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## Reply

We thank Dr. Morice and colleagues for sharing their data regarding reasons for implanting a bare metal stent (BMS) in preference to a drug-eluting stent (DES). In their series, a BMS was chosen because of the need for noncardiac surgery (NCS) within the next year in 5.5% of patients, an incidence similar to that reported in previous studies (1).

We completely agree with the authors that a sizable percentage of BMSs are implanted to avoid the risks associated with long-term dual antiplatelet therapy (DAPT). We also agree with the authors' ideal DES, which would require only a limited period of DAPT after implantation. It is important to emphasize, as we noted in our paper (1), that the actual major adverse cardiac event risk after NCS, a well-known prothrombotic stimulus, remains uncertain, both during the highest risk period (0 to 6 weeks after stent implantation) and thereafter. Further, the value of DAPT to prevent ischemic events during NCS, in the traditional high-risk period and beyond, also is uncertain, as is the relative increased bleeding risk from DAPT continuation. As there is a large cohort of stent patients undergoing NCS, determining the benefit–risk ratio of maintaining DAPT during NCS in a scientifically rigorous study is a laudable goal.

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