



**Fig. 1. Decision flow chart for ad hoc PCI. STEMI, ST elevation myocardial infarction; NSTEMI-ACS, non-ST elevation acute coronary syndrome; PCI, percutaneous coronary intervention.**

are clearer than in patients with less severe symptoms or ischemia. Ad hoc PCI may be inappropriate if complications have occurred during the diagnostic catheterization, excessive radiation or contrast were used, the significance of a lesion cannot be determined, or a heart team approach is indicated to identify the best strategy for treatment of complex coronary disease.

FFR performed immediately after diagnostic angiography can help distinguish lesions that are hemodynamically significant and, therefore, appropriate for ad hoc PCI.<sup>29</sup> IVUS may be useful in assessing the sever-

ity of coronary lesions, but it is not able to assess functional or hemodynamic significance, and there is no consensus on the criteria that define a hemodynamically significant lesion.<sup>2,39,40</sup>

Decisions about ad hoc PCI for multivessel CAD are complex since angiography may overestimate<sup>28</sup> and stress imaging may underestimate<sup>41</sup> the number of significant lesions. FFR-guided PCI produces better outcomes than angiographically guided PCI for multivessel CAD.<sup>28</sup> A strategy of partial revascularization with ad hoc PCI followed by a repeat procedure targeting