Drug-eluting stents (DES) have been a major advance in interventional cardiology, but evidence for using these devices does not exist for all types of lesions or for all subsets of patients. One area where data have been lacking is the indication of diseased aortocoronary saphenous vein grafts (SVGs).

A randomized trial (1) reported in this issue of the Journal narrows the evidence gap. In the SOS (Stenting Of Saphenous Vein Grafts) trial (1), the primary end point of binary restenosis was lower (9% vs. 51%, p < 0.0001) after the use of paclitaxel-eluting stents than after the use of bare-metal stents for lesions in SVGs of diameters of 2.5 to 4.0 mm. An important finding from this 80-patient study was that all-cause mortality was similar between the 2 groups at a median follow-up of 1.5 years.

Previous randomized study. Concerns about late mortality after using DES for SVG lesions emerged in an earlier randomized study. The initial publication of the RRISC (Reduction of Restenosis in Saphenous Vein Grafts) trial (2) reported that the primary end point of late loss was lower after the use of sirolimus-eluting stents than after the use of bare-metal stents for lesions in SVGs of diameters of 2.5 to 4.0 mm. An important finding from this 80-patient study was that all-cause mortality was similar between the 2 groups at a median follow-up of 1.5 years.

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miss, plaque prolapse, and progression of nontarget lesions could mitigate the clinical benefit.

**Nontarget progression.** Patients undergoing stenting of SVG lesions are at increased risk of events caused by the progression of nontarget lesions. After implantation of sirolimus-eluting stents, adverse cardiac events have been more than twice as high after treatment of SVG lesions than after treatment of native-vessel disease (11). Events after 12 months have resulted more commonly from progression of disease at untreated sites than at treated vein graft sites (12). Mortality rates have tended to be much higher after SVG intervention than after native-vessel intervention. In the landmark stent trials, the mortality rate of 7% at 6 months after SVG stenting (7) was higher than the mortality rates of 0.8% at 7 months (13) and 1.5% at 240 days after native-vessel stenting (14).

**Implications of current trials.** The 2 small but well-performed mechanistic trials (1,2) have shown that DES produce better primary angiographic end points than bare-metal stents. This does not mean that DES will produce better clinical outcomes, achieve better angiographic outcomes for all patients with SVG lesions, or even achieve the same angiographic outcomes at different times after stent implantation.

The available evidence suggests that DES are a modest advance for treating patients with SVG lesions (by way of contrast, several large randomized trials have demonstrated that embolic protection devices have been a major advance). The decision to use DES for SVG lesions remains multifaceted and depends on such factors as graft size, predicted adherence to prolonged dual antiplatelet therapy, and the increasingly dominant role of patient preference.

The use of DES for SVG lesions is part of the larger sphere of evidence-based cardiovascular medicine in which, as articulated by Dr. Robert Califf, only 15% of guidelines from the American Heart Association and the American College of Cardiology are based on solid scientific evidence (15). The universal call for additional research has already been made (4). The process of continual assessment, reevaluation, and integration of trial data defines a world that never stands still.

**REFERENCES**


**Key Words:** atherosclerosis • randomized trials • restenosis.