Abstract

Purpose: 5 self-expanding intracranial stents Neuroform (N), Wingspan (W), Solitaire (S), Leo(+) (L), and Enterprise (E) were subjected to an in vitro examination and comparison of their physical features and functional properties in order to better understand the clinical advantages and potential limitations of each device.

Material and Methods: The following features were examined for each stent: visual appearance, radial strength, wall apposition, bending stiffness, gator backing, kink resistance, ovalization, vessel wall coverage, cell size, ease of delivery.

Results: Given are rankings for the 5 stents: radial force at 50% oversizing: L<N<E<S<W; radial force at 15% oversizing: L<E<S<N<W; wall apposition: E<N=W<S; bending stiffness: N<L<W<S<E; gator backing: N and W only; kink resistance: N=W<E<S<L; ovalization: W<L<S<N<E; vessel wall coverage: S<E<N<W<L; cell size: L=W<E<N<S; ease of delivery: W<N<L<E<S. A comparative analysis of the in vitro test results with the clinical experience of the authors is presented in this paper.

Conclusion: The 5 stents have fundamentally different features and there is no stent that is superior in all tested aspects. The selection in an individual treatment should be based on clinical and technical requirements.
intracranial atherosclerotic stenoses is currently limited to Wingspan. Thrombectomy for acute ischemic stroke with Solitaire was anticipated early in the product history and is proving to be very effective [6].

The physical features, the dimensions, and the functional characteristics of these implants show major differences. We assume that physicians follow personal preferences and are guided by their clinical experience in the decision-making for which stent they will use in an individual case. Although some aspects of stent design have been reported in the literature, many stent features and their effect on functional properties are not well understood. We sought to determine and compare the most relevant properties of the currently available intracranial self-expanding stents. Knowledge of these features may help physicians in selecting the most appropriate stent for a given vascular anatomy and clinical purpose and enable them to anticipate its behavior and potential issues. Despite the affiliation of one senior author to ev3 (SS), we tried our best to be as neutral and balanced in the description and interpretation of our observations as possible. We do not feel that any of the examined stents is “the best” but rather think that for a given anatomy or purpose, one stent may be better suited than others.

Material and Methods

The intracranial aneurysm neck bridging stents Neuroform3 (Boston Scientific), Solitaire (ev3), Leo+ (Balt) and Enterprise (Codman Neurovascular) and in addition the stenosis-stent Wingspan (Boston Scientific) were analyzed for various functional and structural attributes. For this purpose, 1–10 units of each stent were used with varying frequencies, as listed in each test.

For visual comparison, images with identical magnification factors (10x and 40x) were taken. Official indications and available dimensions were listed.

The radial force (often termed as “outward radial force” or “radial strength”) of a stent corresponds to the force that the stents exerts on the vessel wall and that is available to support the coils inside an aneurysm. There are several methods to measure the radial force of stents. They include the “Iris Test”, the “V-Block Test”, the “Flat Plate Test”, the “Thin Film Test” and the “Pressure Chamber Test”. We collected data using the “Flat Plate Test”, which is the most commonly used method and allows us to measure radial force of all stents regardless of their design. The “Flat Plate Test” places the stent between 2 flat plates and the radial force of the stent is measured during compression of the 2 plates. In this study, radial force data were collected while the stent diameter was being expanded at 50% of the labeled diameters and measuring the uncovered surface area using a microscope and software program.

chronic outward force (also termed as outward radial force) data were collected while expanding the vessel diameter at about 85% of the labeled vessel diameter. The wall apposition describes a stent’s ability to remain in close contact with the adjacent vessel wall when deployed in a curved vessel. Stents were deployed in 3 mm tubes having a 3.9 mm centerline radius and in 4 mm tubes with a 4.4 mm centerline radius. Images were captured to visually observe the apposition of each stent with the vessel wall in the curved segment.

Conformability describes a stent’s ability to adopt the tortuous path of a vessel, instead of forcing the vessel to straighten. In this study, it was measured by quantifying bending stiffness. Bending stiffness for each stent was determined by measuring the force exerted by a stent when bent around a 12.5 mm block using mechanical testing equipment manufactured by MTS Systems Corporation. That force was multiplied by the length to obtain the bending moment.

Gator backing describes a stent’s tendency to flair its struts outward, forming protrusions, when the stent is placed around an aneurysm. Excessive gator backing may result in poor prevention of coil herniation. To visualize gator backing, stents were deployed within a 3 mm silicone tube with a 12.5 mm radius curve and visually evaluated for the extent of gator backing across the “aneurysm neck”.

Kinking is the buckling of a stent when it is bent over a curve. Kinking can result in vessel occlusion. It was measured by deploying stents within 3 mm silicone tubes with a 12.5 mm radius curve and visually evaluate the extent of kinking.

Ovalization describes the phenomenon of the stent lumen flattening when it is curved (Fig. 1). This may result in flattening of the vessel lumen and ultimately vessel occlusion. Ovalization was tested by deploying the stent into a thin-walled silicone tube and bending the vessel into a 10 mm radius arc. Measured were the minor and major axis lengths of the stent’s cross-section. Calculated was the eccentricity to quantify ovalization: The ability of a neck bridging stent to hold coils inside an aneurysm and the interaction between stent and parent vessel can be measured as the vessel wall coverage. Vessel wall coverage was calculated by deploying stents in mock vessels of indicated diameters and measuring the uncovered surface area using a microscope and software program.

Cell size finally determines the difficulty or ease to catheterize an aneurysm once its orifice is bridged by a stent. The stability of coil retention in an aneurysm is also a function of cell size. Cell sizes of the compared stents were measured under the microscope.
The method of delivery determines the required effort to deploy a stent into the target vessel. The various delivery methods were analyzed from the perspective of clinical functionality.

Results

Magnified views of the structures of the 4 stents further examined may help to understand their features and are shown in Fig. 2. Indications and available sizes are listed in Table 1.

Fig. 3 shows a comparison of the radial force as measured by the “Flat Plate Test”, of the 4 aneurysm stents and in addition of the Wingspan stent. Given is the radial force at 50% compression in the “Flat Plate Test”, with average, maximum and minimum values displayed. There is a clear rank starting with Leo + as the stent with the lowest radial strength, followed by Neuroform3, Enterprise, Solitaire and Wingspan. It may be emphasized that the Wingspan stent has about the 3-fold radial strength of the Leo + stent. 5 measurements were conducted on each stent and varying sample sizes were used for each stent (Leo + = 2, Enterprise = 4, Neuroform = 3, Wingspan = 2, Solitaire = 10).

Fig. 4 shows a comparison of the chronic outward force (outward radial force), as measured by the “Thin Film Test”, of the 4 aneurysm stents and in addition of the Wingspan stent. There is a clear rank starting with Leo + as the stent with the lowest radial force followed by Enterprise, Solitaire, Neuroform 3 and Wingspan. One measurement per stent was conducted using 5 test cycles for each stent (Leo + = 1, Enterprise = 1, Neuroform3 = 2, Wingspan = 2, Solitaire = 30). It is clear that Leo + has the lowest radial force and Wingspan has the highest radial force among all stents tested independent of the test method. Relative ranks of Neuroform3 and Solitaire changes are based on the test method. At higher oversizing, Solitaire shows higher radial force and at lower oversizing Neuroform 3 shows higher radial force. This is attributed to their specific design features. At lower oversizing, an unrolling mechanism may be operative in Solitaire due to a longitudinal split in its design thereby showing lower radial force. Additionally, the closed cell designs tend to exhibit a higher radial force at higher oversizing.

The wall apposition was evaluated in 3 mm tubes having a 3.9 mm radius (Fig. 5a) and in 4 mm tubes with a 4.4 mm radius (Fig. 5b). Neuroform3, due to the open cell design, maintains good wall apposition even in tortuous paths. The wall apposition of the Solitaire stent is similar to that of the Neuroform but better than that of the Enterprise. The wall apposition

![Cell patterns of Solitaire, Neuroform3, Enterprise, and Leo + are shown. The Wingspan stent has a similar cell pattern as the Neuroform3.](image)

**Table 1** Summary of the characteristics of various commercially available stents.

<table>
<thead>
<tr>
<th></th>
<th>Solitaire (ev3)</th>
<th>Enterprise (Codman)</th>
<th>Neuroform (Stryker)</th>
<th>Wingspan (Stryker)</th>
<th>Leo Plus (Balt)</th>
</tr>
</thead>
<tbody>
<tr>
<td>indication</td>
<td>intracranial vascular disease</td>
<td>intracranial aneurysms</td>
<td>intracranial aneurysms</td>
<td>intracranial atherosclerotic stenosis</td>
<td>intracranial aneurysms</td>
</tr>
<tr>
<td>retrievable/repositionable</td>
<td>yes</td>
<td>partially</td>
<td>no</td>
<td>no</td>
<td>partially</td>
</tr>
<tr>
<td>sizes: diameter (mm)</td>
<td>3.4, 5.6</td>
<td>4.5</td>
<td>2.5, 3, 3.5, 4, 4.5</td>
<td>2.5, 3, 3.5, 4, 4.5</td>
<td>2.5, 3.5, 4.5, 5.5</td>
</tr>
<tr>
<td>lengths (mm)</td>
<td>15, 20, 30, 40</td>
<td>14, 22, 28, 37</td>
<td>10, 15, 20, 30</td>
<td>10, 15, 20</td>
<td>12, 15, 18, 20, 25, 30, 35, 40, 50, 75</td>
</tr>
<tr>
<td>vessel range (mm)</td>
<td>2.25–5.5</td>
<td>2.5–4</td>
<td>2–4.5</td>
<td>2–4.5</td>
<td>2–5.5</td>
</tr>
<tr>
<td>cell type</td>
<td>closed</td>
<td>closed</td>
<td>open</td>
<td>open</td>
<td>closed</td>
</tr>
<tr>
<td>radial force (1–4, where 4 is the highest)</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>markers</td>
<td>3 distal and 1 proximal</td>
<td>4 markers on each end</td>
<td>4 markers on each end</td>
<td>4 markers on each end</td>
<td>2 platinum threads on stent body</td>
</tr>
</tbody>
</table>

of the Leo+ stent is highly dependent on the technique of deployment. We therefore omitted this evaluation.

The **bending stiffness** was determined as the moment required for bending a given stent into a 0.5 inch arc (±12.7 mm). One measurement was taken for each stent (Leo = 2, Enterprise = 3, Neuroform3 = 2, Wingspan = 2, Solitaire = 3). Results are shown in Fig. 6. Enterprise has the highest bending stiffness (100%), followed by Solitaire (55%), Wingspan (44%), Leo+ (36%), Neuroform3 (30%). The vessel straightening is expected to be the highest for the Enterprise stent.

The results of **gator backing** visualization are presented in Fig. 7. Only Neuroform3 (and Wingspan) displayed gator-backing. It was not observed with the other stents. **Kinking** was tested in 3 mm silicone tubes with a 12.5 mm radius curve. Results are shown in Fig. 8. One measurement was taken for each stent (Leo+ = 2, Enterprise = 4, Neuroform3 = 1, Wingspan = 1, Solitaire = 1). The Solitaire and Leo+ did not kink around a 1-inch curve. Both, Neuroform3 and Wingspan kinked under these conditions. Enterprise kinked less than Neuroform.

The results of testing for **ovalization** are summarized in Fig. 9a, b. In the stent ovalization in 3 mm and 4 mm curved vessels, each stent was measured 3 times (Leo+ = 2, Enterprise = 4, Neuroform3 = 2, Wingspan = 1, Solitaire = 1). Of the laser cut stents, Enterprise ovalizes the most, while the Wingspan ovalizes the least. Solitaire ovalizes less than Neuroform3 and Enterprise. Leo+ undergoes ovalization, but the extent of ovalization cannot be compared to the other competitor stents. Leo+ does not maintain wall apposition when it is bent. Its kink resistance, conformability, and ovalization are also highly dependent on the deployment technique. The characteristics presented here pertain to the ideal deployment of a Leo+ stent.

The **vessel wall coverage** varies in a wide range between the tested stents. Fig. 10a, b show the results for 3 mm and 4 mm vessels. Solitaire has the lowest vessel wall coverage of all studied intracranial stents. However, this stent has an overlap design, where the aneurysm neck may to be covered by the overlap area. Only when vessel wall coverage is determined for the overlap areas, does it have twice the coverage and which is close to that of Enterprise and Neuroform3. Enterprise and Neuroform3 have similar percentages of vessel wall coverage. A lower percentage of vessel wall coverage may reduce the risk of adverse effect of the stent on the vessel wall. More vessel wall coverage is certainly a requirement for a significant hemodynamic effect. One measurement was taken for each stent (Leo+ = 1, Enterprise = 1, Neuroform3 = 1, Wingspan = 1, Solitaire = 1).

The **cell size** was measured. 5 cells were measured on each stent (Leo+ = 3, Enterprise = 4, Neuroform3 = 1, Wingspan = 1, Solitaire = 1). The ranking starts with Solitaire as the stent with the largest cell size, followed by Neuroform3, Enterprise, Wingspan and Leo+.

**The methods of delivery** of the 5 stents differ significantly. The Neuroform3 stent comes premounted in a 0.027” ID outer microcatheter (Renegade hi flo) and the stent is pushed out of the catheter with an inner catheter, called a stabilizer. Both preparation and insertion of the catheter/stabilizer ensemble are slightly cumbersome and may require assistance from a second person. This drawback is overcome with the latest version of the Neuroform stent (“Neuroform EZ”). Wingspan is also premounted, but the deployment results from the retrieval of an outer catheter, similar to the mechanism of the Wallstent. Leo+, Enterprise and Solitaire are not premounted and are delivered through separate microcatheters. The Leo+ stents are only deployable through dedicated Vasco catheters.

**Discussion**

This work should be a first step towards a comprehensive “physician’s guide” for intracranial stents, as they are available for coronary [12] and carotid stents [13].

The features of the 5 intracranial stents examined in this study are very different. Some of the above-described observations correspond well with other in vitro studies and with clinical experience. The assessment of each stent has to consider various aspects. How well does a stent meet the primary requirements (i.e., retain coils in a wide necked aneurysm)? What effects have to be expected in this context (e.g., vessel straightening, difficulty in catheterizing an aneurysm through stent struts)? How about secondary effects such as hemodynamic influence on the aneurysm? Can adverse effects (e.g., intimal hyperplasia with in-stent stenosis) be expected or anticipated from certain stent features?

The Neuroform was the first self-expanding intracranial stent and became available in a clinical trial in Europe in 2001 [4]. Since then, a large number of publications have focused on various aspects of this device. The basic structure of the Neuroform is a sequence of sinusoidal crown segments of 2.5 mm length. Adjacent crowns have 2 or 3 connecting points. The stent cannot be repositioned after the first crown has been deployed. Stent placement in general was an issue with the first Neuroform gen-
rhythm orifice, wall prolapse into the lumen at the cell center, undulations of the vessel wall, strut and marker embedding into the vessel wall and formation of creases at the strut vertices [22–25]. Vessel straightening by Neuroform was described but is of limited importance in clinical practice [25]. All effects related to the open cells of the Neuroform stent are not possible with the competing closed cell stents of this study. Undulations of the vessel walls are sometimes obvious on angiograms after oversized deployment of a Neuroform or Solitaire stent. Fibrocellular in-growth within the stented vessel segment promotes increased durability of coil-occlusion and may be more pronounced in an open-cell design stent [26]. In-stent stenosis due to neointimal hyperplasia occurs in about 5–6% of patients after Neuroform implantation for aneurysm treatment [27]. Clinically insignificant in-stent stenosis is even more frequent [28]. The rate of in-stent stenosis recurrence after conventional balloon dilatation is high and an accentuation of the intimal hyperplasia adjacent to the stent markers is sometimes evident [29]. In our experience, in-stent stenosis after stent-assisted coiling of aneurysms is generally rare but seems to be increased in patients with underlying vasculitis. Bifurcation reconstruction can be achieved with both “crossing” and “kissing” using Neuroform stents [30,31].

The Wingspan stent was originally developed for the endovascular treatment of intracranial atherosclerotic stenoses [5]. It is actually a design variant of the Neuroform stent with an optimized delivery system and an increased radial force. Some physicians have reported good results with this stent for aneurysm indications [32]. The increased radial force, which is the main differentiating feature of the Wingspan stent from the Neuroform stent, may add some stability for aneurysm coiling. The high in-stent restenosis rate (e.g., 88% for supraclinoid stenoses in patients aged 55 years younger) [33] might also be related to the high radial force of the Wingspan stent. The hemodynamic effects of Neuroform and Wingspan are expected to be more or less equivalent but computational fluid dynamics analysis found more influence on intra-aneurysmal blood flow for the Wingspan stent [34]. Solitaire was the first fully retrievable and detachable intracranial stent [6]. The stent is more stable than Neuroform3 and less thrombogenic than Leo (+) in our clinical experience. Due to the large cell size, catheterization of the aneurysm sac after stent deployment is well controllable and may be easier than with the competitors [35]. In our opinion, the Solitaire stent is less prone to microcatheter-induced deformation or displacement, which may happen with Neuroform and Enterprise, respectively. We
observed that the retrievability of the stent after full deployment allows accurate final positioning as well as temporary stenting similar to balloon remodeling though without blood flow interruption (“stent remodeling”). Controlled detachment can be used to stabilize the stent position during catheterization, coil delivery, or deployment of a second stent. In some clinical situations, there may be an advantage to a stent having a separate guide wire. A central wire running through the lumen of the mounted stent is part of the Neuroform3 and of the Enterprise stent system but is missing at the Solitaire. Such a wire facilitates recatheterization of a stent once deployed but also carries the risk of distal vessel injury. As observed by other sites, the thrombogenicity of the Solitaire stent is low and allows deployment with heparinization and ASA induced antiaggregation only, without the administration of clopidogrel [35]. This is a major advantage in the treatment of patients with recently ruptured aneurysms. The use of heparinization and ASA-induced antiaggregation only is also valid for Enterprise and Neuroform3 stents. An intrinsic hemodynamic effect of the Solitaire is apparently non-existing, mainly due to the large cell size. Endothelialization can be expected as with every intracranial stent but we are not aware of any case of in-stent stenosis after Solitaire-assisted aneurysm coiling. Solitaire is currently not indicated for atherosclerotic stenoses and the in-stent restenosis rate associated with its application in atherosclerotic disease is unknown. Reconstructing vessel bifurcations by crossing stent-in-stent deployment (Y-configuration) is possible with the Solitaire [35]. Leo and Leo + are braided stents, which can be repositioned after partial deployment [36]. Different than laser-cut stents, the Leo(+)’s cells are closed but not predetermined in size and shape. The cells increase in size at the convexity and decrease in size at the concavity. The Leo stent has a braiding angle of 45°, which is increased to 60° for the Leo+. In addition the Leo+ comes with flaired proximal and distal ends and with a 30% increase of radial force [37]. Some authors state a higher radial force for the Leo(+) than the Neuroform3 and the Enterprise stents [38], which is wrong. The original Leo version was known for thromboembolic complications [38]. This issue was overcome with subsequent device modifications, which may be related to the observation that the revised stent (Leo+) does in vitro show neither missection flattening nor the inward crimping of the proximal and distal ends [37]. The effective cell size of the Leo(+) stent is influenced by the diameter of the target vessel. Oversizing of the stent (i.e., the stent is unable to fully expand) will result in larger cell sizes. Larger cells are easier accessible for a microcatheter but have less hemodynamic effect on the aneurysm’s in- and outflows. Among the stents examined, Leo(+) has in general the most distinct hemodynamic effect, which may possibly be applied for flow diversion [38]. A major drawback of the Leo(+) stent-line is the appendent Vaso microcatheter, which is difficult to navigate in tortuous vessels [37]. The Leo(+) stent does not allow either “crossing” or “kissing” deployment and is therefore not suitable for bifurcation reconstruction.

The Enterprise stent is retractable after partial deployment. Exact placement is mostly easy but penetration of the small stent cells with a microcatheter can be challenging [8,9,39]. The body of the stent itself is almost invisible under fluoroscopy [8].
Only proximal and distal tantalum markers allow the identification of the stent position. The ability of the Enterprise stent to cell size, “crossing” 2 Enterprise stents, however, can be quite construction is possible with the Enterprise stent. Due to the small Both “crossing” and “kissing” deployment for bifurcation recon-

mosis treatment with a frequency of about 25% . Focal intimal hyperplasia (stent remodeling” in analogy to balloon remodeling) has successfully been applied with a partially deployed Enterprise stent [42]. There is no comparative study on the safety and efficacy of different self-expanding intracranial aneurysm stents available and in fact such a study would be difficult to justify. In general, Enterprise and Solitaire are certainly more convenient to use than the Neuroform system [39]. Both stents can be deployed through 0.021” ID microcatheters, which can also be used for coil insertion. The Leo+ is a good choice whenever an enhanced hemodynamic effect is required. Some physicians use the Leo+ or Enterprise stent to prepare a target vessel for subsequent flow diverter deployment. Flow diversion by multiple telescoping stents of the same kind has been demonstrated [12, 15]. The efficacy of combinations of stents with various designs (e.g., Enterprise or Neuroform with Solitaire) is unknown.

**Conclusion**

In 2010 five self-expanding intracranial stents were available. They have basically different physical features and clinical functions. None of these stents is ideal in the sense of universally meeting all possible requirements. Knowledge of the stent features, procedural experience and proper technical skills are mandatory for safe and successful endovascular treatment on the basis of individualized decision making. The medical device industry is asked to address the above shown issues. Systematic variations of existing stent designs and new developments are
required to further improve the results of intracranial stenting, way beyond aneurysm treatment. Directions of development should include non-thrombogenic stents deployable without anti-aggregation and methods for mid- and long-term temporary stenting (e.g., bioresorbable stents). Aneurysm stents are only the initial ignition for a device family that will improve the treatment of intracranial stenoses, dissections and acute stroke.

Potential conflicts of interest: Ozlem Kirschek has no potential conflict of interest. Elinna Miloslavski participated in clinical trials for Neuroform, Wingspan and Enterprise. Sebastian Fischer has no potential conflict of interest. Sanjay Shrivastava is Director of R & D for ev3, Irvine, CA, USA. Hans Henkes is co-inventor of the Solitaire stent but has no further financial interest in this device. He participated in clinical trials for Neuroform, Wingspan and Enterprise, was consultant and is proctor to Covidien/ ev3 and is proctor and Medical Board member for Codman Neurovascular.

References