was used to identify the relationship between QCA parameters and FFR value, and receiver operating characteristic (ROC) curve was used to determine predictors of FFR ≤0.75.

**Results** When compared to FFR >0.75 group, FFR ≤0.75 group had higher LL (14.8±7.9 mm vs 10.7±5.4 mm, p=0.024), lower MLD (1.47±0.31 mm vs 1.82±0.51 mm, p=0.028), lower RVD (2.30±0.50 mm vs 2.81±0.64 mm, p=0.036), and lower MLA (2.30±1.50 mm² vs 3.60±2.30 mm², p=0.038). By correlation analysis, significant negative correlation between QCA parameters and FFR included LL (r=−0.209, p=0.040), significant positive correlation included MLD (r=0.414, p=0.040), RVD (r=0.303, p=0.000) and MLA (r=0.315, p=0.002). By using a ROC, we identified MLD ≥1.6 mm to be the best cut-off value to fit with a FFR >0.75 with sensitivity 63%, specificity 82%, and positive predictive value 96%.

**Conclusions** Anatomic parameters of intermediate coronary lesions by QCA show a moderate correlation to FFR value. MLD by QCA may be used as an alternative to FFR when assessing the need for intervention in intermediate coronary lesions.