Fractional flow reserve versus angiography for guiding percutaneous coronary intervention: a meta-analysis

Dongfeng Zhang, Shuzheng Lv, Xiantao Song, Fei Yuan, Feng Xu, Min Zhang, Shuai Yan, Xingmei Cao

ABSTRACT

Objectives The purpose of this study was to investigate whether fractional flow reserve (FFR) should be performed for patients with coronary artery disease (CAD) to guide the percutaneous coronary intervention (PCI) strategy.

Background PCI is the most effective method to improve the outcomes of CAD. However, the proper usage of PCI has not been achieved in clinical practice.

Methods A meta-analysis was performed on angiography-guided PCI and FFR-guided PCI strategies. Prospective and retrospective studies were included when research subjects were patients with CAD undergoing PCI. The primary endpoint was the rate of major adverse cardiac events (MACE) or major adverse cardiac and cerebrovascular events (MACCE). Secondary endpoints included death, myocardial infarction (MI), repeat revascularisation and death or MI.

Results Four prospective and three retrospective studies involving 49 517 patients were included. Absolute risks of MACE/MACCE, death, MI, revascularisation and death or MI for angiography-guided PCI and FFR-guided PCI were 34.8% vs 22.5%, 15.3% vs 7.6%, 8.1% vs 4.2%, 20.4% vs 14.8%, and 21.9% vs 11.8%, respectively. The meta-analysis demonstrated that FFR-guided PCI was associated with lower MACE/MACCE, death or MI (OR: 1.71, 95% CI 1.31 to 2.23), death (OR: 1.64, 95% CI 1.37 to 1.96), MI (OR: 2.05, 95% CI 1.61 to 2.60), repeat revascularisation (OR: 1.25, 95% CI 1.09 to 1.44), and death or MI (OR: 1.84, 95% CI 1.58 to 2.15) than angiography-guided PCI strategy.

Conclusions This meta-analysis supports current guidelines advising the FFR-guided PCI strategy for CAD. PCI should only be performed when haemodynamically significant is found.

INTRODUCTION

To date, coronary artery disease (CAD) remains the leading cause of death worldwide. The standard technique for the diagnosis and treatment of anatomic CAD has been coronary angiography. However, the most important prognostic factor in patients with CAD is the presence and extent of inducible ischaemia. Performing percutaneous coronary intervention (PCI) for stenoses that are anatomically worrisome but not functionally significant will diminish the benefit of relieving ischaemia by exposing the patients to an increased stent-related risk.

Fractional Flow Reserve (FFR), defined as the ratio of pressure distal to the stenosis and aortic pressure after induced maximal hyperaemia, can identify the haemodynamically significant lesions. In patients with multivessel CAD, the FAME (Fractional Flow Reserve vs Angiography for Multivessel Evaluation) study indicates that FFR-guided revascularisation reduces the rate of adverse events when lower healthcare costs than angiography-guided revascularisation. FFR is now considered the gold standard for guiding percutaneous coronary revascularisation with class IA European Society of Cardiology and class IIA American Heart Association practice guideline recommendations. The normal value of FFR is 1.0, regardless of the patient or the specific vessel studied. Coronary lesions with FFR <0.75 are almost always functionally significant, whereas stenoses with FFR >0.80 are rarely associated with inducible ischaemia.

Despite the apparent benefits, the adoption of FFR into daily clinical practice has been limited due to the invasive nature of the procedure, the need for pharmacologic vasodilation, and risks related to instrumentation of the coronary arteries. Almost all studies comparing an angiography-guided PCI strategy with an FFR-guided one in patients with CAD are of a small scale, and most of them are retrospective studies which do not have a high evidence level. We performed this meta-analysis of contemporary clinical trials that compared the two strategies in patients with CAD to identify the advantages of FFR for guiding PCI strategy.

METHODS

Data sources and study selection

PubMed, Embase and Cochrane Controlled Trials Register searches were performed to identify articles published in English before September 2014 on angiography-guided PCI versus FFR-guided PCI for the treatment of CAD. The following medical subject headings and search terms were used: ‘fractional flow reserve’, ‘coronary artery disease’, ‘revascularization’, ‘percutaneous coronary intervention’. The references of selected articles and relevant reviews were screened for potentially suitable references by two independent investigators (SY and XC).

An initial screening of titles or abstracts was conducted, followed by full-text reviews. Studies were included if they met the following criteria: (1) a
study was eligible regardless of whether patients were referred for suspected or known CAD; (2) data had to be stratified to at least two PCI strategies for CAD, angiography-guided PCI and FFR-guided PCI and (3) studies that reported endpoint data of interest. Studies were excluded if they met any one of the following criteria: (1) studies using the same patient sample, (2) ongoing or unpublished studies and (3) data published only as an abstract or as conference proceedings. We scrutinised all eligible reports for potential overlap in the study populations to retain only the largest and latest of the overlapping studies. Differences in investigator assessments of articles were resolved by discussion with a third investigator (DZ).

Data extraction
For each eligible study, we documented the first author, year of publication, study characteristics, patient characteristics and outcomes. Data were abstracted from text, tables and figures by two investigators (FX and MZ). Authors of studies were contacted when results were unclear or when relevant data were not reported. Divergent assessments were resolved by discussing with a third investigator (FY). Study information was recorded as follows: study design, quality indicators, baseline clinical characteristics and clinical outcomes.

Definition
The primary endpoint was the rate of major adverse cardiac events (MACE) or major adverse cardiac and cerebrovascular events (MACCE) during the longest follow-up. Secondary endpoints included long-term death, myocardial infarction (MI) and revascularisation. Death or MI, which was an important clinical variable, was concluded as a secondary endpoint as well. MACE, MACCE, death, MI and revascularisation were defined as reported in each study.

Quality assessment
The quality of prospective and retrospective studies was assessed, respectively.

Statistical analysis
All statistical analysis was performed using Review Manager 5.1 (Cochrane Center, Denmark). OR and 95% CI were used as summary statistics. Heterogeneity across studies was analysed using I². An I² statistic value of >50% was defined as statistical heterogeneity. Pooled estimates were first calculated using the Mantel-Haenszel fixed-effects model, whereas the DerSimonian and Lair random-effects model was used if there was heterogeneity. Funnel plots were used to assess potential publication bias.

Exploring heterogeneity is critical for understanding the factors that influence endpoints. The following methods were used to explore sources of heterogeneity: (1) subgroup analysis (prospective and retrospective groups) and (2) sensitivity analysis performed by repeating analyses following the removal of each study, one at a time. All p values were two-tailed, with statistical significance set at p<0.05.

This study was performed according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement.

RESULTS
Study characteristics
Seven studies including 49 517 patients met our inclusion criteria, including four prospective and three retrospective studies published between 2005 and 2014. Details of the screening process for eligible studies are shown in figure 1. The study and population characteristics and a list of all studies included in the meta-analysis are presented in table 1.

Eligible patients in the FAME study have lesions that are ≥50% narrowed and that the investigator feels require stenting in ≥2 major epicardial vessels. The other study compared patients with stable angina and ≥2 single lesions located in major epicardial coronary arteries, or one major epicardial vessel and a branch originating from a major epicardial vessel. One study compared PCI strategies in patients with coronary bifurcation lesions with jailed side branches after successful drug eluting stent (DES) implantation at the main branches. One study compared angiography-guided PCI and FFR-guided PCI strategy in patients with coronary stenosis in small vessels. Another study compared the two strategies in patients with at least one intermediate stenosis of an arterial or a venous bypass graft. Quality assessment results are detailed (see online supplementary table S1 and S2). The assessment of the funnel plot suggested no publication bias (see online supplementary figure S1).

Angiography-guided PCI was the more frequently performed strategy (44 697 of 49 517 patients, 90.3%). Baseline characteristics of the included studies are presented in detail (see online supplementary table S3). Additionally, summaries of baseline mean/percentages are provided for the included studies.

Figure 1 Flow diagram of study inclusion and exclusion criteria.
Main outcomes

In the study by Di Serafino et al, MACCE was defined as the composite of all-cause death, non-fatal MI, target vessel failure, and cerebrovascular accidents. In summary, MACE/MACCE was reported in six studies. Absolute risks of MACE/MACCE were 34.8% for angiography-guided PCI and 22.5% for FFR-guided PCI. The use of FFR led to a reduction of absolute risk by 12.3%. Signs of heterogeneity were found across trials ($I^2=55\%$, 95% CI 0% to 82%), and a random-effects model was used. Compared with angiography-guided PCI, FFR-guided PCI was associated with an obviously decreased MACE/MACCE (OR: 1.71, 95% CI 1.31 to 2.23, $p<0.001$) (figure 2).

Long-term death for both strategies was reported in six studies. Absolute risks of death were 15.3% for angiography-guided PCI and 7.6% for FFR-guided PCI. The use of FFR led to a reduction of absolute risk by 7.7%. Heterogeneity was not found across trials ($I^2=0\%$, 95% CI 0% to 79%), and a fixed-effects model was used. FFR-guided PCI was associated with a decreased follow-up death in comparison with the angiography-guided PCI strategy (OR: 1.64, 95% CI 1.37 to 1.96, $p<0.001$) (figure 3). Additionally, inhospital mortality reported in the study from Frohlich et al was used for a second analysis because the long-term mortality was not available (OR: 1.68, 95% CI 1.41 to 2.01, $p<0.001$).

Absolute risks of MI were 8.1% for angiography-guided PCI and 4.2% for FFR-guided PCI. The use of FFR led to a reduction of absolute risk by 3.9%. No heterogeneity was found among the studies ($I^2=44\%$, 95% CI 0% to 79%), and a fixed-effects model was used. The difference between two groups was significant (OR: 2.05, 95% CI 1.61 to 2.60, $p<0.001$), which indicates that the angiography-guided PCI may increase the risk of MI (figure 4).

In summary, the absolute risk of revascularisation was 20.4% for angiography-guided PCI and 14.8% for FFR-guided PCI. The use of FFR led to a reduction of absolute risk by 5.7%. No heterogeneity was found among the studies ($I^2=48\%$, 95% CI 0% to 80%), and a fixed-effects model was used. FFR-guided PCI was associated with a decreased repeat revascularisation compared with the angiography-guided PCI strategy (OR: 1.25, 95% CI 1.09 to 1.44, $p=0.002$) (figure 5). Three articles reported on any revascularisation (OR: 1.76, 95% CI 1.18 to 2.63, $p=0.005$), while another three provided the details of target vessel revascularisation (TVR) (OR: 1.31, 95% CI 0.90 to 1.91, $p=0.16$).

Four studies provided information regarding death or MI. The absolute risks of death or MI were 21.9% for angiography-guided PCI and 11.8% for FFR-guided PCI. The use of FFR led to a reduction of absolute risk by 10.2%. Signs of heterogeneity were not found across trials ($I^2=0\%$, 95% CI 0% to 85%), and a fixed effects model was used. FFR-guided PCI was associated with an obvious decrease in long-term death or MI compared to the angiography-guided PCI strategy (OR: 1.84, 95% CI 1.58 to 2.13, $p<0.001$) (figure 6).

Sensitivity analysis

Subgroup analysis showed no signs of heterogeneity after excluding the retrospective studies ($I^2=48\%$, 95% CI 0% to 80%) of the FFR-guided PCI group consisted of fewer current smokers (18.2% vs 19.3%), more patients with hypertension (67.0% vs 59.6%), and used less stents per patient (1.03 vs 1.67). No differences were observed regarding age (65.8 vs 67.8 years), sex (70.7% vs 73.7%), diabetes (25.8% vs 24.5%), hypercholesterolaemia (61.1% vs 80.8%), DES (33.2% vs 67.2%), and contrast agent amount (274.2 vs 297.3 mL).
Angiography-guided PCI was associated with an increased MACE/MACCE in comparison with FFR-guided PCI strategy (OR: 1.41, 95% CI 1.06 to 1.88, p=0.02). We also performed sensitivity analyses by repeating analyses following the removal of each study one at a time (data not shown). The heterogeneity of MACE/MACCE no longer existed when the study by Puymirat et al was removed (I²=40%, 95% CI 0% to 78%). Nonetheless, FFR-guided PCI was still associated with a better outcome of MACE/MACCE than the angiography-guided PCI strategy (OR: 1.47, 95% CI 1.30 to 1.66, p<0.001) (see online supplementary figure S2). Sensitivity analyses were also performed by removing the study with the largest sample size (table 2).

DISCUSSION

This meta-analysis supports current guidelines advising the FFR performance for CAD patients, and lesions should only be treated when haemodynamic significance is found. Angiography-guided PCI should be discouraged because the visual estimation of coronary stenosis severity during coronary angiography does not reveal its haemodynamic significance even when performed and analysed by experienced cardiologists. To our knowledge, this meta-analysis is the only one comparing angiography-guided PCI and FFR-guided PCI strategies.

PCI procedures are always associated with many potential serious procedural complications such as restenosis, stent thrombosis, contrast-induced nephropathy and bleeding. PCI should only be performed in cases in which the benefit of revascularisation outweighs the risk of complications, while this benefit is mainly attributable to the reduction of myocardial ischaemia. FFR was first described by Pijls et al and De Bruyne et al. Randomised studies have resulted in the consensus that PCI should be performed selectively in coronary lesions in which FFR is positive.

The prospective, randomised, multicenter FAME study has shown a favourable 2-year clinical outcome of FFR-guided PCI compared with angiography-guided PCI in a broad population of patients. This is the only randomised study incorporated into our meta-analysis. In this study, 1005 CAD patients with multivessel disease were randomly assigned to angiography-guided PCI procedures.
Figure 4  Angiography-guided percutaneous coronary intervention (PCI) versus fractional flow reserve-guided PCI myocardial infarction.

Figure 5  Angiography-guided percutaneous coronary intervention (PCI) versus fractional flow reserve-guided PCI repeat revascularisation.

Figure 6  Angiography-guided percutaneous coronary intervention (PCI) versus fractional flow reserve-guided PCI death or myocardial infarction.
Coronary artery disease

### Table 2

<table>
<thead>
<tr>
<th>Study</th>
<th>FFR (95% CI)</th>
<th>Results</th>
<th>p Value</th>
<th>FFR (95% CI)</th>
<th>Results</th>
<th>p Value</th>
<th>FFR (95% CI)</th>
<th>Results</th>
<th>p Value</th>
<th>FFR (95% CI)</th>
<th>Results</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frohlich, 2014</td>
<td>≥0.85</td>
<td>0% (0% to 85%)</td>
<td>&lt;0.001</td>
<td>1.58 (1.21 to 2.06)</td>
<td>(0%) to 85%</td>
<td>0.01</td>
<td>39%</td>
<td>1.91 (1.41 to 2.59)</td>
<td>0% to 85%</td>
<td>0.002</td>
<td>59% (0% to 65%)</td>
<td>0% to 77%</td>
</tr>
<tr>
<td>Li, 2013</td>
<td>≥0.75</td>
<td>0% (0% to 88%)</td>
<td>&lt;0.001</td>
<td>3.57 (1.30 to 9.75)</td>
<td>0% to 85%</td>
<td>0.002</td>
<td>57% (0% to 94%)</td>
<td>1.90</td>
<td>0.02</td>
<td>57% (0% to 94%)</td>
<td>1.90</td>
<td>0.02</td>
</tr>
<tr>
<td>Li et al</td>
<td>≥0.75</td>
<td>0% (0% to 88%)</td>
<td>&lt;0.001</td>
<td>1.64 (1.37 to 1.96)</td>
<td>0% to 85%</td>
<td>0.002</td>
<td>57% (0% to 94%)</td>
<td>1.90</td>
<td>0.02</td>
<td>57% (0% to 94%)</td>
<td>1.90</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Table 2: Sensitivity analyses by removing the study with the largest sample.

MACE, major adverse cardiac events; MACCE, major adverse cardiac and cerebrovascular events; MI, myocardial infarction; RR, relative risk; RD, risk difference.

The recent introduction of a novel computational method has enabled the calculation of \( \text{FFR}_{CT} \) from cardiac CT imaging data.
without the need for additional imaging, medication, or modification of CT acquisition protocols to determine the functional significance of coronary artery lesions. Its diagnostic accuracy has been evaluated in three prospective, multicenter studies using measured FFR as the reference standard.18–20 This would greatly help patients and their physicians avoid unnecessary procedures, and will result in significant cost savings to the health system.

In patients with stable CAD and objectively documented myocardial ischaemia diagnosed by stress testing or FFR, a collateral control remains the most effective way of reducing and revascularisation should be addressed. Prevention by risk factors control remains the most effective way of reducing adverse outcomes through healthy lifestyle and medications.

Study limitations
Seven studies including 49 517 patients met our inclusion criteria. The issue of bias and heterogeneity might not be fully investigated using such small sample size. Because of limited randomised data, this meta-analysis included both prospective and retrospective studies. Therefore, more than half the included studies were retrospective analyses. The inclusion of studies with different designs and retrospective studies is likely to have induced heterogeneity in the results, as illustrated by the differences found between prospective and retrospective studies. Furthermore, lesions of different characteristics were incorporated because limited studies were found comparing angiography-guided and FFR-guided PCI. TVR was only reported in three studies. Only one study performed by Pijs et al5 included all enrolled patients in their analysis of primary and secondary endpoints according to the intention-to-treat (ITT) principle. Frohlich et al10 performed a complete case analysis, and patients with missing values were excluded. The missing data in each study will possibly induce heterogeneity and influence the results. The results and conclusions should be interpreted with these limitations in mind.

CONCLUSIONS
This meta-analysis supports current guidelines advising the FFR-guided PCI strategy for CAD. PCI should only be performed when haemodynamic significance is found. More prospective research should be performed to investigate the efficacy and safety of FFR measurement in different kinds of lesions.

Acknowledgements
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Contributors
Conceived and designed the experiments: DZ, SL, XS. Performed the experiments: DZ, FY, FX, MZ. Analysed the data: SY, XC. Wrote the paper: DZ, XS.

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Competing interests
None.

Patient consent
Obtained.

Provenance and peer review
Not commissioned; externally peer reviewed.

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REFERENCES

Key messages
What is already known on this subject?
Fractional flow reserve (FFR) is recommended to guide percutaneous coronary revascularisation. However, the adoption of FFR into daily clinical practice has been limited due to the invasive nature of the procedure, the need for pharmacologic vasodilation, and risks related to the instrumentation of the coronary arteries.

What might this study add?
FFR-guided percutaneous coronary intervention (PCI) was associated with lower major adverse cardiac events/major adverse cardiac and cerebrovascular events (OR: 1.71, 95% CI 1.31 to 2.23), death (OR: 1.64, 95% CI 1.37 to 1.96), myocardial infarction (MI) (OR: 2.05, 95% CI 1.61 to 2.60), repeat revascularisation (OR: 1.25, 95% CI 1.09 to 1.44), and death or MI (OR: 1.84, 95% CI 1.58 to 2.15) than angiography-guided PCI strategy. Percutaneous coronary revascularisation should be determined by FFR results.

How might this impact on clinical practice?
This study summarises the importance of FFR, and provides strong evidence for FFR-guided PCI.
Coronary artery disease


Supplementary figure 1. Funnel Plot of Studies Examining the Primary Endpoint

Supplementary figure 2. Sensitivity Analysis
### 3.1.1 Prospective studies

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Angiography-guided PCI Events</th>
<th>Total</th>
<th>FFR-guided PCI Events</th>
<th>Total</th>
<th>Weight</th>
<th>Odds Ratio</th>
<th>M-H. Fixed</th>
<th>95% CI</th>
<th>Odds Ratio</th>
<th>M-H. Fixed</th>
<th>95% CI</th>
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<tr>
<td>Koo 2008</td>
<td>4</td>
<td>108</td>
<td>5</td>
<td>108</td>
<td>1.1%</td>
<td>0.79 [0.21, 3.03]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pijs 2010</td>
<td>111</td>
<td>496</td>
<td>91</td>
<td>509</td>
<td>16.3%</td>
<td>1.32 [0.97, 1.81]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wongpanandu 2005</td>
<td>19</td>
<td>70</td>
<td>5</td>
<td>53</td>
<td>10%</td>
<td>3.58 [1.24, 10.33]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>674</td>
<td>670</td>
<td>18.4%</td>
<td></td>
<td></td>
<td>1.41 [1.36, 1.46]</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total events</td>
<td>134</td>
<td>101</td>
<td></td>
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<td></td>
<td></td>
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</table>

Heterogeneity: $\chi^2 = 3.82$, df = 2 ($P = 0.15$); $I^2 = 48$

Test for overall effect: $Z = 2.34$ ($P = 0.02$)

### 3.1.2 Retrospective studies

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Angiography-guided PCI Events</th>
<th>Total</th>
<th>FFR-guided PCI Events</th>
<th>Total</th>
<th>Weight</th>
<th>Odds Ratio</th>
<th>M-H. Fixed</th>
<th>95% CI</th>
<th>Odds Ratio</th>
<th>M-H. Fixed</th>
<th>95% CI</th>
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</thead>
<tbody>
<tr>
<td>Di Serafino 2013</td>
<td>77</td>
<td>158</td>
<td>18</td>
<td>65</td>
<td>3.1%</td>
<td>2.48 [1.33, 4.64]</td>
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<tr>
<td>Li 2013</td>
<td>2292</td>
<td>6206</td>
<td>311</td>
<td>1090</td>
<td>78.6%</td>
<td>1.44 [1.25, 1.69]</td>
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<td>Subtotal (95% CI)</td>
<td>6426</td>
<td>1155</td>
<td>81.6%</td>
<td></td>
<td></td>
<td>1.48 [1.29, 1.70]</td>
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<tr>
<td>Total events</td>
<td>2369</td>
<td>329</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Heterogeneity: $\chi^2 = 2.73$, df = 1 ($P = 0.10$); $I^2 = 62$

Test for overall effect: $Z = 5.61$ ($P < 0.00001$)

Total (95% CI)  7100  1825  100.0%  1.47 [1.30, 1.66]

Total events  2503  430

Heterogeneity: $\chi^2 = 6.69$, df = 4 ($P = 0.15$); $I^2 = 40$

Test for overall effect: $Z = 6.06$ ($P < 0.00001$)

Test for subgroups differences: $\chi^2 = 0.09$, df = 1 ($P = 0.76$); $I^2 = 0%$.

Favors angiography-guided  Favor FFR-guided
### Supplementary table 1. Quality of Prospective Studies

<table>
<thead>
<tr>
<th>Primary Author , Year Published</th>
<th>RCT</th>
<th>Power Calculation</th>
<th>Blinded Assessment of Outcomes</th>
<th>ITT Analysis</th>
<th>Repeat Coronary Angiography During Follow-up</th>
<th>Completed Follow-up</th>
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</thead>
<tbody>
<tr>
<td>Fröhlich, 2014</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>100%</td>
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<tr>
<td>Koo, 2008</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>98.2%</td>
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<td>Pijls, 2010</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Initially assigned strategy</td>
<td>93.6%</td>
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<td>Wongpraparat, 2005</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>89.8%</td>
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</table>

RCT = randomized clinical trial; ITT = intention-to-treat; other abbreviations as in Table 1.

### Supplementary table 2. Quality of Retrospective Studies

<table>
<thead>
<tr>
<th>Primary Author , Year Published</th>
<th>Control for Confounders</th>
<th>Blinded Assessment of Outcomes</th>
<th>Repeat Coronary Angiography During Follow-up</th>
<th>Completed Follow-up</th>
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<tbody>
<tr>
<td>Di Serafino, 2013</td>
<td>± (registry)</td>
<td>Yes</td>
<td>–</td>
<td>96%</td>
</tr>
<tr>
<td>Li, 2013</td>
<td>± (registry)</td>
<td>N/A</td>
<td>–</td>
<td>95.8%</td>
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<tr>
<td>Puymirat, 2012</td>
<td>± (registry)</td>
<td>Yes</td>
<td>–</td>
<td>97%</td>
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± = issue possibly source of bias; – = issue likely to be source of bias; other abbreviations as in Table 1.

### Supplementary table 3. Baseline Characteristics of Included Studies

<table>
<thead>
<tr>
<th>Age, Mean, yrs</th>
<th>Male, %</th>
<th>Current Smoker, %</th>
<th>Diabetes, %</th>
<th>Hypertension, %</th>
<th>Hypercholesterolem</th>
<th>Stents used per patient, n</th>
<th>DES, %</th>
<th>Contrast agent, ml</th>
<th>Cost, €</th>
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<tr>
<td>Primary Author , Year Published</td>
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<td>Fröhlich, 2014</td>
<td>65.8</td>
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<td>Koo, 2008</td>
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Prospective studies

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<th>Summary of baseline mean/percentage</th>
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DES = drug eluting stent; FFR = fractional flow reserve; N/A = not available; *median.