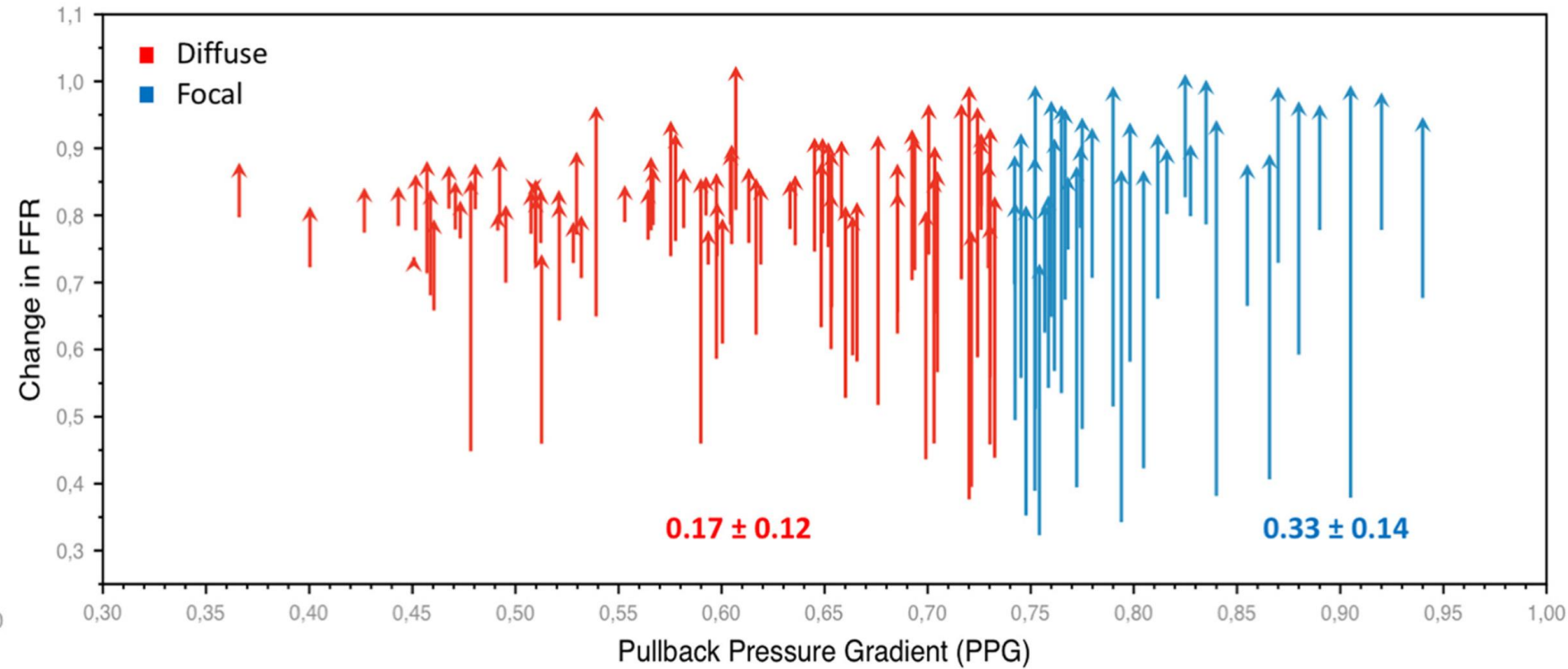
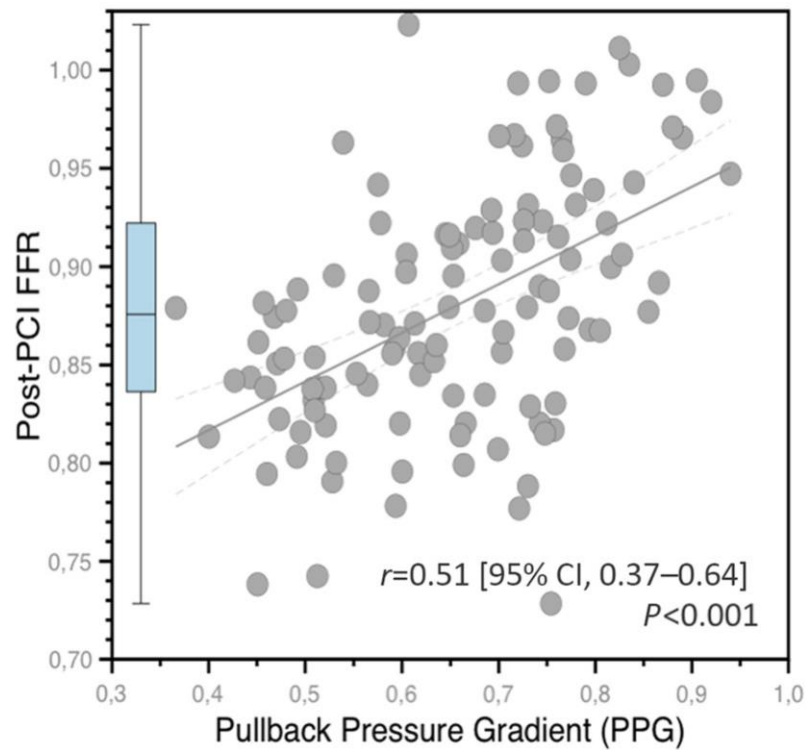
Continuum of plaque distribution



1 = focal, 0 = diffuse

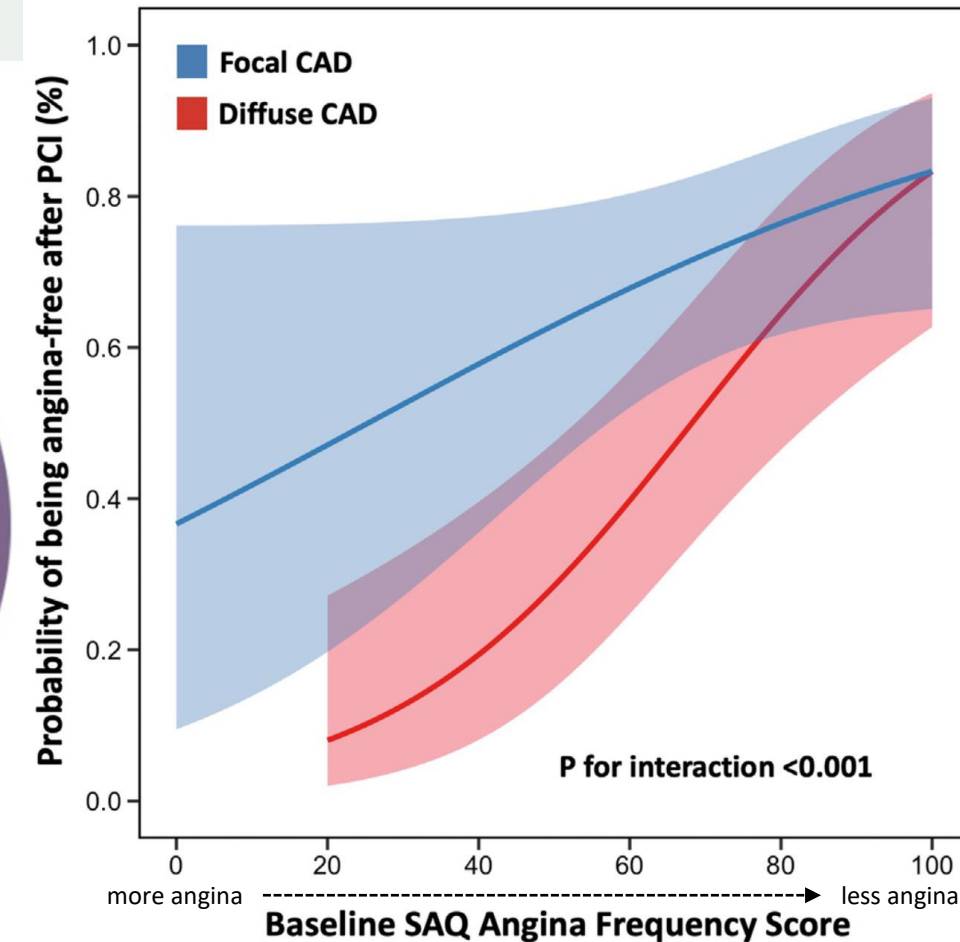
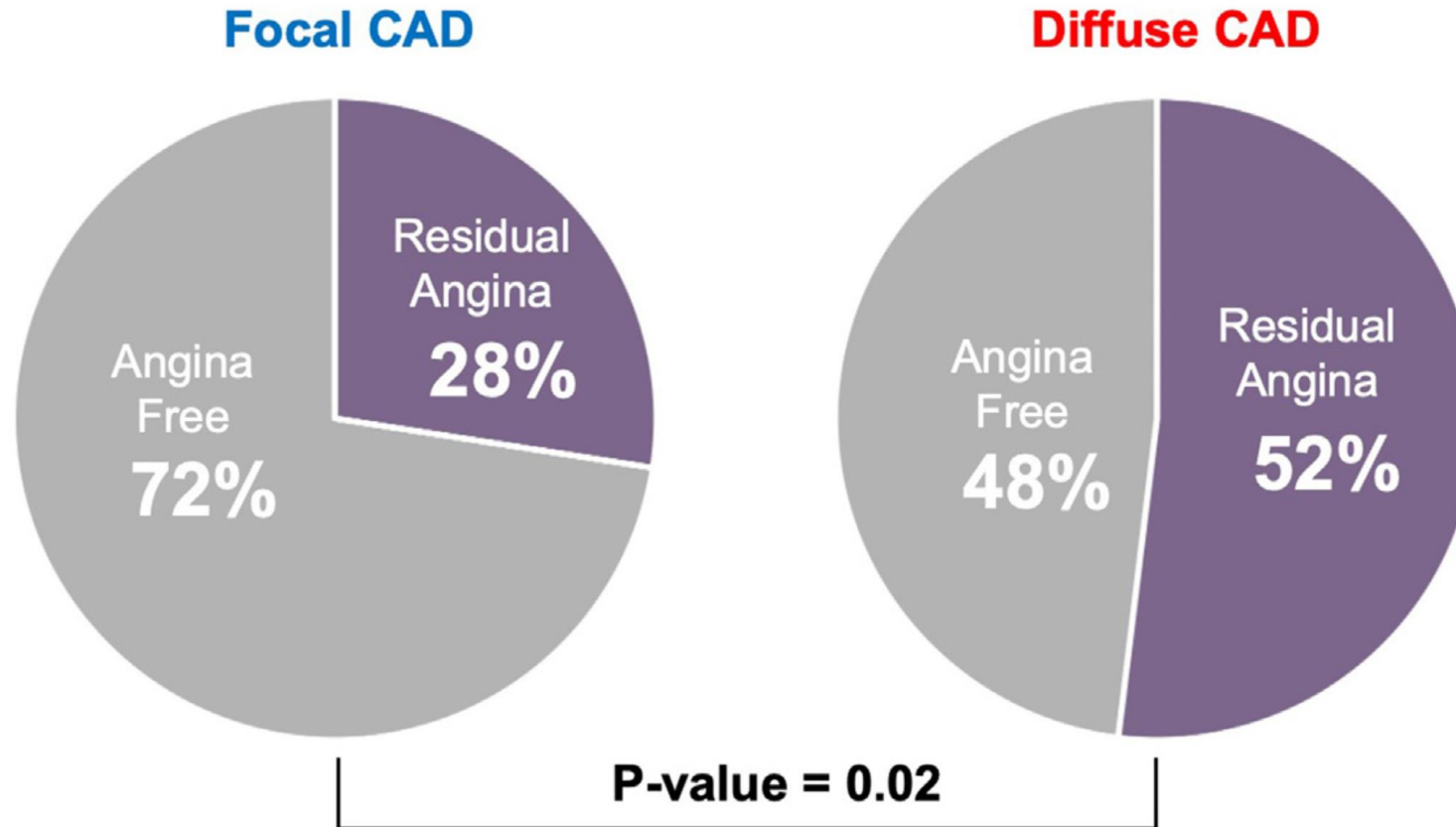


Focal PPG indicates larger final FFR and Δ

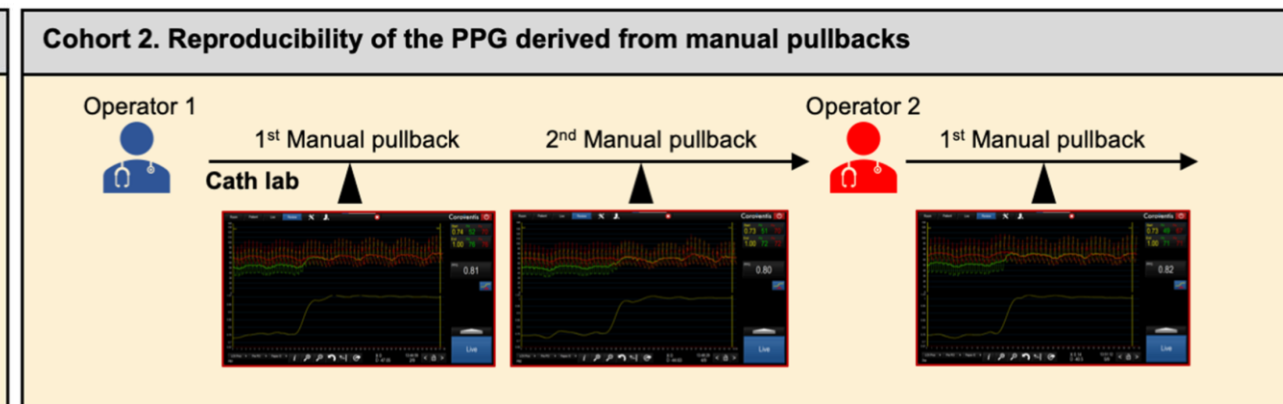
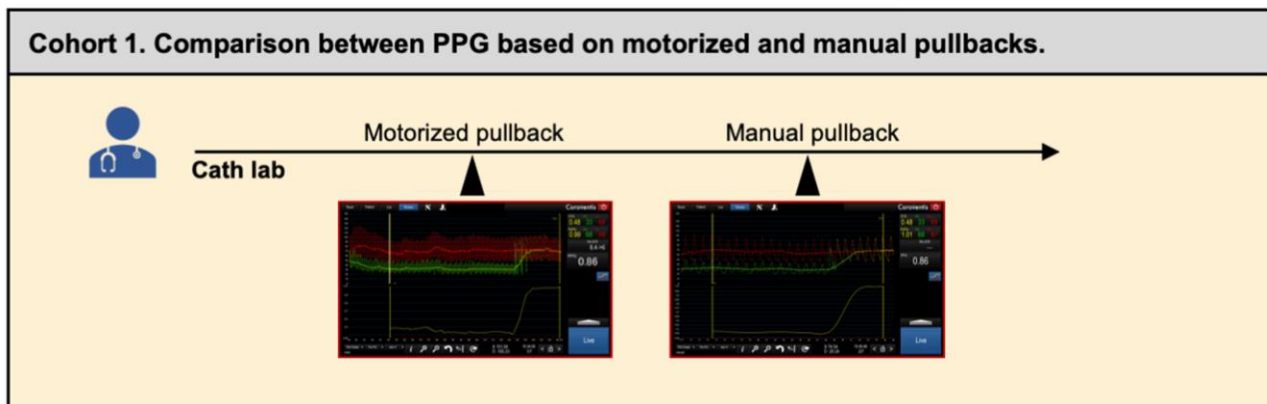
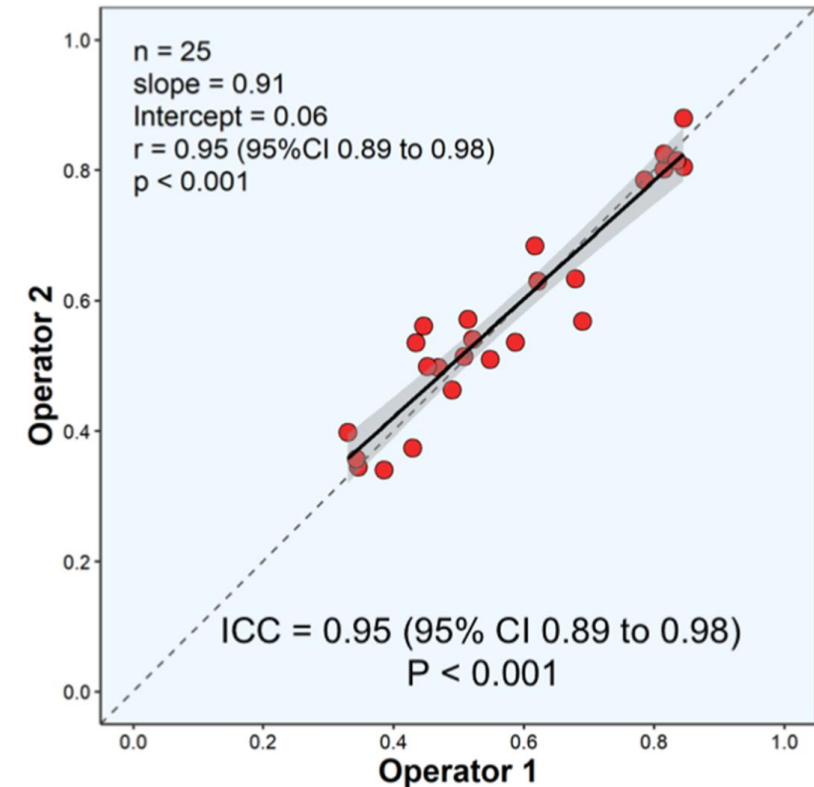
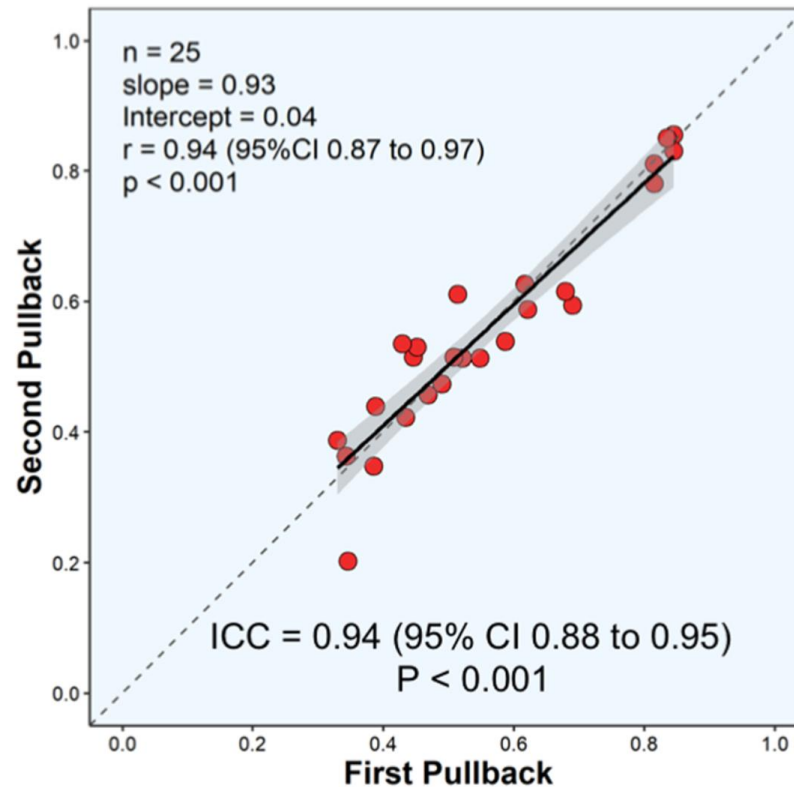
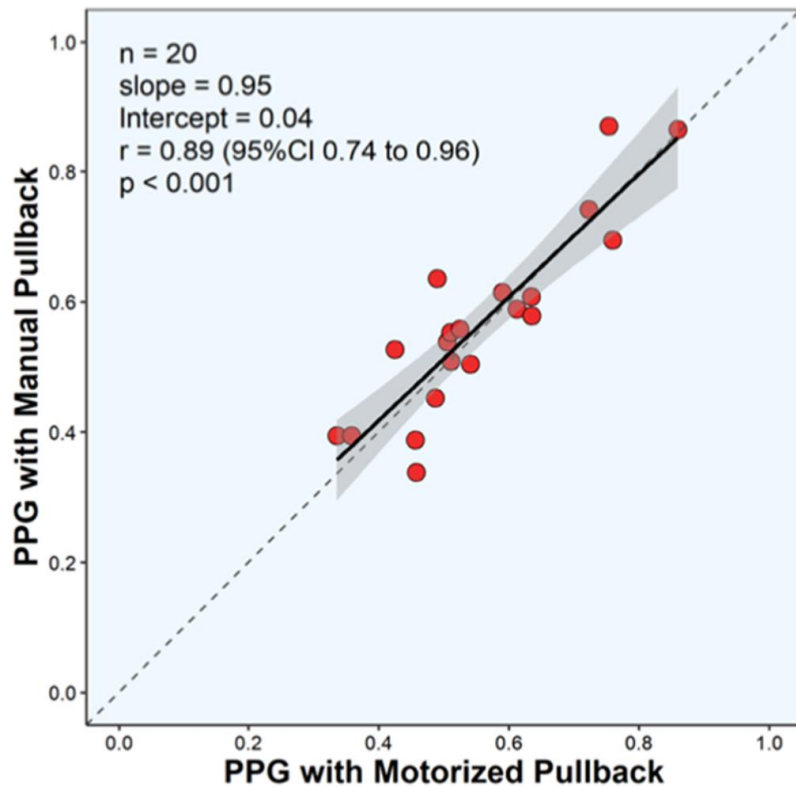


Less residual angina after PCI for focal PPG

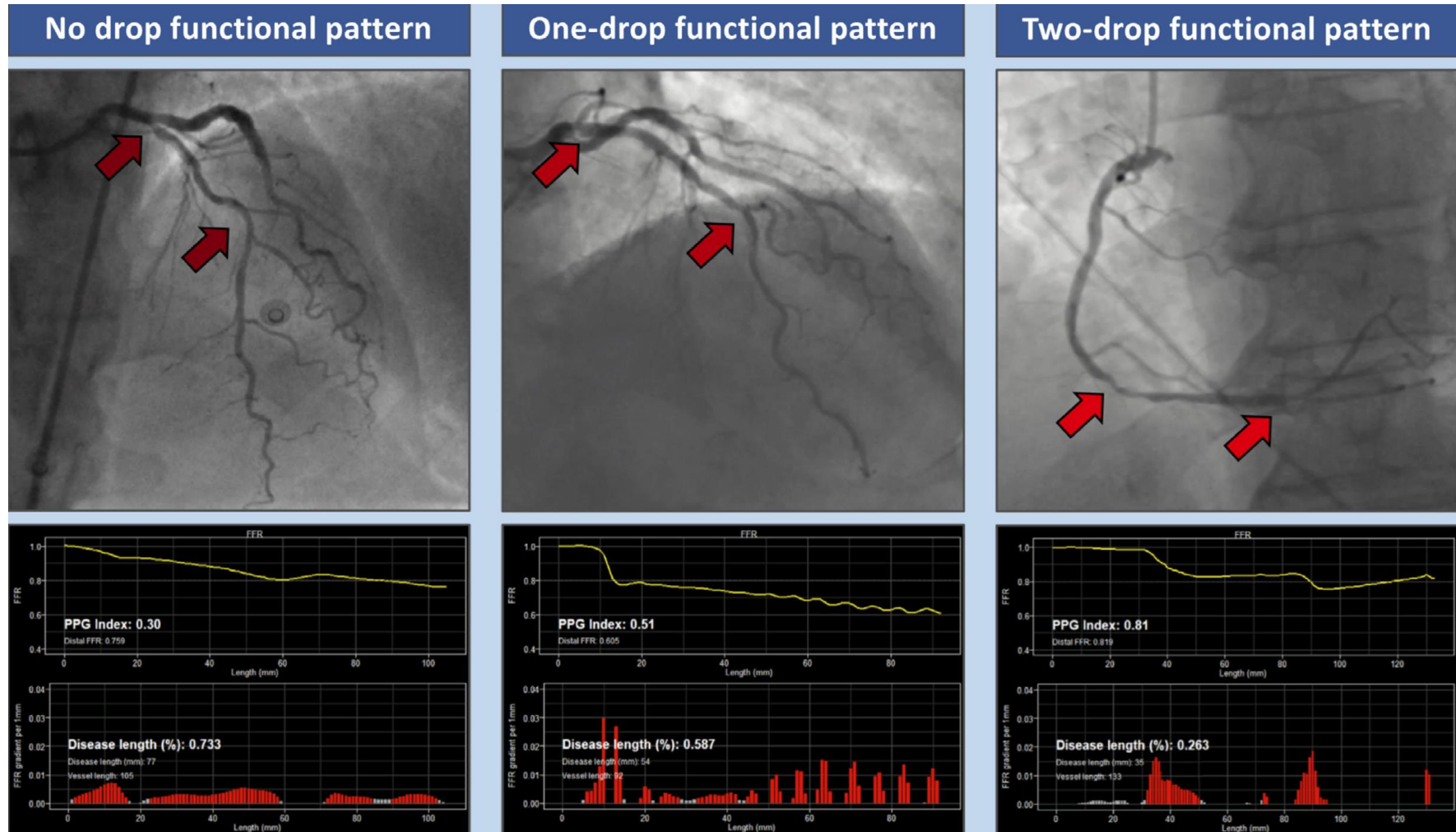
Rate of Freedom From Angina After Percutaneous Coronary Intervention Stratified by CAD Patterns



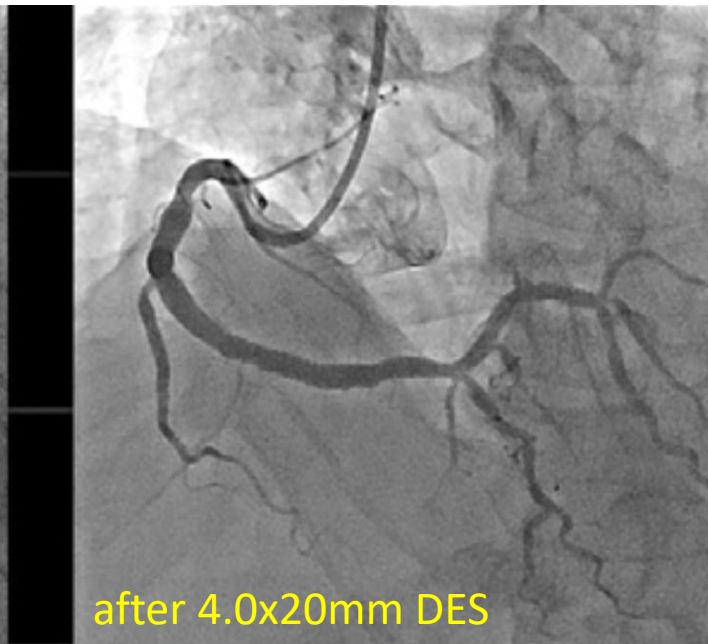
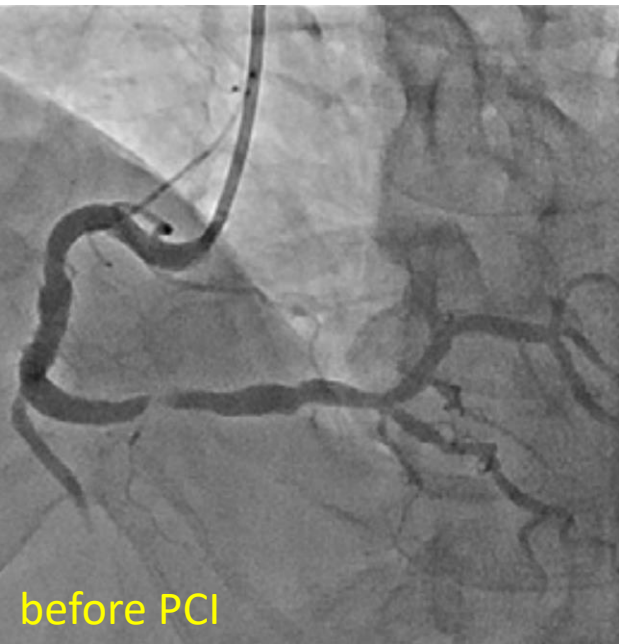
PPG is practical (reproducible by hand)



What about serial lesions?



High PPG can lead to RFR vs **FFR** discordance



before

RFR = 0.91

FFR = 0.66

PPG = 0.91

after

RFR = 0.92

FFR = 0.96

Δ +0.30

70 year-old man
prior PCI, several risk factors
refractory CCS class I angina

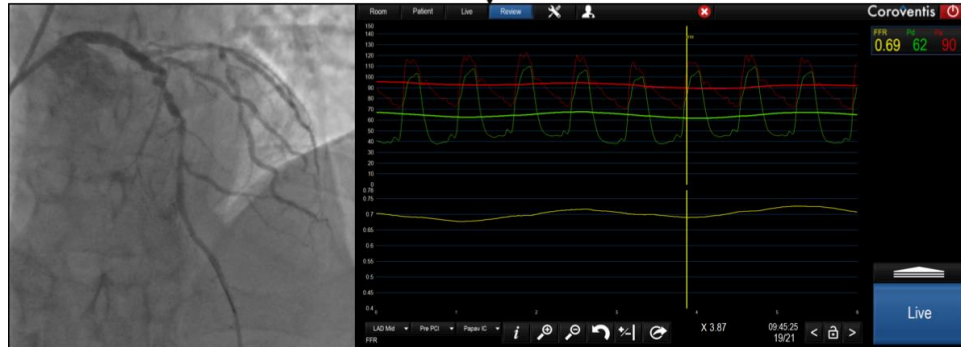
PPG registry

and what did I do?

PPG Global Registry of 982 subjects

Stable patients with significant coronary artery disease ($\text{FFR} \leq 0.80$) and intention to perform PCI

Initial strategy based on angiography and distal point physiology



FFR Pullback with Pullback Pressure Gradient (PPG)



Adapted Treatment Decision

OMT

PCI

CABG

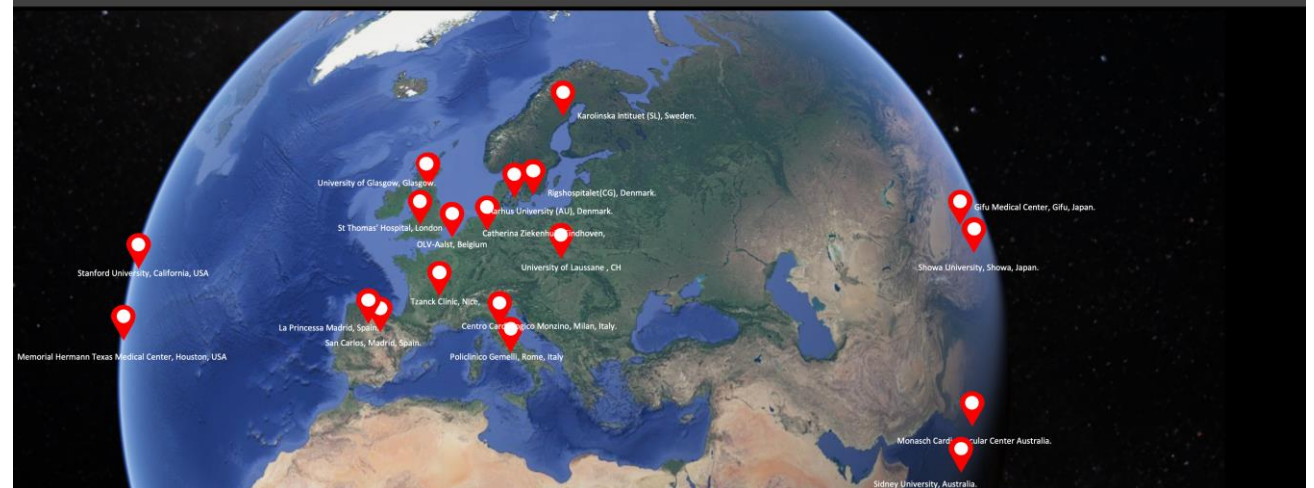
Primary objective
Predictive capacity of PPG for
Post-PCI FFR

Secondary objectives

Patient reported and clinical outcomes stratified by focal and diffuse disease
at 1, 2, and 3 years

23 Clinical Sites

PPG GLOBAL



Opted for medical treatment!

