




ORIGINAL RESEARCH

Clinical Outcomes of Percutaneous Coronary Intervention for Bifurcation Lesions According to Medina Classification

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BACKGROUND: Coronary bifurcation lesions (CBLs) are frequently encountered in clinical practice and are associated with worse outcomes after percutaneous coronary intervention. However, there are limited data around the prognostic impact of different CBL distributions.

METHODS AND RESULTS: All CBL percutaneous coronary intervention procedures from the prospective e-Ultimaster (Prospective, Single-Arm, Multi Centre Observations Ultimaster Des Registry) multicenter international registry were analyzed according to CBL distribution as defined by the Medina classification. Cox proportional hazards models were used to compare the hazard ratio (HR) of the primary outcome, 1-year target lesion failure (composite of cardiac death, target vessel-related myocardial infarction, and clinically driven target lesion revascularization), and its individual components between Medina subtypes using Medina 1.0.0 as the reference category. A total of 4003 CBL procedures were included. The most prevalent Medina subtypes were 1.1.1 (35.5%) and 1.1.0 (26.8%), whereas the least prevalent was 0.0.1 (3.5%). Overall, there were no significant differences in patient and procedural characteristics among Medina subtypes. Only Medina 1.1.1 and 0.0.1 subtypes were associated with increased target lesion failure (HR, 2.6 [95% CI, 1.3–5.5] and HR, 4.0 [95% CI, 1.6–9.0], respectively) at 1 year, compared with Medina 1.0.0, prompted by clinically driven target lesion revascularization (HR, 3.1 [95% CI, 1.1–8.6] and HR, 4.6 [95% CI, 1.3–16.0], respectively) as well as cardiac death in Medina 0.0.1 (HR, 4.7 [95% CI, 1.0–21.6]). No differences in secondary outcomes were observed between Medina subtypes.

CONCLUSIONS: In a large multicenter registry analysis of coronary bifurcation percutaneous coronary intervention procedures, we demonstrate prognostic differences in 1-year outcomes between different CBL distributions, with Medina 1.1.1 and 0.0.1 subtypes associated with an increased risk of target lesion failure.

Key Words: bifurcation ■ drug-eluting stent ■ Medina classification ■ outcomes ■ percutaneous coronary intervention

Coronary bifurcation lesions (CBLs) are some of the most challenging and frequently encountered lesion subsets in interventional practice, representing nearly 20% of all percutaneous coronary intervention (PCI) procedures.^{1,2} Although several classifications of CBLs exist, the Medina classification, endorsed by major bodies such as the European Bifurcation Club,

is the most widely used.^{2–5} This classification assigns a binary value (0 or 1) to the proximal and distal main branches (MBs) as well as the side branch (SB), in that respective order, based on the presence (1) or absence (0) of significant plaque burden ($\geq 50\%$ stenosis) in that vascular segment.⁴ Furthermore, CBLs can be classified into true bifurcation lesions, if both the MB and SB have

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CLINICAL PERSPECTIVE

What Is New?

- This is the first study to examine the prognostic difference in 1-year clinical outcomes after coronary bifurcation lesion percutaneous coronary intervention according to Medina subtype in a large multinational cohort.
- Our findings demonstrate that the most prevalent coronary bifurcation lesion subtypes are Medina 1.1.1 (35.5%) and 1.1.0 (26.8%), whereas the least prevalent is Medina 0.0.1 (3.5%).
- Only 2 Medina subtypes (1.1.1 and 0.0.1) were associated with increased target lesion failure at 1 year, whereas no prognostic differences were observed for other subtypes.

What Are the Clinical Implications?

- Greater caution is warranted for patients with specific coronary bifurcation lesion distributions, namely Medina 1.1.1 and 0.0.1, who may need to be followed up more closely given their increased risk of target lesion failure at 1 year following intervention.
- Further research is needed to further optimize outcomes of patients with isolated side branch lesions (Medina 0.0.1) who are at a 4-fold higher risk of target lesion failure at 1 year.

Nonstandard Abbreviations and Acronyms

CBL	coronary bifurcation lesion
MB	main branch
SB	side branch
TLF	target lesion failure
TLR	target lesion revascularization
TVF	target vessel failure

significant stenosis, and nontrue bifurcation lesions if either the MB or SB is not significantly stenosed.

Although previous studies have examined clinical outcomes of CBL PCI according to lesion complexity (simple versus complex bifurcations) or true versus nontrue bifurcations,^{6–9} none have systematically examined the prognostic impact of disease distribution within the CBL on mid- or long-term outcomes following PCI.^{10–12}

The present study sought to compare the impact of disease distribution according to Medina classification on 1-year clinical outcomes adjudicated by an independent clinical events committee among patients undergoing bifurcation PCI within the e-Ultimaster

(Prospective, Single-Arm, Multi Centre Observations Ultimaster Des Registry).

METHODS

Study Data Set

The e-Ultimaster study is a large, international, prospective observational study that enrolled 37 198 patients between October 2014 and June 2018 in 378 hospitals from 50 countries including sites in Europe, Asia, Africa, the Middle East, South America, and Mexico. Eligibility criteria were minimal to enroll an all-comer population, and included (1) age ≥18 years and (2) an indication for a PCI according to routine hospital practice. The Ultimaster sirolimus-eluting coronary stent (Terumo, Tokyo, Japan) is made of cobalt-chromium with a strut thickness of 80 μm. Sirolimus is released from an abluminal applied bi-oresorbable polymer coating (poly-D,L-lactic acid polycaprolactone) that is fully metabolized through dl-lactide and caprolactone into carbon dioxide and water in 3 to 4 months. The study was approved by the ethical committees of the participating sites, and all patients provided written informed consent. The clinicaltrials.gov identifier is NCT02188355. The data used for the purpose of this study are only available to designated researchers and cannot be shared with other researchers. However, all efforts were made to describe the methods in detail.

Study Population and Follow-Up

All patients with a single CBL at the index procedure from the e-Ultimaster study were included, stratified into 7 permutations according to their Medina classification (true bifurcations: 0.1.1, 1.0.1, 1.1.1; nontrue bifurcations: 0.0.1, 0.1.0, 1.0.0, 1.1.0) (Figure S1). There were no restrictions on the clinical indication, the number of lesions to be treated, or number of stents to be implanted. Because the Medina classification was not available for 56 (1.4%) patients, they were excluded from our analysis. Follow-up was up to 1 year, except

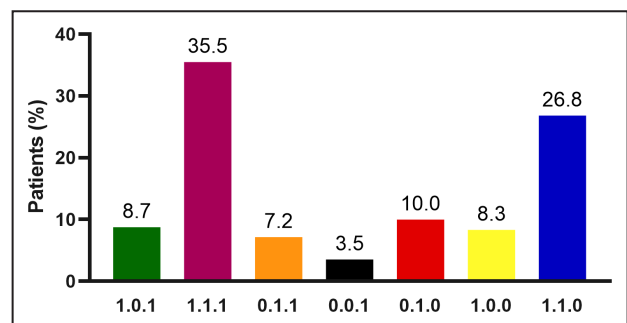


Figure 1. Distribution of coronary bifurcation lesions as per the Medina classification subtype.

Table 1. Baseline Patient and Procedural Characteristics According to Medina Classification Subtype

Characteristic	True bifurcation				Nontrue bifurcation				P value
	Medina 1.0.1	Medina 1.1.1	Medina 0.1.1	Medina 0.0.1	Medina 0.1.0	Medina 1.0.0	Medina 1.1.0		
	n=356	n=1420	n=291	n=137	n=399	n=336	n=1064		
Age, y, mean±SD [n]	65.1±11.3 [356]	65.7±11.4 [1420]	64.9±10.7 [291]	65.9±10.8 [137]	65.2±11.2 [399]	65.0±11.6 [336]	65.8±10.8 [1064]	0.709	
Men, % [n]	73.3 [261/356]	77.5 [1101/1420]	74.2 [216/291]	70.8 [97/137]	75.9 [303/399]	77.1 [259/336]	77.4 [824/1064]	0.338	
Diabetes, % [n]	25.1 [89/354]	28.7 [405/1410]	29.3 [84/287]	31.4 [43/137]	26.6 [106/399]	21.9 [73/334]	25.6 [271/1057]	0.111	
Insulin-dependent diabetes, % [n]	4.8 [17/354]	5.3 [74/1410]	8.0 [23/287]	5.8 [8/137]	4.5 [18/399]	4.2 [14/334]	4.9 [52/1057]	0.412	
Hypertension, % [n]	68.7 [233/339]	69.1 [9400]	71.4 [200/280]	72.9 [97/133]	71.1 [273/384]	66.3 [212]	67.5 [674/998]	0.588	
Hypercholesterolemia, % [n]	57.9 [188/325]	62.2 [825/1326]	61.3 [171/279]	58.9 [76/129]	63.9 [246]	61.5 [193/314]	63.8 [629/986]	0.555	
Current smoking, % [n]	23.7 [70/295]	23.7 [288/1215]	19.6 [49/250]	24.8 [27/109]	23.1 [80/347]	27.3 [76/278]	23.6 [211/894]	0.608	
Previous MI, % [n]	24.3 [83/341]	25.4 [3479]	26.3 [75/286]	27.3 [36/132]	21.0 [82/391]	20.7 [67/324]	23.5 [246/1046]	0.318	
Previous PTCA, % [n]	26.5 [93/351]	29.5 [410/1392]	30.3 [87/287]	38.2 [52]	30.9 [123/398]	28.7 [94/328]	32.0 [337/1052]	0.179	
Previous CABG, % [n]	5.2 [18/347]	5.4 [75/1383]	4.5 [13/287]	3.7 [5]	2.8 [11/394]	2.7 [9/329]	4.4 [46/1046]	0.210	
Chronic coronary syndrome, % [n]	48.0 [171/356]	49.0 [696/1420]	55.9 [162/290]	49.6 [68/137]	55.8 [222/398]	49.4 [166/336]	54.6 [580/1063]	0.020	
Acute coronary syndrome, % [n]	52.0 [185/356]	51.0 [724/1420]	44.1 [128/290]	50.4 [69/137]	44.2 [176/398]	50.6 [170/336]	45.4 [483/1063]	0.020	
Unstable angina	13.8 [49/356]	13.3 [189/1420]	10.7 [31/290]	23.4 [32/137]	13.1 [52/398]	9.8 [33/336]	11.7 [124/1063]	0.004	
NSTEMI	24.7 [88/356]	23.0 [327/1420]	24.1 [70/290]	16.1 [22/137]	20.6 [82/398]	25.9 [87/336]	21.9 [233/1063]	0.237	
STEMI	13.5 [48/356]	14.7 [208/1420]	9.3 [27/290]	11.0 [15/137]	10.6 [42/398]	14.9 [50/336]	11.9 [126/1063]	0.064	
Femoral access, % [n]	21.1 [75/356]	21.3 [302/1420]	19.9 [58/291]	18.3 [25/137]	15.8 [63/399]	15.5 [52/336]	17.9 [190/1064]	0.059	
Radial access, % [n]	79.5 [283/356]	79.4 [1127/1420]	80.8 [235/291]	81.0 [111/137]	85.2 [340/399]	83.9 [282/336]	83.5 [888/1064]	0.042	
Intracoronary imaging use, % [n]	7.6 [27/356]	10.4 [148/1420]	10.7 [31/291]	11.0 [15/137]	12.8 [51/399]	13.1 [44/336]	14.5 [154/1064]	0.008	
Lesion preparation, % [n]									
Atherectomy	0.6 [2/356]	2.0 [29/1420]	0.0 [0/291]	0.0 [0/137]	1.0 [4/399]	0.6 [2/336]	1.5 [16/1064]	0.020	
Cutting balloon	0.8 [3/356]	1.6 [23/1420]	3.4 [10/291]	1.5 [2/137]	1.5 [6/399]	1.2 [4/336]	1.3 [14/1064]	0.190	
Thrombus aspiration	3.1 [11/356]	2.8 [40/1420]	1.7 [5/291]	1.5 [2/137]	3.0 [12/399]	3.9 [13/336]	2.8 [30/1064]	0.720	
Overall no. of lesions treated, mean±SD [N]	1.5±0.7 [356]	1.4±0.7 [1420]	1.5±0.8 [291]	1.4±0.8 [137]	1.3±0.6 [399]	1.4±0.6 [336]	1.4±0.7 [1063]	0.058	
No. of stents implanted, mean±SD [N]	1.8±1.0 [356]	2.0±1.1 [1420]	2.1±1.1 [291]	1.7±0.9 [137]	1.5±0.8 [399]	1.5±0.8 [336]	1.8±1.0 [1063]	<0.001	

(Continued)

Table 1. Continued

Characteristic	True bifurcation				Nontrue bifurcation				P value
	Medina 1.0.1 n=356	Medina 1.1.1 n=1420	Medina 0.1.1 n=291	Medina 0.0.1 n=137	Medina 1.0.0 n=336	Medina 1.1.0 n=1064			
Bifurcation main vessel, % [n]									
Left main	5.9 [21/356]	12.8 [181/1420]	8.6 [25/291]	2.2 [3/137]	8.3 [33/399]	14.9 [158/1064]	<0.001		
Left anterior descending	53.4 [190/356]	63.2 [897/1420]	69.1 [201/291]	47.5 [65/137]	65.4 [261/399]	58.1 [618/1064]	<0.001		
Left circumflex	34.8 [124/356]	17.0 [241/1420]	18.2 [53/291]	43.1 [59/137]	19.3 [77/399]	17.3 [184/1064]	<0.001		
Right coronary artery	5.9 [21/356]	7.0 [100/1420]	4.1 [12/291]	7.3 [10/137]	7.0 [28/399]	9.8 [104/1064]	<0.001		
Bifurcation technique, % [n]									
1 stent	64.6 [212/328]	65.2 [897/1376]	52.2 [145/278]	56.8 [21/37]	97.4 [378/388]	94.3 [987/1047]	<0.001		
2 stents	35.4 [116/328]	34.8 [479/1376]	47.8 [133/278]	43.2 [16/37]	2.6 [10/388]	5.7 [60/1047]	<0.001		
POT	29.2 [103/353]	41.1 [581/1415]	31.5 [91/289]	15.3 [21/137]	38.9 [155/398]	30.9 [322/1042]	<0.001		

CABG indicates coronary artery bypass graft surgery; MI, myocardial infarction; NSTEMI, non-ST-segment-elevation myocardial infarction; POT, proximal optimization technique; PTCA, percutaneous transluminal coronary angiography; and STEMI, ST-segment-elevation myocardial infarction.

for patients in whom no Ultimaster stent was implanted, in which follow-up was only available to discharge. The event rates (see Outcomes) at 1-year follow-up were calculated based upon the number of patients who had a 1-year follow-up visit or experienced a clinical event. All primary outcome-related adverse events were adjudicated by an independent clinical events committee.

Outcomes

The primary outcome measure was target lesion failure (TLF), defined as the composite of cardiac death, target vessel-related myocardial infarction, and clinically driven target lesion revascularization. Secondary outcomes included target vessel failure (TVF), composite of cardiac death, target vessel myocardial infarction and clinically driven target vessel revascularization, and patient-oriented composite end point, defined as a composite of all-cause death, any myocardial infarction (MI), and any revascularization. For MI, the extended historical definition was applied that primarily uses creatine kinase myocardial band, or if not available troponin, as a cardiac biomarker criterion.¹³ All deaths, MI, target lesion revascularizations (TLRs) or target vessel revascularizations, and stent thrombosis were adjudicated by an independent clinical events committee.

Statistical Analysis

Continuous variables are reported as mean along with SD and compared using the ANOVA test, whereas categorical variables are reported as frequency and percentage and compared using the χ^2 test. Analyses were performed with SAS version 9.4 software (SAS Institute, Cary, NC). Cox proportional hazards models were performed using Medina 1.0.0 as the reference category to assess the hazard ratio (HR) of 1-year outcomes across different Medina subtypes, adjusting for PCI indication (chronic coronary syndrome, unstable angina, non-ST-segment-elevation myocardial infarction, and ST-segment-elevation myocardial infarction), CBL vessel location (right coronary artery, left main stem, left anterior descending artery, and left circumflex artery), radial access, stenting strategy (1 versus 2 stents), and use of intracoronary imaging and/or proximal optimization technique.

RESULTS

A total of 4003 patients undergoing PCI for CBLs at the index procedure were included in the analysis. The most prevalent lesion subtypes were Medina 1.1.1 (n=1420, 35.5%) and Medina 1.1.0 (n=1064, 26.8%), whereas the least prevalent subtype was Medina 0.0.1 (n=137, 3.5%) (Figure 1).

Table 2. One-Year Clinical Outcomes According to Medina Classification Subtype

Outcome	True bifurcation			Nontrue bifurcation				P value
	1.0.1	1.1.1	0.1.1	0.0.1	0.1.0	1.0.0	1.1.0	
	n=337	n=1368	n=276	n=136	n=385	n=320	n=1033	
TLF, % [n]	4.5% [15]	6.1% [83]*	2.9% [8]	8.1% [11]†	3.4% [13]	2.5% [8]	4.7% [49]	0.016
TVF, % [n]	5.3% [18]	7.4% [101]*	2.9% [8]	8.8% [12]*	3.9% [15]	4.1% [13]	5.8% [60]	0.009
POCE, % [n]	9.8% [33]	10.8% [148]*	6.2% [17]	9.6% [13]	7.0% [27]	6.3% [20]	9.7% [100]	0.040
All-cause death, % [n]	3.6% [12]	3.6% [49]	0.7% [2]	2.9% [4]	2.9% [11]	1.9% [6]	1.9% [20]	0.056
Cardiac death, % [n]	1.2% [4]	2.4% [33]	0.4% [1]	2.9% [4]	2.1% [8]	0.9% [3]	1.5% [15]	0.115
TV-MI, % [n]	1.5% [5]	1.8% [25]	0.4% [1]	0.7% [1]	0.3% [1]	0.9% [3]	1.4% [14]	0.179
CD-TVR, % [n]	3.9% [13]	4.9% [67]	2.5% [7]	6.6% [9]	1.6% [6]	2.8% [9]	4.1% [42]	0.028
CD-TLR, % [n]	3.0% [10]	3.4% [46]*	2.5% [7]	5.2% [7]*	1.0% [4]	1.3% [4]	2.8% [29]	0.068
Definite/probable ST, % [n]	1.2% [4]	1.1% [15]	0.0% [0]	0.0% [0]	0.3% [1]	0.9% [3]	0.7% [7]	0.290

CD-TLR indicates clinically driven target lesion revascularization; CD-TVR, clinically driven target vessel revascularization; POCE, patient-oriented composite end point (composite of all-cause death, any myocardial infarction, and any revascularization); ST, stent thrombosis; TLF, target lesion failure (composite of cardiac death, target vessel myocardial infarction, and clinically driven target lesion revascularization); TVF, target vessel failure (composite of cardiac death, target vessel myocardial infarction, and clinically driven target vessel revascularization); and TV-MI, target vessel myocardial infarction.

*P<0.05 vs Medina 1.0.0.

†P<0.01 vs Medina 1.0.0.

Patient and Procedural Characteristics

The median age for the entire cohort was ~65years, with the majority being men (70.8%–77.5%), undergoing PCI for chronic coronary syndrome (48.0%–55.9%) (Table 1). However, no differences were observed between Medina subtypes for characteristics such as age, sex, diabetes, hypertension, hypercholesterolemia and previous MI, coronary artery bypass graft surgery, and percutaneous transluminal coronary angioplasty. Acute coronary syndrome was the most frequent indication for Medina 1.0.1 (52.0%) and the least frequent for Medina 0.1.1 (44.1%).

In terms of procedural characteristics, the rate of use of intracoronary imaging was highest in the Medina 1.1.0 subtype (14.5%) and lowest in the Medina 1.0.1 subtype (7.6%) (Table 1). Although there was no difference in the mean number of total lesions treated among Medina subtypes, the greatest number of stents implanted were in Medina 0.1.1 (2.1±1.1), whereas the lowest was in Medina 0.1.0 and 1.0.0 (1.5±0.8 each). Overall, the left anterior descending artery was the most treated vessel, and this was most frequent in Medina 0.1.1 (69.1%) and least frequent in Medina 0.0.1 (47.5%). The majority of CBLs were treated by a

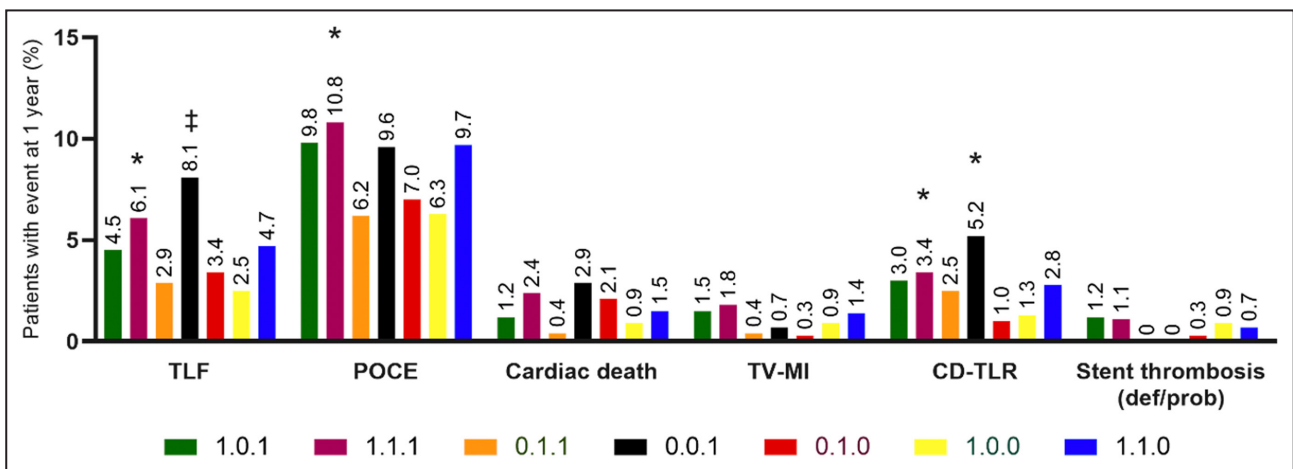


Figure 2. Clinical outcomes at 1 year as per the Medina classification subtype.

CD-TLR indicates clinically driven target lesion revascularization; def/prob, definite/probable; POCE, patient-oriented composite end point (composite of all-cause death, any myocardial infarction, and any revascularization); TLF, target lesion failure (composite of cardiac death, target-vessel myocardial infarction, and clinically driven target lesion revascularization); and TV-MI, target vessel myocardial infarction. Symbols indicate significant P value vs Medina 1.0.0: *P<0.05 and **P<0.01, the rest are nonsignificant (P>0.05).

Table 3. HR With 95% CI of Clinical Outcomes at 1 Year According to Medina Classification*

Outcome	HR (95% CI)											
	True bifurcation					Nontrue bifurcation						
	1.0:1	P value	1.1:1	P value	0.1:1	P value	0.1:0	P value	1.1:0	P value		
Target lesion failure	2.0 (0.9–4.9)	0.106	2.6 (1.3–5.5)	0.001	1.3 (0.5–3.5)	0.629	4.0 (1.6–9.9)	0.003	1.5 (0.6–3.7)	0.332	1.9 (0.9–4.1)	0.083
Cardiac death	1.6 (0.4–7.2)	0.547	2.9 (0.9–9.6)	0.086	0.5 (0.0–4.7)	0.534	4.7 (1.0–21.6)	0.044	2.7 (0.7–10.1)	0.148	1.6 (0.5–5.4)	0.474
Target vessel myocardial infarction	1.7 (0.4–7.1)	0.490	2.2 (0.6–7.4)	0.211	0.4 (0.0–3.7)	0.406	0.9 (0.1–8.6)	0.918	0.3 (0.0–3.1)	0.322	1.5 (0.4–5.3)	0.512
Clinically driven target lesion revascularization	2.8 (0.9–8.9)	0.089	3.1 (1.1–8.6)	0.034	2.3 (0.7–7.9)	0.197	4.6 (1.3–16.0)	0.015	0.9 (0.2–3.8)	0.926	2.3 (0.8–6.5)	0.120
Stent thrombosis (definite/probable)	1.0 (0.2–4.7)	0.988	1.1 (0.3–4.0)	0.877	†	†	†	†	0.3 (0.0–3.2)	0.335	0.8 (0.2–3.1)	0.738

HR indicates hazard ratio.
 *Reference is Medina 1.0.0.
 †Zero events.

1-stent technique, especially the nontrue bifurcation subtypes Medina 0.1.0 (97.4%), Medina 1.0.0 (96.3%), and Medina 1.1.0 (94.3%), whereas the use of a 2-stent technique was highest in true bifurcations (34.8%–47.8%) as well as Medina 0.0.1 (43.2%). The proximal optimization technique was more frequently used in the Medina 1.1.1 subtype (41.1%) and least commonly in Medina 0.0.1 (15.3%). Furthermore, the overall use of the proximal optimization technique and poststenting kissing balloon was higher in 2-stent than 1-stent techniques (77.4% versus 31.1% and 49.4% versus 36.8%, respectively). Several 2-stent techniques were used for true and nontrue bifurcations (Tables S1 and S2, respectively), T-stenting (23.8%) being the most used, followed by the Crush technique (17.0%) and TAP (16.1%) in true bifurcation lesions. There was a variation depending on the type of the true bifurcation. For nontrue bifurcations, another technique that was not specified was the most used (29.6%), whereas for true bifurcations, T-stenting was the common strategy (23.8%).

Clinical Outcomes

Overall, TLF and TVF rates were highest in Medina 1.1.1 (6.1% and 7.4%, respectively) and Medina 0.0.1 (8.1% and 8.8%, respectively) subtypes, whereas the lowest TLF and target vessel revascularization rates were in the Medina 1.0.0 and Medina 0.1.1 subtypes, respectively (TLF: 2.5%, TVF: 2.9%) (Table 2, Figure 2). The high TLF and TVF rates were primarily driven by high rates of clinically driven TLR and target vessel revascularization, respectively. Patient-oriented composite end point rates were highest among Medina 1.1.1 (10.8%), Medina 0.0.1 (9.6%), and Medina 1.1.0 (9.7%) subtypes compared with all other bifurcation distributions. No statistically significant differences between Medina subtypes were observed for other outcomes including all-cause and cardiac death, target vessel MI, and definite/probable stent thrombosis.

Using Medina 1.0.0 as the reference category, the risk of 1-year TLF was only increased in Medina 1.1.1 (HR, 2.6 [95% CI, 1.3–5.5]) and Medina 0.0.1 (HR, 4.0 [95% CI, 1.6–9.9]) subtypes, driven by an increased risk of clinically driven TLR in either subtype (Medina 1.1.1: HR, 3.1 [95% CI, 1.1–8.6]; Medina 0.0.1: HR, 4.6 [95% CI, 1.3–16.0]) and cardiac death in the Medina 0.0.1 subtype (HR, 4.7 [95% CI, 1.0–21.6]) (Table 3, Figure 3). No other differences in risk of adverse clinical outcomes (target vessel MI, cardiac death, and stent thrombosis) were observed between Medina 1.0.0 and other Medina subtypes.

Subgroup Analysis

Comparison by Medina subtype found no difference between stenting techniques (1 versus 2 stents) except

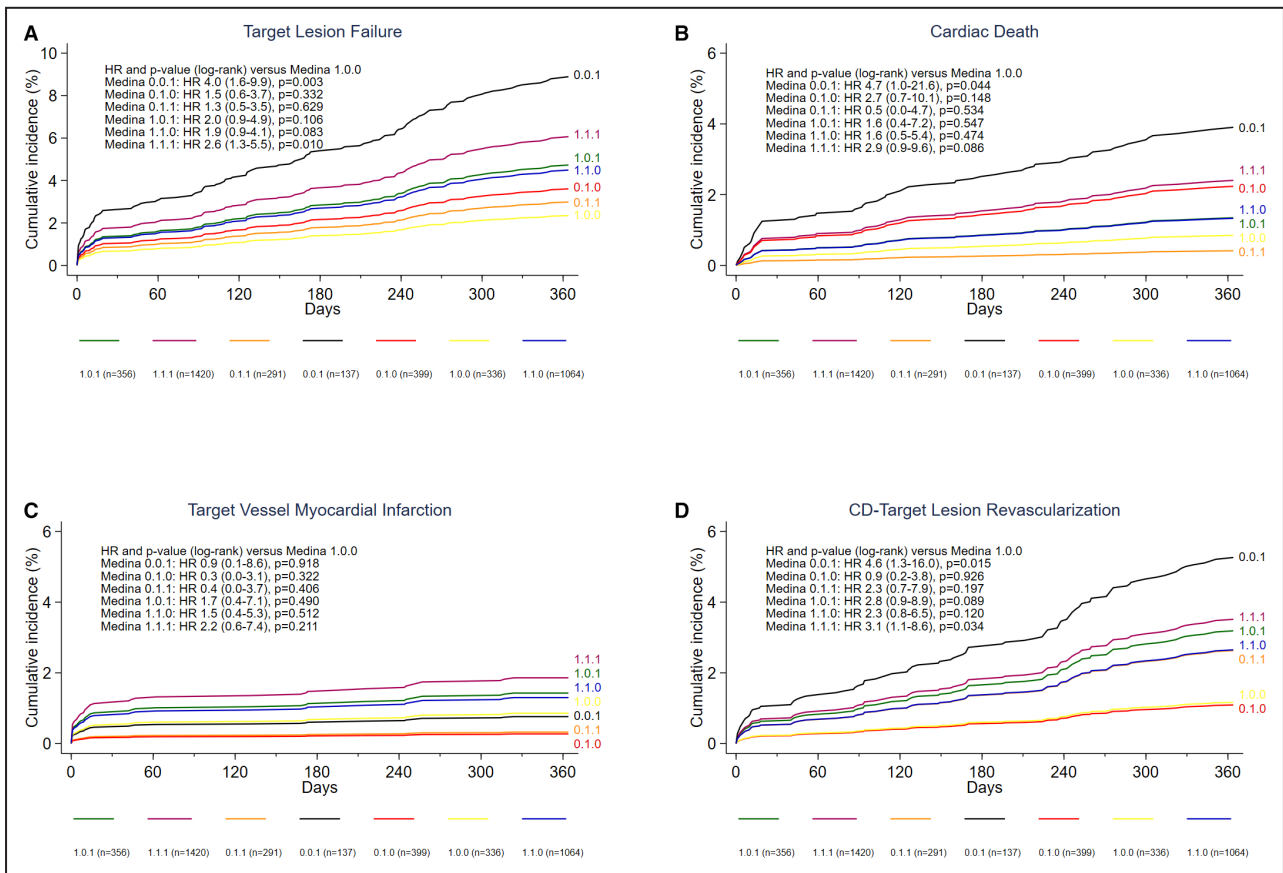


Figure 3. Hazard ratio (HR) and 95% CI for individual Medina subtypes for (A) target lesion failure, (B) cardiac death, (C) target vessel myocardial infarction, and (D) clinically driven (CD) target lesion revascularization. Reference is Medina 1.0.0.

in the Medina 1.0.0 group, where a 2-stent strategy was associated with higher rates of clinically driven TLR (8.3% versus 1.0%, $P<0.05$) (Table S3). Furthermore, there were no differences in clinical outcomes at 1 year per type of 2-stent technique except for all-cause death, with the lowest rate observed with V-stenting (0.0%, 0/48) and the highest with the Culotte technique (9.2%, 8/87). (Table S4).

Tables S5 and S6 summarize 1-year clinical outcomes for bifurcation lesions involving the left main and left anterior descending arteries, respectively, as per the Medina classification. No differences in clinical outcomes were observed between Medina subtypes, except for patient-oriented composite end point for lesions involving the left main artery for which the highest rate was observed in Medina 1.1.1 (21.9%) and the lowest in Medina 0.0.1 (0.0%).

DISCUSSION

The present study is the first to outline the impact of lesion distribution according to Medina classification on 1-year clinical outcomes among >4000 patients

undergoing CBL PCI using the same contemporary stent platform. Our findings can be summarized as follows (Figure 4). First, we found that Medina 1.1.1 (35.5%) and Medina 1.1.0 (26.8%) were the most prevalent CBL distributions, whereas Medina 0.0.1 (3.5%) was the least prevalent. Second, no clinically meaningful differences in patient characteristics were observed following stratification for Medina subtypes. Despite this, PCI of Medina 1.1.1 and 0.0.1 subtypes was associated with significantly higher crude rates of TLF compared with all other bifurcation distributions and were independently associated with an increased hazard of TLF (2.6- and 4-fold, respectively) at 1 year.

Although previous studies have examined differences in procedural outcomes between true and non-true CBLs, there are limited data on the prognostic impact of disease distribution in CBLs.¹⁰⁻¹² Our findings highlight differences in 1-year outcomes between CBL distributions, with the greatest hazard for TLF and TVF observed among Medina 1.1.1 and Medina 0.0.1, even after adjustment for baseline differences between Medina subtypes. Given the limited previous literature comparing outcomes between CBL lesion

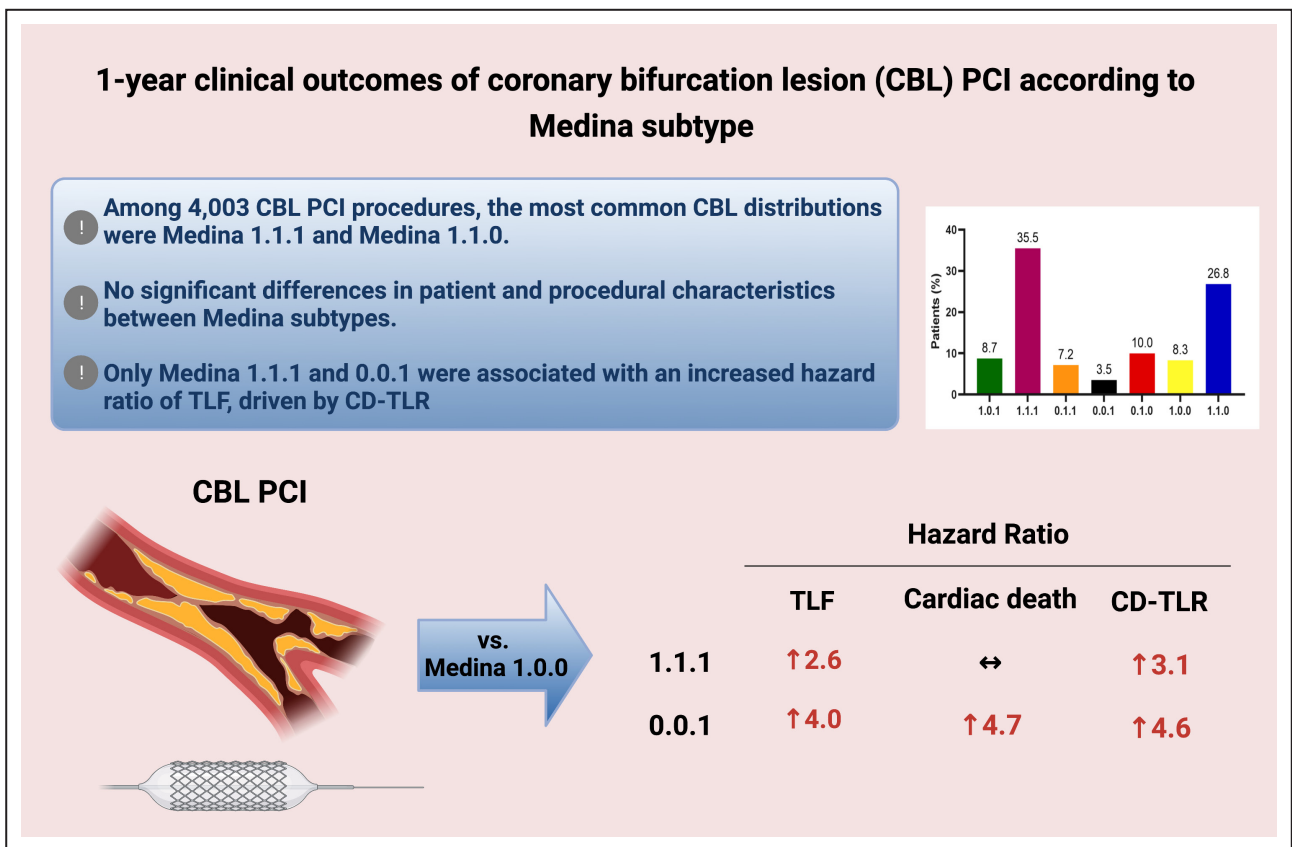


Figure 4. Summary of study findings.

CBL indicates coronary bifurcation lesion; CD-TLR, target lesion revascularization; PCI, percutaneous coronary intervention; and TLF, target lesion failure.

distributions, it is difficult to place our findings within the context of other studies. A study of 2897 patients undergoing CBL PCI reported higher crude rates of Major acute cardiovascular events and cardiac death/MI among specific Medina subtypes (Medina 1.1.1: 12.4% and 4.5%, respectively; Medina 0.1.1: 13.9% and 3.7%, respectively).¹⁰ However, the authors did not compare outcomes between different Medina subtypes except within true CBL groups (Medina 1.1.1 and Medina 0.1.1 versus Medina 1.0.1) and reported no differences between these groups. Furthermore, their findings were derived from an old procedural cohort (enrolled between 2003 and 2009), managed with older (first and second) generation drug-eluting stents. In contrast, Todara et al reported no difference in in-hospital and 12-month cardiac death, TLR, and reinfarction between Medina 1.1.1 and all other subtypes combined.¹¹ However, their analysis was based on a small sample size (n=120, including n=25 with Medina 1.1.1) from an old procedural cohort (2005–2006), where 25% of patient were not managed with a drug-eluting stent.

The finding that 0.0.1 isolated SB disease has the highest hazard of TLF is interesting and deserves further comment. Our subgroup analysis suggests that the worse outcomes associated with 0.0.1 are

observed irrespective of whether a single- or 2-stent approach is used. Isolated SB disease is complex to treat, because lesions are often fibrocalcific with significant recoil, which makes achieving good minimal luminal area challenging, particularly if the lesions are not adequately prepared.^{14,15} Furthermore, isolated SB lesions often supply a limited myocardial territory (<10%), with only 1 in 5 non-left main artery SB lesions shown to supply >10% fractional myocardial mass in a multicenter registry analysis of 482 patients undergoing computed tomography coronary angiography.¹⁶ Isolated SB lesions are also difficult to treat, because identification of the ostium may be challenging, resulting in geographical or ostial miss, or compromise of the main vessel, which may account for 27% of isolated SB lesions treated with a 2-stent approach. Furthermore, stent underexpansion or recoil, smaller SB vessel size in relation to the MB, and SB length may all contribute to the worse outcomes observed in this group.^{17–19} The mean stent diameter for SB 0.0.1 lesions in our study was 2.79mm compared with >3mm used to treat MB lesions. Consequently, many operators may choose to treat these lesions conservatively or use alternative interventional strategies such as drug-eluting balloons, although there is limited evidence to support the latter.

An observational study of 49 patients of Medina 0.0.1 lesions with associated ischemia showed that careful predilatation with a cutting balloon followed by a drug-eluting balloon use was sufficient in the majority of cases, with only 14% requiring stent implantation for acute recoil/coronary dissection.²⁰ Nevertheless, their reported rate of TLF was still high at 14%, 1-year after the procedure. The present findings highlight the complexity of this lesion subset, for which there are limited evidence-based therapies, and emphasize the need for prospective work around alternative management strategies for isolated SB lesions.

Limitations

There are several limitations to the present study. First, the outcomes that we report are only in patients treated with PCI; our data do not inform on outcomes of lesions treated medically, which is particularly relevant for isolated SB lesions. Second, although the events in our study were independently adjudicated, it is possible that some events were underreported. However, measures to preserve the quality of data reporting, including on-site and remote monitoring, and close communication with the participating sites were in place. Furthermore, the Medina classification was identified based on data submitted in the electronic case report form and not assessed from a core laboratory. Third, some of the CIs in our results are wide because of the relatively small sample size for individual Medina subgroups. Finally, our findings are based on 1-year outcomes, and it is possible that further prognostic differences are observed between Medina subtypes on longer follow-up.

CONCLUSIONS

Within prospective multicenter data collection with independent event adjudication, we demonstrated significant prognostic differences among 4000 bifurcation PCI procedures according to coronary bifurcation distribution patterns, with Medina 1.1.1 and Medina 0.0.1 associated with worse clinical outcomes at 1 year, including clinically driven TLR and consequently TLF, compared with other Medina subtypes. The present findings should prompt greater caution among operators when managing these higher-risk lesions.

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R.D. is an employee of Terumo Europe. F.v.L. is a consultant to Terumo Europe. The remaining authors have no disclosures to report.

Supplemental Material

Data S1
Tables S1–S6
Figure S1

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Ormanov; Pavlodar Regional Cardiologic Center: Ruslan Baisebenov; Regional Cardiosurgery Center: Azamat Kenzhinovich Zhashkeyev; Rudnyi City Hospital: Azamat Yerzhanov; The Almaty City Heart Center: Orazbek Sakhov; Semey State Medical University, Interventional Cardiology Dpt: Ersin Sabitov; **KUWAIT** Sabah Al Ahmad Cardiac Center: Vladimir Kotevski; **LEBANON** Hôpital Abou Jaoudé: Daou Abdo; Labib Medical Center: Ahmad Serhal; **LITHUANIA** Hospital Of Lithuanian University Of Health Sciences Kauno klinikos: Ramunas Unikas; Klaipeda Seamen's Hospital: Aurimas Knokneris; **MACEDONIA** City General Hospital: Vladimir Ristovski; University Clinic Of Cardiology: Sasko Kedev; **MALAYSIA** Desa Park City: Chong Yoon Sin; Hospital Serdang: Abdul Kahar Ghapar; Hospital Sultanah Bahiyah: Abd Syukur Bin Abdullah; Hospital Tengku Ampuan Afzan: Siti Khairani bt Zainal Abidin; HSC Medical Center: Tee Chee Hian; UiTM Sg. Buloh Campus: Nicholas Chua Yul Chye; **MEXICO** Clinica Hospital San Jose de Navojoa: Santiago Sandoval Navarrete; Hospital Fray Juan de San Miguel de Uruapan: Juan Jorge Beltran Ochoa; Hospital Star Medica Merida: Sergio Alonso Villareal Umaña; Casa del Corazon de la Peninsula de Yucatan SCP: Carlos Ramon Rodas Caceres; **MOROCCO** Cherradi_Clinique Agdal: Rhizlan Cherradi; Clinique Achifaa de Casablanca: Anass Assaidi; Clinique Grant Atlas: Dounia Benzaroual; Clinique Internationale de Marrakech: Fahd Chaara; **NETHERLANDS** Albert Schweitzer Ziekenhuis: Martijn Scholte; Amphia Ziekenhuis: Alexander J.J. Ijsselmuiden; Catharina Ziekenhuis: W.A.L. Pim Tonino; Jeroen Bosch Ziekenhuis: Jawed Polad; Jacob van Eck; Maasstad Ziekenhuis: Pieter Cornelis Smits; Meander MC: Fabrizio Spano; Medisch Centrum Haaglanden: Lucas H. Savalle; Medisch Spectrum Twente, Enschede: Clemens Von Birgelen; Rijnstate Ziekenhuis: Peter W. Danse; Schepers Hospital: Gillian Jessurun; Zorgzaam Ziekenhuis Zeeuws-Vlaanderen: Pieter Bisschops; **OMAN** Muscat Private Hospital: Amr Hassan; **POLAND** Instytut Kardiologii im. Prymasa Tys ąlecia Stefana Kardynała Wyszyńskiego: Adam Witkowski; Miedziove Centrum Zdrowia: Adrian Wlodarczak; Szpital Kliniczny Przemienienia Paskiego Um Im. K. Marcinkowskiego W Poznaniu: Maciej Lesiak; **PORTUGAL** CHLN Norte Hospital Santa María: Pedro Canas Da Silva; **ROMANIA** Centrele de Excelenta Ares: Alexandru Voican; Clinicile Icco S.R.L.: Mihai Ursu; Cordismed Timisoara: Milovan Slovenski; Spitalul Judetean de Urgenta Sibiu: Ioan Bitea Cornel; **SAUDI ARABIA** Dallah Hospital, Riyadh: Samih Lawand; King Fahad Cardiac Center: Tarek Kashour; Prince Abdullah Bin Abdul Aziz Musad Cardiac Center: Muhammad Aurangzaib Mughal; **SERBIA** Cardiovascular Institute Dedinje: Dragan Sagic; Clinical Center Kragujevac: Nikola Jagic; Cardiology Clinic, Clinical Centre of Serbia: Vladan Vukcevic; Kbc Zvezdara: Alexandar Davidovic; CHC Bezanijska Kosa: Sasa Hinic; **SLOVAKIA** Stredodlovensky Ustav Srdcovych A Cievnych Chorob: Martin Hudec; **SOUTH AFRICA** Ethekwini Hospital & Heart Centre: Shiraz Gafoor; Ismail Soosiwala; Milpark Hospital: Graham Cassel; Netcare Greenacres Hospital: Martin Tawanda Butau; Netcare Union Hospital: Jean-Paul Theron; Netcare Unitas Hospital: Jean Vorster; Netcare Unitas Hospital: Pieter Blomerus; Netcare Unitas Hospital: Iftikar Osman Ebrahim; Netcare Unitas Hospital: Jacobus Badenhorst; **SPAIN** Bellvitge University Hospital: Joan Antonio Gomez; Complejo Hospitalario Universitario A Coruña (CHUAC): Nicolás Vázquez Gonzalez; Hospital 12 Octubre: Fernando Sarnago; Hospital Cabueñes: Iñigo Lozano; Hospital Clínico Lozano Blesa de Zaragoza: José Ramón Ruiz Arroyo; Hospital Clínico Universitario de Santiago de Compostela: Ramiro Trillo Nouche; Clinico Universitario Valencia: Juan Sanchís; Hospital de Cruces-Barakaldo: Juan Alcibar; Hospital Universitario Donostia: Mariano Larman; Hospital de Galdakao: José Ramón Rumoroso; Hospital de La Cruz Roja de Córdoba: José Suárez de Lezo; Hospital de León: Maria López Benito; Hospital de Mérida: Pablo Cerrato Garcia; Hospital de Navarra: Baltasar Lainez; Hospital del Mar: Beatriz Vaquerizo; Hospital Fundacion Alcorcon: Javier Botas; Hospital G. Trias I Pujol: Eduard Fernández Nofrerias; Hospital General Castellón: Pascual Baello Monge; Hospital General Ciudad Real: Fernando Lozano Ruiz-Poveda; Hospital General de Albacete: Jesus Maria Jimenez Mazuecos; Hospital General Universitario de Burgos: Javier Robles; Hospital Infanta Cristina: José Ramon Lopez Minguez; Hospital Juan Ramón Jiménez: Pepi Garcia; Clinica La Luz: Jorge Palazuelos; Hospital Manises: Gema Miñana; Hospital Marqués de Valdecilla: Jose Javier Zuco; Hospital Meixoeiro-Medtec: Andrés Iñiguez Romo; Hospital Moncloa: Eulogio Garcia Fernandez; Hospital Puerta de Hierro: Javier Goicolea; Hospital Reina Sofia

de Córdoba: Manuel Pan; Clínica San Fransisco de Asis: Arturo García Touchard; Hospital San Pedro: Javier Fernández; Hospital San Pedro de Alcantara-Caceres: Javier Fernandez Portales; Hospital San Rafael: Gonzalo Peña; Hospital Sant Pau: Antonio Peñaranda Serra; Hospital Santa Lucía de Cartagena Hospital Nostra Señora Rossell: José Domingo Cascón; Hospital Txagorritxu: Alfonso Torres; Hospital Universitario de Gran Canaria Dr Negrin: Pedro Martin Lorenzo; Hospital Universitario de Guadalajara: Javier Balaguer Requena; Hospital Universitario Lucus Augusti (HULA): Raymundo Ocaranza Sanchez; Hospital Universitario Miguel Servet (H.U.M.S.): Jose Antonio Diarte de Miguel; Hospital Vall d'Hebron: Bruno García Del Blanco; Hospital Virgen Arrixaca: Eduardo Pinar; Hospital Virgen de La Salud: P. José Moreu Burgos; Instituto Cardiologico Hospital Campo Grande: Juan Manuel Duran; San Juan de Alicante: Ramón López Palop; Universitario Central de Asturias: César Moris-De La Tassa; SWEDEN Gävle Sjukhus: Robert Kastberg; Mälarsjukshuet: Finn Hjortevang; Skaraborgs Sjukhus v Skövde: Jason Stewart; Sundvalls Sjukhus: Espen Haugen; Universitets Sjukhuset I Örebro: Ole Fröbert; Västmanlads Sjukhus Västerås: Amra Kåregren; **SWITZERLAND** Cardiocentro Lugano, Ticino: Giovanni Pedrazzini; Herz Gefäss Zentrum Zürich: Peter Wenaweser; Hôpital de La Tour: Edoardo De Benedetti; Hôpitaux Universitaires de Genève: Maro Roffi; Kantonsspital Baselland: Gregor Leibundgut; Kantonsspital Frauenfeld Spital Thurgau AG: Michael Neuhaus; Kantonsspital Luzern: Florim Cuculi; **THAILAND** Central Chest Institute Of Thailand: Wirash Kehasukcharoen; HRH Princess Maha Chakri Sirindhorn Medical Center (Nakornayok): Arthit Wongsoasup; Paolo Memorial Hospital Phaholyothin: Niphonth Srisuwanunt; **TUNISIA** Dr. Mohamed Drissa Clinique Hannibal Lac 2: Mohamed Akram Drissa; Dr. Ben Chedli Tarek - Soukra Medical: Ben Chedli Tarek; Dr. Bouziri - Clinique Générale Et Cardiovasculaire de Tunis: Sami Bouziri; Dr. Elyes Kharrat - Bassatine Clinic: Elyes Kharrat; Polyclinique El bassatine_Dr. Mohamed Najeh Abid: Mohamed Najeh Abid; Clinique Générale et Cardiovasculaire de Tunis _Dr. Saloua Trabelsi: Saloua Trabelsi; Polyclinique El Bassatine: Rridha Ennouri; **UKRAINE** Heart Institute: Andriy Khohlov; NAMS Amosov | Emergency Endovascular Surgery Department: Sergii Salo; NAMS Amosov | X-Ray Diagnostics And Invasive Cardiology Department: Yevhenii Aksonov; S.P.M.C. of Pediatric Cardiology and Cardiac Surgery: Georgiy Mankovskiy; **UNITED ARAB EMIRATES** Al Noor Hospital - Airport: Mohammad Andron; Al Qassimi Hospital: Arif Al Nooryani; Al Zahra Private Hospital, Dubai: Syed Nazir; Belhoul Speciality Hospital, Dubai: Muhammad Adnan Raufi; Dr. Sulaiman Al Habib: Albert Alahmar; Dubai Hospital: Hesham Ahmed Osman; Iranian Hospital, Dubai: Seyed Bagher Tabatabaei; Lifecare Hospital: Khaled Galal; Prime Hospital, Dubai: Murali Krishna; Rashid Hospital: Fahad Omar Baslaib; **UNITED KINGDOM** Essex Cardiothoracic Centre, Basildon: Rohan Jagathesan; Bedford Hospital: Ramesh de Silva; Blackpool Victoria Hospital: Jonas Eichhofer; Bradford Teaching Hospitals: John Kurian; Croydon University Hospital: Sanjay Kumar; Dorset County Hospital: Javed Iqbal; Eastbourne District General Hospital: David Walker; Freeman Hospital: Rajiv Das; GBS Re Bucks Healthcare NHS Trust (Buckinghamshire, Wycombe): Piers Clifford; James Cook University Hospital: David Austin; Kettering General Hospital: Javed Ehtisham; Kings Mill Hospital: Ifti Fazal; Lincoln County Hospital: Kelvin Lee; Lister Hospital, Stevenage: Paul Kotwinski; The Royal Wolverhampton Hospitals: Shahzad Munir; Norfolk And Norwich University Hospital: Alisdair Ryding; Northwick Park Hospital: Ahmed Elghamaz; Plymouth Hospital: Girish Viswanathan; Queen Elizabeth Hospital, Birmingham: Sagar Doshi; Queens Medical Center Nottingham: Sachin Jadhav; Royal Berkshire Hospital: Nicos Spyrou; Royal Blackburn Hospital: John Mcdonald; Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust: Suneel Talwar; Royal Brompton And Harefield: Robert Smith; Royal Cornwall Hospitals: Sen Devadathan; Derby Teaching Hospitals: Kamal Chitkara; The Royal Free Hospital: Sundeep Kalra; Royal Gwent Hospital, Newport: James Cullen; Royal Stoke University Hospital: Mamas Mamas; Royal Sussex Hospital, Brighton: David Hildick Smith; Royal United Hospital, Bath: Kevin Carson; Salisbury District Hospital: Tim Wells; Sandwell And West Birmingham Hospitals: Chetan Varma; Sheffield Teaching Hospital: James Richardson; Tunbridge Wells Hospital: Clive Lawson; UH Coventry and Warwickshire: Rajathurai Thirumaran; University Hospital South Manchester: Hussain Contractor; University Hospital Of Wales: Rito Mitra; University Hospitals Of Leicester: Ian Hudson; West Middlesex Hospital: Sukhinder Nijjer;

Western Sussex Hospitals - Worthing Hospital: Nicholas Pegge; Worcestershire Acute Hospitals NHS Trust: Helen Routledge; Wrightington Hospital: V J Karthikeyan; **UZBEKISTAN** Republic Specialized Center of Surgery: Mirjamol Mirumarovich Zufarov; **VIETNAM** Thong Nhat Hospital: Nguyen Van Tan

Table S1. Type of 2-stent techniques used for patients with a true bifurcation lesion.

True	Missing	Crush	Culotte	Kissing stents	Other	T-stenting	TAP	V-stenting
0.1.1	1.5% (2/133)	13.5% (18/133)	12.8% (17/133)	9.8% (13/133)	6.0% (8/133)	21.1% (28/133)	15.0% (20/133)	20.3% (27/133)
1.0.1	0.9% (1/116)	12.9% (15/116)	6.0% (7/116)	6.9% (8/116)	40.0% (46/116)	24.1% (28/116)	5.2% (6/116)	4.3% (5/116)
1.1.1	1.0% (5/479)	19.0% (91/479)	13.8% (66/479)	7.9% (38/479)	10.4% (50/479)	24.4% (117/479)	19.0% (91/479)	4.4% (21/479)
All	1.1% (8/728)	17.0% (124/728)	12.4% (90/728)	8.1% (59/728)	14.3% (104/728)	23.8% (173/728)	16.1% (117/728)	7.3% (53/728)

Table S2. Type of 2-stent techniques used for patients with a non-true bifurcation lesion.

Non-true	Missing	Crush	Culotte	Kissing stents	Other	T-stenting	TAP	V-stenting
0.0.1	0.0% (0/16)	6.3% (1/16)	18.8% (3/16)	6.3% (1/16)	18.8% (3/16)	37.5% (6/16)	6.3% (1/16)	6.3% (1/16)
0.1.0	0.0% (0/10)	0.0% (0/10)	40.0% (4/10)	0.0% (0/10)	30.0% (3/10)	10.0% (1/10)	10.0% (1/10)	10.0% (1/10)
1.0.0	0.0% (0/12)	8.3% (1/12)	0.0% (0/12)	25.0% (3/12)	0.0% (0/12)	58.3% (7/12)	0.0% (0/12)	8.3% (1/12)
1.1.0	5.0% (3/60)	5.0% (3/60)	8.3% (5/60)	6.7% (4/60)	38.3% (23/60)	20.0% (12/60)	11.7% (7/60)	5.0% (3/60)
All	3.1% (3/98)	5.1% (5/98)	12.2% (12/98)	8.2% (8/98)	29.6% (29/98)	26.5% (26/98)	9.2% (9/98)	6.2% (6/98)

Table S3. Clinical outcomes at 1-year for true and non-true bifurcations according to stent strategy (1 vs. 2 stents) and Medina classification subtype.

	True bifurcation						Non-true bifurcation							
	0.1.1	0.1.1	1.0.1	1.0.1	1.1.1	1.1.1	0.0.1	0.0.1	0.1.0	0.1.0	1.0.0	1.0.0	1.1.0	1.1.0
	1-stent n=141	2-stent n=129	1-stent n=211	2-stent n=108	1-stent n=879	2-stent n=463	1-stent n=42	2-stent n=16	1-stent n=367	2-stent n=10	1-stent n=302	2-stent n=12	1-stent n=962	2-stent n=60
TLF, % [n]	2.8 [4]	2.3 [3]	4.3 [9]	5.6 [6]	5.5 [48]	6.7 [31]	11.9 [5]	12.5 [2]	3.5 [13]	0.0 [0]	2.3 [7]	8.3 [1]	4.9 [47]	3.3 [2]
POCE, % [n]	6.4 [9]	5.4 [7]	9.0 [19]	12.0 [13]	9.8 [86]	12.3 [57]	14.3 [6]	12.5 [2]	7.4 [27]	0.0 [0]	6.3 [19]	8.3 [1]	10.0 [96]	3.3 [2]
Cardiac death, % [n]	0.7 [1]	0.0 [0]	0.5 [1]	2.8 [3]	2.3 [20]	2.4 [11]	4.8 [2]	6.3 [1]	2.2 [8]	0.0 [0]	1.0 [3]	0.0 [0]	1.6 [15]	0.0 [0]
TV-MI, % [n]	0.0 [0]	0.0 [0]	1.4 [3]	1.9 [2]	1.6 [14]	1.9 [9]	2.4 [1]	0.0 [0]	0.3 [1]	0.0 [0]	1.0 [3]	0.0 [0]	1.4 [13]	1.7 [1]
CD-TLR, % [n]	2.1 [3]	2.3 [3]	3.8 [8]	1.9 [2]	3.1 [27]	3.7 [17]	7.1 [3]	6.3 [1]	1.1 [4]	0.0 [0]	1.0 [3]	8.3 [1]*	2.9 [28]	1.7 [1]
ST [def/prob], % [n]	0.0 [0]	0.0 [0]	0.5 [1]	2.8 [3]	0.8 [7]	1.3 [6]	0.0 [0]	0.0 [0]	0.3 [1]	0.0 [0]	1.0 [3]	0.0 [0]	0.7 [7]	0.0 [0]

*p-value for 1 vs. 2-stent strategy: <0.05, non-significant for all other outcomes.

Table S4. Clinical outcomes at 1-year per type of 2-stent technique.

2-stents	Crush	Culotte	Kissing stents	Other	T-stenting	TAP	V-stenting	p-value
TLF	8.6% (10/117)	9.2% (8/87)	1.7% (1/58)	4.0% (4/101)	5.4% (9/167)	5.3% (6/114)	2.1% (1/48)	0.29
POCE	11.1% (13/117)	20.7% (18/87)	8.6% (5/58)	10.9% (11/101)	7.8% (13/167)	10.5% (12/114)	6.3% (3/48)	0.07
All death	2.6% (3/117)	9.2% (8/87)	3.5% (2/58)	7.9% (8/101)	1.2% (2/167)	0.9% (1/114)	0.0% (0/48)	<0.01
Cardiac death	2.6% (3/117)	4.6% (4/87)	1.7% (1/58)	4.0% (4/101)	0.6% (1/167)	0.9% (1/114)	0.0% (0/48)	0.21
All MI	3.4% (4/117)	3.5% (3/87)	0.0% (0/58)	1.0% (1/101)	2.4% (4/167)	0.9% (1/114)	2.1% (1/48)	0.59
CD-TLR	6.0% (7/117)	3.5% (3/87)	0.0% (0/58)	0.0% (0/101)	3.6% (6/167)	4.4% (5/114)	2.1% (1/48)	0.17
Stent thrombosis (def/prob)	1.7% (2/117)	2.3% (2/87)	0.0% (0/58)	1.0% (1/101)	1.2% (2/167)	1.8% (2/114)	0.0% (0/48)	0.87

Table S5. Clinical outcomes at 1-year for bifurcation lesions involving the left main per Medina classifications.

Left main	0.0.1	0.1.0	0.1.1	1.0.0	1.0.1	1.1.0	1.1.1	P-value
TLF	0.0% (0/3)	9.4% (3/32)	4.2% (1/24)	2.8% (1/36)	5.3% (1/19)	7.1% (11/154)	13.5% (24/178)	0.25
POCE	0.0% (0/3)	18.8% (6/32)	4.2% (1/24)	2.8% (1/36)	15.8% (3/19)	13.6% (21/154)	21.9% (39/178)	0.04
All death	0.0% (0/3)	9.4% (3/32)	4.2% (1/24)	0.0% (0/36)	15.8% (3/19)	4.6% (7/154)	9.6% (17/178)	0.17
Cardiac death	0.0% (0/3)	6.3% (2/32)	4.2% (1/24)	0.0% (0/36)	5.3% (1/19)	3.3% (5/154)	6.2% (11/178)	0.70
All MI	0.0% (0/3)	3.1% (1/32)	0.0% (0/24)	0.0% (0/36)	0.0% (0/19)	0.7% (1/154)	2.8% (5/178)	0.62
CD-TLR	0.0% (0/3)	0.0% (0/32)	0.0% (0/24)	2.8% (1/36)	0.0% (0/19)	3.9% (6/154)	7.3% (13/178)	0.29
Stent thrombosis (def/prob)	0.0% (0/3)	0.0% (0/32)	0.0% (0/24)	0.0% (0/36)	0.0% (0/19)	0.7% (1/154)	1.1% (2/178)	0.97

Table S6. Clinical outcomes at 1-year for bifurcation lesions involving the LAD per Medina classifications.

LAD	0.0.1	0.1.0	0.1.1	1.0.0	1.0.1	1.1.0	1.1.1	P-value
TLF	7.7% (5/65)	2.8% (7/252)	2.6% (5/193)	3.5% (6/171)	6.0% (11/183)	3.3% (20/599)	5.5% (47/858)	0.11
POCE	9.2% (6/65)	5.2% (13/252)	5.7% (11/193)	8.2% (14/171)	12.6% (23/183)	7.5% (45/599)	8.9% (76/858)	0.11
All death	3.1% (2/65)	2.4% (6/252)	0.5% (1/193)	2.9% (5/171)	1.6% (3/183)	1.2% (7/599)	3.2% (27/858)	0.12
Cardiac death	3.1% (2/65)	1.6% (4/252)	0.0% (0/193)	1.8% (3/171)	0.0% (0/183)	0.8% (5/599)	2.1% (18/858)	0.08
All MI	0.0% (0/65)	0.8% (2/252)	0.0% (0/193)	1.2% (2/171)	3.8% (7/183)	1.8% (11/599)	2.2% (19/858)	0.07
CD-TLR	4.6% (3/65)	1.2% (3/252)	2.6% (5/193)	1.8% (3/171)	5.5% (10/183)	2.3% (14/599)	2.8% (24/858)	0.15
Stent thrombosis (def/prob)	0.0% (0/65)	0.4% (1/252)	0.0% (0/193)	1.2% (2/171)	1.6% (3/183)	0.7% (4/599)	1.1% (9/858)	0.52

Figure S1. Bifurcation subtypes as per the Medina classification.

