intravascular ultrasound (IVUS) in evaluating intermediate
truncal lesions and suggesting that a cut-off value of 6
mm$^2$ for the minimum luminal area (MLA) is safe in the
long term.

The prognostic importance of left main trunk disease
(LMT) is unquestionable. For this reason, the need arose
to find a useful tool, whether physiological with a
pressure guide wire, or anatomical using IVUS, which
would permit us to adequately evaluate the severity of
the defect and predict cases of future coronary events.
Our team communicated the results of using the
fractional flow reserve (FFR) in evaluating moderate
LMT lesions in the short term.$^2$ We studied 27
consecutive patients with 30%-50% apparent
angiographic stenosis; of these cases, 20 did not undergo
LMT revascularisation due to having a negative FFR.
These patients presented a minimum luminal diameter
(MLD) of 2.21 (0.61) mm, and a mean FFR of 0.88
(0.04). The MLD of the patients with a positive FFR
was 1.8 (0.46) mm$^2$. After a follow-up period of 3.5
years, there were no cardiovascular events apart from
that described in our article$^2$; only 3 patients died, from
non-cardiovascular causes. This data confirms the long-
term safety of postponing revascularisation with the
additional information provided by the pressure
guidewire.

Our study, like that of de la Torre et al,$^1$ describes a
subgroup of patients from daily clinical practice for which
intracoronary diagnostic techniques are necessary to
provide a more reliable diagnosis, given the obvious
prognostic implication for LMT lesions. A small number
of complications have been described for new treatments,
such as the pharmacoactive stent or minimally invasive
surgery, but it will always be higher if the treatments are
unnecessary.

Both studies present similar clinical and
angiographic characteristics, particularly a lesion
MLD <2 mm in patients with a positive FFR and an
MLA of ≤6 mm$^2$. This could indicate that in patients
with a MLD <2 mm, regardless of the stenosis
percentage, one may opt for intervention rather than
obtaining additional information using intracoronary
diagnostic techniques. Similar results are described
in studies by Beche et al$^3$ and Jasti et al$^4$ on evaluating
intermediate lesions using intracoronary diagnostic
techniques; all of these studies show that patients with
coronary stenosis of the LMT and a MLD <2 mm are
the ones with severe anatomical or functional stenosis.
Even Abizaid et al$^5$ state that patients with
cardiovascular events and moderate LMT lesions are
those with a MLD of 2 mm.

In conclusion, for moderately severe LCO defects, we
are able to gather more information by physiological
examination with a pressure guide wire or by anatomical
examination with IVUS, both of which are
complementary, safe techniques for postponing
intervention. An MLD <2 mm would indicate a severe

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**Is Coronary Angiography Still Valuable for Assessing Intermediate Left Main Coronary Artery Lesions When Compared With Intracoronary Diagnostic Techniques?**

**To the Editor:**

It was with great interest that we read the excellent
article by de la Torre et al$^1$ demonstrating the use of

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case in which it would be unnecessary to use either of the above techniques.

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Response

To the Editor:

We thank Muñoz García et al for their interest in our article.¹ I found their contribution to be timely and interesting, as it reports the experiences of a centre using the pressure guidewire to evaluate intermediate trunk lesions. This group possesses recognised experience in using this diagnostic technique.

I would like to highlight a few aspects related to this study and our own, beginning with the applicability of these strategies. An angiographic reading of an intermediate degree of stenosis is not sufficient; rather, there should be no doubt as to the “guilt” of the lesion (resolved by the ECG and ischemia testing).

Secondly, it is essential that the study be well-elaborated, whether using intracoronary ultrasound (ICUS), which guarantees proper visualisation of the entire trajectory up to the aortoostial union, or with a pressure guidewire, preferably using intravenous adenosine in the ostial lesions, and in sufficiently high doses if by the intracoronary method. Some studies have shown that intracoronary adenosine infusion does not attain the maximum hyperaemic state²,³ and that, as the team in Murcia has shown,⁴ only doses much higher than those initially recommended (>60 µg) achieve that effect.

Finally, with respect to the technique to be used, one should use that with which he or she is most familiar and experienced. According to publications, the cut-off value for the ICUS would be 6 mm² of the luminal area. Nevertheless, there are particular situations in which one technique or another might be preferable, such as cases of morphologically complex defects or those in which “artefacts” are suspected (bifurcations, ostium, calcifications) where ICUS might be more useful, or when percutaneous revascularisation is considered in the case of a significant defect, given that ICUS is of considerable help in guiding the process and assessing its results.

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