EuroPCR 2026

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Congress Review

Review of EuroPCR 2026

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THE ANNUAL world-leading course in interventional cardiology, EuroPCR, welcomed 12,147 participants to Paris, France, for a dynamic 4-day event at the Palais des Congrès. Bringing together interventional cardiologists, cardiac surgeons, imaging specialists, nurses, allied healthcare professionals, researchers, innovators, and industry representatives from around the globe, the course once again provided a unique platform for sharing expertise, advancing education, and improving patient care.

The scale and reach of EuroPCR 2026 reflected the continued growth of the global interventional community. This year's programme featured more than 500 educational sessions, over 200 training workshops, 24 live cases transmitted from eight live centres, and 145 sessions streamed through the Course Platform. Supported by more than 1,100 faculty members, 1,500 presenters, 106 industry partners, and 76 international collaborations, the meeting delivered an extensive educational experience. The scientific programme was shaped by a record 3,494 submissions, highlighting the ongoing commitment of the community to innovation and evidence generation.

The Opening Ceremony was led by Course Directors Thomas Cuisset, APHM Hôpital La Timone Adultes, Marseille, France; Nieves Gonzalo, Hospital Clinico San Carlos, Madrid, Spain; Bernard Prendergast, Cleveland Clinic London, UK; and Nicolas Dumonteil, Clinique Pasteur, Toulouse, France, who joined live from Toulouse. Together, they introduced the central theme, or 'fil rouge', of EuroPCR 2026: complications. Recognising that complications are encountered by all interventional cardiologists in daily practice, the directors emphasised the meeting's core message that "education saves lives." They highlighted the importance of openly sharing not only successes, but also challenges and complications, reinforcing EuroPCR's longstanding culture of collective learning and continuous improvement.

Building on this theme, the directors outlined three principal objectives for the course: to better understand the mechanisms underlying complications, to improve strategies for their prevention, and to optimise their management when they occur. Ultimately, these goals are aimed at enhancing patient outcomes across the spectrum of cardiovascular interventions.

The ceremony also paid tribute to the pioneers whose vision helped shape EuroPCR into the world-renowned

course it is today. Jean Marco, founder of the original course established in 1989, was present during the ceremony and was recognised alongside Jean Fajadet, Clinique Pasteur, Toulouse, France; and William Wijns, The Lambe Institute for Translational Medicine and Curam, Galway, Ireland, for their enduring contributions to the field and to the EuroPCR community. The directors reflected on the importance of continuing the work of those who came before, while fostering a collaborative environment in which knowledge, experience, and expertise can be shared across generations of practitioners.

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Several important additions enriched the EuroPCR 2026 programme. A new Calcium Skills Lab offered participants a comprehensive exploration of calcified coronary artery disease, covering diagnosis, pathophysiology, imaging, treatment strategies, and complication management. A dedicated chronic total occlusion programme was also introduced, featuring live cases, abstract presentations, and case-based discussions focused on chronic total occlusion interventions and their broader relevance to complex percutaneous coronary intervention practice. Innovation remained a central focus, with the launch of a new Innovation Track designed to create continuity between Innovators Day and the wider EuroPCR programme, encompassing advances in interventional technologies, imaging, and AI. Complementing this initiative, attendees were able to visit a dedicated AI Lab for the first time, providing hands-on opportunities to explore the growing role of AI in cardiovascular intervention.

Among the scientific highlights of the meeting were three major late-breaking trials, selected by the Course Directors for their potential to influence practice worldwide. These included studies examining coronary revascularisation in patients undergoing transcatheter aortic valve implantation, outcomes following left atrial appendage closure versus direct oral anticoagulants across different age groups in patients with atrial fibrillation, and long-term mortality following revascularisation for left main coronary artery disease.

Read on for key insights from EuroPCR 2026 and the latest advances shaping the future of interventional cardiology.

LAAC Shows Comparable Outcomes to DOAC Across Age Groups in AF

NEW data from a prespecified subgroup analysis of the CHAMPION-AF trial presented at EuroPCR 2026 showed that left atrial appendage closure (LAAC) demonstrated similar efficacy to direct oral anticoagulant (DOAC) therapy across different age groups in patients with atrial fibrillation (AF), while significantly reducing non-procedural bleeding events.[1]

AF is one of the most common cardiac rhythm disorders and is associated with a substantially increased risk of stroke. Oral anticoagulants remain the standard approach for stroke prevention, but long-term treatment can increase bleeding risk and may not be suitable for all patients. LAAC has emerged as an alternative strategy that mechanically seals the left atrial appendage, a major source of clot formation in AF.

Earlier this year, the main CHAMPION-AF trial reported that device-based LAAC was non-inferior to DOAC therapy for the composite endpoint of cardiovascular death, stroke, or systemic embolism, while offering superior safety for non-procedure-related bleeding. This new subgroup analysis evaluated whether patient age influenced these outcomes.

The analysis included 1,915 patients younger than 75 years and 1,085 patients aged 75 years or older. Investigators compared the incidence of cardiovascular death, stroke, or systemic embolism over 3 years between patients treated with LAAC and those receiving DOAC therapy.

Results showed that the primary efficacy endpoint was similar between treatment groups regardless of age. In patients younger than 75 years, the hazard ratio (HR) for LAAC versus DOAC was 1.07 (95% CI: 0.67–1.71; p=0.7789). Among patients aged 75 years or older, the HR was 1.34 (95% CI: 0.85–2.12; p=0.2036), with no significant interaction between age and treatment effect.

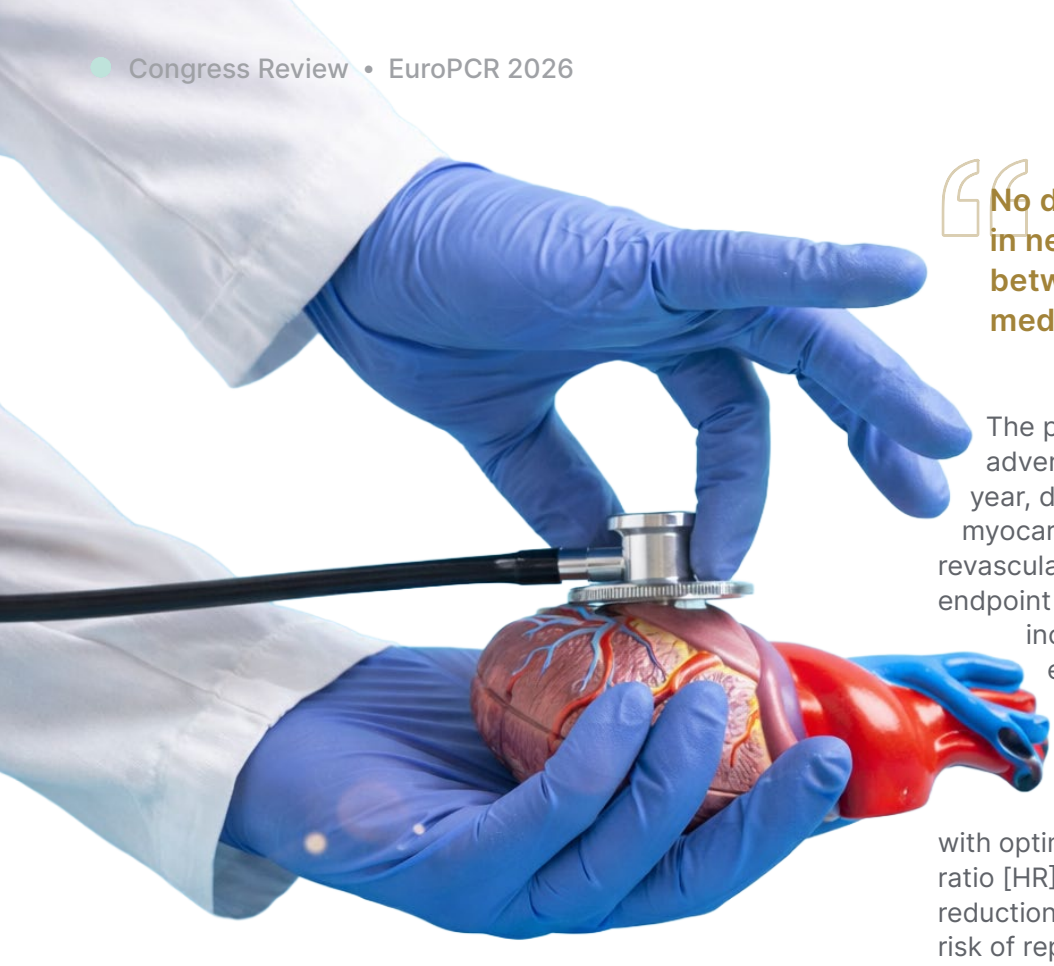
36%

In patients younger than **75 years**, bleeding risk was reduced by **36%** with LAAC compared with DOAC therapy (HR: 0.64; 95% CI: 0.50–0.82; p<0.0001)

Importantly, LAAC was associated with significantly lower rates of non-procedural major and clinically relevant non-major bleeding in both age groups. In patients younger than 75 years, bleeding risk was reduced by 36% with LAAC compared with DOAC therapy (HR: 0.64; 95% CI: 0.50–0.82; p<0.0001). Similar findings were observed in older patients (HR: 0.68; 95% CI: 0.51–0.91; p=0.0002).

Although intention-to-treat analysis suggested a higher incidence of ischaemic stroke with LAAC, this difference was no longer significant among patients who received their assigned treatment as intended. Rates of disabling ischaemic stroke remained very low and comparable across treatment groups and age categories.

The findings suggest that age alone should not exclude otherwise suitable patients from consideration for LAAC. However, investigators noted that subgroup analyses have inherent limitations, including reduced statistical power, and emphasised that decisions between LAAC and DOAC therapy should continue to be individualised through shared decision-making between clinicians and patients.



> **No difference was observed in net adverse clinical events between PCI and optimal medical treatment**

Coronary Revascularisation May Improve Outcomes After TAVI

NOVEL data from a patient-level meta-analysis, presented at EuroPCR 2026, suggest that coronary revascularisation may offer a modest clinical benefit for patients with severe aortic stenosis and coronary artery disease undergoing transcatheter aortic valve implantation (TAVI).[2]

The analysis pooled individual participant data from four contemporary RCTs that evaluated percutaneous coronary intervention (PCI) against optimal medical treatment in patients undergoing TAVI. Although the trials differed in design, all addressed ongoing uncertainty surrounding the role of coronary revascularisation in this population and the most appropriate method for assessing coronary lesions.

A total of 1,050 patients were included. Among them, 439 underwent fractional flow reserve-guided PCI, 255 underwent angiography-guided PCI, and 356 received optimal medical treatment alone.

Overall, **PCI** was associated with a lower risk of major adverse cardiac events compared with optimal medical treatment (hazard ratio: 0.70; 95% CI: 0.49–0.99)

The primary endpoint was major adverse cardiac events at 1 year, defined as all-cause death, myocardial infarction, any coronary revascularisation, and stroke. A co-primary endpoint of net adverse clinical events included major adverse cardiac events plus major bleeding.

Overall, PCI was associated with a lower risk of major adverse cardiac events compared with optimal medical treatment (hazard ratio [HR]: 0.70; 95% CI: 0.49–0.99). This reduction was primarily driven by a lower risk of repeat coronary revascularisation: (HR: 0.34; 95% CI: 0.14–0.80).

However, no difference was observed in net adverse clinical events between PCI and optimal medical treatment.

When analysed according to assessment strategy, fractional flow reserve-guided PCI was associated with lower risks of both major adverse cardiac events (HR: 0.58; 95% CI: 0.37–0.91) and net adverse clinical events (HR: 0.68; 95% CI: 0.51–0.90) compared with optimal medical treatment.

In contrast, angiography-guided PCI showed no significant differences in either endpoint compared with optimal medical treatment. Rates of major bleeding were 8.2% with fractional flow reserve-guided intervention, 13.7% with angiography-guided intervention, and 12.6% with optimal medical treatment.

These data represent the most comprehensive patient-level assessment to date of coronary revascularisation in patients with severe aortic stenosis and coronary artery disease undergoing TAVI. The findings suggest that routine intervention may offer limited benefit, while a selective physiology-informed approach could improve clinical outcomes.

Prognostic Impact of IVUS-Guided Left Main PCI at 10 Years

RESEARCH presented at EuroPCR 2026 has demonstrated a long-term analysis from the NOBLE trial examining whether intravascular ultrasound (IVUS) guidance influences outcomes following percutaneous coronary intervention (PCI) for left main coronary artery (LMCA) disease.[3]

The NOBLE trial enrolled 1,201 patients with unprotected LMCA disease across 36 centres in Northern Europe between 2008–2015. Patients were randomised to PCI or coronary artery bypass graft (CABG), with IVUS strongly recommended during PCI procedures. For this analysis, investigators compared outcomes among patients treated with CABG (n=574), PCI with post-procedural IVUS (n=443), and PCI without post-procedural IVUS (n=160). The primary endpoint was all-cause mortality at 10 years, while secondary endpoints included major adverse cardiac and cerebrovascular events (MACCE) at 5 years. Propensity-adjusted Cox regression models were used to account for baseline differences.

Complete 10-year mortality follow-up was available for 98% of participants. In crude analyses, mortality was significantly higher among patients who underwent PCI without IVUS compared with both CABG and IVUS-guided PCI (33.9% versus 23.3% and 20.6%, respectively; p=0.0047). After adjustment, mortality remained comparable between IVUS-guided PCI and CABG (hazard ratio [HR]: 0.85; 95% CI: 0.68–1.15), whereas PCI without IVUS was associated with numerically higher mortality relative to CABG (HR: 1.33; 95% CI: 0.98–1.81; overall treatment effect: p=0.031).

Despite these mortality findings, CABG remained superior for the composite MACCE endpoint. Compared with CABG, patients treated with IVUS-guided PCI experienced a 52% higher risk of MACCE (HR: 1.52; 95% CI: 1.17–1.98), while

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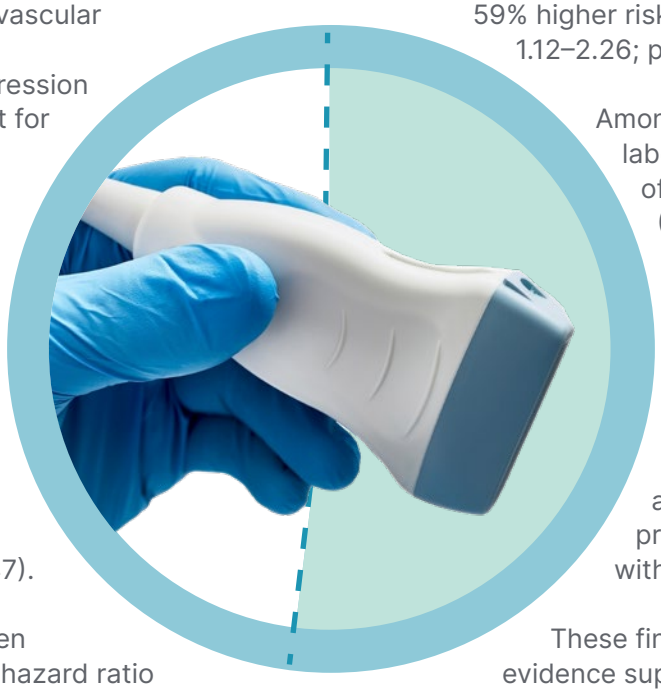
those undergoing PCI without IVUS had a 59% higher risk (HR: 1.59; 95% CI: 1.12–2.26; p=0.0025).



52%

Compared with CABG, patients treated with IVUS-guided PCI experienced a **52% higher risk of MACCE**

Among 224 patients with a core laboratory assessment of minimum stent area (MSA), median LMCA MSA was 13.5 mm². No significant association was observed between larger post-procedural MSA and long-term mortality, suggesting that factors beyond stent expansion alone may contribute to the prognostic benefit associated with IVUS use.

These findings reinforce the growing evidence supporting intracoronary imaging during complex coronary interventions. While CABG continued to provide superior protection against MACCE, IVUS-guided PCI achieved comparable long-term survival, whereas omission of IVUS was associated with worse mortality outcomes. The results highlight the importance of routine imaging guidance when performing PCI in patients with unprotected LMCA disease, and further support IVUS as a key component of contemporary left main intervention.

TAVR Versus Surgical Aortic Valve Replacement in Patients on Dialysis

SELECTING the optimal aortic valve replacement strategy for patients receiving dialysis remains particularly challenging due to their elevated procedural risk and reduced life expectancy. A large real-world analysis comparing transcatheter aortic valve replacement (TAVR), bioprosthetic surgical aortic valve replacement (SAVR), and mechanical SAVR in patients with end-stage renal disease requiring dialysis was presented at EuroPCR 2026.[4]

Using data from the United States Renal Data System (USRDS), investigators conducted a retrospective analysis of patients undergoing isolated aortic valve replacement between 2012–2020. The study included 13,527 patients, comprising 8,948 who underwent TAVR, 2,938 who received a bioprosthetic surgical valve, and 1,641 who underwent mechanical SAVR. To minimise baseline differences between groups, inverse probability of treatment weighting was applied, achieving a good balance across most demographic and clinical characteristics.

TAVR was associated with clear advantages in the perioperative period. In both unmatched and weighted analyses, patients undergoing TAVR experienced significantly lower intraoperative mortality compared with either surgical approach. Following adjustment, intraoperative mortality was 2.8% with TAVR, compared with 6.4% for bioprosthetic SAVR and 6.5% for mechanical SAVR ($p<0.01$). TAVR recipients also demonstrated lower rates of prolonged mechanical ventilation and substantially shorter ICU stays, with a median ICU stay of just 1 day compared with 5 days for both surgical groups.

Despite these early benefits, long-term outcomes favoured surgery. Kaplan–Meier analyses revealed significantly higher all-cause mortality among patients treated with TAVR compared with either form of SAVR, a finding that remained significant after adjustment. Similar results were observed when kidney transplantation was included as a competing risk, suggesting that the survival advantage associated with surgery was robust across analytical approaches.

“TAVR was associated with clear advantages in the perioperative period. In both unmatched and weighted analyses”

The investigators also evaluated cerebrovascular and bleeding outcomes. Although stroke rates initially appeared lower in the TAVR cohort, this difference was no longer significant after adjustment for baseline characteristics. In contrast, patients receiving mechanical valves experienced significantly higher bleeding rates than those treated with either TAVR or bioprosthetic SAVR, both before and after inverse probability of treatment weighting adjustment.

These findings highlight the complex balance between procedural safety and long-term durability when selecting valve replacement strategies in patients who are dependent on dialysis. While TAVR offered lower perioperative mortality, reduced respiratory complications, and shorter ICU stays, these short-term advantages did not translate into superior long-term survival. The authors suggest that TAVR may be most appropriate for patients with limited life expectancy or prohibitive surgical risk, whereas younger and fitter patients receiving dialysis may derive greater long-term benefit from surgical valve replacement.

Radial Wall Strain Predicts High-Risk STEMI Lesions

RADIAL wall strain in patients with ST-segment elevation myocardial infarction (STEMI) may help identify high-risk non-culprit lesions associated with future target-lesion failure, according to a retrospective study presented at EuroPCR.[5] The findings suggest that angiography-derived radial wall strain provides incremental prognostic value beyond standard anatomical and functional assessments.

The researchers aimed to evaluate the prognostic utility of angiography-derived radial wall strain in predicting adverse events in untreated mild-to-moderate non-culprit lesions in patients with STEMI. Radial wall strain is a novel index of plaque biomechanical deformation that reflects the mechanical stress experienced by coronary plaques.

The primary endpoint was target-lesion failure, defined as a composite of cardiac death, target-lesion myocardial infarction, and unplanned target-lesion revascularisation.

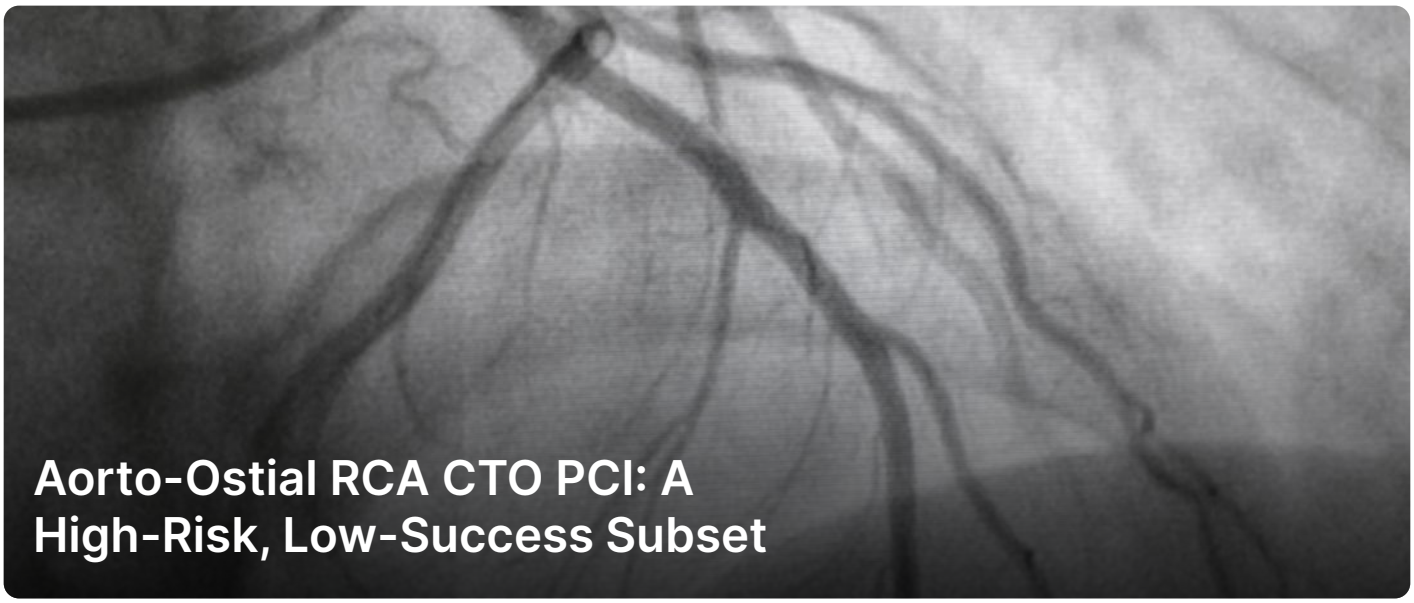
A total of 403 untreated non-culprit lesions from 243 patients with STEMI were included in the analysis. Over a median follow-up period of 3.9 years, target-lesion failure occurred in 33 lesions (8%).

Lesions with a maximum radial wall strain of ≥13% demonstrated a significantly higher incidence of target-lesion failure compared with lesions below this threshold (26.0% versus 3.0%; p<0.001). Furthermore, maximum radial wall strain independently predicted target-lesion failure, with an adjusted hazard ratio of 1.46 (95% CI: 1.32–1.61; p<0.001).

The investigators also reported that radial wall strain showed good discriminative performance, with an area under the curve of 0.79 (95% CI: 0.69–0.89; p<0.001). Importantly, radial wall strain provided significant incremental prognostic value over both quantitative coronary angiography stenosis assessment and Murray's law-based quantitative flow ratio.

The authors concluded that radial wall strain may improve risk stratification in patients with STEMI by identifying non-culprit lesions at increased risk of future adverse events. They suggested this approach could help guide intensified secondary prevention strategies and support more personalised management following STEMI.

> **The findings suggest that angiography-derived radial wall strain provides incremental prognostic value beyond standard anatomical and functional assessments**



Aorto-Ostial RCA CTO PCI: A High-Risk, Low-Success Subset

PERCUTANEOUS coronary intervention (PCI) of aorto-ostial right coronary artery (RCA) chronic total occlusions (CTO) is considered one of the most technical challenges in interventional cardiology practice. Outcomes are associated with significantly lower procedural success and higher rates of adverse events compared with non-ostial RCA CTOs. One of the largest contemporary analyses of this complex lesion subset to date, presented at EuroPCR 2026, evaluated outcomes from 26,374 patients undergoing RCA CTO PCI between 2016–2024.[6]

Of the patients evaluated, 2,850 presented with aorto-ostial lesions. Technical success was achieved in 79.6% of aorto-ostial RCA CTO procedures, a significantly lower rate than the 89.7% observed in non-aorto-ostial lesions (p<0.001). On multivariable analysis, an aorto-ostial location emerged as an independent predictor of procedural failure (adjusted odds ratio (OR): 1.77; p<0.001), reinforcing the unique anatomical and procedural constraints posed by these lesions.

Findings also pointed to a significantly higher incidence of major adverse cardiovascular events in the aorto-ostial cohort compared with non-ostial RCA CTO PCI (4.0% versus 2.7%; p=0.011).

Several lesion- and patient-specific characteristics were independently associated with technical failure in the aorto-ostial subgroup. These included a stumpless proximal cap (adjusted OR: 2.58), severe calcification (adjusted OR: 2.00), moderate-to-severe vessel tortuosity (adjusted OR: 2.24), and prior coronary artery bypass grafting (adjusted OR: 1.45).

During the presentation, the authors highlighted that current CTO scoring systems may not adequately capture the specific anatomical complexity of aorto-ostial lesions, and suggested that the development of a dedicated scoring approach could help improve procedural planning and risk stratification in this challenging subset.

Despite advances in contemporary CTO techniques, the absence of a clear proximal cap, extensive calcium burden and challenging vessel geometry continue to limit crossing success. Together, the findings underscore the importance of dedicated equipment, operator experience, and precise lesion assessment in patients presenting with aorto-ostial RCA CTOs.

Published data in this patient population remain limited. Hence, this study adds important large-scale evidence to the field with further characterisation of a lesion subset that continues to present significant procedural challenges in complex CTO PCI.

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Myocardial Bridging May Warrant Provocation Testing in Suspected INOCA

MYOCARDIAL bridging, a congenital anatomical variant in which a coronary artery travels through the myocardium rather than over its surface, has traditionally been regarded as benign, but emerging evidence presented at EuroPCR 2026 suggests it may contribute to abnormal coronary vasomotion and vasospastic symptoms in patients with ischaemia and no obstructive coronary artery disease (INOCA).[7]

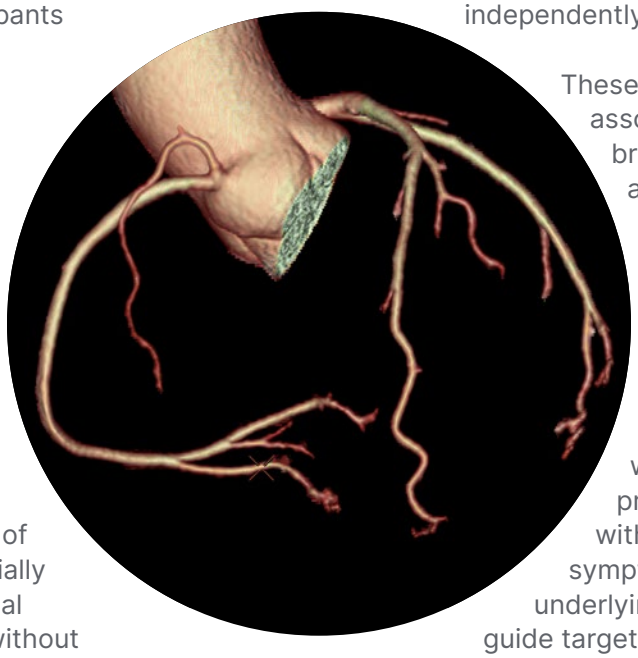
The research assessed whether myocardial bridging independently associates with vasospastic angina in patients with INOCA undergoing invasive coronary assessment, finding that it more than doubled the risk of epicardial coronary spasm.

The authors analysed data from 1,118 consecutive patients enrolled in an international multicentre cohort study who underwent protocolised invasive coronary endotyping. All participants received coronary angiography, physiological assessment, and standardised intracoronary acetylcholine provocation testing. Myocardial bridging was identified angiographically, and the primary outcome was epicardial coronary spasm during provocation testing.

Myocardial bridging was identified in 11.3% patients overall. Among 1,088 evaluable patients, epicardial coronary spasm occurred in 17.4%. Rates of epicardial spasm were substantially higher in patients with myocardial bridging compared with those without bridging (31.1% versus 15.2%; p<0.001).

In the fully adjusted regression analysis of 939 complete cases, myocardial bridging remained independently associated with epicardial coronary spasm, with an odds ratio of 2.59 (95% CI: 1.62–4.16; p<0.001). Average marginal effects analysis demonstrated that myocardial bridging increased the absolute probability of spasm by 12.7%. Notably, myocardial bridging emerged as the strongest predictor of epicardial spasm, while traditional cardiovascular risk factors were not independently significant.

> **These findings support an association between myocardial bridging and vasospastic angina in patients with INOCA, with potential implications for routine clinical assessment across European clinics**



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These findings support an association between myocardial bridging and vasospastic angina in patients with INOCA, with potential implications for routine clinical assessment across European clinics. Clinicians who identify myocardial bridging during angiography may wish to consider coronary provocation testing in patients with suspected vasospastic symptoms, as recognition of an underlying vasomotor disorder could guide targeted therapy and improve symptom management.

In terms of limitations, the study's observational design prevents conclusions regarding causality, and myocardial bridging was identified angiographically rather than with advanced imaging modalities, which may underestimate prevalence. Nevertheless, the large multicentre cohort and standardised invasive testing strengthen the relevance of the findings to clinical practice.

Operator Adherence to OCT Guidance Linked to Lower MACE

NEW data from the ILUMIEN-V AERO study, presented at EuroPCR 2026, suggest that the clinical benefit of optical coherence tomography (OCT)-guided percutaneous coronary intervention (PCI) depends not only on the use of intracoronary imaging, but on how effectively operators act on the information it provides.[8]

This analysis evaluated whether adherence to OCT-guided decision-making was associated with improved clinical outcomes following PCI. ILUMIEN-V AERO is a prospective, multicentre observational study that was conducted across 17 centres in Germany and the UK, enrolling 708 patients with 761 lesions treated using OCT-guided PCI.

Investigators assessed operator performance using a 10-component adherence index covering key stages of OCT-guided PCI, including image quality, landing-zone selection, stent sizing, identification of procedural complications, assessment of stent expansion, post-PCI optimisation, and concordance with independent core laboratory findings. Operators were classified as having high or low adherence according to the median adherence score.

Among 63 participating operators, the median adherence index was 64%. High-adherence operators treated 444 patients, while low-adherence operators treated 264 patients. Baseline lesion complexity and vessel characteristics were comparable between groups.

At 6 months, patients treated by high-adherence operators experienced significantly lower rates of major adverse cardiac events, defined as myocardial infarction, target vessel revascularisation, or all-cause death. Major adverse cardiac events occurred in 1.8% of patients treated by high-adherence operators compared with 6.1% among those treated by low-adherence operators, corresponding to an adjusted hazard ratio of 0.31 (95% CI: 0.17–0.56; p<0.001).

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Notably, the greatest differences between groups were observed in adherence to OCT-guided landing-zone selection, achievement of post-PCI optimisation, and agreement with core laboratory assessment of final PCI results. Despite these outcome differences, minimum stent area was similar between groups, suggesting that procedural success was not explained by stent expansion metrics alone.

The findings indicate that active interpretation of OCT findings and subsequent procedural decision-making may be critical determinants of clinical benefit. According to the investigators, the results support the concept that successful OCT-guided PCI requires meaningful engagement with imaging data rather than simply performing OCT or targeting optimisation thresholds.

The findings indicate that active interpretation of OCT findings and subsequent procedural decision-making may be critical determinants of clinical benefit

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