SUPPLEMENTARY DATA

See below the rest of the survey items and responses, other than the ones presented in figures 1 and 2.

3. Is your center capable of performing intracoronary images?

![Pie chart showing the results of the survey for intracoronary images.

4. If the intravascular ultrasound (IVUS) and the optical coherence tomography (OCT) are both available, do you have any preferences for diagnosing spontaneous coronary artery dissection (SCAD)?

![Pie chart showing the results of the survey for the diagnosis of SCAD.](https://example.com/image-url)
6. On diagnostic suspicion of a significant, non-critical mid-anterior descending artery with TIMI (Thrombolysis in Myocardial Infarction) flow-3 and no other lesions in a patient with acute coronary syndrome and a clinical profile suggestive of SCAD, what would your approach be?
7. With respect to the previous point, if you make the decision of performing one coronary angiography or a follow-up CT scan to see the progression of the lesion, for how long would you wait before performing the new study?

- I do not perform this imaging modality
- After a few days or 1 week after acute presentation
- At 1 month
- At 3-6 months

8. With respect to the coronary computed tomography angiography, choose among the following uses of this imaging modality at your center.

Note: in this question you can choose more than one option

- It is widely used as a first-line imaging modality precisely in patients with chest pain and clinical profile of SCAD: 12.4%
- Once the SCAD has been diagnosed, it is used as a first-line imaging modality in the presence of recurring pain without confirmed ischemia (as a gatekeeper for coronary angiography): 18.6%
- Follow-up of cases with high-risk lesions (proximal, severe, multivessel) without revascularization: 39.8%
- Routine angiography monitoring (as in the case of the previous question): 39.1%
9. With respect to the practice at your center, what is the approximate number of SCADs that end up undergoing angioplasty (including any intervention on the vessel to improve coronary flow: guidewire, balloon, device) versus purely conservative approach?

10. In a patient with active ischemia and occlusion in the mid-anterior descending artery, after partially restoring flow through a guidewire, there is suspicion of SCAD. What would your next step be?
11. What is your experience with regards of the use of the cutting balloon in cases of compressive intramural hematoma?

12. If you make the decision of implanting a stent guided with intracoronary imaging, what would the length of this stent be?
13. If an angioplasty is required, what device would you use in a 50-year-old post-menopause, hypertensive patient with SCAD?

- Drug-free bare-metal stent: 67.7%
- Drug-eluting bare-metal stent: 14.9%
- Bioresorbable stent: 14.3%
- I would not try to implant a stent: 3.1%

14. Based on your own experience, what is the criterion that should indicate revascularization surgery in a patient with SCAD?

- Only in cases of failed or complicated angioplasty: 46.0%
- Option 1 + primary revascularization in cases of compromised left main coronary artery: 31.1%
- Option 1 + primary revascularization in cases of severe compromise to the left main coronary artery or multivessel disease: 19.3%
- I have never indicated it: 3.7%
17. In a patient with acute coronary syndrome and one SCAD in the mid-distal anterior descending artery with TIMI flow 3 managed conservatively who comes to our office 1 month after being discharged and who remains eventless, would you consider not to prescribe any antiaggregant medication?
19. With respect to the physical activity recommended for SCAD survivors, would you make any special considerations?

- 37.3%: No, I would recommend going back normal life after the first month under supervision
- 22.4%: Same recommendations given to patients with atherosclerotic disease
- 40.4%: I would emphasize the usefulness of cardiac rehabilitation

20. Would you discourage pregnancy in young survivors of SCAD?

- 73.2%: Yes
- 19.3%: No, but in case of pregnancy I would consider it a pregnancy of high cardiovascular risk
- 7.5%: No

21. Based on your own experience, are patients with SCAD systematically follow-up through imaging modalities for the screening of non-coronary arteriopathies: fibromuscular dysplasia, aneurysms, etc.?

- 45.3%: Yes, it has been happening for quite a few years ago now
- 25.5%: Yes, recently
- 19.3%: Not systematically
- 9.9%: No
22. If such a screening does exist – whether occasional or systematic- what imaging modalities have been used here?

Note: in this question you can choose more than one option.

- Invasive angiography (selective injection) in non-coronary territories: renal arteries, femoral arteries... 18.1%
- Non-invasive angiography with CT scan 76.4%
- Non-invasive angiography with MRI 27.6%

23. Based on your own perception and knowledge, what do you think is the overall risk of major cardiac adverse event recurrence at a 3-year follow-up for survivors of SCAD?
24. Based on your own perception, would you find useful to have practical algorithms and management recommendations available?