

Reply to the Letter to the Editor: "The Qualitative Assessment for Ostial Side Branch Disease in Isolated Non-Left Main Coronary Artery"

Editöre Mektup Yanıtı: "Sol Ana Koroner Arter Olmayan İzole Ostial Yan Dal Hastalığının Kalitatif Olarak Değerlendirilmesi"

To the Editor,

We thank Dr. Fatih Uzun¹ for his insightful comments on our study.² Our study explored the characteristics and long-term follow-up of patients with isolated ostial diagonal stenosis concerning percutaneous coronary intervention (PCI) and the presence of angina. As highlighted in the letter, when classifying bifurcation lesions, the Bifurcation Academic Research Consortium recommends evaluating whether the side branch (SB) is left main or non-left main coronary artery (non-LMCA), regardless of the extent and involvement of the SB. Criteria were set for non-LMCA bifurcation lesions to show the prognostic significance of the SB. In coronary angiography, the following criteria should be met: I) the SB length exceeds 73 mm; II) SNUH score ≥ 2 ; III) if the SB is a diagonal artery, its diameter is less than 2.5 mm; and IV) if only one diagonal artery is required, it should be a dominant diagonal artery, and a non-dominant circumflex artery should also be present.³ However, it is essential to note that this recommendation is not specific to ostial diagonal artery disease (0.0.1 lesions).

Only patients with ostial diagonal artery disease as a culprit lesion were included in our study. Diagonal artery length was not an exclusion criterion. Retrospectively analyzing the data, we observed no significant difference between the two groups. The median with interquartile range (IQR) was 57 (12) for the percutaneous coronary intervention (PCI) group compared to 61 (14) for the medical group, with $P = 0.132$. All patients with a vessel diameter over 1.5 mm were included. Comparing angiography data, the affected diagonal artery diameter did not differ between the groups [(median, IQR) 2.25 (0.25) for PCI group vs. 2.25 (0.50) for the medical group, $P = 0.082$]. Similarly, there was no difference in which diagonal artery branch was affected between the two groups ($P = 0.654$). Additionally, myocardial perfusion scintigraphy was used to investigate ischemia in 30 patients, revealing no significant difference between the two groups [medical treatment group 17/24 (70.8%), PCI group 4/6 (66.7%)].

A limitation of our study is the absence of techniques like intravascular ultrasound (IVUS) and optical coherence tomography (OCT). Incorporating intravascular imaging methods in future studies will enhance the qualitative assessment of isolated ostial side branch diseases.⁴

In conclusion, we believe that our results support the hypothesis that PCI is not significantly superior to medical treatment in isolated ostial side branch lesions.

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LETTER TO THE EDITOR REPLY EDİTÖRE MEKTUP YANITI

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