



Comparison of the polymer-free biolimus-coated BioFreedom stent with the thin-strut biodegradable polymer sirolimus-eluting Orsiro stent in an all-comers population treated with percutaneous coronary intervention: Rationale and design of the randomized SORT OUT IX trial

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Background In patients with increased bleeding risk during dual antiplatelet therapy, the biolimus A9-coated BioFreedom, a stainless steel drug-coated stent devoid of polymer, has shown superiority compared to a bare-metal stent. The aim of this study was to investigate whether the polymer-free biolimus A9-coated BioFreedom is noninferior to a modern thin-strut biodegradable polymer cobalt-chromium sirolimus-eluting Orsiro stent in an all-comers patient population treated with percutaneous coronary intervention.

Methods The multicenter SORT OUT IX trial (NCT02623140) randomly assigned all-comers patients to treatment with the BioFreedom drug-coated stent or the biodegradable polymer Orsiro stent in 4 Danish University Hospitals. The primary end point target lesion failure is a composite of cardiac death, myocardial infarction (not related to other than index lesion), or target lesion revascularization within 12 months. Clinically driven event detection based on Danish registries will be used and continue through 5 years. Assuming an event rate of 4.2% in each stent group, 1,563 patients in each treatment arm will provide 90% power to detect noninferiority of the drug-coated BioFreedom stent with a noninferiority margin of 2.1%.

Results A total of 3,150 patients have been randomized and enrolled in the study.

Conclusions The SORT OUT IX trial will determine whether the drug-coated BioFreedom stent is noninferior to a modern biodegradable polymer Orsiro stent. (*Am Heart J* 2019;213:1-7.)

In percutaneous coronary intervention (PCI) with drug-eluting stent (DES), the durable polymer used for first- and second-generation DESs has been suspected as a

potential trigger of vessel wall inflammation and late adverse outcomes.¹ Hence, newer-generation DESs with either biodegradable polymers or more biocompatible durable polymers, which have the potential to abolish these late events, have been developed.²⁻⁵ The target lesion failure rate for the biodegradable polymer sirolimus-eluting Orsiro stent was noninferior to the gold standard everolimus-eluting stents in the BIOSCIENCE³ trial and noninferior to the biodegradable polymer biolimus-eluting Nobori stent in the SORT OUT VII trial.⁶ A polymer-free and carrier-free biolimus A9-coated BioFreedom stent has been developed, which is a highly lipophilic sirolimus analogue that transfers the biolimus A9 into the vessel wall over a period of 1 month.⁷ Compared to the biodegradable polymer sirolimus-eluting Orsiro stent, the stents properties differ in the

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following: (1) the biolimus A9 BioFreedom stent is polymer free, and the sirolimus-eluting Orsiro stent has a silicon carbide coating and a circumferential polymer coating where the polymer degradation is taking place after 12-24 months; (2) the biolimus A9 BioFreedom stent has thicker stent struts (120 μm compared to the 60-80 μm for the sirolimus-eluting Orsiro stent; and (3) faster drug release (1 month vs 12 weeks). The BioFreedom stent has shown superiority to a bare-metal stent (BMS) in patients treated with only 1 month of dual antiplatelet therapy (DAPT).^{7,8} However, it has not previously been studied if the BioFreedom stent has similar outcome results as a modern DES. In the SORT OUT IX trial, we have designed a registry-based randomized controlled noninferiority trial comparing the polymer-free biolimus A9-coated BioFreedom stent with the sirolimus-eluting Orsiro stent in a population-based all-comers setting using registry detection of clinically driven events.

Methods

Patients and study design

SORT OUT IX is a randomized, multicenter, single-blind, all-comers, 2-arm, noninferiority trial comparing the polymer-free biolimus A9-coated BioFreedom to the biodegradable polymer cobalt-chromium sirolimus-eluting Orsiro stent in patients treated with PCI. Patients were eligible if they were at least 18 years old, had chronic stable coronary artery disease or acute coronary syndromes including ST-segment elevation myocardial infarction (MI), and had at least 1 coronary lesion with more than 50% diameter stenosis requiring treatment with a DES. If multiple lesions were treated, the allocated study stent had to be used in all lesions. No restrictions were placed on number of treated lesions, number of treated vessels, or lesion length. Exclusion criteria were life expectancy of less than 1 year; an allergy to aspirin, clopidogrel, ticagrelor, sirolimus, or biolimus; participation in another randomized stent trial; or inability to provide written informed consent. The trial is registered with [ClinicalTrials.gov](https://clinicaltrials.gov), NCT02623140, and the study protocol was approved by the Danish Research Ethics Committee (S-20150132) and The Danish Data Protection Agency (15/47707).

Informed consent and randomization

Between December 2015 and April 2017, a total of 3,150 patients were randomly assigned to treatment with polymer-free biolimus A9-coated BioFreedom or biodegradable polymer cobalt-chromium sirolimus-eluting Orsiro stent at 4 Danish sites: 3 sites in Western Denmark (Odense University Hospital, Aarhus University Hospital, and Aalborg University Hospital) and the Copenhagen University Hospital (Rigshospitalet). All patients signed the informed consent before randomization. Patients were enrolled by the investigators and randomly allocated to

treatment groups after diagnostic coronary angiography and before PCI. Block randomization by center (permuted blocks of random sizes [2/4/6]) was used to assign patients in a 1:1 ratio to receive the polymer-free biolimus A9-coated BioFreedom stent (Biosensors, Morges, Switzerland) or the biodegradable polymer cobalt-chromium sirolimus-eluting Orsiro stent (Biotronik, Bülach, Switzerland). An independent organization computer-generated the allocation sequence, stratified by gender and presence of diabetes. Patients were assigned to treatment through a Web-based Trial Partner randomization system. Although operators were not blinded, all individuals analyzing data were masked to treatment assignment.

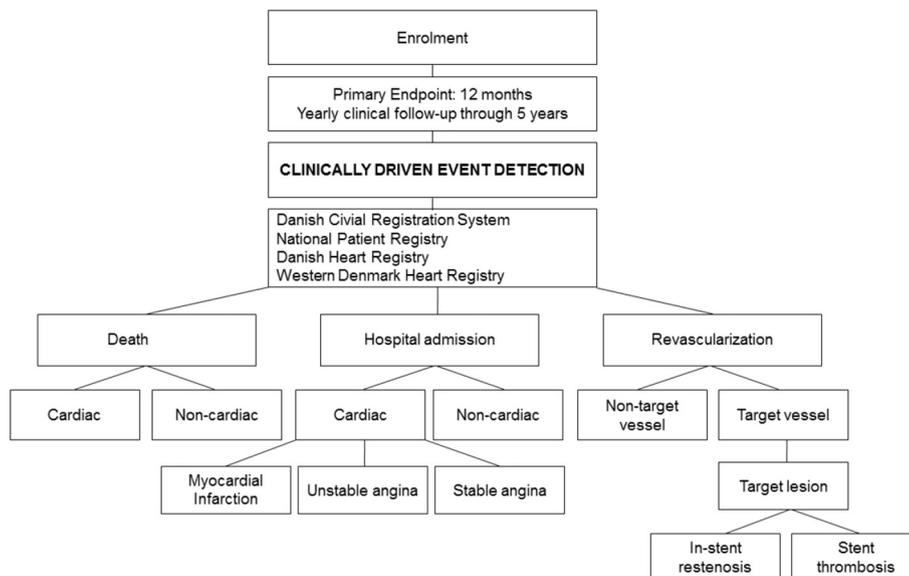
Study procedures and antithrombotic therapy

The Orsiro stent was available in 6 diameters (2.25, 2.50, 2.75, 3.00, 3.50, and 4.00 mm) and 9 lengths (9, 13, 15, 18, 22, 26, 30, 35, and 40 mm). The BioFreedom stent was available in 6 diameters (2.25, 2.50, 2.75, 3.00, 3.50, and 4.00 mm) and 8 lengths (8, 11, 14, 18, 24, 28, 33, and 38 mm). Stents were implanted according to standard techniques. Direct stenting without prior balloon dilation was allowed. Full lesion coverage was attempted by implanting 1 or more stents. DESs not specified by the random allocation scheme and BMSs were prohibited, unless the study stent could not be implanted. In such cases, other stents or balloon angioplasty alone were allowed. Before implantation, patients were treated with acetylsalicylic acid (loading dose of 300 mg) and loaded with clopidogrel 600 mg, ticagrelor 180, or prasugrel 60 mg. Combination of DAPT was left to the discretion of the participating center, whereas the duration of DAPT was recommended for 6 months in patients with stable angina pectoris and 12 months in patients with acute coronary syndromes. Unfractionated heparin dose (70-100 IU/kg) was administered before the procedure. Glycoprotein IIb/IIIa inhibitors or bivalirudin was used at the operator's discretion. All risk factors, baseline information, and procedure data are typed into the Western Denmark Heart Registry,⁹ which contains detailed patient- and procedure-specific information on all coronary angiographies, coronary interventions, and coronary bypass surgery performed at the 3 interventional and 8 noninterventional cardiac centers in Western Denmark. For patients enrolled at Rigshospitalet (using another database system), the same variables were typed into a separate database and merged with data from the Western Denmark Heart Registry for patients enrolled at the other 3 centers.

Outcome measures

The primary end point, *target lesion failure* (TLF), is a composite of cardiac death, MI (not related to other than index lesion) or clinically indicated target lesion revascularization (TLR) within 12 months. Individual components of the primary end point comprise the secondary end points:

Figure 1



Clinically driven event registration.

cardiac death; MI; clinically indicated TLR; all deaths (cardiac and noncardiac) and target vessel revascularizations; definite, probable, possible, and overall stent thrombosis according to the Academic Research Consortium definition¹⁰; and a patient-related composite end point (all deaths, all MIs, or any revascularization). Clinical follow-up will be continued through 5 years.

Definitions

Cardiac death: any death due to an evident cardiac cause, any death related to PCI, an unwitnessed death, or death from unknown causes.

Myocardial infarction: the universal definition used by the European Society of Cardiology, the American College of Cardiology, the American Heart Association, and the World Heart Federation.¹¹ Biomarkers were not routinely assessed before or after the index PCI procedure. **Myocardial infarction not related to other than index lesion:** any MI that is not clearly attributable to a nontarget vessel.

Stent thrombosis: definite, probable, or possible stent thrombosis according to the Academic Research Consortium¹⁰ definition.

Target vessel revascularization: any repeat PCI or surgical bypass of any segment within the entire major coronary vessel that was proximal or distal to a target lesion, including upstream and downstream branches, and the target lesion itself.

Target lesion revascularization: repeat revascularization caused by a more than 50% stenosis within the stent or

within a 5-mm border proximal or distal to the stent. Target vessel and target lesion revascularizations were clinically driven.

Comorbidity: For all patients, we obtained data on all hospital diagnoses from the Danish National Registry of Patients covering all Danish hospitals from 1977 until the implantation date.¹² We then computed Charlson Comorbidity Index score, which covers 19 major disease categories, including diabetes mellitus, heart failure, cerebrovascular diseases, and cancer.¹³

Clinically driven event detection was used to avoid study-induced reinterventions (Figure 1). Data on mortality, hospital admission, coronary angiography, repeat PCI, and coronary artery bypass surgery were obtained for all randomly allocated patients from the following national Danish administrative and health care registries: the Civil Registration System¹⁴; the Western Denmark Heart Registry^{9,15,16}; and the Danish National Registry of Patients,¹² which maintains records on all hospitalizations in Denmark.

The Danish National Health Service provides universal tax-supported health care, guaranteeing residents free access to general practitioners and hospitals. The Danish Civil Registration System has kept electronic records on gender, birth date, residence, emigration date, and vital status changes since 1968,¹⁴ with daily updates; the 10-digit civil registration number assigned at birth and used in all registries allows accurate record linkage. The Civil Registration System provided vital status data for our study participants and minimized loss to follow-up. The

National Registry of Causes of Deaths and the Danish National Registry of Patients provided information on causes of death and diagnoses assigned by the treating physician during hospitalizations (coded according to the *International Classification of Diseases, 10th Revision*).¹²

This methodology has been used in previous SORT OUT III-VII publications.^{6,17-20} An independent event committee, masked to treatment group assignment during the adjudication process, reviewed all end points and source documents to adjudicate causes of death, reasons for hospital admission, and diagnosis of MI. Two dedicated PCI operators at each participating center reviewed independently cine films for the event committee to classify stent thrombosis, TLR, and TVR (either with PCI or with coronary artery bypass grafting).

Statistical analysis

In analyses of every end point, follow-up will continue until the date of an end point event, death, emigration, or 12 months after stent implantation, whichever comes first. Survival curves will be constructed based on time to events, accounting for the competing risk of death. Hazard ratios will be computed using Cox proportional-hazards regression analysis. Patients treated with the Orsiro stent will be used as the reference group for the overall analyses. Subgroup analyses (diabetes and acute coronary syndrome) will be performed. Hazard ratios will be calculated for TLF at 12-month follow-up for pre-specified patient subgroups (based on baseline demographic and clinical characteristics). The intention-to-treat principle will be used in all analyses.

Sample size

The trial is powered for assessing noninferiority of the biolimus A9-coated BioFreedom stent to the thin-strut biodegradable polymer cobalt-chromium sirolimus-eluting Orsiro stent with respect to the primary end point at 12 months. An event rate of 4.2% is assumed in each stent group. With a sample size of 1,563 patients in each treatment arm, a 2-group large-sample normal approximation test of proportions with a 1-sided .050 significance level will have 90% power to detect noninferiority with a predetermined noninferiority margin of 2.1%. The sample size of 1,563 in each treatment arm assumes 0% lost-to-follow-up rate given the use of the Civil Registration System. A total number of 3,150 patients will be enrolled.

Role of the funding source

This study is investigator initiated and supported with an equal unrestricted grant from Biotronik, Bülach, Switzerland, and Biosensors Interventional Technologies Pte Ltd, Singapore. These companies did not have a role in study design, data collection, data analysis, or interpretation of

results. They also did not have access to the clinical trial database or an opportunity to review the manuscript.

Discussion

The SORT OUT IX trial will provide head-to-head randomized comparison of 2 modern DESs with different designs: the biolimus A9-coated BioFreedom, a stainless steel drug-coated stent devoid of polymer, and the thin-strut biodegradable polymer cobalt-chromium sirolimus-eluting Orsiro stent. Compared to the biolimus A9 BioFreedom stent, the biodegradable polymer sirolimus-eluting Orsiro stent has a silicon carbide coating and a circumferential polymer coating where the polymer degradation is taking place, ultrathin cobalt-chromium stent struts, and slower drug release. The sirolimus-eluting Orsiro stent has shown excellent efficacy and safety outcomes in several randomized clinical trials^{3,6,21,22} and is a particularly suitable reference device for comparative stent studies.

Among PCI-treated patients with high risk for bleeding, the BioFreedom was superior to a similar BMS in patients treated with DAPT for 1 month. Risks of MI and TLR were significantly lower in the BioFreedom-treated patients compared to patients treated with a BMS. In two-thirds of the patient population, age (>75 years) was one of the risk factors for high risk for bleeding. The 1-year rate of definite stent thrombosis was higher than seen with modern thinner-strut DES,^{3,6,21-23} and three-fourths of the definite stent thrombosis occurred early when the patients were still on DAPT without differences among the BioFreedom- and the BMS-treated patients. Safety and efficacy benefits of BioFreedom stent were maintained for 2 years.⁸

The optimal duration of DAPT in patients treated with complex lesions and/or high bleeding risk patients remains undetermined, and in addition, new stent designs using a bioabsorbable polymer might allow shorter duration of DAPT. In a recent meta-analysis, the authors concluded that stent type may partially affect the outcome, together with DAPT length.²⁴

Our study use patient-driven event detection based on Danish registries.²⁵ This registry-based randomized clinical trial design has been used in all SORT OUT trials,^{6,17-20} in the "Prevention of Contrast Induced Nephropathy with N-Acetyl Cysteine and/or Sodium Bicarbonate in Patients with ST-Segment Myocardial Infarction. A prospective, randomized, open-labelled trial" (CIN-STEMI),²⁶ and in the "Thrombus Aspiration During ST-Segment Elevation Myocardial Infarction" (TASTE) trial²⁷ and has received substantial interest as a way of undertaking large-scale, independent clinical trials. The SORT-OUT trials are the first known registry-based randomized clinical trials worldwide and also introduced this new concept in the Nordic countries.

Advantages of this approach include a substantial reduction in the expense associated with a randomized

trial because we are able to use the established registry infrastructure. Moreover, the study design provides data that are more comparable to real-life situations because of the absence of study-related intervention and participants will be exposed to the same clinical monitoring as nonstudy patients. Data on mortality (cardiac and noncardiac) are obtained from the Danish Civil Registration System¹⁴; hospital admission for MI from the Danish National Registry of Patients¹²; and basic descriptive data, coronary angiography, repeat PCI, and coronary bypass surgery from the Western Denmark Heart Registry.⁹ Patient-driven event detection based on Danish registries will result in a nearly 100% follow-up unless the patients have emigrated, which the CPR registry obtains information about with current residence of all Danish citizens.

In a population-based health care database like the Western Denmark Heart Registry, data are collected for quality-control and administrative purposes. This may reduce certain forms of bias, such as nonresponse bias, recall bias, and bias from loss to follow-up, which may influence prognostic estimates.²⁸ Also, there are considerable costs associated with conducting a randomized controlled trial. The Western Denmark Heart Registry contains detailed patient- and procedure-specific information on all coronary angiographies, coronary interventions, and coronary bypass surgical procedures performed at the 3 interventional centers in Western Denmark.

In Denmark, all citizens have a personal civil registration number assigned at birth or upon immigration.¹⁴ This unique personal identifier allows linkage of individual-level information across registries and databases. The Danish Civil Registration System is updated daily and maintains records on date of birth, death, and current residence of all Danish citizens. The Danish National Registry of Patients²⁹ contains information on all admissions and outpatient visits to the 52 Danish hospitals. For each hospital admission, the registry records dates of admission and discharge, surgical procedures performed, and up to 20 diagnoses classified according to the *International Classification of Diseases, Eighth Revision*, until the end of 1993 and *10th Revision* thereafter.¹²

Like any conventional randomized trial, the SORT OUT trials use independent end point committee adjudication. Although the Danish health care databases capture events of sufficient severity for patients to seek medical attention, these records might underestimate event rates compared with follow-up by dedicated trial staff.³⁰ However, this situation should not bias differences detected between treatment groups, and the negligible loss to follow-up probably compensated for this potential limitation.

Limitations

The primary end point is assessed after 1 year, and the TLF at 1 year may not predict the long-term outcome

with safety and efficacy after 5 years.³¹ The clinical outcomes after implantation of DESs have improved in recent years. Therefore, we expect that the event rate in our study is representative of the real event rate among this patient population. Both study stents are available on the market, and even if one of the study stents will be replaced by a newer-generation DES, both stent types have still been implanted in many patients, so the results with 1-year as well as long-term follow-up will be relevant. All patients were recommended 6-12 months of DAPT. Bleeding complications are not registered and may be underreported with registry information. Noninferiority testing in essence flips the traditional null and alternative hypotheses. Using this approach, the null hypothesis is that the new treatment is worse than the old treatment. This means that rather than assuming that there is no difference, the null hypothesis is that a difference exists and that the new treatment is inferior. As in a traditional trial, the 2 conclusions available from the statistical tests are reject or failure to reject the null hypothesis. Rejecting the null hypothesis is making the statement that the new treatment is not worse than the old treatment. This implies that the new treatment is as good or even better than the old.

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This study was an investigator initiated study and supported with an equal unrestricted grants from Biosensors, Morges Switzerland and Biotronik, Bülach, Switzerland. The companies did not have a role in study design, data collection, data analysis, or interpretation of results. They also did not have access to the clinical trial database or an opportunity to review the manuscript.

Disclosures

L. O. J. has received research grants from Terumo, Biotronik, St Jude Medical, and Biosensors to her institution and honoraria from Biotronik. E. H. C. has received research grants Biotronik and Biosensors to his institution. M. M. has received lecture and/or consulting fees from Bayer, Novo Nordisk, Bristol-Myers Squibb, Boehringer-Ingelheim, and Astra-Zeneca and a research grant from Volcano (now Philips). J. F. L. has received research grants from Biotronik and Biosensors to his institution. B. R., T. E., H. S. H., S. E. J., H. E. B., and J. K. report no conflicts of interest.

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