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# Lung volume reduction coil treatment for patients with severe emphysema: a European multicentre trial

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## ABSTRACT

**Background** The lung volume reduction (LVR) coil is a minimally invasive bronchoscopic nitinol device designed to reduce hyperinflation and improve elastic recoil in severe emphysema. We investigated the feasibility, safety and efficacy of LVR coil treatment in a prospective multicentre cohort trial in patients with severe emphysema.

**Methods** Patients were treated in 11 centres. Safety was evaluated by recording all adverse events, efficacy by the St George's Respiratory Questionnaire (SGRQ) as primary endpoint, and pulmonary function testing, modified Medical Research Council dyspnoea score (mMRC) and 6-min walk distance (6MWD) up to 12 months after the final treatment.

**Results** Sixty patients (60.9 ± 7.5 years, forced expiratory volume in 1 s (FEV<sub>1</sub>) 30.2 ± 6.3% pred) were bronchoscopically treated with coils (55 bilateral, 5 unilateral), with a median of 10 (range 5–15) coils per lobe. Within 30 days post-treatment, seven chronic obstructive pulmonary disease exacerbations (6.1%), six pneumonias (5.2%), four pneumothoraces (3.5%) and one haemoptysis (0.9%) occurred as serious adverse events. At 6 and 12 months, respectively, ΔSGRQ was -12.1 ± 12.9 and -11.1 ± 13.3 points, Δ6MWD was +29.7 ± 74.1 m and +51.4 ± 76 m, ΔFEV<sub>1</sub> was +0.11 ± 0.20 L and +0.11 ± 0.30 L, and ΔRV (residual volume) was -0.65 ± 0.90 L and -0.71 ± 0.81 L (all p < 0.01). Post hoc analyses showed significant responses for SGRQ, 6MWD and RV in patients with both heterogeneous and homogeneous emphysema.

**Conclusions** LVR coil treatment results in significant clinical improvements in patients with severe emphysema, with a good safety profile and sustained results for up to 1 year.

**Trial registration number:** NCT01328899.

## INTRODUCTION

For patients with advanced chronic obstructive pulmonary disease (COPD) who, despite optimal medical management still have severe dyspnoea, bronchoscopic lung volume reduction could be a beneficial treatment option.<sup>1–2</sup> Although lung volume reduction surgery and lung transplantation are still valid treatment modalities for patients with COPD, the use of these interventions is very limited because of strict patient selection criteria, significant morbidity and donor shortage.<sup>3–5</sup>

## Key messages

### What is the key question?

- ▶ Is lung volume reduction coil treatment feasible and does it sustainably improve quality of life and clinical outcomes in a broad group of patients with severe emphysema treated in a multicentre setting?

### What is the bottom line?

- ▶ Bronchoscopic lung volume reduction coil treatment is associated with a good safety profile and significantly improves quality of life, exercise capacity and pulmonary function in a broad group of patients with severe emphysema, with sustained results at 1 year.

### Why read on?

- ▶ Further post hoc analysis of CT scan heterogeneity showed significant responses in both heterogeneous and homogeneous emphysema, suggesting that lung volume reduction coil treatment may benefit patients with both heterogeneous and homogeneous emphysema disease distribution.

To date, bronchoscopic lung volume reduction using one-way endobronchial valves (EBV) has been the most extensively investigated technique in this field.<sup>6–8</sup> However, successful clinical outcomes from EBV therapy can only be achieved in patients with no interlobar collateral ventilation and when the one-way valves are placed to entirely block all the airways into the target lobe, which can be technically difficult due to local anatomy and in the absence of significant experience with these devices.<sup>6–8</sup> It is estimated that only about 33% of patients with severe emphysema have no collateral ventilation between the target and adjacent lobe and can thus potentially be treated using one-way valves.<sup>1</sup> This clearly shows the need for alternative bronchoscopic treatments that work independently of the presence of collateral ventilation.

In 2010 we reported the first human trial using bronchoscopically delivered nitinol lung volume reduction (LVR) coils.<sup>9</sup> Up to six shape-memory coils per lung were placed in patients with severe emphysema, resulting in moderate effects only in

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the patients with heterogeneous emphysema but without any serious adverse events. After that first trial we improved the LVR coil treatment to target the most diseased areas of the lung with approximately 10 coils placed per lobe, in order to maximise re-tensioning of the airway network. The results using this approach in 16 patients with upper lobe predominant heterogeneous emphysema have previously been published, showing feasibility and safety and also demonstrating statistically and clinically significant improvements in pulmonary function, exercise capacity and quality of life.<sup>10</sup> Surprisingly, even in this early pilot phase, two-thirds of the patients treated responded beyond the minimal clinically important differences (MCID) for forced expiratory volume in 1 s (FEV<sub>1</sub>),<sup>11</sup> residual volume (RV),<sup>12</sup> 6-min walk distance (6MWD)<sup>13</sup> and St George's Respiratory Questionnaire (SGRQ).<sup>14</sup>

Following the successful early experiences in these two pilot trials, the current study allowed further investigation into the feasibility, safety and efficacy of LVR coil treatment in a multi-centre setting in a larger group of patients.

## METHODS

This prospective open-label multicentre feasibility study was conducted in 11 hospitals in France, Germany and the Netherlands and was approved by the ethics committee at each site. The first patient was enrolled in December 2009 and the final patient in October 2011. The initial protocol proposed a follow-up period of 6 months following initial treatment. However, because the Dutch and French ethics committees required a 12-month follow-up period, the protocol was modified to require a 12-month follow-up for patients in the Netherlands and France, while maintaining the original 6-month follow-up period for patients in Germany. This paper reports on all patients in the study at both exit points.

## Patients

Patients with COPD with upper or lower lobe predominant bilateral heterogeneous emphysema on chest CT scan as judged by the treating physician were considered for inclusion. All patients were intended to be treated bilaterally, in accordance with the protocol assessment schedule. The inclusion and exclusion criteria are presented in [box 1](#).

## Lung volume reduction (LVR) coil treatment

LVR coil treatment was performed as previously described.<sup>10</sup> Briefly, the RePneu LVR coil (PneumRx, USA) ([figure 1](#)) is an implantable device composed of preformed nitinol wire which is straightened for delivery via a therapeutic flexible bronchoscope into subsegmental airways using a special delivery catheter, cartridge and loading forceps. Once in place, it is released and recovers to a non-straight predetermined shape upon deployment. Seven sizes of coil were available (70, 85, 100, 125, 150, 175 and 200 mm). All procedures were performed under general anaesthesia and the deployment of the coil was visualised under fluoroscopy. The coils were deployed with the objective of achieving equal subsegmental distribution throughout one target lobe. The contralateral procedure was performed at least 1 month after the first procedure.

## Assessments and follow-up

Screening assessments included medical history, physical examination, dyspnoea assessment by the modified Medical Research Council dyspnoea scale (mMRC), quality of life assessment by the SGRQ,<sup>15</sup> echocardiogram, pre- and post-bronchodilator

## Box 1 Main study inclusion and exclusion criteria

### Main inclusion criteria

- ▶ >35 years of age
- ▶ CT scan indicates bilateral heterogeneous emphysema
- ▶ Post-bronchodilator FEV<sub>1</sub> <45% of predicted
- ▶ Total lung capacity >100% of predicted
- ▶ RV >175% of predicted
- ▶ mMRC >2 (0–4)
- ▶ Stopped smoking for >8 weeks prior to entering the study

### Main exclusion criteria

- ▶ Change in FEV<sub>1</sub> >20% post-bronchodilator
- ▶ Tlco <20% of predicted
- ▶ History of recurrent clinically significant respiratory infection
- ▶ Pulmonary hypertension: right ventricular pressure >50 mm Hg
- ▶ Inability to walk >140 m in 6 min
- ▶ Previous LVR surgery, lung transplant or lobectomy
- ▶ Clinically significant bronchiectasis
- ▶ Giant bullae more than one-third lung volume
- ▶ Severe destructed homogeneous emphysema by CT scan
- ▶ Patient on antiplatelet agent (eg, clopidogrel) or anticoagulant therapy (eg, heparin or coumadin) or has not been weaned off prior to procedure

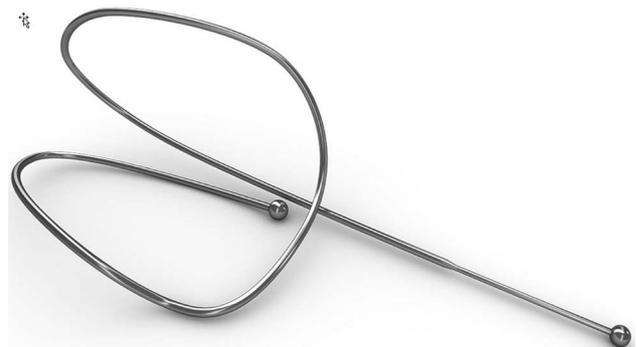
FEV<sub>1</sub>, forced expiratory volume in 1 s; LVR, lung volume reduction; mMRC, modified Medical Research Council dyspnoea score; RV, residual volume; Tlco, carbon monoxide lung transfer factor.

spirometry, lung volume measurements by body plethysmography,<sup>16</sup> 6MWT,<sup>17</sup> chest X-ray and a thoracic CT scan.

The patient was kept at least overnight after the procedure. A 1-month follow-up evaluation was performed, after which the second procedure was scheduled. Patients were then followed at 1, 3, 6 and 12 months (the latter only in France and The Netherlands).

## Primary/secondary endpoints and safety objectives

The primary efficacy endpoint was the improvement in SGRQ total score from baseline compared with the score at 6 months. The secondary efficacy endpoints were the comparison between baseline and 6 months for forced vital capacity (FVC), FEV<sub>1</sub>, RV, residual volume to total lung capacity (RV/TLC) ratio, improvement in 6MWD and mMRC score. The responder rate



**Figure 1** Fully deployed nitinol RePneu lung volume reduction coil.

at 6 months was calculated using the MCID defined for FEV<sub>1</sub>,<sup>11</sup> RV,<sup>12</sup> 6MWD<sup>13</sup> and SGRQ.<sup>14</sup>

The safety objectives were to identify the number and type of device-related and procedure-related adverse events related to the use of the LVR coil.

### Post hoc CT scan analyses

Since inclusion in this trial was based on the treating physicians' visual chest CT judgement, a post hoc analysis was performed on these CT scans to analyse the relationships between the response to LVR coil treatment at 12 months follow-up and the level of heterogeneity assessed by a blinded qualitative visual 4-point tissue destruction score scale (0–25%, 26–50%, 51–75%, >75% visible tissue destruction), as well as by calculating the percentage area of destruction below –950 Hounsfield Units (HU) between the upper and lower lobes of both lungs. Quantitative CT analyses were blinded and performed with CIRRUS Lung 13.10 (Diagnostic Image Analysis Group Nijmegen, The Netherlands; Fraunhofer MEVIS, Bremen, Germany). The lungs and lobes were automatically segmented and visually inspected. Emphysema was quantified per lobe as an emphysema score: the percentage of voxels below –950 HU.<sup>18</sup>

For the visual assessment, a patient was classified as heterogeneous if there was a difference of >1 point between ipsilateral lobes on both sides. For the computerised assessment, a patient was classified as heterogeneous when the difference for both lungs in the lung tissue destruction score was >25% at –950 HU between ipsilateral upper and lower lobes.

### Statistics

This trial was powered on the statistical significant difference in expected SGRQ total score between baseline and the 6-month follow-up time point using an  $\alpha < 0.05$  with a power of 0.90, taking a patient loss to follow-up of 10% into account.<sup>10</sup>

Data are presented as mean  $\pm$  SD, except for the presentation of the five unilateral cases and descriptive statistics on the detailed procedural results (table 2) where data are expressed as median (minimum–maximum) or median when appropriate. The statistical significance of changes from baseline was assessed by the paired Student *t* test. A linear regression analysis was performed to associate outcome at 6 months for changes in SGRQ and 6MWD, using as baseline regressors RV% pred, RV/TLC, FEV<sub>1</sub>% pred, FVC, age, carbon monoxide lung transfer factor (Tlco) and emphysema type (homogeneous or heterogeneous disease). The models were simple linear with no interactions or terms higher than first order included;  $p < 0.05$  was considered statistically significant. SAS V9.3 was used for all analyses. All data in this trial were independently monitored by a contract research organisation.

## RESULTS

### Patients and procedures

Sixty patients were enrolled between December 2009 and October 2011 and their baseline demographics are shown in table 1). A total of 115 procedures were performed (5 patients had unilateral treatment, figure 2) in which a total of 1125 LVR coils were placed. A median of 10 coils (range 5–15) was placed per lobe (table 2).

### Safety

No periprocedural serious adverse events occurred in the 115 bronchoscopies performed under general anaesthesia. No death or respiratory failure was reported. A summary of all serious and non-serious respiratory adverse events is listed in table 3.

**Table 1** Patient demographics and baseline characteristics (n=60)

Gender F/M	33/27
Age, years	60.9 $\pm$ 7.5
Pack-years	39.5 $\pm$ 18.2
BMI, kg/m <sup>2</sup>	24.92 $\pm$ 4.49
FEV <sub>1</sub> , L	0.83 $\pm$ 0.25
FEV <sub>1</sub> , % pred	30.17 $\pm$ 6.32
FVC, L	2.49 $\pm$ 0.78
FVC, % pred	73.95 $\pm$ 16.94
FEV <sub>1</sub> /FVC	0.34 $\pm$ 0.07
RV, L	5.29 $\pm$ 1.32
RV, % pred	249.2 $\pm$ 53.2
RV/TLC	65.55 $\pm$ 8.19
6MWD, m	316 $\pm$ 102
SGRQ, points	61.5 $\pm$ 14.3
Supplemental oxygen	35/60 (58%)
mMRC, points	3.0 $\pm$ 0.75

Data are shown as mean  $\pm$  SD.

BMI, body mass index; FEV<sub>1</sub>, forced expiratory volume in 1 s; FVC, forced vital capacity; mMRC, modified Medical Research Council dyspnoea score; 6MWD, 6-min walking distance; RV, residual volume; RV/TLC, residual volume to total lung capacity ratio; SGRQ, St George's Respiratory Questionnaire total score.

All events were treated and resolved with routine medical care and without sequelae.

### Efficacy

#### All patients

Of the 60 patients who were bilaterally treated, 58 were evaluable at 6 months and 34 at 12 months (24 patients from Germany exited the study at 6 months). Because the German cohort exited the study at 6 months, we segregated the data to compare patients with 1-year follow-up data against their own 6-month results to analyse the sustainability of the clinical improvements within the same population (table 4). Across key clinical parameters, FEV<sub>1</sub>% pred, RV% pred and SGRQ results were sustained while mean 6MWD actually improved between 6 and 12 months. The MCID responder percentages for FEV<sub>1</sub>, RV, 6MWD and SGRQ are shown in table 5.

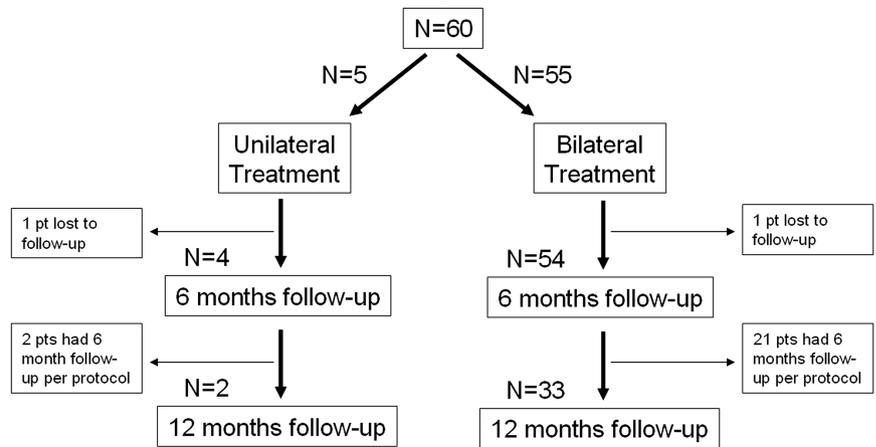
#### Unilateral patients

Five patients were treated unilaterally. The reasons for treating only one lung were: lost to follow-up in two patients; second lung on second look not suitable for treatment (bullae) in one patient; and second lung declined by two patients (one improved satisfactory and one did not want to proceed with the trial). At 6-month follow-up in four evaluable patients, the median change in FEV<sub>1</sub> was +4.7% (range –17.8% to +17.0%), median change in 6MWD was +29 m (range –46 m to +92 m) and RV and RV/TLC remained stable.

### Heterogeneous versus homogeneous disease

In the 33 bilaterally treated patients with 12 months follow-up, the post hoc visual qualitative CT score of the degree of tissue destruction classified 20 patients as heterogeneous and 13 as homogeneous. When using the CT software analysis, 16 patients were classified as heterogeneous and 17 as homogeneous. Regardless of the classification method, both heterogeneous and homogeneous patients showed significant improvement at 1 year (table 6).

Figure 2 Study flow chart.



**Upper versus lower lobe disease**

In this trial lower lobe treatment was performed in 10 patients, of whom nine could be evaluated at the 6-month endpoint. Except for FEV<sub>1</sub> (+0.04±0.08 L for lower lobe vs +0.15±0.23 L for upper lobe; p=0.026), there were no statistically significant differences in the clinical responses between patients with upper versus lower lobe disease for RV, 6MWD and SGRQ.

**Responder analysis**

To identify LVR coil treatment responders we performed a multivariable analysis for the primary endpoint SGRQ and for the 6MWD. None of the input regressors (RV% pred, RV/TLC, FEV<sub>1</sub>% pred, FVC, age, TLCO and emphysema type) were useful in associating patient outcomes at 6 months.

**DISCUSSION**

This prospective multicentre study assessed the long-term safety and improvements in patient-related outcome measures of LVR coil treatment in 60 patients with severe emphysema. The results show an acceptable safety profile associated with a significant and sustained improvement over 12 months in relevant clinical and functional parameters including FEV<sub>1</sub>, RV, 6MWD and SGRQ.

This is the largest LVR coil study to date, and also evaluated longer-term results of LVR coil treatment. In our first pilot study (n=16) using the current treatment approach (median 10 coils per lung) and coil design, significant clinical and functional improvements were seen at 6 months including SGRQ (-14.9 points), FEV<sub>1</sub> (+14.9%), RV (-11.4%) and 6MWD (+84 m) with an acceptable safety profile.<sup>10</sup> Recently, Shah *et al*<sup>19</sup> reported the results at 90 days after bilateral LVR coil treatment for 46 patients included in a randomised controlled study and demonstrated a significant improvement in SGRQ (-8.1 points), FEV<sub>1</sub> (+14%), RV (-0.51 L) and 6MWD (+51 m), with no difference in serious adverse events between treatment and control groups.

**Table 2** Lung volume reduction coil procedural results

Number of procedures	115
Procedure time, min	
Mean	49.9±23.2
Median	45.0 (20–135)
Post-procedure hospital stay, days	
Mean	2.3±2.8
Median	1.0 (0–19)
Coils per procedure, n	
Mean	9.8±1.4
Median	10 (5–15)
Total coils implanted	1125
Upper, right lobe	437
Upper, left lobe	450
Lower, right lobe	110
Lower, left lobe	121
Middle, right lobe	7
LVR coil implant size	
70 mm	5
85 mm	20
100 mm	508
125 mm	462
150 mm	101
175 mm	28
200 mm	1

Data are shown as numbers, mean±SD or median (minimum – maximum). LVR, lung volume reduction.

**Table 3** Adverse events

	Treatment–1 month		>1–6 months		>6–12 months	
	Events	Patients	Events	Patients	Events	Patients
<b>Serious respiratory adverse events</b>						
COPD exacerbation	7	7	12	10	4	3
Pneumonia	6	5	3	3	6	6
Haemoptysis	1	1	0	0	0	0
Pneumothorax	4	4	2	2	1	1
<b>Respiratory adverse events</b>						
COPD exacerbation	8	7	21	15	19	15
Pneumonia	5	3	4	3	3	3
Mild haemoptysis (<5 mL)	61	35	3	3	2	2
Cough	2	2	3	3	0	0
Transient chest pain	28	20	7	6	3	3

Adverse events presented per procedure for the first month after each procedure (115 procedures in total), for patients in the 1–6 month follow-up period (n=58) and for patients in the 6–12 month follow-up period (n=35). Events reported for both unilateral and bilateral treated patients. COPD, chronic obstructive pulmonary disease.

**Table 4** Efficacy results at 6 and 12 months

	6 Months Overall group (N=58)	6 Months 12-month follow-up group (N=34)	12 Months 12-month follow-up group (N=34)
FEV <sub>1</sub> , L	+0.11±0.20 (n=54, p<0.001)	+0.12±0.28 (n=33, p=0.021)	+0.11±0.30 (n=34, p=0.037)
FEV <sub>1</sub> , % pred (% change)	+15.36±26.68 (n=54, p<0.001)	+17.81±31.71 (n=33, p=0.003)	+16.04±35.54 (n=34, p=0.017)
FVC, L	+0.20±0.53 (n=54, p=0.008)	+0.33±0.57 (n=33, p=0.002)	+0.28±0.45 (n=34, p=0.001)
RV, L	-0.65±0.90 (n=58, p<0.001)	-0.80±1.03 (n=34, p<0.001)	-0.71±0.81 (n=34, p<0.001)
RV, % pred (% change)	-11.31±15.25 (n=58, p<0.001)	-14.38±15.42 (n=34, p<0.001)	-13.75±12.65 (n=34, p<0.001)
RV/TLC	-4.51±12.19 (n=58, p=0.007)	-6.06±8.58 (n=34, p<0.001)	-3.12±15.59 (n=34, p=0.245)
6MWD, m	+29.7±74.1 (n=56, p=0.004)	+42.4±73.5 (n=34, p=0.002)	+51.4±76.1 (n=32, p=0.003)
SGRQ, points	-12.1±12.9 (n=56, p<0.001)	-10.4±15.8 (n=33, p<0.001)	-11.1±13.3 (n=32, p<0.001)
mMRC, points	-0.6±1.2 (n=58, p<0.001)	0.8±0.9 (n=34, p<0.001)	-0.7±0.8 (n=34, p<0.001)

Efficacy at 6 months for all LVR coil treatments (n=58, overall group) and at 6 and 12 months (n=34, 12-month follow-up group columns). Results are given as change from baseline. Data are shown as mean±SD.

Data in parentheses are the numbers of actual measurements available per variable tested followed by the actual p value.

6MWD, 6-min walking distance; FEV<sub>1</sub>, forced expiratory volume in 1 s; FVC, forced vital capacity; mMRC, modified Medical Research Council dyspnoea score; RV, residual volume; SGRQ, St George's Respiratory Questionnaire total score; TLC, total lung capacity.

In the present multicentre study involving 11 centres, no serious adverse events were reported during the LVR coil treatment procedures, demonstrating procedural safety. Serious adverse events (table 3) mainly occurred in the 30 days after the procedure, with all events resolving with regular medical care and without sequelae. Our results confirm the acceptable safety profile for LVR coil treatment with a rate of adverse events similar to previous reports on LVR coil treatment.<sup>10 19</sup> The rate of post-procedure exacerbations and pneumonia is comparable to reported events with endobronchial one-way valves.<sup>6 8</sup> Importantly, the total rate of these COPD-related events following endoscopic implants did not exceed the number of exacerbations and pneumonia that were reported in the EASE trial sham bronchoscopy control group.<sup>20</sup> LVR coil specific procedure-induced events that occur are typically very mild haemoptysis or coloured sputum requiring no intervention in about 50% of subjects and temporary chest discomfort for a few days requiring either a standard painkiller regimen for a few days or no intervention at all in about one-third of subjects treated.

Regarding efficacy, our results show significant improvements in clinical and functional parameters at 6 months with a magnitude of response in line with the two recent reports on LVR coil treatment,<sup>10 19</sup> reporting on 6- and 3-month follow-up, respectively. Our study provides the first longer-term analysis of data over 12 months after bilateral LVR coil treatment and demonstrates a sustained response at 12 months. To better analyse the relevance of the efficacy results, we analysed the MCID in

FEV<sub>1</sub>,<sup>11</sup> RV,<sup>12</sup> 6MWD<sup>13</sup> and SGRQ<sup>14</sup> and found a significant responder rate at 6 and 12 months for these clinical endpoints (table 5).

The cohort trial design can, of course, induce bias. However, the results reported are higher than reported MCID for our endpoints and show similar efficacy across multiple centres. Furthermore, we have previously shown that, even in a sham-controlled bronchoscopic interventional trial design, no real placebo effect could be observed in patients with severe COPD.<sup>20</sup>

To better understand the predictors of response to LVR coil treatment, we conducted a multivariate analysis to assess the relationship between the response to treatment and baseline variables typically identified as predictors of outcome, such as hyperinflation and emphysema heterogeneity. Using the 6-month endpoints, none of the evaluated baseline variables provided a meaningful predictor of response to LVR coil treatment. Other potential variables could include nuanced emphysema phenotypes beyond heterogeneous or homogeneous classification, such as more or less small airways disease, centrilobular versus panlobular emphysema and variability in placement strategies including proximal versus distal placement within the subsegmental airways and/or the number and size of coils deployed. The current active clinical trials (NCT01822795<sup>21</sup> and NCT01608490) and future meta-analysis data of patients treated in the four European clinical studies thus far may increase the statistical power sufficiently to perform this analysis better. In our study, where broad selection criteria were purposely used in order to evaluate the effectiveness in a population of patients representative of the patients we see in daily practice, we found a large variability of response between patients. However, responder rates overall for several endpoints were already high (table 5).

The difficulty of identifying strong predictors of success has been previously demonstrated by a predictive multivariate effort completed in a much larger patient cohort (n=608) for outcome after lung volume reduction surgery. In this large group, only a very weak signal for RV/TLC and emphysema distribution could be demonstrated.<sup>22</sup>

Lung hyperinflation is a major feature of emphysema and is associated with dyspnoea, exercise intolerance and compromised daily physical activity.<sup>23 24</sup> In this study, neither baseline RV nor RV/TLC predicted the response to LVR coil treatment. This is

**Table 5** Responder rates at 6 and 12 months

Variable	MCID	6 months (%)	12 months (%)
FEV <sub>1</sub>	≥12% <sup>11</sup>	48.0	40.6
RV	≥0.35 <sup>12</sup>	64.8	57.6
6MWD	≥26 m <sup>13</sup>	52.8	60.0
SGRQ	≥4 points <sup>14</sup>	74.1	65.6
SGRQ	≥8 points	61.1	53.1

Responder rates at 6 and 12 months after bilateral lung volume reduction coil treatment using minimal clinically important differences (MCID) for forced expiratory volume in 1 s (FEV<sub>1</sub>), residual volume (RV), 6-min walking distance (6MWD) and the St George's Respiratory Questionnaire total score (SGRQ). Results are given as percentage of responders to total patients.

**Table 6** Results at 12 months after bilateral LVR coil treatment for patients classified as heterogeneous and homogeneous emphysema

	Visual CT assessment*			Digital CT assessment*		
	(12 month follow-up group)			(12 month follow-up group)		
	Heterogeneous (n=20)	Homogeneous (n=13)	p Value	Heterogeneous (n=16)	Homogeneous (n=17)	p Value
$\Delta$ FEV <sub>1</sub> , L	+0.14±0.30	+0.08±0.28	0.585	+0.18±0.32	+0.05±0.26	0.220
$\Delta$ RV, L	-0.69±0.87	-0.68±0.46	0.859	-0.75±0.78	-0.66±0.72	0.719
$\Delta$ 6MWD, m	+53.9±65.1	+46.0±67.9	0.739	+74.9±67.4	+27.9±57.8	0.049
$\Delta$ SGRQ, points	-12.9±15.1	-7.3±8.7	0.187	-12.4±13.9	-9.1±12.9	0.491

Results are given as mean±SD change from baseline. Heterogeneity and homogeneity were assessed by both a visual CT assessment (a 4-point qualitative score of the degree of tissue destruction where a difference of  $\leq 1$  point for both lungs was regarded as homogeneous) and a digital CT assessment (where the software calculated the percentage area of destruction at -950 Hounsfield Units; a difference of  $\leq 25\%$  in destruction for both lungs was regarded as homogeneous).

6MWD, 6-min walking distance; FEV<sub>1</sub>, forced expiratory volume in 1 s; LVR, lung volume reduction; RV, residual volume; SGRQ, St George's Respiratory Questionnaire total score.

\*p<0.05 for all end-points compared to baseline.

possibly due to the fact that RV >175% pred was an inclusion criterion, resulting in treatment of severe static hyperinflated patients (mean baseline RV 249.2±53.2% pred). On the other hand, the magnitude of change in RV after LVR coil treatment was associated with more favourable mean clinical and functional outcomes in this study, suggesting that RV changes may be viewed as a marker of response to treatment and that, by selecting patients with more potential for significant RV decrease, the likelihood of significant clinical benefit may be increased. The finding that RV is reduced by LVR coil treatment might be related to mechanical volume compression of lung tissue exerted by the coils, as well as improvement in elastic recoil achieved by decreasing airway resistance.<sup>25</sup>

When comparing the results for patients with upper lobe versus lower lobe treatment, no outcome differences were observed for RV, 6MWD and SGRQ. The lower FEV<sub>1</sub> results seen with lower lobe coil treatments is comparable to the experience with lung volume reduction surgery in the lower lobes where the effect on improving FEV<sub>1</sub> is also limited compared with other outcome variables.<sup>26</sup> However, because FEV<sub>1</sub> in general shows poor correlation with performance in patients with severe emphysema,<sup>27</sup> and that patient-relevant outcomes such as 6MWD and SGRQ show strong improvement even in lower lobe subjects, lower lobe treatment with coils appears to be a clinically valid treatment option with clear patient benefit. Future work will evaluate whether, as currently hypothesised, the much bigger lower lobes require a greater number of coils to optimise results.

Our post hoc CT analysis showed that a large number of patients were classified as homogeneous when using both a visual and a digital assessment, even though the inclusion criteria called for heterogeneous patients per clinicians' visual assessment. This finding should be cautiously considered, since this trial was not designed to prospectively identify homogeneous emphysema patients and the two methods of creating a heterogeneous versus a homogeneous group are arbitrary. Our results show that LVR coil treatment also benefits patients with less pronounced heterogeneous to homogeneous disease. Our data showed a statistically and clinically significant benefit for both groups compared with baseline, with overall a potentially increased mean efficacy for the heterogeneous patient group. The fact that LVR coil treatment also shows efficacy in patients with homogeneous emphysema is a very important finding, challenging the assumption that only patients with heterogeneous emphysema will respond to LVR coil treatment, as has been shown for surgical lung volume reduction<sup>28</sup> and EBV.<sup>6, 7</sup> Of note, other bronchoscopic techniques such as thermal

vapour ablation<sup>29</sup> and sealant therapy<sup>30</sup> are also restricted to upper lobe predominant heterogeneous emphysema, leaving a broad group of patients with non-upper lobe predominant and homogeneous disease without a treatment option. It can be hypothesised that LVR coil treatment is similarly efficient in both heterogeneous and homogeneous emphysema because of a different mechanism of action from true 'lung volume reducing' therapies, as the primary mechanism of action of coils appears to be mechanical re-tensioning of the airway network rather than just reducing absolute lung volume alone. However, additional studies are necessary to better characterise the mechanisms of action of coils and also to confirm the efficacy of LVR coil treatment in homogeneous emphysema, which represents a large number of patients usually excluded from other surgical and bronchoscopic lung volume reduction treatment options.

In conclusion, this study provides multicentre evidence for the feasibility, procedural safety and efficacy of LVR coil treatment in patients with both heterogeneous and homogeneous emphysema. Further studies are underway to confirm efficacy in long-term randomised trials. Additional studies are needed to improve the understanding of the predictive factors of response in order to better select the responders to LVR coil treatment.

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KK received and MH receives consultancy fees from PneumRx. D-JS and GD are physician advisors to PneumRx and received travel reimbursements and speaker fees for educational sessions. EMvR has no competing interest.

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**Patient consent** All subjects gave written informed consent.

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## REFERENCES

- Shah PL, Herth FJ. Current status of bronchoscopic lung volume reduction with endobronchial valves. *Thorax* 2014;69:280–6.
- Gasparini S, Zucchetto L, Bonifazi M, et al. Bronchoscopic treatment of emphysema: state of the art. *Respiration* 2012;84:250–63.
- Fishman A, Martinez F, Naunheim K, et al. A randomized trial comparing lung-volume-reduction surgery with medical therapy for severe emphysema. *N Engl J Med* 2003;348:2059–73.
- Criner GJ, Cordova F, Sternberg AL, et al. The NETT: part I. Lessons learned about emphysema. *Am J Respir Crit Care Med* 2011;184:763–70.
- Meyers BF, Patterson GA. Chronic obstructive pulmonary disease. 10: Bullectomy, lung volume reduction surgery, and transplantation for patients with chronic obstructive pulmonary disease. *Thorax* 2003;58:634–8.
- Sciruba FC, Ernst A, Herth FJ, et al. A randomized study of endobronchial valves for advanced emphysema. *N Engl J Med* 2010;363:1233–44.
- Herth FJ, Noppen M, Valipour A, et al. Efficacy predictors of lung volume reduction with Zephyr valves in a European cohort. *Eur Respir J* 2012;39:1334–42.
- Herth FJ, Eberhardt R, Gompelmann D, et al. Radiological and clinical outcomes of using Chartis to plan endobronchial valve treatment. *Eur Respir J* 2013;41:302–8.
- Herth FJ, Eberhardt R, Gompelmann D, et al. Bronchoscopic lung volume reduction with a dedicated coil: a clinical pilot study. *Thorax* 2010;4:225–31.
- Slebos DJ, Klooster K, Ernst A, et al. Bronchoscopic lung volume reduction coil treatment of patients with severe heterogeneous emphysema. *Chest* 2012;142:574–82.
- Donohue JF. Minimal clinically important differences in COPD lung function. *COPD* 2005;2:111–24.
- Hartman JE, Ten Hacken NH, Klooster K, et al. The minimal important difference for residual volume in patients with severe emphysema. *Eur Respir J* 2012;40:1137–41.
- Puhan MA, Chandra D, Mosenifar Z, et al. The minimal important difference of exercise tests in severe COPD. *Eur Respir J* 2011;37:784–90.
- Jones PW. St George's respiratory questionnaire: MCID. *COPD* 2005;2:75–9.
- Jones PW, Quirk FH, Baveystock CM, et al. A self-complete measure of health status for chronic airflow limitation. The St George's Respiratory Questionnaire. *Am Rev Respir Dis* 1992;145:1321–7.
- Miller MR, Crapo R, Hankinson J, et al. General considerations for lung function testing. *Eur Respir J* 2005;26:153–61.
- ATS Committee on Proficiency Standards for Clinical Pulmonary Function Laboratories. ATS statement: guidelines for the six-minute walk test. *Am J Respir Crit Care Med* 2002;166:111–7.
- van Rikxoort EM, de Hoop B, Viergever MA, et al. Automatic lung segmentation from thoracic computed tomography scans using a hybrid approach with error detection. *Med Phys* 2009;36:2934–47.
- Shah PL, Zoumot Z, Singh S, et al. Endobronchial coils for the treatment of severe emphysema with hyperinflation (RESET): a randomised controlled trial. *Lancet Respir Med* 2013;1:233–40.
- Shah PL, Slebos DJ, Cardoso PF, et al. Bronchoscopic lung-volume reduction with Exhale airway stents for emphysema (EASE trial): randomised, sham-controlled, multicentre trial. *Lancet* 2011;378:997–1005.
- Deslee G, Barbe C, Bourdin A, et al. Cost-effectiveness of lung volume reduction coil treatment in emphysema: STIC REVOLENS. *Rev Mal Respir* 2012;29:1157–64.
- Washko GR, Martinez FJ, Hoffman EA, et al. Physiological and computed tomographic predictors of outcome from lung volume reduction surgery. *Am J Respir Crit Care Med* 2010;181:494–500.
- Cooper CB. The connection between chronic obstructive pulmonary disease symptoms and hyperinflation and its impact on exercise and function. *Am J Med* 2006;119:21–31.
- García-Río F, Lores V, Mediano O, et al. Daily physical activity in patients with chronic obstructive pulmonary disease is mainly associated with dynamic hyperinflation. *Am J Respir Crit Care Med* 2009;180:506–12.
- Baraldo S, Turato G, Saetta M. Pathophysiology of the small airways in chronic obstructive pulmonary disease. *Respiration* 2012;84:89–97.
- Stoller JK, Gildea TR, Ries AL, et al. Lung volume reduction surgery in patients with emphysema and alpha-1 antitrypsin deficiency. *Ann Thorac Surg* 2007;83(Suppl 1):241–51.
- Mahler DA, Faryniarz K, Tomlinson D, et al. Impact of dyspnea and physiologic function on general health status in patients with chronic obstructive pulmonary disease. *Chest* 1992;102:395–401.
- Naunheim KS, Wood DE, Mohsenifar Z, et al. Long-term follow-up of patients receiving lung-volume-reduction surgery versus medical therapy for severe emphysema by the National Emphysema Treatment Trial Research Group. *Ann Thorac Surg* 2006;82:431–43.
- Snell G, Herth FJ, Hopkins P, et al. Bronchoscopic thermal vapour ablation therapy in the management of heterogeneous emphysema. *Eur Respir J* 2012;39:1326–33.
- Herth FJ, Gompelmann D, Stanzel F, et al. Treatment of advanced emphysema with emphysematous lung sealant (AeriSeal(R)). *Respiration* 2011;82:36–45.