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

LETTER TO THE EDITOR
REPLY

To the Editor,

We sincerely thank the authors[1] for their thoughtful comments regarding our recently published study[2] evaluating drug-coated balloon (DCB) angioplasty for isolated side branch lesions. We appreciate their interest in the post-procedural antiplatelet strategy, which indeed represents an important component of DCB-based coronary intervention.

In our study, antiplatelet therapy was determined according to the clinical presentation rather than the presence of angiographically minor dissections. Patients with chronic coronary syndrome received aspirin plus clopidogrel for 1 month after successful DCB-only angioplasty, whereas patients presenting with acute coronary syndrome received guideline-directed dual antiplatelet therapy (DAPT) for 12 months, in accordance with current European Society of Cardiology (ESC) recommendations.[3,4] The presence of non-flow-limiting type A or B dissections did not modify either the duration of DAPT or the selection of the P2Y12 inhibitor.

Importantly, current evidence does not support prolonging DAPT solely because of angiographically minor dissections after successful DCB treatment. The 2023 German Consensus Group recommends 1 month of DAPT following uncomplicated DCB angioplasty in de novo lesions and does not propose longer DAPT for type A–B dissections.[5] Similarly, the 2024 International DCB Consensus Group recommends standard DAPT after successful DCB treatment provided that there is no flow-limiting dissection or bailout stenting.[6] Therefore, our antiplatelet strategy was fully consistent with contemporary consensus recommendations.

The concern regarding untreated type A–B dissections is understandable; however, increasing evidence suggests that these lesions represent a benign angiographic finding rather than a clinically significant complication. Optical coherence tomography–based studies have demonstrated spontaneous endothelial healing after DCB treatment despite the absence of a permanent metallic scaffold.[7] Furthermore, the EASTBOURNE substudy showed that most non-flow-limiting dissections healed completely without an increased incidence of target lesion failure or major adverse cardiovascular events.[8] Likewise, Gitto et al[9] demonstrated that minor dissections after DCB angioplasty were not associated with adverse long-term clinical outcomes.

The authors also questioned whether the choice or duration of DAPT might have contributed to persistent angina or repeat coronary angiography during follow-up. Although this hypothesis is interesting, our study was not designed to evaluate different antiplatelet strategies, and no subgroup analysis according to DAPT regimen was performed. Moreover, persistent angina following PCI is multifactorial and may result from coronary microvascular dysfunction, vasospastic disease, diffuse atherosclerosis, progression of non-target lesions, or residual ischemia unrelated to the treated side branch.[10] Likewise, repeat coronary angiography in

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our cohort was clinically driven and should not be interpreted as evidence of target lesion failure.

Finally, the primary objective of our study was to evaluate the procedural safety and feasibility of DCB angioplasty in isolated Medina 0.0.1 lesions. Nevertheless, we fully agree with the authors that future prospective studies incorporating standardized antiplatelet regimens together with serial OCT imaging would further clarify whether selected patient subgroups might benefit from individualized antiplatelet strategies.

We sincerely thank the authors for their valuable comments[1], which have provided an opportunity to further clarify this important aspect of DCB therapy.

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