Title: Separate study of true B2 bifurcation lesions is vital for bifurcation PCI. Using The Medina classification will lead to confusion as it separates true bifurcation lesions into 3 unnecessary subgroups. In the Movahed Bifurcation classification, tru bifurcation lesions are summarized in one category called B2 (lesion). B for bifurcation 2 meaning both ostia have disease making it the ideal classification for bifurcation research or clinical use with unlimited additional suffixes that can be added if needed.

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With great interest, I read the paper entitled: "OCT or Angiography Guidance for PCI in Complex Bifurcation Lesions" published in the New England Journal of Medicine. (1) The Authors did a great job in randomizing patients to optical coherent tomography (OCT) vs. no OCT-guided bifurcation intervention. However, the most important anatomic features of a given bifurcation lesion were not mentioned and not studied at all. It is important that only true bifurcation lesions called B2 lesions (B for bifurcation, 2 meaning both ostia have significant disease) based on the Movahed bifurcation classification (2-4) needs a complex approach including the use of OCT. Not separating their bifurcation lesions into true vs. not true

bifurcation lesions, they are not able to answer the simple questions: Do we really need OCT in non-true bifurcation lesions? Unfortunately, by not having any analysis of this important anatomical feature in this manuscript, the benefit of OCT remains uncertain for true or non-true lesions that could lead to under or overuse of OCT during bifurcation coronary interventions.

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