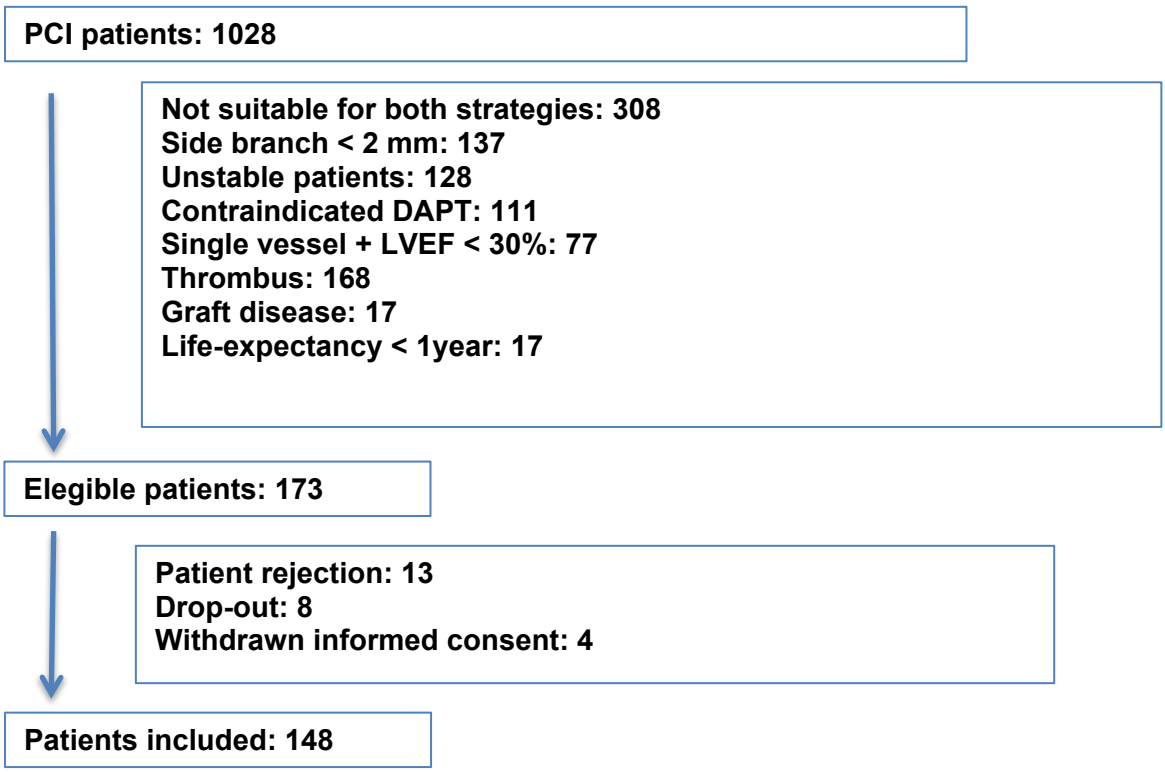
Palazuelos J, et al. Rotablation approach for bifurcation lesions: a pilot randomized study. *REC Interv Cardiol.* 2020.
https://doi.org/10.24875/RECICE.M20000138

SUPPLEMENTARY DATA

Figure 1 of the supplementary data. Bifurcator population selection flow chart.



PCI, percutaneous coronary intervention; DAPT: dual antiplatelet treatment, LVEF: left ventricle ejection fraction.

Appendix of the supplementary data. Material and methods.

Definitions

- Target vessel failure: composite of cardiac death, vessel-related myocardial infarction, target vessel revascularization and target bifurcation restenosis during follow-up.

- Target vessel revascularization was defined as repeat revascularization of the target vessel by percutaneous coronary intervention (PCI) or bypass graft surgery.
- Target lesion revascularization was defined as repeat PCI of the lesion within 5 mm of stent deployment or bypass graft surgery of the target vessel.
- Target bifurcation restenosis was defined as repeat revascularization with a stenosis diameter > 50% within 5 mm proximal or distal to carina of bifurcation.
- Stent thrombosis was assessed according to the definitions of the Academic Research Consortium as definite, probable, or possible stent thrombosis.
- A bifurcation should be considered if: *a)* treating the main vessel could compromise a large side-branch (> 2 mm), *b)* treating an ostial side-branch disease could involve the main vessel or *c)* when main vessel and side-branch are disease.

Sample size. No randomized publications on this subset are available for we cannot use the sample size formula. We used the ARCSINUS approximation and estimated we should include (accepting an alpha risk of 0.05 and a beta risk of 0.2 in a two-sided test) at least 60 subjects in each group to find as statistically significant a proportion difference. It has been anticipated a drop-out rate < 1%. Finally, we had calculated the definitive sample size after we had included 12 patients in each arm. Random assignment of patients to treatment group was done with EPIDAT 4.0 software.

Periprocedural medications. At the time of PCI, all patients were on double antiplatelet therapy with aspirin (100 mg daily) and clopidogrel (300 mg loading dose on the day before the PCI or 75 mg daily for more than 3 days before the procedure) or ticagrelor (180 mg loading dose on the day or the day before or 90 mg twice daily for more than 3 days before the procedure) or prasugrel (60 mg loading dose on the day or the day before the PCI or 10 mg daily for more than 3 days before the procedure) Procedural anticoagulation was achieved with unfractionated

heparin (70 to 100 U/kg intravenous bolus) or bivaluridine. Use of glycoprotein IIb/IIIa inhibitors was per operator discretion. After the procedure, all patients received double antiplatelet therapy with aspirin 100 mg and clopidogrel 75 mg or ticagrelor 90 mg (twice) or prasugrel 10 mg for 12 months with the indication to continue aspirin indefinitely.

Laboratory testing and follow-up. Success and outcome before hospital discharge and during FU were collected. After PCI, all patients underwent post-PCI electrocardiogram, and 6- and 24-h assessment of troponin T and creatine kinase-myocardial band (CK-MB) levels. Thereafter, further electrocardiogram and enzyme evaluations were performed if clinically indicated. After PCI, the in-hospital clinical course was carefully monitored, whereas, after discharge, patients' clinical follow-up was carried out through personal interview or telephone calls each 6 months. Patients underwent angiographic control only clinically driven. Cardiovascular risk factors control, drugs completion and blood test controls were performed according to referring physician discretion.