System, resulting in 100% follow-up. However, we are looking into retrieving secondary endpoints such as cardiovascular mortality and, based on intuition, we think this will further improve the prognostic strength of GLS in our cohort.

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One Good Friend Is Better Than Many

We have read with great interest the paper by Prati et al. (1) on the CLI-OPLI II study (Centro per la Lotta contro l'Infarto-Optimisation of Percutaneous Coronary Intervention). The newly defined *suboptimal stent deployment* was associated with an increased risk of major adverse cardiac events. Since the evidence to support the clinical benefit of optical coherence tomography (OCT) during percutaneous coronary intervention (PCI) remains limited, this study provides important information about its use for stent deployment. However, we would like to draw attention to the data presented in the CLI-OPCI II study, especially regarding baseline characteristics and definitions of suboptimal OCT stent deployment.

First, the combination of many conditions obfuscates the interpretation of results. Patients with different clinical presentations (stable ischemic heart disease and an acute coronary syndrome) and different types of stents (i.e., bare-metal stent, drug-eluting stent, and bioabsorbable vascular scaffold) were included. Since in other studies, PCI guidance using imaging has been beneficial mostly in acute coronary syndrome (2) (i.e., ST-segment elevation myocardial infarction), and each device has a different neointimal growth pattern and extent, it is difficult to draw any conclusion from this report.

Second, the parameters for suboptimal stent deployment are too many to be measured and interpreted online in the catheterization laboratory. The authors suggested 6 significant factors that had different weightings. Conversely, in the most recent published IVUS-XPL (Impact of Intravascular Ultrasound Guidance on Outcomes of Xience Prime Stents in Long Lesions) trial, the authors chose only 1 IVUS criterion for stent optimization after PCI (3). This latter simple approach is easier to adopt and implement in clinical practice.

Third, the definition of suboptimal OCT stent deployment has been changed (Table 1), despite the authors' claim: "The aim of the present study was to assess the impact of these pre-specified OCT

TABLE 1 Stent Underexpansion Criteria			
	CLI-OPCI I	**CLI-OPCI II**	**XPL IVUS**
In-stent MLA	≥90% of average reference lumen area or ≥100% of lumen area of reference segment with lowest lumen area	<70% of average reference lumen area or in-stent minimum or lumen area (MLA) <4.5 mm^2	MLA greater than lumen area at distal reference segment
Edge dissection	Linear rim of tissue with width ≥200 μm	Linear rim of tissue with width ≥200 μm	
Reference lumen narrowing	Lumen area <4.0 mm^2	Lumen area <4.5 mm^2	
Malapposition	Stent-adjacent vessel lumen distance >200 μm	Stent-adjacent vessel lumen distance >200 μm	
Intrastent plaque/thrombus protrusion	Intraluminal mass ≥200 μm in thickness	Intraluminal mass ≥500 μm in thickness	

CLI-OPCI = Centro per la Lotta contro l'Infarto-Optimisation of Percutaneous Coronary Intervention; MLA = minimal lumen area.

quantitative criteria (CLI OPCI I study) on clinical outcomes after PCI" (4). It would be a great contribution to the field if the authors would present an analysis similar to that of the XPL study (considering only 1 criterion, minimal lumen area greater than the lumen area at the distal reference segment) to present a simplified approach that could be easily embraced in clinical practice.

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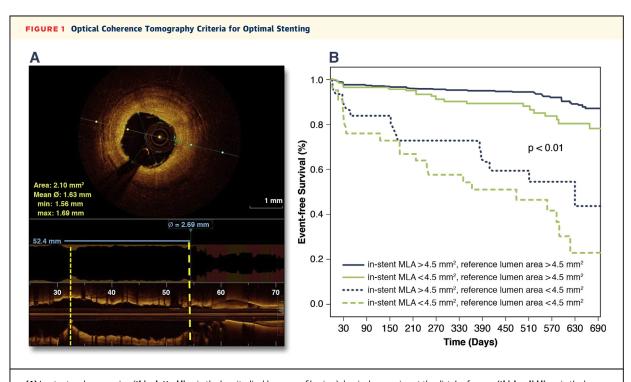
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THE AUTHORS REPLY:

The main advantage of optical coherence tomography (OCT) resides in its ability to identify issues that may be missed by intravascular ultrasound (IVUS); however, OCT may provide operators with an excess of information that may lead to an overreaction, in an effort to correct innocent but ominous-looking anatomic issues.

The CLI-OPCI (Centro per la Lotta contro l'Infarto-Optimisation of Percutaneous Coronary Intervention) II study (1) was specifically designed to answer these crucial questions in "everyday" practice and therefore included a heterogeneous population, with demographic, clinical, and procedural differences. Importantly, the CLI-OPCI project was conceived years ago to gather OCT data from more centers, year by year, with the goal of refining our understanding

FIGURE 1 Optical Coherence Tomography Criteria for Optimal Stenting

(A) In-stent underexpansion (**thin dotted line** in the longitudinal lumen profile view); luminal narrowing at the distal reference (**thick solid lines** in the lumen profile view and upper quadrants). **(B)** Event-free survival from major adverse cardiac events. MLA = minimal lumen area.