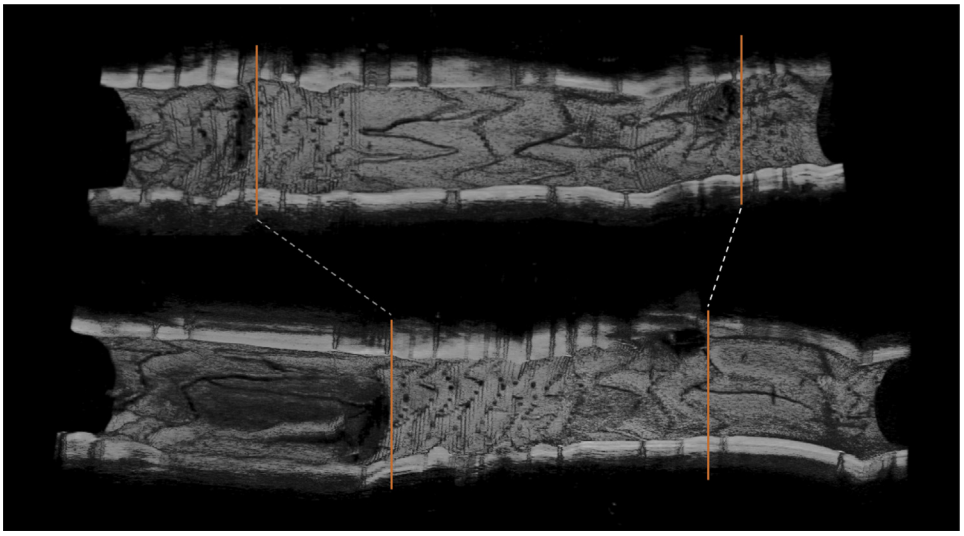
**FIGURE 1 Uncertain Length Measurements by Optical Coherence Tomography**



Two consecutive corresponding optical coherence tomography acquisitions of the same section showing catheter motion artifact with differences in elongation and compression between the 2 pullbacks.

include methodological limitations in measuring strut thickness by OCT as this is not a simple task.

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## REFERENCES

**1.** Ohno Y, Attizzani GF, Capodanno D, et al. Longitudinal elongation, axial compression, and effects on strut geometry of bioresorbable vascular scaffolds: insights from 2- and 3-dimensional optical coherence tomography imaging. J Am Coll Cardiol Intv 2015;8:e35–7.

**2.** van Ditzhuijzen NS, Karanasos A, Bruining N, et al. The impact of Fourier-Domain optical coherence tomography catheter induced motion artefacts on quantitative measurements of a PLLA-based bioresorbable scaffold. Int J Cardiovasc Imaging 2014;30:1013–26.

**3.** Hebsgaard L, Nielsen TM, Tu S, et al. Co-registration of optical coherence tomography and X-ray angiography in percutaneous coronary intervention. The Does Optical Coherence Tomography Optimize Revascularization (DOCTOR) fusion study. Int J Cardiol 2014;182C:272–8.

**4.** Okamura T, Onuma Y, Garcia-Garcia HM, Bruining N, Serruys PW. High-speed intracoronary optical frequency domain imaging: implications for three-dimensional reconstruction and quantitative analysis. EuroIntervention 2012; 7:1216–26.

**5.** Wang T, Wieser W, Springeling G, et al. Intravascular optical coherence tomography imaging at 3200 frames per second. Opt Lett 2013;38: 1715–7.

## REPLY: Triple Antithrombotic Therapy Following Anterior ST-Segment Elevation Myocardial Infarction

We thank Drs. Potter and Bastiany (1) for their interest in our paper (2). We compared patients with anterior ST-segment myocardial infarction managed with primary percutaneous coronary intervention (PCI) who were subsequently prescribed warfarin to patients who were not. We excluded patients with left ventricular thrombus found on a transthoracic echocardiogram (TTE). The primary outcome was a composite of net adverse clinical events (NACE) consisting of all-cause mortality, stroke, reinfarction, or major bleeding at 180 days of the TTE.

The propensity score was derived by fitting a multivariable logistic regression model where treatment (warfarin vs. no warfarin) was used as the outcome. The derived propensity score was then used to derive the weights for the inverse probability weighting logistic regression model where NACE was

used as the outcome and warfarin as the independent variable. In addition, a multivariable analysis using a logistic regression model was performed to determine the independent effect of adding warfarin therapy on NACE. The apical score, left ventricular ejection fraction, and the presence of cardiogenic shock were entered into the model.

In patients deemed not to require oral anticoagulants, heparin was discontinued immediately after the TTE; however, heparin was continued as bridging therapy in patients to be started on warfarin. The decision to start warfarin exposed patients to full-dose anticoagulation therapy during the hospital stay, and therefore, it is appropriate to count events that occurred during this interval.

By propensity score analysis, allocation to warfarin therapy was an independent predictor of NACE (odds ratio [OR]: 4.01, 95% confidence interval [CI]: 2.15 to 7.50, $p < 0.0001$). In a separate multivariable analysis, the odds of NACE remained significantly higher in comparison to patients who were not prescribed warfarin (OR: 3.13, 95% CI: 1.34 to 7.22, $p = 0.007$). In conclusion, our results do not support the addition of warfarin therapy following primary PCI in patients with apical akinesis or dyskinesis.

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## REFERENCES

**1.** Potter BJ, Bastiany A. Triple antithrombotic therapy following anterior ST-segment elevation myocardial infarction. J Am Coll Cardiol Intv 2015;8:1002–3.

**2.** Le May MR, Acharya S, Wells GA, et al. Prophylactic warfarin therapy after primary percutaneous coronary intervention for anterior ST-segment elevation myocardial infarction. J Am Coll Cardiol Intv 2015;8( Pt B):155–62.