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IN THIS ISSUE OF EUROINTERVENTION

The 16th expert consensus from the European Bifurcation Club; ticagrelor or aspirin monotherapy 1 year after PCI; magnesium scaffolds in STEMI; the relationship between coronary vasospasm and atherosclerosis in ANOCA; lifetime valve journey with severe aortic stenosis; endovascular atherectomy in PAD; and more: including our new impact factor!

Davide Capodanno, *Editor-in-Chief*

The new impact factor of EuroIntervention is 7.728, the highest in the history of our Journal and, for the first time, above the psychological threshold of 7. With that, the journal remains in the first quartile of cardiovascular journals, now occupying the second position worldwide among all interventional cardiology journals.

This year while waiting for the verdict (this year it arrived on June 28th) I considered, for a few minutes, the insane idea of writing an editorial with a positive tone in the event of a favourable impact factor (i.e., in this case higher than last year's 6.534) and another editorial with a less positive tone, but still inspired by optimism in the event of a less favourable impact factor… just to be ready for the worst. But then, luckily, I came to my senses and just waited for the event to unfold, like

everyone else. The reason for being fatalistic is because the impact factor calculation, which I wrote about last year, is something that you can only predict within certain limits.

So, here we are. This year, due to the innovations introduced by Clarivate (the company that runs the impact factor), there came a point when I even came to doubt the only certain thing in the whole equation: the denominator of the formula. As it turned out, the good thing was that this year too our forecast was an underestimation. But beyond this, an increase in the impact factor is useful only if it convinces more authors to choose our Journal more frequently for submitting their best articles (a trend that we noted last year).

For those of us who work at the Journal, the Impact Factor is a tribute to the idea of improvement that we have been thinking about since the beginning. Numbers are not everything, because the service we try to offer the community of interventional cardiologists is far more important and also, equally important, is whether we are perceived by the scientific community as an authoritative source, or even as a pleasant entertainment.

Here at EuroIntervention we know no other formula than trying to do our best. So, head down and pedal hard – here's what we've prepared for you in this issue.

We begin with the first instalment of the European Bifurcation Club's expert consensus on provisional stenting focusing on implantation of the first stent in the provisional pathway when treating coronary bifurcation lesions. Authors **Remo Albiero, Goran Stankovic and colleagues** outline the latest knowledge concerning provisional stenting in coronary bifurcations, with a detailed description of the technical and procedural challenges that an operator faces at each step. This expert consensus takes into account the evolution in experience and knowledge that has, over the last few years, vastly improved the procedure and provides a systematic view of the pitfalls and troubleshooting that might be needed.

In coronary interventions, ticagrelor monotherapy versus aspirin monotherapy is the subject of an analysis from the GLOBAL LEADERS trial. **Masafumi Ono, Patrick W. Serruys and colleagues** explore optimal antiplatelet regimens one year after a successful percutaneous coronary intervention (PCI). Studying those patients who were free from events at the end of their first year post-PCI and who adhered to their prescribed regimen, the authors concluded that ticagrelor monotherapy could be an alternative to aspirin monotherapy for secondary prevention with the results showing, when compared to aspirin alone in this type of patient, that ticagrelor monotherapy during the 12 months after PCI was associated with a reduced risk of ischaemic events, albeit with an increased risk of bleeding. This article is accompanied by an editorial by **Hyo-Soo Kim and Jeehoon Kang**.

Three-year results from the MAGSTEMI trial is the subject of the next article by **Luis Ortega-Paz, Manel Sabaté and colleagues** who compared the use of either a magnesium-based bioresorbable scaffold (MgBRS) or sirolimus-eluting stent (SES) in the treatment of patients with ST-segment elevation myocardial infarction (STEMI). MgBRS was associated

with a higher incidence of target lesion revascularisation than SES during the first year, with no difference between the two devices afterwards. With a potentially favourable safety profile, further studies are needed with new iterations of MgBRS that could respond to the limitations seen in the device used in this trial by increasing scaffolding duration or radial force.

Is coronary vasospasm associated with more advanced atherosclerotic disease? This is the question that authors **Dario Pellegrini, Peter Damman and colleagues** answer in this study looking at patients with ischaemia and non-obstructive coronary artery disease. Evaluated by optical coherence tomography, after coronary vasospasm was triggered by acetylcholine, the authors noted that the different patterns of vasospasm all shared similarities in terms of the state of advancement of atherosclerotic disease, an observation which could allow for identifying high-risk groups and improving long-term prognosis.

Turning to valvular disease, **Giorgio A. Medranda, Toby Rogers and colleagues** consider the challenges of optimal lifetime management of patients with aortic stenosis (AS) who have been treated by implantation of bioprosthetic valves. Over time these valves may degenerate with redo transcatheter aortic valve implantation (TAVI) becoming necessary, which itself carries several potential consequences. Using a computed tomography simulation, the authors found that they could predict whether a patient might have to undergo these redo procedures allowing for the option, especially among younger patients with symptomatic severe AS, of choosing, for instance, surgery first over TAVI. This article is accompanied by an editorial by **Bernard Prendergast and Tiffany Patterson**.

Another consideration, when choosing between TAVI or a surgical procedure, is the problem of AS in morbidly obese patients. Because clear data are lacking in this regard, **Angela McInerney, Luis Nombela-Franco and colleagues** performed a retrospective multicentre propensity-score matched study comparing TAVI outcomes to those after surgical aortic valve replacement (SAVR). They confirmed that each strategy had its drawbacks, with TAVI requiring more pacemaker implantation and higher rates of moderate to severe aortic regurgitation, while post-SAVR, these morbidly obese patients required more blood transfusions, and had more kidney injuries, access site infections and incidents of pneumonia whilst in the hospital. Outcomes between the two groups at midterm were similar, though TAVI had less periprocedural morbidity and mortality. This article is accompanied by an editorial by **Fausto Biancari**.

Finally, we look at peripheral interventions and the safety and effectiveness of atherectomy for treating complex and calcified lesions in patients with peripheral artery disease. **Sorin Giusca, Grigorios Korosoglou and colleagues** found that Phoenix atherectomy could be performed with acceptable results and relatively low rates of bailout stenting and clinically acceptable target lesion revascularisation rates. While future trials are still relevant, these results are promising and could indicate an "atherectomy-first" strategy for peripheral artery disease patients in the future.

And now, on to the articles.