A Prospective Randomized Multicenter Single Blinded Study to Assess the Safety and Effectiveness of the SELUTION SLR* 014 Drug Eluting Balloon in the Treatment of Below-the-Knee (BTK) Atherosclerotic Disease in Patients with Chronic Limb Threatening Ischemia (CLTI)

Published: 23-12-2022
Last updated: 08-02-2025

To demonstrate superior efficacy and non-inferior safety of the SELUTION SLR 014 DEB compared to PTA (uncoated balloon) in the treatment of peripheral arterial disease (PAD) in the BTK arteries in CLTI patients.

Ethical review	Approved WMO
Status	Pending
Health condition type	Skin vascular abnormalities
Study type	Interventional

Summary

ID

NL-OMON56385

Source
ToetsingOnline

Brief title
SELUTION4BTK study

Condition

- Skin vascular abnormalities
- Vascular therapeutic procedures
- Arteriosclerosis, stenosis, vascular insufficiency and necrosis

Synonym
Chronic Limb Threatening Ischemia (CLTI); Peripheral Artery Disease (PAD)

Research involving
Human

Sponsors and support

Primary sponsor: MedAlliance LLC
Source(s) of monetary or material Support: MedAlliance

Intervention

Keyword: Below-The-Knee (BTK) arteries, Drug Eluting Balloon (DEB), Percutaneous Transluminal Angioplasty (PTA), Peripheral Arterial Disease (PAD)

Outcome measures

Primary outcome

The primary efficacy endpoint is a hierarchical composite efficacy endpoint

determined by pair-wise comparisons among all subjects (Win Ratio method)

according to the following pre-specified hierarchy of adverse outcomes

evaluated at 6 months post-procedure:

• Major (above-the-ankle) amputation

• Clinically driven target lesion revascularization (CD-TLR)

• Target lesion occlusion by angiography (or in order of preference CTA, MRA or

DUS if angiography data is not available)

• Transverse View Area Loss (TVAL%) by angiography.

The primary safety endpoint is the freedom from the composite of Major Adverse

Limb Events (MALE) and all-cause perioperative death (POD) at 30 days. MALE is

defined as major (above-the-ankle) amputation or major reintervention (new

bypass graft, jump/ interposition graft revision, thrombectomy/thrombolysis) of

the index limb.

Secondary outcome

If both primary endpoints are met, the following endpoints will be tested for superiority in a sequential manner:

• Freedom from the composite of major (above-the-ankle) amputation, CD-TLR, and target lesion occlusion by angiography (if angiography is not available, the decision will be made on a secondary modality, in order of preference: CTA, MRA or DUS) [evaluated at 6 months]

• Primary patency by angiography (or CTA, MRA as last resort if angiography data is not available), defined as binary primary patency (open/occluded) as adjudicated by the angiographic core laboratory (ACL) [evaluated at 6 months].

The following exploratory secondary endpoints will be reported at 1, 6, 12, 24, and 36 months (unless otherwise indicated):

Secondary Efficacy Endpoints:

• Exploratory hierarchical composite efficacy endpoint, evaluated at 6 months and defined as a hierarchical evaluation of:

o Major (above-the-ankle) amputation;

o Clinically driven target lesion revascularization (CD-TLR);

o Target lesion occlusion by angiography (if angiography is not available, the decision will be made on a secondary modality, in order of preference: CTA, MRA or DUS);

o Binary restenosis (diameter stenosis [DS] > 50%);

• Exploratory composite efficacy endpoint, evaluated at 6, 12, 24, and 36 months and defined as a composite of the following components:

o Major (above-the-ankle) amputation;

o Clinically driven target lesion revascularization (CD-TLR);

o Target lesion occlusion by DUS;

• Primary sustained clinical improvement, defined as freedom from target limb major amputation and CD-TLR AND increase in Rutherford category from baseline.

• Secondary sustained clinical improvement, defined as freedom from target limb major amputation AND increase in Rutherford category from baseline.

• Major amputation, defined as above-the-ankle amputation of the target limb.

• Amputation-free survival, defined as freedom from all-cause mortality and major amputation.

• Primary assisted patency, defined as freedom from ACL adjudicated occlusion on angiography (or, if angiography is not available, by CTA, MRA or Duplex ultrasound core laboratory [DCL] adjudicated duplex ultrasound), irrespective of interventions for stenoses.

• Secondary patency, defined as freedom from permanent occlusion (occlusion at the last follow-up imaging) as determined by the ACL or DCL.

• CD-TLR, defined as re-intervention on target lesion(s) due to recurrent/persistent/worsening symptoms and the angiographic finding of >= 50% restenosis of target lesion by ACL measurement.

• Clinically-driven Target Vessel Revascularization (TVR), defined as re-intervention on target vessel due to recurrent/persistent/worsening symptoms and the angiographic finding of >= 50% restenosis of target vessel by ACL

measurement

• Change in Rutherford category from baseline.

• Change in ankle brachial index (ABI), toe brachial index (TBI), and toe pressures from baseline.

• Change in Quality of Life (QOL) measures from baseline (EQ-5D and VascuQol instruments)

Secondary Safety Endpoints:

• MALE, defined as the composite of major (above-the-ankle) amputation and major reintervention (new bypass graft, jump/ interposition graft revision, thrombectomy/thrombolysis) of the index limb.

• Major cardiovascular events, defined as the composite of cardiovascular death, myocardial infarction (MI), and stroke.

• All-cause mortality [evaluated at discharge, 1, 6, and 12 months, and 2-5 years]

Secondary Performance Endpoints:

• Device success, defined as successful delivery, balloon inflation, deflation and retrieval of the intact investigational device [evaluated post-procedure]

• Procedural (technical) success, defined as device success and residual diameter stenosis <= 30% on completion angiography by core lab assessment [evaluated post-procedure]

• Clinical success, defined as procedural success without procedural complications (death, above-ankle target limb amputation, thrombosis of the

target lesion or TLR) prior to discharge (evaluated at discharge defined as immediately prior to hospital discharge from the index procedure or within 7 days, whichever occurs first).

Secondary Angiographic Imaging Measures [at 6 months]:

• Subsegmental analysis: proportion of segments with binary restenosis (diameter stenosis [DS] > 50%)

• Subsegmental analysis: Mean late lumen loss (LLL) of all segments; mean %DS of all segments.

• TVAL%.

Secondary Wound Measures:

* Wound Healing, defined as core laboratory-reported status of each index wound in comparison to baseline. Descriptive categories to be captured on CRFs: 1) Improved 2) Unchanged 3) Worse 4) Healed/Complete Closure. Note: New wounds (appearing at any time after index procedure) are identified and tracked in similar fashion as index wounds, adopting the initial evaluation & images as *baseline* for future comparisons.

* Wound Ischemia, foot infection (WIfI) Classification: investigator-reported granular descriptors of Wound, Ischemia, and Foot Infection.

Inflow Lesion Measures:

The following measures will be reported in the subgroup of subjects who underwent inflow lesion treatment with a SELUTION SLR 018 DEB:

• Inflow lesion primary patency, defined as freedom from inflow lesion re-intervention, freedom from restenosis by angiographic core lab (DS > 50%), or if angiography is not available, by core lab adjudicated DUS peak systolic velocity ratio (PSVR) of <= 2.4 and absence of occlusion of the inflow lesion.
• Inflow lesion primary-assisted patency, defined as freedom from inflow lesion re-intervention, freedom from restenosis by angiographic core lab (DS > 50%), or in the absence of angiography, by DUS core lab adjudicated PSVR of <= 2.4 and absence of occlusion of the inflow lesion irrespective of interventions for stenoses.
Inflow lesion secondary patency, defined as freedom from permanent occlusion (occlusion at the last follow-up imaging) as determined by angiographic core lab or, in the absence of angiography, by the duplex ultrasound core lab.

Study description

Background summary

Peripheral Arterial Disease and CLTI
Chronic Limb Threatening Ischemia (CLTI), previously Critical Limb Ischemia (CLI), describes a clinical condition caused by Peripheral Arterial Disease (PAD) characterized by rest pain, gangrene, or ulceration of greater than 2 weeks.
PAD is common, becoming more so, and carries considerable morbidity and mortality. In 2010 more than 200 million people worldwide were considered to be living with the condition, an increase of 23.5% since 2000 largely driven by an ageing population and increasing prevalence of diabetes mellitus (DM) (1). In males living in the United States (US) PAD is present in 6.5% aged 60-69, 11.6% 70-79, and 29.4% older than 80. The equivalent rates for women are 5.3%, 11.5% and 24.3% (2). The true incidence of CLTI is difficult to estimate but a 2013 meta-analysis estimated a prevalence of 0.11-1.59% (Meta-analysis of the prevalence, incidence and natural history of critical limb ischemia (3), and analysis of Medicare and Medicaid data suggested a prevalence of 1.33% and incidence of 0.35% in Americans aged 40 and over. These data indicate 3500 new

cases per million population per year (4). Although CLTI represents <10% of those patients with PAD the condition carries significant morbidity, mortality and reduction in quality of life.
CLTI has a high risk of premature death and amputation that increases with increasing severity of disease. The clinical condition of the leg is graded using the Rutherford Categories; Rutherford 1-3 describes increasing severity of intermittent claudication (IC), Rutherford 4 includes rest pain, 5 minor tissue loss and 6 major tissue loss. From analysis of a large insurance dataset, at 4 years the risk of amputation for R4 is 12.1%, R5 35.3% and R6 67.3% (5). In 2015 there were an estimated 504,000 US patients living with an amputation due to PAD. This is projected to more than double by 2050 (6).
The risk factors for PAD include smoking, DM, hypertension, and dyslipidemia. Chronic kidney disease, present in 13.1% of the US population (6), is a strong risk factor for PAD and has a high risk of limb loss particularly when associated with DM (7).
Endovascular Intervention
All patients with PAD will have risk factor modification which includes smoking cessation, lipid lowering, antithrombotics, optimization of treatment for hypertension and diabetes, exercise where appropriate and foot care.
The viability of a limb is threatened by the complex interaction of a number of factors which include tissue perfusion, neuropathy and infection. The overall management of CLTI is therefore complex and requires specialized care from vascular surgery, cardiology, interventional radiology, diabetology, podiatry, tissue viability nurses and orthopedic surgery. However, a major goal is to improve perfusion of oxygenated blood to the distal tissues. How that is best achieved will depend upon the frailty of the patient, ongoing clinical conditions (e.g. wound sepsis), and distribution of occlusive PAD affecting the limb.
Patients with CLTI have widespread disease affecting at least 2 levels from aorto-iliac, femoro-popliteal or below knee segments. Patients with DM and CKD have an increased tendency for diffuse calcified disease affecting infrapopliteal and pedal arteries (9). There are limited data comparing open surgical revascularization against endovascular techniques but the latter has gained popularity because of the comparable safety of the procedure, shorter in-hospital stay and frailty of the patients.
Endovascular techniques are widely used in the aorto-iliac and femoropopliteal arteries. However, patients with CLTI most often require treatment of occluded below knee arteries where endovascular therapies have been less successful at maintaining patency. Percutaneous balloon angioplasty (PTA) remains the staple technique. A meta-analysis of infrapopliteal angioplasty to treat CLI showed a 1 and 36 month primary patency of 77.4 % and 48.6% (10). Outcomes are worse in complex disease with lesions longer than 8 cm having a 3 month patency of only 31% (11). Stents in general are used primarily as bail-out to treat high grade residual disease after PTA. A RCT comparing PTA vs a paclitaxel coated balloon failed to show any patency benefit but did identify a signal towards higher amputation following use of the paclitaxel coated balloon (12).
Patients with renal failure typically have disease that is calcified and

peripheral, affecting tibial and pedal arteries, and making successful revascularization difficult. Whilst some degree of renal failure is common in the adult population, patients with severe CKD, in general, have either been excluded from major studies or not analyzed separately. What data is available would suggest that PTA in patients with CKD results in higher mortality and worse clinical outcomes including amputation (13, 14).

Anti-Restenotic Drug

The majority of approved DCBs use Paclitaxel as the anti-restenotic drug. The alternative to Paclitaxel is Sirolimus, but to date there are only two CE marked Sirolimus DCBs (MedAlliance SELUTION SLR and Concept Medical*s Magic Touch).

Paclitaxel has predominated in DCBs due to its greater stability and ease of balloon coating compared to Sirolimus. Both drugs have different anti-restenotic modes of action and different safety profiles. Paclitaxel is rapidly absorbed and has long tissue retention properties(15). In contrast Sirolimus tissue absorption is slow and the drug spreads throughout the entire arterial wall where it dilutes down to sub-therapeutic levels (16) unless Sirolimus is continuously delivered over a period of time (17).

Sirolimus is considered to be cytostatic and therefore less toxic than drugs which act later in the cell cycle such as Paclitaxel (18), resulting in a wider therapeutic range with a three orders of magnitude higher margin of safety. Due to the potency of Sirolimus, only a small amount is required to achieve an anti-proliferative effect. In-vitro studies have determined that a concentration of 1 ng/ml is sufficient to inhibit DNA synthesis and cell growth (19). Furthermore, Sirolimus is one of the most widely used drugs on DES for the prevention of coronary artery restenosis. The first patient with Coronary Artery Disease (CAD) was treated with a Sirolimus Eluting Stent (CYPHER Sirolimus-eluting coronary stent, Cordis) in 1999. Since then, the CYPHER Sirolimus-eluting coronary stent has been used in nearly 4 million patients worldwide. It has consistently proven to control late loss across all vessel sizes and across a broad patient population, even in the most complex types of patients such as patients with diabetes and acute myocardial infarction, and has a proven safety profile out to 10 years (20). The key properties of the two anti-restenotic drugs are presented below (21).

Recently, safety concerns have been raised regarding the use of Paclitaxel on DCBs in the periphery. A systematic review and meta-analysis performed Katsanos et al to evaluate the use
of paclitaxel balloons and/or stents in femoropopliteal applications was published in 2018 (22). The study reviewed 28 RCTs with 4663 patients. The review identified an increased risk of death 2 years and 5 years post-treatment in patients treated with paclitaxel balloons and/or stents compared to the control arm. Despite the concerns raised by Katsanos et al, a plausible mechanism linking Paclitaxel and death remains elusive. Nonetheless, the study has prompted guidance from FDA, BFARM and MHRA.

The FDA guidance was as follows:

Based on the FDA's review of available data and the Advisory Panel conclusions,

we recommend that health care providers consider the following recommendations:
• Continue diligent monitoring of patients who have been treated with paclitaxel-coated balloons and paclitaxel-eluting stents.
• When making treatme

Study objective

To demonstrate superior efficacy and non-inferior safety of the SELUTION SLR 014 DEB compared to PTA (uncoated balloon) in the treatment of peripheral arterial disease (PAD) in the BTK arteries in CLTI patients.

Study design

This prospective, multicenter, single-blind, randomized, controlled superiority clinical trial will enroll up to 376 randomized subjects and up to 100 United States (US) registry subjects at up to 60 sites in the US, Europe, New Zealand, and Asia. A minimum of 50% of randomized subjects will be enrolled in the US.

Randomized Cohort:
Up to 376 subjects who meet all eligibility criteria will be randomized 1:1 (stratified by enrolling site and adjunctive lesion preparation therapy use) to one of two treatment arms:

• Intervention - treatment with the SELUTION SLR 014 DEB
• Control - treatment with a commercially available PTA ((uncoated balloon)

Randomization will occur after successful treatment of any significant (>= 50% diameter stenosis) inflow lesion and successful wire crossing and lesion preparation of the BTK target lesion. Inflow lesion treatment can be performed with any commercially available non-DCB, non-drug eluting stent (DES) device or with the SELUTION SLR 018 DEB.

Subjects will have clinical follow-up in hospital and at 30 days, 6 months, 12 months, and 2 and 3 years; as a last resort, if the subject is unable to travel to the site, a phone follow-up should be conducted to collect all available data. Telephone follow-up will be conducted at 4 and 5 years to assess all-cause mortality. Angiographic imaging follow-up must be performed at 6 months in all subjects, and duplex ultrasound (DUS) imaging follow-up must be performed at 6 and 12 months in all subjects. Imaging follow-up should be performed after the 6-month clinical follow-up has occurred. Note: Computed Tomography Angiography (CTA) or Magnetic Resonance Angiography (MRA)

Intervention

Patients participating in this study were selected to undergo a balloon angioplasty procedure. The primary and secondary endpoints are followed for 3

years after the procedure. Mortality from any cause is followed for 5 years after the procedure.

Study burden and risks

Potential risks associated with the SELUTION 014 DEB are those related to conducting PTA procedures for the treatment of peripheral artery lesions, using the SELUTION 014 DEB as PTA Balloon Catheter and the administration of Sirolimus. Limited published data is available for the specific risks associated with the use of Sirolimus DEBs and therefore the risk occurrence presented below is based on similar techniques, alternative therapies or competitor products.

1. Conducting PTA Procedures
The potential risks related to conducting PTA procedures for the treatment of peripheral artery lesions include, but are not limited to the following:
• Allergic reaction to contrast medium, anticoagulants and antiplatelets
• Amputation/loss of limb
• Aneurysm or pseudoaneurysm
• Arteriovenous (AV) fistula
• Arrhythmias
• Death
• Embolization
• Fever
• Hematoma
• Haemorrhage, incl. bleeding at puncture site
• Hypotension/hypertension
• Increased Procedure Time/Additional Interventions
• Inflammation
• Occlusion
• Pain or tenderness
Pneumothorax or haemothorax
• Renal failure
• Sepsis/infection
• Shock
• Stroke
• Thrombosis
• Vessel dissection, occlusion, perforation, recoil, restenosis, rupture, or spasm

2. Use of SELUTION 014 DEB
The potential additional risks related to using the SELUTION SLR* 014 DEB as PTA Balloon Catheter include, but are not limited to the following:
• Allergic reaction to balloon catheter components
• Detachment of balloon catheter components
• Embolization of balloon catheter material
• Failure of the balloon catheter to perform as intended

(inflation/deflation/retrieval)
• Failure of the balloon catheter to reach or cross the lesion
• Rupture or pinhole of the balloon
Risks associated with the SELUTION SLR* 014 DEB were identified and evaluated using an FMEA approach in accordance with EN ISO 14971:2012, Medical Devices - Application of risk management to medical devices.
The risk management analysis was completed by identifying the hazards and estimating the probabilities and severities of risks associated with energy hazards, biological hazards, environmental hazards and hazard arising from functional failure, maintenance, aging and substantial misuse. All efforts have been made to minimize these risks during the development and pre-clinical testing of the SELUTION SLR* 014 DEB. Therefore, it is believed that the risks have been reduced to as low as possible for this type of device, without compromising its intended purpose and use.

3. Administration of Sirolimus
The potential risks related to the administration of Sirolimus include, but are not limited to the following:
• Abnormal liver function tests
• Anaemia
• Arthralgias
• Diarrhoea
• Hypercholesterolemia
• Hypersensitivity, including anaphylactic/anaphylactoid type reactions
• Hypertriglyceridemia
• Hypokalaemia
• Infections
• Interstitial lung disease
• Leukopenia
• Lymphoma and other malignancies
• Thrombocytopenia
The potential risks listed above are related to the oral administration of Sirolimus at significantly higher doses than what would be delivered by the SELUTION SLR* 014 DEB locally to the artery wall. In addition, due to the low dosage and local administration significant pharmacological interactions are not anticipated.

There are no guaranteed benefits from participation in this study.
In this clinical investigation, all subjects will have a more intense medical follow-up compared with standard practice, which can be beneficial to the long term clinical outcome of study participants.
Additionally, information gained from the conduct of this study may be of benefit to others with the same medical condition.

Contacts

Public
MedAlliance LLC

4 Jenner Suite 180/190
Irvine 92618
US
Scientific
MedAlliance LLC

4 Jenner Suite 180/190
Irvine 92618
US

Trial sites

Listed location countries

Netherlands

Eligibility criteria

Age
Adults (18-64 years)
Elderly (65 years and older)

Inclusion criteria

CLINICAL INCLUSION CRITERIA
1. Subject age is >= 18 years or older depending on local regulations.
2. Subject life expectancy is >= 1 year.
3. Subject has documented chronic limb-threatening ischemia in the target limb with Rutherford classification category 4, 5 or 6 and symptoms of > 2 weeks duration.
4. Subject is willing and able to provide written informed consent and comply with study procedures and required follow-up evaluations.
5. Female subjects only: If female, then subjects of childbearing potential must be non-breastfeeding and have a negative pregnancy test <= 7 days before the procedure and be prepared to use effective contraception for 24 months after treatment.

ANGIOGRAPHIC INCLUSION CRITERIA
1. Target lesion(s) must lie distal to the tibial plateau and above the tibiotalar joint line within the BTK arteries. There is no limitation on total target lesion length. Two in-line areas of stenosis are considered multiple lesions if a) there is 2 cm of normal appearing artery between them, and b) at least 1 cm of the normal appearing artery is not treated. Otherwise, the lesions should be considered a single lesion and the entire segment should be treated with the assigned devices. If multiple SELUTION* SLR DEB are used, the total allowable drug dose per patient by summing the drug dose per individual balloons must be <= 4396µg.
2. Distal tibial and pedal runoff for each target lesion treated is patent (defined as <50% stenosis of the associated distal tibial artery and pedal outflow arteries).
3. Target vessel reference diameter(s) are >= 2mm and <= 4mm.
4. Arterial inflow (ipsilateral common iliac, external iliac, common femoral and profunda femoris arteries, SFA and popliteal artery proximal to the tibial plateau) is free from >= 50% stenosis as confirmed on angiography.
a) If >= 50% inflow stenosis of the common and external iliac, superficial femoral, and proximal popliteal arteries is found, it must be successfully treated during the index procedure.
b) Completion angiography must confirm successful treatment of inflow disease (<=30% residual stenosis, no distal embolization, and no Grade C or greater dissection) prior to pre-dilation and randomization of the BTK target lesion(s).
5. Successful pre-dilatation (defined by <= 30% residual stenosis, no distal embolization, and no Grade C or greater dissection) of all target lesions with uncoated PTA catheter sized to the reference vessel diameter must be accomplished before randomization.

Exclusion criteria

CLINICAL EXCLUSION CRITERIA
1. Subject underwent failed POBA intervention on the target lesion(s) within 3 months of the index procedure.
2. Subject underwent surgical or endovascular procedure within 14 days prior to index procedure, or is planned for surgical or endovascular procedure within 30 days following index procedure, with the exception of:
a) Diagnostic angiography prior to index procedure
b) Treatment of contralateral iliac disease and/or treatment of inflow disease of the index limb that is completed prior to randomization
c) Planned amputation of digit(s) of the index limb at the phalangeal level
d) Debridement of a foot wound
3. Subject has infrainguinal disease in the contralateral leg that requires treatment at the index procedure, or treatment planned to occur within 14 days prior to the index procedure or within 30 days after the index procedure.

4. Subject is planned to undergo major amputation of either leg.
5. Subject has undergone any prior major amputation of the ipsilateral extremity.
6. Subject is unable to tolerate dual antiplatelet therapy.
7. Subject has undergone non-coronary artery treatment with any limus based drug-coated or drug-eluting balloon/stent/other device within one year prior to index procedure.
8. Subject has undergone prior DCB, DES or BMS treatment of current target lesion(s).
9. Subject has known hypersensitivity or allergy to Sirolimus or other pharmacologic agents (such as contrast agent, heparin, bivalirudin) required for the procedure, and this hypersensitivity/allergy cannot be adequately pre-treated.
10. Subject has experienced stroke or MI within 3 months of index procedure.
11. Subject had onset of index limb symptoms less than 14 days prior to index procedure (acute limb ischemia).
12. Subject has undergone prior bypass of arteries of the index limb (except for iliac artery bypass).
13. Subject has non-atherosclerotic disease of the index limb (including aneurysmal disease, vasculitis, Buerger*s disease)
14. Subject has target lesion(s) that require (pre-)treatment with alternative therapies such as thrombolysis, thrombus aspiration, cutting/scoring/contoured balloon, stenting, laser, cryoplasty, brachytherapy, intravascular lithotripsy, or re-entry device.
15. Subject has target lesion(s) that require treatment via pedal site.
16. Subject has target lesion(s) that require access via upper extremity arteries.
17. Subject has extensive tissue loss salvageable only with complex foot reconstruction or non-traditional trans metatarsal amputations. This includes subjects with:
a) Osteomyelitis involving, more proximal to, the metatarsal head(s)
b) Any heel wound or wound with calcaneal bone involvement
c) Wounds that are deemed to be neuropathic or non-ischemic in nature
d) Wounds that would require flap coverage or complex wound management for large soft tissue defect
e) Full-thickness wounds on the dorsum of the foot with exposed tendon or bone
f) Venous or mixed wounds.
18. Subject has hypercoagulable state or disorder, or coagulopathy, including platelet count less than 100,000 per microliter.
19. Subject has systemic infection (WBC > 12,000 and febrile). [Note: Enrollment permitted after successful treatment of infection with resolution of leukocytosis and/or febrile state].
20. Subject has known immune compromise (e.g., HIV, SLE) or is receiving treatment with immune suppressive medications.
21. Subject is receiving (or is scheduled to receive) cancer treatment with surgery or chemotherapy or radiation therapy, or has metastatic malignancy.
22. Subject has acute renal insufficiency confirmed through 50% increase of

serum creatinine within 48 hours before procedure and/or decrease in urine output.
23. Subject with renal transplantation.
24. Subject has supplemental O2-dependent COPD.
25. Subject has NYHA class IV congestive heart failure.
26. Subject has unstable angina.
27. Subject is bedridden.
28. Subject has a body mass index (BMI) < 18.
29. Subject is currently participating in another investigational drug or device study that has not completed primary endpoint follow-up.
30. Subject has other anatomic, medical, social, or psychological conditions that in the investigator*s opinion could limit the patient's ability to participate in the clinical study and/or comply with the follow-up requirements.
31. Subject is unable to provide valid written consent for study participation (study participants cannot have informed consent provided by legal guardian or family member).

ANGIOGRAPHIC EXCLUSION CRITERIA
1. Presence of a previously placed stent in the target vessel(s), with the exception of:
a. Target lesion located >=30mm from stent, AND
b. <= 30% in-stent-restenosis
2. Failure to successfully cross the target lesion.
3. Residual stenosis > 30%, distal embolization, and Grade C or greater dissection after pre-dilatation of target lesion .
4. Intra-arterial thrombus, thromboembolism or atheroembolism in the index limb noted on initial diagnostic angiography or following treatment of inflow disease.
5. Requires treatment of the tibial arteries distal to the tibiotalar joint line, or treatment of the pedal arteries.

Study design

Design

Study type:	Interventional
Intervention model:	Parallel
Allocation:	Randomized controlled trial
Masking:	Single blinded (masking used)
Control:	Active
Primary purpose:	Treatment

Recruitment

NL

Recruitment status:	Pending
Start date (anticipated):	01-05-2022
Enrollment:	25
Type:	Anticipated

Medical products/devices used

Generic name:	SELUTION SLR 014 Drug Eluting Balloon
Registration:	No

Ethics review

Approved WMO Date:	23-12-2022
Application type:	First submission
Review commission:	MEC-U: Medical Research Ethics Committees United (Nieuwegein)
Approved WMO Date:	21-09-2023
Application type:	Amendment
Review commission:	MEC-U: Medical Research Ethics Committees United (Nieuwegein)
Approved WMO Date:	23-05-2024
Application type:	Amendment
Review commission:	MEC-U: Medical Research Ethics Committees United (Nieuwegein)
Approved WMO Date:	29-01-2025
Application type:	Amendment
Review commission:	MEC-U: Medical Research Ethics Committees United (Nieuwegein)

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
ClinicalTrials.gov	NCT05055297
CCMO	NL79168.000.21