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Antiplatelet Strategy After Drug-Coated Balloon Angioplasty for Isolated Side Branch Lesions: The Missing Piece of the Puzzle

LETTER TO THE EDITOR

To the Editor,

We read with great interest the recent study by Akın et al[1] entitled "Safety Profile of Drug-Coated Balloon Angioplasty for Isolated Side Branch Lesions: A Single-Center Experience," published in *The Anatolian Journal of Cardiology*.[1] The authors should be congratulated for addressing a highly challenging clinical scenario—isolated side branch (SB) stenosis (Medina 0.0.1)—with an innovative, stentless drug-coated balloon (DCB) approach, demonstrating an impressive procedural success rate of 97.9%.

While the acute angiographic outcomes and the absence of acute thrombosis are highly reassuring, a critical clinical aspect regarding post-procedural management remains unaddressed. The authors reported a relatively high incidence of type A–B coronary dissections (35.4%). Although these dissections were non-flow-limiting and did not require bailout stenting, their presence introduces a significant clinical dilemma regarding post-procedural antithrombotic therapy.

According to the International DCB Consensus Group recommendations, a 4-week course of dual antiplatelet therapy (DAPT) is generally recommended after uncomplicated DCB-only angioplasty in de novo coronary lesions.[2] However, a substantial proportion of patients were left with untreated, bare dissections. In combination with a high-risk patient profile (50% diabetes, 75% hypertension, and 56.2% prior myocardial infarction), this creates a challenging balance between ischemic and bleeding risks.

Advanced optical coherence tomography (OCT) studies indicate that while most minor dissections heal biologically over time under the influence of anti-proliferative drugs, the endothelialization window may be delayed in the presence of complex plaque morphology or suboptimal lesion preparation.[3] Interestingly, despite the high angiographic success reported by the authors, 12.5% of the patients suffered from persistent post-procedural angina, and 16.7% required a repeat coronary angiography during a mean follow-up of 423 days.[1] It remains uncertain whether the choice, potency (e.g., clopidogrel vs. ticagrelor), or duration of the DAPT regimen played a role in these soft ischemic endpoints or late lumen changes.

Consequently, to help clinicians safely reproduce these favorable "stentless" results in their daily practice, it would be highly valuable if the authors could clarify their post-procedural antiplatelet protocol. Did patients with type A–B dissections receive a different antiplatelet strategy (either in duration or P2Y12 inhibitor selection) compared with those without dissections? Sharing these insights would significantly enhance the clinical utility and generalizability of this valuable study.

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