In Reply We thank Henry et al for their comments about spontaneous coronary artery dissection (SCAD) as an alternative cause of the acute non-ST-elevation myocardial infarction in this patient case. Like myocardial bridging (MB), SCAD is usually seen in women presenting with anginal chest pain and no history of heart disease. Furthermore, most patients with SCAD can be treated conservatively, as SCAD can heal spontaneously. However, angiography findings of significant systole-dependent coronary artery narrowing were more consistent with MB than non-phase-dependent stenosis seen in SCAD. The characteristic type 1 angiographic classification involving arterial wall contrast staining and multiple radiolucent lumens was not appreciated. In less evident cases (types 2 and 3), additional imaging with intravascular ultrasonography or optical coherence tomography can be performed, but these modalities were not used at the discretion of the interventional team. Therefore, with our working diagnosis of MB based on clinical picture and angiographic appearance, the coexistence of SCAD cannot be categorically ruled out. We agree that a definitive diagnosis of MB or SCAD may require multimodality imaging.

In regard to the transthoracic echocardiography, it was performed 12 hours after troponin levels peaked. Despite these elevated biomarker levels, the mechanism for ischemia must be considered. In our opinion, absence of regional wall motion abnormalities shortly after presentation and resolution of ischemic symptoms made a diagnosis of MB more plausible.

As for medical management, the decision to prescribe a statin medication and low-dose aspirin was based on the patient’s presentation with non-ST-elevation myocardial infarction with a high estimated 10-year risk of atherosclerotic cardiovascular disease of 12.5%. We agree that aspirin would usually not be indicated in isolated MB without presence of an acute coronary syndrome. Likewise, the role of statins would be debatable in patients with low predicted cardiac event risk.