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ity of the dissected arteries, which are at risk of rupture (5). The bottom line is that SCAD is a condition that rarely requires PCI. In cases that do, which by definition should be at high risk because of major ongoing ischemia refractory to medical treatment and/or hemodynamic/electrical instability, we should continue to follow the basic principles: 1) Focus on major vascular territories (proximal/mid-segments), 2) Ensure accurate intraluminal positioning of the wire, and 3) Stent implantation from healthy to healthy individual to reduce the probability of hematoma/dissection propagation.

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Author's Reply

To the Editor,

We are thankful for the valuable comments on our case report (1). We agree that an adequate stent length exceeding the lesion length is important, as highlighted in the recent European Society of Cardiology (ESC) spontaneous coronary artery dissection (SCAD) position paper (2). In this case, we implanted the longest drug-eluting stent available (48 mm). However, that did not prevent proximal and distal hematoma propagation, and 2 additional stents were required (1). The point on cutting balloon angioplasty is well-taken, as this treatment modality has also been mentioned in the ESC SCAD position paper to reduce hematoma/dissection propagation during angioplasty/stent deployment and to reduce the length of the stented segments (2). Nevertheless, we did not embrace cutting balloon angioplasty for the SCAD indication as the overall published experience is limited to case reports (3). In a recently published Canadian SCAD cohort study including 750 patients, the cutting balloon technique was used only in 5 of the 103 patients who underwent percutaneous coronary intervention (PCI) (4). A major concern related to this technique is the fragil-

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