

Reply to Letter to the Editor: "A Modified Medina and Movahed (3M) Classification of Coronary Bifurcation Lesions"

To the Editor,

With great interest we read the letter entitled "A Modified Medina and Movahed (3M) Classification of Coronary Bifurcation Lesions" published in your journal.¹ This paper addresses the previously published method of coronary bifurcation classification based on Medina and Movahed classifications (3M classification).^{2,3} and argues that our novel descriptive coding system.⁴ is difficult to remember. However, we believe that our descriptive coding system is not only practical and useful but also contains more descriptive information and is easier to remember. 3M classification uses binary locational status for every coronary bifurcation such as left main and non-left main bifurcations. However, our descriptive coding system uses a prefix representing any possible bifurcation site in the coronary tree, such as LM (indicates a bifurcation lesion at distal Left Main coronary artery), LAD (left anterior descending coronary artery–diagonal branch bifurcation), CX (circumflex coronary artery–obtuse marginal branch bifurcation), RCA_m (indicates a mid-right coronary artery–significant right ventricular branch bifurcation), RCA_d (indicates a distal RCA bifurcation at crux), D or OM (indicates bifurcation lesions involving branches of diagonal or obtuse marginal). In addition, our descriptive coding system includes precise bifurcation angle and coronary artery size information. Information on coronary artery diameters at proximal, distal, and branch vessel sites can be decisive in choosing appropriate stent diameters. Finally, we include information regarding the side branch's lesion length (by adding L (long) or S (short) codes depending on whether the lesion length is ≥ 10 mm or < 10 mm) and significance of percent stenosis (by adding an asterisk on the dimension code of the side branch) which possibly help interventionalist choose the best stenting technique. All the descriptive information regarding coronary bifurcation is expressed in a fashion similar to cardiac pacemaker mode nomenclature as we all familiar with. For example, LAD₃₀ (14, 13, 13*, L) indicates a (1, 1, 1) left anterior descending–diagonal branch bifurcation with a narrow bifurcation angle of 30°. The LAD size proximal to bifurcation, the LAD size distal to bifurcation and the diagonal branch size are 4 mm, 3 mm, and 3 mm, respectively. Diagonal branch is severely diseased with ≥ 90 stenosis and ≥ 10 mm lesion length. In this scenario, based on the narrow bifurcation angle and comparable distal to side branch vessel sizes with severely diseased side branch, it is wise to be well prepared for 2-stent strategy with culotte technique.

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LETTER TO THE EDITOR REPLY

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Cite this article as: Ağaç MT, Vatan MB, Çakar MA, Tatlı E. Reply to letter to the editor: "A modified medina and movahed (3M) classification of coronary bifurcation lesions". *Anatol J Cardiol.* 2024;28(4):215.

DOI:10.14744/AnatolJCardiol.2023.4020