2016 ACC/AHA Guideline Focused Update on Duration of Dual Antiplatelet Therapy in Patients With Coronary Artery Disease

A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines


Developed in Collaboration With the American Association for Thoracic Surgery, American Society of Anesthesiologists, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Anesthesiologists, and Society of Thoracic Surgeons

Endorsed by Preventive Cardiovascular Nurses Association and Society for Vascular Surgery

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Preamble

Incorporation of new study results, medications, or devices that merit modification of existing clinical practice guideline recommendations, or the addition of new recommendations, is critical to ensuring that guidelines reflect current knowledge, available treatment options, and optimum medical care. To keep pace with evolving evidence, the American College of Cardiology (ACC)/American Heart Association (AHA) Task Force on Clinical Practice Guidelines (“Task Force”) has issued this focused update to revise existing guideline recommendations on the basis of recently published study data. This update has been subject to rigorous, multilevel review and approval, similar to the full guidelines. For specific focused update criteria and additional methodological details, please see the ACC/AHA guideline methodology manual (1).

Modernization—Processes have evolved over time in response to published reports from the Institute of Medicine (2,3) and ACC/AHA mandates (4-7), leading to adoption of a “knowledge byte” format. This process entails delineation of a recommendation addressing a specific clinical question, followed by concise text (ideally <500 words) and hyperlinked to supportive evidence. This approach better accommodates time constraints on busy clinicians, facilitates easier access to recommendations via electronic search engines and other evolving technology, and supports the evolution of guidelines as “living documents” that can be dynamically updated as needed.

Class of Recommendation and Level of Evidence—The Class of Recommendation (COR) and Level of Evidence (LOE) are derived independently of each other according to established criteria. The COR indicates the strength of recommendation, encompassing the estimated magnitude and certainty of benefit of a clinical action in proportion to risk. The LOE rates the quality of scientific evidence supporting the intervention on the basis of the type, quantity, and consistency of data from clinical trials and other sources (Table 1). Recommendations in this focused update reflect the new 2015 COR/LOE system, in which LOE B and C are subcategorized for the purpose of increased granularity (1,7,8).

Relationships With Industry and Other Entities—The ACC and AHA exclusively sponsor the work of guideline writing committees (GWCs) without commercial support, and members volunteer time for this activity. Selected organizations and professional societies with related interests and expertise are invited to participate as partners or collaborators. The Task Force makes every effort to avoid actual, potential, or perceived conflicts of interest that might arise through relationships with industry or other entities (RWI). All GWC members and reviewers are required to fully disclose current industry relationships or personal interests, beginning 12 months before initiation of the writing effort. Management of RWI involves selecting a balanced
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GWC and requires that both the chair and a majority of GWC members have no relevant RWI (see Appendix 1 for the definition of relevance). GWC members are restricted with regard to writing or voting on sections to which RWI apply. Members of the GWC who recused themselves from voting are indicated and specific section recusals are noted in Appendixes 1 and 2. In addition, for transparency, GWC members’ comprehensive disclosure information is available as an Online Supplement (http://circ.ahajournals.org/lookup/suppl/doi:10.1161/CIR.0000000000000404/-/DC1). Comprehensive disclosure information for the Task Force is also available at http://www.acc.org/about-acc/leadership/guidelines-and-documents-task-forces.aspx. The Task Force strives to avoid bias by selecting experts from a broad array of backgrounds representing different geographic regions, genders, ethnicities, intellectual perspectives, and scopes of clinical activities.

**Intended Use**—Guidelines provide recommendations applicable to patients with or at risk of developing cardiovascular disease. The focus is on medical practice in the United States, but guidelines developed in collaboration with other organizations may have a broader target. Although guidelines may be used to inform regulatory or payer decisions, the intent is to improve quality of care and align with patients’ interests. The guidelines are reviewed annually by the Task Force and are official policy of the ACC and AHA. Each guideline is considered current unless and until it is updated, revised, or superseded by a published addendum.

**Related Issues**—For additional information pertaining to the methodology for grading evidence, assessment of benefit and harm, shared decision making between the patient and clinician, structure of evidence tables and summaries, standardized terminology for articulating recommendations, organizational involvement, peer review, and policies regarding periodic assessment and updating of guideline documents, we encourage readers to consult the ACC/AHA guideline methodology manual (1).

Jonathan L. Halperin, MD, FACC, FAHA

Chair, ACC/AHA Task Force on Clinical Practice Guidelines
Table 1. Applying Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatments, or Diagnostic Testing in Patient Care* (Updated August 2015)

<table>
<thead>
<tr>
<th>CLASS (STRENGTH) OF RECOMMENDATION</th>
<th>LEVEL (QUALITY) OF EVIDENCE†</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLASS I (STRONG)</strong></td>
<td></td>
</tr>
<tr>
<td>Benefit &gt;&gt; Risk</td>
<td></td>
</tr>
<tr>
<td>Suggested phrases for writing recommendations:</td>
<td></td>
</tr>
<tr>
<td>• Is recommended</td>
<td><strong>LEVEL A</strong></td>
</tr>
<tr>
<td>• Is indicated/useful/effective/beneficial</td>
<td>- High-quality evidence from more than 1 RCT</td>
</tr>
<tr>
<td>• Should be performed/administered/other</td>
<td>- Meta-analyses of high-quality RCTs</td>
</tr>
<tr>
<td>• Comparative-Effectiveness Phrases‡:</td>
<td>- One or more RCTs corroborated by high-quality registry studies</td>
</tr>
<tr>
<td>▪ Treatment/strategy A is recommended/indicated in preference to treatment B</td>
<td></td>
</tr>
<tr>
<td>▪ Treatment A should be chosen over treatment B</td>
<td></td>
</tr>
<tr>
<td><strong>CLASS IIa (MODERATE)</strong></td>
<td><strong>LEVEL B-R</strong></td>
</tr>
<tr>
<td>Benefit &gt;&gt; Risk</td>
<td>(Randomized)</td>
</tr>
<tr>
<td>Suggested phrases for writing recommendations:</td>
<td></td>
</tr>
<tr>
<td>• Is reasonable</td>
<td><strong>LEVEL B-NR</strong></td>
</tr>
<tr>
<td>• Can be useful/effective/beneficial</td>
<td>(Nonrandomized)</td>
</tr>
<tr>
<td>• Comparative-Effectiveness Phrases‡:</td>
<td></td>
</tr>
<tr>
<td>▪ Treatment/strategy A is probably recommended/indicated in preference to treatment B</td>
<td>- Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies</td>
</tr>
<tr>
<td>▪ It is reasonable to choose treatment A over treatment B</td>
<td>- Meta-analyses of such studies</td>
</tr>
<tr>
<td><strong>CLASS IIb (WEAK)</strong></td>
<td><strong>LEVEL C-LD</strong></td>
</tr>
<tr>
<td>Benefit ≥ Risk</td>
<td>(Limited Data)</td>
</tr>
<tr>
<td>Suggested phrases for writing recommendations:</td>
<td></td>
</tr>
<tr>
<td>• May/might be reasonable</td>
<td><strong>LEVEL C-EO</strong></td>
</tr>
<tr>
<td>• May/might be considered</td>
<td>(Expert Opinion)</td>
</tr>
<tr>
<td>• Usefulness/effectiveness is unknown/unclear/uncertaint or not well established</td>
<td>- Randomized or nonrandomized observational or registry studies with limitations of design or execution</td>
</tr>
<tr>
<td>• Physiological or mechanistic studies in human subjects</td>
<td>- Meta-analyses of such studies</td>
</tr>
<tr>
<td><strong>CLASS III: No Benefit (MODERATE)</strong></td>
<td></td>
</tr>
<tr>
<td>(Generally, LOE A or B use only)</td>
<td></td>
</tr>
<tr>
<td>Benefit = Risk</td>
<td></td>
</tr>
<tr>
<td>Suggested phrases for writing recommendations:</td>
<td></td>
</tr>
<tr>
<td>• Not recommended</td>
<td></td>
</tr>
<tr>
<td>• Not indicated/useful/effective/beneficial</td>
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<tr>
<td>• Should not be performed/administered/other</td>
<td></td>
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<tr>
<td><strong>CLASS III: Harm (STRONG)</strong></td>
<td></td>
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<tr>
<td>Risk &gt; Benefit</td>
<td></td>
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<tr>
<td>Suggested phrases for writing recommendations:</td>
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<tr>
<td>• Potentially harmful</td>
<td></td>
</tr>
<tr>
<td>• Causes harm</td>
<td></td>
</tr>
<tr>
<td>• Associated with excess morbidity/mortality</td>
<td></td>
</tr>
<tr>
<td>• Should not be performed/administered/other</td>
<td></td>
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</tbody>
</table>

* The outcome or result of the intervention should be specified (an improved clinical outcome or increased diagnostic accuracy or incremental prognostic information).
† For comparative-effectiveness recommendations (COR I and IIa; LOE A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.
‡ The method of assessing quality is evolving, including the application of standardized, widely used, and preferably validated evidence grading tools; and for systematic reviews, the incorporation of an Evidence Review Committee.

COR and LOE are determined independently (any COR may be paired with any LOE).
1. Introduction


The impetus for this focused update review is 11 studies (16-27) of patients treated with coronary stent implantation (predominantly with drug-eluting stents [DES]) assessing shorter-duration or longer-duration DAPT, as well as a large, randomized controlled trial (RCT) of patients 1 to 3 years after myocardial infarction (MI) assessing the efficacy of DAPT compared with aspirin monotherapy (28). These studies were published after the formulation of recommendations for duration of DAPT in prior guidelines. The specific mandate of the present writing group is to evaluate, update, harmonize, and, when possible, simplify recommendations on duration of DAPT.

Although there are several potential combinations of antiplatelet therapy, the term and acronym DAPT has been used to specifically refer to combination antiplatelet therapy with aspirin and a P2Y$_{12}$ receptor inhibitor (clopidogrel, prasugrel, or ticagrelor) and will be used similarly in this focused update. Recommendations in this focused update on duration of DAPT, aspirin dosing in patients treated with DAPT, and timing of elective noncardiac surgery in patients treated with percutaneous coronary intervention (PCI) and DAPT supersede prior corresponding recommendations in the 6 relevant guidelines. These recommendations for duration of DAPT apply to newer-generation stents and, in general, only to those not treated with oral anticoagulant therapy. For the purposes of this focused update, patients with a history of acute coronary syndrome (ACS) >1 year prior who have since remained free of recurrent ACS are considered to have transitioned to stable ischemic heart disease (SIHD) and are addressed in the section on SIHD. Issues and recommendations with regard to P2Y$_{12}$ inhibitor “pretreatment,” “preloading,” and loading are beyond the scope of this document but are addressed in other guidelines (9,14,29).
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This focused update is designed to function both as a standalone document and to serve as an update to the relevant sections on duration of DAPT in the 6 clinical practice guidelines, replacing relevant text, figures, and recommendations. Thus, by necessity, there is some redundancy in different sections of this document. When possible, the “knowledge byte” format was used for recommendations. In some cases, the complexity of this document required a modification of the knowledge byte format, with several interrelated recommendations grouped together, followed by concise associated text (<250 words of text per recommendation).

1.1. Methodology and Evidence Review

Clinical trials published since the 2011 PCI guideline (9) and the 2011 coronary artery bypass graft (CABG) guideline (10), published in a peer-reviewed format through December 2015, were reviewed by the Task Force to identify trials and other key data that might affect guideline recommendations. The information considered important enough to prompt updated recommendations is included in evidence tables in the Online Data Supplement.

In accord with recommendations by the Institute of Medicine (2,3) and the ACC/AHA Task Force Methodology Summit (1,6), 3 critical (PICOTS-formatted); population, intervention, comparison, outcome, timing, setting) questions were developed to address the critical questions related to duration of DAPT. These 3 critical questions were the basis of a formal systematic review and evaluation of the relevant study data by an Evidence Review Committee (ERC) (30). Concurrent with this process, writing group members evaluated study data relevant to the numerous current recommendations in the 6 guidelines, including topics not covered in the 3 critical questions (e.g., DAPT after CABG). The findings of the ERC and the writing group members were formally presented and discussed, and then modifications to existing recommendations were considered. Recommendations that are based on a body of evidence that includes a systematic review conducted by the ERC are denoted by the superscript SR (e.g., LOE B-R\textsuperscript{SR}). See the ERC systematic review report, “Duration of Dual Antiplatelet Therapy: A Systematic Review for the 2016 Guideline Update,” for the complete evidence review report (30).

1.2. Organization of the Writing Group

Recommendations on duration of DAPT are currently included in 6 clinical practice guidelines, which are interrelated and overlapping because they address the management of patients with CAD. Therefore, the writing group consisted of the chairs/vice chairs and/or members of all 6 guidelines, representing the fields of cardiovascular medicine, interventional cardiology, cardiac surgery, internal medicine, and cardiovascular anesthesia, as well as expertise in trial design and statistical analysis.

1.3. Review and Approval

This focused update was reviewed by the writing committee members from the 6 guidelines; by 5 official
reviewers from the ACC and AHA; 2 reviewer each from the American Association for Thoracic Surgery, American College of Emergency Physicians, American Society of Anesthesiologists, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Anesthesiologists, and the Society of Thoracic Surgeons; and by 23 additional content reviewers. Reviewers’ RWI information is published in this document (Appendix 2).

This document was approved for publication by the governing bodies of the ACC and the AHA and was endorsed by the American Association for Thoracic Surgery, American Society of Anesthesiologists, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Anesthesiologists, and the Society of Thoracic Surgeons.
2. Critical Questions and Systematic Review Findings

2.1. Critical Questions on Duration of DAPT

The 3 critical (PICOTS-formatted) questions on DAPT duration are listed in Table 2. Most contemporary studies of DAPT have compared either shorter (3 to 6 months) (17-21) or longer (18 to 48 months) (16,22-26) duration of therapy with 12 months of DAPT, which is the recommended or minimal duration of therapy for most patients in ACC/AHA (9,13,14) and European Society of Cardiology (31-33) guidelines published between 2011 and 2014. Recommendations based on the findings from the critical question–focused systematic reviews are provided in Sections 4 to 8 of the present document.

Table 2. Critical (PICOTS-Formatted) Questions on DAPT Duration

| Q1: in patients treated with newer (non-first) generation DES for (1) SIHD or (2) ACS, compared with 12 months of DAPT, is 3–6 months of DAPT as effective in preventing stent thrombosis, preventing MACE and/or reducing bleeding complications? |
| Q2: in patients treated with newer (non-first) generation DES, compared with 12 months of DAPT, does >12 (18–48) months of DAPT result in differences in mortality rate, decreased MACE, decreased stent thrombosis, and/or increased bleeding? |
| Q3: in post-MI (NSTEMI or STEMI) patients who are clinically stable and >12 months past their event, does continued DAPT, compared with aspirin monotherapy, result in differences in mortality rate, decreased nonfatal MI, decreased MACE, and/or increased bleeding? |

ACS indicates acute coronary syndrome; DAPT, dual antiplatelet therapy; DES, drug-eluting stents; MACE, major adverse cardiac events; MI, myocardial infarction; NSTEMI, non–ST-elevation myocardial infarction; PICOTS, population, intervention, comparison, outcome, timing, and setting; SIHD, stable ischemic heart disease; and STEMI, ST-elevation myocardial infarction.

2.2. Studies of Shorter-Duration DAPT After Stent Implantation

Five RCTs of patients treated with elective DES implantation have compared shorter-duration (3 to 6 months) DAPT with 12 months of DAPT (17-21) (Data Supplement 1). The trials primarily enrolled low-risk (non-ACS) patients, with only a small proportion having had a recent MI. The main endpoints of these noninferiority trials were composite ischemic events (or net composite events) and stent thrombosis. These studies, as well as several meta-analyses (34-37) and an analysis by the ERC (30), did not find any increased risk of stent thrombosis with shorter-duration DAPT. A shorter duration of DAPT results in fewer bleeding complications (30,34-36). Shorter-duration DAPT may be most reasonable in patients currently being treated with “newer-generation” (e.g., everolimus- or zotarolimus-eluting) DES, which are associated with lower stent thrombosis and MI rates than those of “first-generation” (e.g., sirolimus- and paclitaxel-eluting) DES, which are rarely, if ever, used in current clinical practice (16,36,38).
2.3. Studies of Longer-Duration DAPT After Stent Implantation

Six RCTs, consisting predominantly of patients treated with elective DES implantation, compared prolonged DAPT (total therapy duration: 18 to 48 months) with 6 to 12 months of DAPT to determine whether extended therapy reduces late and very late stent thrombosis and prevents ischemic events associated with disease progression and plaque rupture at other nonstented sites (16,22-27) (Data Supplement 2). In the Dual Antiplatelet Therapy study—the largest of these trials—patients who had undergone DES implantation, had been treated with DAPT for 12 months, and were without ischemic or bleeding events during this period were randomized to an additional 18 months of DAPT or to aspirin monotherapy (16). Extended DAPT resulted in a 0.7% absolute reduction in very late stent thrombosis, a 2.0% absolute reduction in MI, a 1.6% absolute reduction in major adverse cardiac events (MACE), and a 0.9% absolute increase in moderate or severe bleeding. In the subgroup of patients treated with everolimus-eluting stents—currently the most commonly used stent—extended DAPT resulted in a 0.4% absolute reduction in stent thrombosis, a 1.1% absolute reduction in MI, and a 1.2% absolute increase in moderate/severe bleeding (39).

Taken as a whole, studies of longer-duration (“prolonged” or “extended”) DAPT (16,22-27) for an additional 18 to 36 months after DES found an absolute decrease in late stent thrombosis and ischemic complications of ≈1% to 2% and an absolute increase in bleeding complications of ≈1% (Data Supplements 2 and 3). A weighted risk-benefit analysis by the ERC of studies of patients treated with DES found 6 fewer MIs and 3 fewer stent thromboses but 5 additional major bleeds per 1,000 patients treated with prolonged DAPT per year (30).

2.4. Other Studies Relevant to DAPT >1 Year After MI

The CHARISMA (Clopidogrel for High Atherothrombotic Risk and Ischemic Stabilization, Management, and Avoidance) trial randomized patients with established atherosclerosis or at high risk of clinical atherosclerotic disease to either DAPT (with clopidogrel) or aspirin monotherapy; with DAPT, no significant reduction was found in ischemic effects at a median follow-up of 28 months, but there was a 0.4% absolute increase in severe bleeding (40). A post hoc analysis of patients enrolled in the study with prior MI found a 1.7% absolute decrease in the composite endpoint of cardiovascular death, MI, or stroke events with DAPT, with no benefit in those with CAD without prior MI (40,41).

Patients in the PEGASUS-TIMI 54 (Prevention of Cardiovascular Events in Patients with Prior Heart Attack Using Ticagrelor Compared to Placebo on a Background of Aspirin—Thrombolysis In Myocardial Infarction 54) trial were randomized 1 to 3 years after MI with additional high-risk features to either DAPT (with ticagrelor 60 mg or 90 mg twice daily) or continued aspirin monotherapy (28). After a mean of 33 months of therapy, DAPT, when compared with aspirin monotherapy, resulted in a 1.2% to 1.3% absolute reduction in the primary composite endpoint of cardiovascular death, MI, or stroke and a 1.2% to 1.5% absolute increase in
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major bleeding, with no excess in fatal bleeding or intracranial hemorrhage. In subgroup analysis, the greatest reduction in ischemic events with prolonged DAPT was in patients in whom P2Y$_{12}$ inhibitor therapy either had not been discontinued or had been discontinued for $\leq 30$ days (absolute reduction in MACE: 1.9% to 2.5%). No benefit was seen in patients in whom P2Y$_{12}$ inhibitor therapy had been discontinued $>1$ year before enrollment in the study (42).

In the Dual Antiplatelet Therapy study, the benefit/risk ratio for prolonged DAPT was more favorable for those presenting with MI than those with SIHD (43). In an analysis of patients with a history of prior MI enrolled in 6 RCTs of extended/prolonged DAPT, extended DAPT significantly decreased the absolute risk of MACE by 1.1% and significantly increased the absolute risk of major bleeding by 0.8% (44).

Taken as a whole, trials of prolonged or extended DAPT suggest that the benefit/risk ratio of prolonged DAPT may be more favorable for those with prior MI, with an absolute decrease in ischemic events of $\approx 1\%$ to $3\%$ at the cost of an absolute increase in bleeding events of $\approx 1\%$ over the course of several years of prolonged or extended therapy (median durations of therapy: 18 to 33 months) (Data Supplements 3 and 4). This appears biologically plausible because patients with prior MI (usually mediated by plaque rupture) may be at greater risk for future plaque rupture than those without prior MI (37,40,41).

2.5. Prolonged/Extended DAPT and Mortality Rate

An unexpected finding in the Dual Antiplatelet Therapy study (16) was a borderline-significant increase in overall mortality rate (0.5% absolute increase) with 30 months of DAPT versus 12 months of DAPT in DES-treated patients, which was due to significantly increased deaths from noncardiovascular causes (most commonly cancer), with no increase in cardiovascular deaths, and no significant increase in fatal bleeding (45). Five subsequent meta-analyses (35-37,46,47) restricted to RCTs of studies enrolling patients treated with predominantly newer generation DES, published prior to the presentation of the OPTIDUAL (Optimal Dual Antiplatelet Therapy) trial, found numerically (36,47) or statistically (35,37,46) significant increased risk of all-cause (though not cardiovascular) death associated with prolonged duration of DAPT (Data Supplements 3 and 4).

In contrast, a meta-analysis that combined studies of DAPT duration after stent implantation with studies of DAPT duration for other indications (48) and an analysis of 6 trials restricted to post-MI patients treated with DAPT (44) found no increase in cardiovascular or noncardiovascular mortality rate associated with prolonged DAPT (Data Supplement 3). A U.S. Food and Drug Administration drug safety communication, based on an evaluation of long-term clinical trials of patients with cardiovascular disease or stroke treated with clopidogrel, concluded that long-term clopidogrel treatment did not increase the risk of all-cause death or cancer-related death (49). The primary analysis by the ERC of 11 RCTs (including OPTIDUAL) compared use of DAPT for 18 to 48 months with use of DAPT for 6 to 12 months in patients who had received predominantly...
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newer-generation DES and found no statistically significant difference in all-cause mortality rate (30).

A majority of writing group members believe the data as a whole do not seem to suggest prolonged DAPT results in increased mortality.

3. Overriding Concepts and Recommendations for DAPT and Duration of Therapy

3.1. General Overriding Concepts

Overriding concepts and relevant recommendations for DAPT and duration of therapy are summarized in Table 3. Intensification of antiplatelet therapy, with the addition of a P2Y$_{12}$ inhibitor to aspirin monotherapy, necessitates a fundamental tradeoff between decreasing ischemic risk and increasing bleeding risk (40,41,50-52). Similarly, longer compared with shorter duration of DAPT generally results in decreased ischemic risk at the expense of increased bleeding risk (16,24,28,30,46). Use of more potent P2Y$_{12}$ inhibitors (ticagrelor or prasugrel) in place of clopidogrel also results in decreased ischemic risk and increased bleeding risk (53-55).

In general, recommendations for duration of DAPT in the present focused update consist of a Class I recommendation (“should be given”) for a minimum period of time (in most cases 6 to 12 months) and a Class IIb recommendation (“may be considered”) for continuation of DAPT beyond that period of time. Shorter-duration DAPT can be considered for patients at lower ischemic risk with high bleeding risk, whereas longer-duration DAPT may be reasonable for patients at higher ischemic risk with lower bleeding risk. These recommendations do not generally apply to patients treated with oral anticoagulant therapy, who were excluded from almost all studies of DAPT duration and who are at significantly increased bleeding risk (as discussed in Section 3.4). Decisions about duration of DAPT are best made on an individual basis and should integrate clinical judgment, assessment of the benefit/risk ratio, and patient preference. Aspirin therapy is almost always continued indefinitely in patients with CAD, and recommendations on duration of DAPT should be taken to mean the recommended duration of P2Y$_{12}$ inhibitor therapy (in addition to aspirin therapy). Figure 1 summarizes recommendations for duration of DAPT according to clinical status.
Table 3. Overriding Concepts and Updated Recommendations for DAPT and Duration

- Intensification of antiplatelet therapy, with the addition of a P2Y$_{12}$ inhibitor to aspirin monotherapy, as well as prolongation of DAPT, necessitates a fundamental tradeoff between decreasing ischemic risk and increasing bleeding risk. Decisions about treatment with and duration of DAPT require a thoughtful assessment of the benefit/risk ratio, integration of study data, and consideration of patient preference.

- In general, shorter-duration DAPT can be considered for patients at lower ischemic risk with high bleeding risk, whereas longer-duration DAPT may be reasonable for patients at higher ischemic risk with lower bleeding risk.

- Prior recommendations for duration of DAPT for patients treated with DES were based on data from “first-generation” DES, which are rarely if ever used in current clinical practice. Compared with first-generation stents, newer-generation stents have an improved safety profile and lower risk of stent thrombosis. Recommendations in this focused update apply to newer-generation stents.

- Updated recommendations for duration of DAPT are now similar for patients with NSTE-ACS and STEMI, as both are part of the spectrum of acute coronary syndrome.

- A Class I recommendation (“should be given”) in most clinical settings is made for at least 6-12 months of DAPT (depending on the setting), and a Class IIb recommendation (“may be reasonable”) is made for prolonged DAPT beyond this initial 6- to 12-month period.

- In studies of prolonged DAPT after DES implantation or after MI, duration of therapy was limited to several years (akin to many other studied therapies). Thus, in patients for whom the benefit/risk ratio seemingly favors prolonged therapy, the true optimal duration of therapy is unknown.

- Recommendations in the document apply specifically to duration of P2Y$_{12}$ inhibitor therapy in patients with CAD treated with DAPT. Aspirin therapy should almost always be continued indefinitely in patients with CAD.

- Lower daily doses of aspirin, including in patients treated with DAPT, are associated with lower bleeding complications and comparable ischemic protection (56-60) than are higher doses of aspirin. The recommended daily dose of aspirin in patients treated with DAPT is 81 mg (range, 75 mg to 100 mg).

CAD indicates coronary artery disease; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; MI, myocardial infarction; NSTE-ACS, non–ST-elevation acute coronary syndrome; and STEMI, ST-elevation myocardial infarction.
Figure 1. Master Treatment Algorithm for Duration of P2Y₁₂ Inhibitor Therapy in Patients With CAD Treated With DAPT

Colors correspond to Class of Recommendation in Table 1. Clopidogrel is the only currently used P2Y₁₂ inhibitor studied in patients with SIHD undergoing PCI. Aspirin therapy is almost always continued indefinitely in patients with CAD. Patients with a history of ACS >1 year prior who have since remained free of recurrent ACS are considered to have transitioned to SIHD. In patients treated with DAPT after DES implantation who develop a high risk of bleeding (e.g., treatment with oral anticoagulant therapy), are at high risk of severe bleeding complication (e.g., major intracranial surgery), or develop significant overt bleeding, discontinuation of P2Y₁₂ inhibitor therapy after 3 months for SIHD or after 6 months for ACS may be reasonable. Arrows at the bottom of the figure denote that the optimal duration of prolonged DAPT is not established.

ACS indicates acute coronary syndrome; BMS, bare metal stent; CABG, coronary artery bypass graft surgery; CAD, coronary artery disease; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; Hx, history; lytic, fibrinolytic therapy; NSTE-ACS, non–ST-elevation acute coronary syndrome; PCI, percutaneous coronary intervention; SIHD, stable ischemic heart disease; S/P, status post; and STEMI, ST-elevation myocardial infarction.
3.2. Factors Associated With Increased Ischemic and Bleeding Risk

Factors that have been associated with increased ischemic risk (including increased risk of stent thrombosis) and increased bleeding risk are listed in Table 4. Individual patients may have factors for both increased ischemic and bleeding risk, and some factors are associated with both increased ischemic and bleeding risk, making it difficult in many patients to assess the benefit/risk ratio of prolonged DAPT.

A new risk score (the “DAPT score”), derived from the Dual Antiplatelet Therapy study, may be useful for decisions about whether to continue (prolong or extend) DAPT in patients treated with coronary stent implantation. Analysis of study data suggest that in patients treated for 1 year with DAPT without significant bleeding or ischemic events, the benefit/risk ratio with prolonged DAPT may be favorable for those with a high DAPT score (≥2) because prolonged DAPT reduces net (ischemic plus bleeding) events when compared with nonprolonged DAPT (61). Conversely, in those with a low DAPT score (<2), the benefit/risk ratio with prolonged DAPT is not favorable (increased bleeding without a reduction in ischemic events). Factors that contribute to a high DAPT score include diabetes mellitus, current cigarette use, prior PCI or prior MI, congestive heart failure or left ventricular ejection fraction <30%, MI at presentation, vein graft PCI, and stent diameter <3 mm; older age contributes to a low (less favorable) DAPT score. Factors and their weighting used to calculate a DAPT score are provided in Table 5.

Table 4. Clinical and Procedural Factors Associated With Increased Ischemic Risk (Including Stent Thrombosis) or Increased Bleeding Risk (62-70)

<table>
<thead>
<tr>
<th>Increased Ischemic Risk/Risk of Stent Thrombosis (may favor longer-duration DAPT)</th>
<th>Increased Bleeding Risk (may favor shorter-duration DAPT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased ischemic risk</td>
<td>• History of prior bleeding</td>
</tr>
<tr>
<td>• Advanced age</td>
<td>• Oral anticoagulant therapy</td>
</tr>
<tr>
<td>• ACS presentation</td>
<td>• Female sex</td>
</tr>
<tr>
<td>• Multiple prior MIs</td>
<td>• Advanced age</td>
</tr>
<tr>
<td>• Extensive CAD</td>
<td>• Low body weight</td>
</tr>
<tr>
<td>• Diabetes mellitus</td>
<td>• CKD</td>
</tr>
<tr>
<td>• CKD</td>
<td>• Diabetes mellitus</td>
</tr>
<tr>
<td>Increased risk of stent thrombosis</td>
<td>• Anemia</td>
</tr>
<tr>
<td>• ACS presentation</td>
<td>• Chronic steroid or NSAID therapy</td>
</tr>
<tr>
<td>• Diabetes mellitus</td>
<td></td>
</tr>
<tr>
<td>• Left ventricular ejection fraction &lt;40%</td>
<td></td>
</tr>
<tr>
<td>• First-generation drug-eluting stent</td>
<td></td>
</tr>
<tr>
<td>• Stent undersizing</td>
<td></td>
</tr>
<tr>
<td>• Stent underdeployment</td>
<td></td>
</tr>
<tr>
<td>• Small stent diameter</td>
<td></td>
</tr>
<tr>
<td>• Greater stent length</td>
<td></td>
</tr>
<tr>
<td>• Bifurcation stents</td>
<td></td>
</tr>
<tr>
<td>• In-stent restenosis</td>
<td></td>
</tr>
</tbody>
</table>

ACS indicates acute coronary syndrome; CAD, coronary artery disease; CKD, chronic kidney disease; DAPT, dual antiplatelet therapy; MI, myocardial infarction; and NSAID, nonsteroidal anti-inflammatory drug.
Table 5. Factors Used to Calculate a “DAPT Score”

<table>
<thead>
<tr>
<th>Variable</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥75 y</td>
<td>-2</td>
</tr>
<tr>
<td>Age 65 to &lt;75 y</td>
<td>-1</td>
</tr>
<tr>
<td>Age &lt;65 y</td>
<td>0</td>
</tr>
<tr>
<td>Current cigarette smoker</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1</td>
</tr>
<tr>
<td>MI at presentation</td>
<td>1</td>
</tr>
<tr>
<td>Prior PCI or prior MI</td>
<td>1</td>
</tr>
<tr>
<td>Stent diameter &lt;3 mm</td>
<td>1</td>
</tr>
<tr>
<td>Paclitaxel-eluting stent</td>
<td>1</td>
</tr>
<tr>
<td>CHF or LVEF &lt;30%</td>
<td>2</td>
</tr>
<tr>
<td>Saphenous vein graft PCI</td>
<td>2</td>
</tr>
</tbody>
</table>

A score of ≥2 is associated with a favorable benefit/risk ratio for prolonged DAPT while a score of <2 is associated with an unfavorable benefit/risk ratio.

CHF indicates congestive heart failure; DAPT, dual antiplatelet therapy; LVEF, left ventricular ejection fraction; MI, myocardial infarction; and PCI, percutaneous coronary intervention. Adapted with permission from Yeh et al. (61).

3.3. Specific P2Y₁₂ Inhibitors: Recommendations

See Online Data Supplement 5 for evidence supporting these recommendations.

Recommendations for Specific P2Y₁₂ Inhibitors

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIa</td>
<td>B-R</td>
<td>In patients with ACS (NSTEMI or STEMI) treated with DAPT after coronary stent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>implantation and in patients with NSTEMI treated with medical therapy alone (without revascularization), it is reasonable to use ticagrelor in preference to clopidogrel for maintenance P2Y₁₂ inhibitor therapy (53,71,72).</td>
</tr>
<tr>
<td>IIa</td>
<td>B-R</td>
<td>In patients with ACS (NSTEMI or STEMI) treated with DAPT after coronary stent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>implantation who are not at high risk for bleeding complications and who do not have a history of stroke or TIA, it is reasonable to choose prasugrel over clopidogrel for maintenance P2Y₁₂ inhibitor therapy (54,55).</td>
</tr>
</tbody>
</table>
In the PLATO (Platelet Inhibition and Patient Outcomes) trial (53), patients with ACS were treated with either medical therapy alone or medical therapy plus PCI. Treatment with ticagrelor 90 mg twice daily, compared with clopidogrel 75 mg once daily, resulted in fewer ischemic complications and stent thromboses but more frequent non–CABG-related bleeding (Data Supplement 5). In the TRITON-TIMI 38 (Therapeutic Outcomes by Optimizing Platelet Inhibition With Prasugrel–Thrombolysis In Myocardial Infarction 38) (54) study, patients with ACS undergoing planned PCI were treated with prasugrel 10 mg daily, compared with clopidogrel 75 mg daily. Prasugrel treatment resulted in fewer ischemic complications and stent thromboses but more frequent bleeding, including life-threatening and fatal bleeding. Because of increased rates of major bleeding with prasugrel (compared with clopidogrel), there was no net benefit of prasugrel therapy in those ≥75 years of age and those <60 kg, and there was net harm (including increased risk of intracranial hemorrhage) in those with prior stroke or transient ischemic attack (TIA). The Class IIa preferential recommendations for ticagrelor 90 mg twice daily and for prasugrel 10 mg once daily (compared with clopidogrel) in the 2014 Non–ST-Elevation Acute Coronary Syndromes (NSTE-ACS) guideline are continued in this focused update and are now included in relevant PCI and ST-Elevation Myocardial Infarction (STEMI) recommendations, as well.

In the PEGASUS-TIMI 54 study of post-MI patients, both 60-mg and 90-mg twice-daily doses of ticagrelor were evaluated (28). The benefit/risk ratio appears to be numerically more favorable for the 60-mg dose, although no formal statistical comparison was made between results of the 2 dosing regimens. The 60-mg twice-daily dose has now been approved by the U.S. Food and Drug Administration for reduction in ischemic events in patients with ACS or a history of MI (73).

### 3.4. Platelet Function Testing, Genetic Testing, and Switching of P2Y<sub>12</sub> Inhibitors

The role of platelet function testing and genetic testing in patients treated with DAPT is addressed in the 2011 ACCF/AHA/SCAI PCI guideline and the 2014 ACC/AHA NSTE-ACS guideline (9,14). To date, no RCT has demonstrated that routine platelet function testing or genetic testing to guide P2Y<sub>12</sub> inhibitor therapy improves outcome; thus, the routine use of platelet function and genetic testing is not recommended (Class III: No Benefit).

No randomized data are available on the long-term safety or efficacy of “switching” patients treated for weeks or months with a P2Y<sub>12</sub> inhibitor to a different P2Y<sub>12</sub> inhibitor.

### 3.5. Proton Pump Inhibitors and DAPT

The use of proton pump inhibitors (PPIs) in patients treated with DAPT is discussed in a 2010
ACCF/ACG/AHA expert consensus document (74). Recommendations on the use of PPIs are given in the 2011 ACCF/AHA/SCAI PCI guideline (9). PPIs should be used in patients with a history of prior gastrointestinal bleeding treated with DAPT (Class I). In patients with increased risk of gastrointestinal bleeding, including those with advanced age and those with concomitant use of warfarin, steroids, or nonsteroidal anti-inflammatory drugs, use of PPIs is reasonable (Class IIa). Routine use of PPIs is not recommended for patients at low risk of gastrointestinal bleeding (Class III: No Benefit).

3.6. Aspirin Dosing in Patients Treated With DAPT: Recommendation

See Online Data Supplement 6 for evidence supporting this recommendation.

Recommedation for Aspirin Dosing in Patients Treated With DAPT

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>B-NR</td>
<td>In patients treated with DAPT, a daily aspirin dose of 81 mg (range, 75 mg to 100 mg) is recommended (56-60,75-78).</td>
</tr>
</tbody>
</table>

Because aspirin dosing recommendations across ACC/AHA clinical practice guidelines are not consistent with regard to dose or class of recommendation, and because aspirin is a component of DAPT, a comprehensive review of these issues was undertaken. Large overviews, including studies of nearly 200,000 persons, have consistently shown that lower aspirin doses (≤100 mg daily) are associated with less major and total bleeding than are higher doses, either when used as monotherapy or when combined with the P2Y₁₂ inhibitor clopidogrel (56,58,75,76,78). Daily aspirin doses as low as 30 mg to 50 mg inactivate the platelet cyclo-oxygenase-1 enzyme and inhibit thromboxane production (79-81). Studies comparing lower (75 mg to 150 mg) with higher aspirin doses have consistently found comparable ischemic event rates with either dose when used as monotherapy or when combined with the P2Y₁₂ inhibitor clopidogrel (56-60,78). The efficacy of ticagrelor seems to be decreased in patients treated with higher aspirin doses (≥300 mg daily) versus lower aspirin doses (≤100 mg daily) (82). On the basis of available data, the optimal range of aspirin dose in patients treated with DAPT that provides maximal protection from ischemic events and minimizes bleeding risk appears to be 75 mg to 100 mg (Data Supplement 6). For practical purposes, because the relevant aspirin dose available in the United States is 81 mg, this maintenance dose is recommended in patients with CAD treated with DAPT. The ongoing ADAPTABLE (Aspirin Dosing: A Patient-Centric Trial Assessing Benefits and Long-term Effectiveness) trial, which the present writing group endorses, is expected to yield additional information on optimal aspirin dosing in patients with atherosclerotic cardiovascular disease (83).

3.7. Triple Therapy (Aspirin, P2Y₁₂ Inhibitor, and Oral Anticoagulant)

The recommended management of patients on “triple therapy” (aspirin, P2Y₁₂ inhibitor, and oral anticoagulant) is beyond the scope of this focused update. However, a brief discussion of the topic is included for the purposes of completeness and end-user education.
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Compared with oral anticoagulation therapy alone, the addition of DAPT to oral anticoagulant therapy results in at least a 2- to 3-fold increase in bleeding complications (84-87). Discussion and recommendations on triple therapy are provided in the 2014 ACC/AHA NSTE-ACS guideline (14), a 2014 European joint consensus document (88), a North American consensus document (85), and several comprehensive state-of-the-art papers and reviews. A partial summary and synthesis of these recommendations are given in Table 6.

One trial comparing “double therapy” (oral anticoagulant plus clopidogrel) with triple therapy (oral anticoagulant plus aspirin and clopidogrel) (89) and 1 trial comparing differing durations of triple therapy have been published (90). Several more similar trials comparing oral anticoagulant therapy plus P2Y₁₂ inhibitor with triple therapy are ongoing.

Table 6. Summary and Synthesis of Guideline, Expert Consensus Documents, and Comprehensive Review Article Recommendations on the Management of Patients Treated With Triple Therapy (14,88,91-93)

- Assess ischemic and bleeding risks using validated risk predictors (e.g., CHA₂DS₂-VASc, HAS-BLED)
- Keep triple therapy duration as short as possible; dual therapy only (oral anticoagulant and clopidogrel) may be considered in select patients
- Consider a target INR of 2.0–2.5 when warfarin is used
- Clopidogrel is the P2Y₁₂ inhibitor of choice
- Use low-dose (≤100 mg daily) aspirin
- PPIs should be used in patients with a history of gastrointestinal bleeding and are reasonable to use in patients with increased risk of gastrointestinal bleeding

CHÁ₂DS₂-VASc indicates congestive heart failure, hypertension, age ≥75 years (doubled), diabetes mellitus, prior stroke or transient ischemic attack or thromboembolism (doubled), vascular disease, age 65-74 years, sex category; HAS-BLED, hypertension, abnormal renal/liver function, stroke, bleeding history or predisposition, labile INR, elderly, drugs/alcohol concomitantly; INR, international normalized ratio; and PPIs, proton pump inhibitors.

4. Percutaneous Coronary Intervention

4.1. Duration of DAPT in Patients With SIHD Treated With PCI: Recommendations

See Online Data Supplements 1 to 3 and 6 to 9 for evidence supporting these recommendations.

Recommendations for Duration of DAPT in Patients With SIHD Treated With PCI

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>A</td>
<td>In patients with SIHD treated with DAPT after BMS implantation, P2Y₁₂ inhibitor therapy with clopidogrel should be given for a minimum of 1 month (94,95).</td>
</tr>
<tr>
<td>I</td>
<td>B-R</td>
<td>In patients with SIHD treated with DAPT after DES implantation, P2Y₁₂ inhibitor therapy with clopidogrel should be given for at least 6 months (17,18,21,30,96,97).</td>
</tr>
<tr>
<td>I</td>
<td>B-NR</td>
<td>In patients treated with DAPT, the recommended daily dose of aspirin is</td>
</tr>
</tbody>
</table>
### 4.2. Duration of DAPT in Patients With ACS Treated With PCI: Recommendations

See [Online Data Supplements 1 to 9](http://circ.ahajournals.org/) for evidence supporting these recommendations.

#### Recommendations for Duration of DAPT in Patients With ACS Treated With PCI

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>B-R</td>
<td>In patients with ACS (NSTE-ACS or STEMI) treated with DAPT after BMS or DES implantation, P2Y&lt;sub&gt;12&lt;/sub&gt; inhibitor therapy (clopidogrel, prasugrel, or ticagrelor) should be given for at least 12 months (16,50-55,72,96-98).</td>
</tr>
<tr>
<td>I</td>
<td>B-NR</td>
<td>In patients treated with DAPT, the recommended daily dose of aspirin is 81 mg (range, 75 mg to 100 mg) (56-60,75-78).</td>
</tr>
<tr>
<td>IIA</td>
<td>B-R</td>
<td>In patients with ACS (NSTE-ACS or STEMI) treated with DAPT after coronary stent implantation, it is reasonable to use ticagrelor in preference to clopidogrel for maintenance P2Y&lt;sub&gt;12&lt;/sub&gt; inhibitor therapy (53,72).</td>
</tr>
<tr>
<td>IIA</td>
<td>B-R</td>
<td>In patients with ACS (NSTE-ACS or STEMI) treated with DAPT after coronary stent implantation who are not at high risk for bleeding complications and who do not have a history of stroke or TIA, it is reasonable to choose prasugrel over clopidogrel for maintenance P2Y&lt;sub&gt;12&lt;/sub&gt; inhibitor therapy (54,55).</td>
</tr>
<tr>
<td>IIB</td>
<td>A</td>
<td>In patients with ACS (NSTE-ACS or STEMI) treated with coronary stent implantation who have tolerated DAPT without a bleeding complication and who are not at high bleeding risk (e.g., prior bleeding on DAPT, coagulopathy, oral anticoagulant use), continuation of DAPT (clopidogrel, prasugrel, or ticagrelor) may be reasonable (16,22-26,28,30,40,41,43,53,54,72).</td>
</tr>
<tr>
<td>IIB</td>
<td>C-LD</td>
<td>In patients with ACS treated with DAPT after DES implantation who develop a high risk of bleeding (e.g., treatment with oral anticoagulant therapy), are at high risk of severe bleeding complication (e.g., major intracranial surgery), or develop significant overt bleeding, discontinuation of P2Y&lt;sub&gt;12&lt;/sub&gt; inhibitor therapy after 3 months may be reasonable (19,20,34,36,37).</td>
</tr>
</tbody>
</table>
intracranial surgery), or develop significant overt bleeding, discontinuation of P2Y₁₂ inhibitor therapy after 6 months may be reasonable (17-21,34,36,37).

III: Harm B-R Prasugrel should not be administered to patients with a prior history of stroke or TIA (54).

SR indicates systematic review.

4.3. Duration of DAPT in Patients With SIHD and ACS Treated with PCI

DAPT in patients treated with coronary stent implantation reduces the risk of stent thrombosis and ischemic events (50,51,94,95,99) (Data Supplement 7). The risk of stent thrombosis in patients treated with a bare metal stent (BMS) is greatest in the first days to weeks after implantation (99,100). Cessation of DAPT during this period, particularly in cases of patients undergoing surgery, is associated with an unacceptable rate of often catastrophic stent thrombosis (101-103). Thus, a minimum duration of DAPT of 1 month is generally recommended for patients treated with BMS. In current practice, BMS are generally reserved for patients who cannot receive DAPT for more than ≈1 month for reasons of active bleeding, nonadherence to medical therapy, or planned surgery.

The recommended minimum duration of DAPT in patients treated with first-generation DES, based primarily on observational data and one subgroup analysis, has been 12 months (9,51,97,104,105). Compared with first-generation DES, currently used newer-generation DES have a lower risk of stent thrombosis and appear to require a shorter minimum duration of DAPT (17,18,21,38,96,97). Five RCTs (17-21) of primarily low-risk (non-ACS) patients treated with DES comparing shorter-duration (3 to 6 months) DAPT with 12 months of DAPT, as well as several meta-analyses (34-37) and an analysis by the ERC (30), did not find an increased risk of stent thrombosis with shorter-duration DAPT, although the individual trials were underpowered to detect such a difference (Data Supplements 1 and 3). Therefore, in patients with SIHD treated with DES, the minimum recommended duration of DAPT has been decreased from 12 to 6 months.

The PCI-CURE analysis (51) of patients in the CURE (Clopidogrel in Unstable Angina to Prevent Recurrent Events) trial (52) demonstrated that treatment with DAPT for up to 12 months in patients with NSTE-ACS treated with BMS reduced ischemic events compared with aspirin monotherapy (Data Supplement 4). Based Primarily on the CURE trial and PCI-CURE analyses, the prior recommendation that patients with NSTE-ACS treated with coronary stent implantation be treated with DAPT for at least 12 months is continued in this update and has been extrapolated to patients with STEMI treated with PCI as well, on the basis of the consideration that NSTE-ACS and STEMI are part of the spectrum of ACS.

As detailed in Section 2, treatment with prolonged (or “extended”) DAPT beyond a minimum recommended duration of therapy necessitates a fundamental tradeoff between decreasing ischemic risk (e.g., MI and stent thrombosis) and increasing bleeding risk (16,30,34,36,37,46). Prolonged or extended DAPT for an additional 18 to 36 months (after an initial 6 to 12 months of DAPT) in patients treated with DES implantation
results in an absolute decrease in stent thrombosis and ischemic complications of ≈1% to 2% and an absolute increase in bleeding complications of ≈1% (Data Supplements 1, 2, and 3) (16,22-27,30,35-37,46). Newer-generation stents, particularly everolimus-eluting stents, are associated with lower rates of stent thrombosis, and the absolute reduction in the rate of stent thrombosis with prolonged DAPT in patients treated with everolimus-eluting stents is modest (39,106-109).

The benefit/risk ratio of prolonged DAPT in patients treated with PCI may be more favorable for those with prior MI (or ACS) than for those with SIHD (28,41,43). Preliminary data suggest that in patients with a high DAPT score the benefit/risk ratio with prolonged DAPT may be favorable and that in those with a low DAPT score the benefit/risk ratio with prolonged DAPT is not favorable (61). In patients treated with coronary stent implantation who have increased bleeding risk (e.g., oral anticoagulation), increased risk of severe bleeding complications (e.g., major intracranial surgery), or significant overt bleeding, the benefit/risk ratio may favor shorter-than-recommended duration of DAPT (17-21,34,36). Decisions about treatment with and duration of DAPT require a thoughtful assessment of the benefit/risk ratio, integration of current and future study data, and consideration of patient preference.

In studies of drug-eluting bioabsorbable polymer stents and bioabsorbable stents (third- and fourth-generation stents), by study protocol, DAPT was continued for at least 6 to 12 months (110-116). In a study of a novel polymer-free and carrier-free drug-coated stent in patients at high risk of bleeding complications, by study protocol, DAPT was continued for only 1 month (117). These stents have not been included in the studies of shorter- or longer-duration (prolonged/extended) DAPT discussed in this focused update. Because none of these stents (except one biodegradable polymer DES) was approved by the U.S. Food and Drug Administration at the time this focused update was written, recommendations for duration of DAPT for such stents are not included.

Recommendations for duration of DAPT in patients treated with PCI are summarized in Figure 2.
Figure 2. Treatment Algorithm for Duration of P2Y₁₂ Inhibitor Therapy in Patients Treated With PCI

Colors correspond to Class of Recommendation in Table 1. Arrows at the bottom of the figure denote that the optimal duration of prolonged DAPT is not established. Clopidogrel is the only currently used P2Y₁₂ inhibitor studied in patients with SIHD undergoing PCI. Aspirin therapy is almost always continued indefinitely in patients with coronary artery disease.

*High bleeding risk denotes those who have or develop a high risk of bleeding (e.g., treatment with oral anticoagulant therapy) or are at increased risk of severe bleeding complication (e.g., major intracranial surgery).

ACS indicates acute coronary syndrome; BMS, bare metal stent; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; PCI, percutaneous coronary intervention; and SIHD, stable ischemic heart disease.
5. CABG: Recommendations

See *Online Data Supplements 4, 6, 10, and 11* for evidence supporting these recommendations.

**Recommendations for CABG**

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>C-E0</td>
<td>In patients treated with DAPT after coronary stent implantation who subsequently undergo CABG, P2Y₁₂ inhibitor therapy should be resumed postoperatively so that DAPT continues until the recommended duration of therapy is completed.</td>
</tr>
<tr>
<td>I</td>
<td>C-LD</td>
<td>In patients with ACS (NSTE-ACS or STEMI) being treated with DAPT who undergo CABG, P2Y₁₂ inhibitor therapy should be resumed after CABG to complete 12 months of DAPT therapy after ACS (52-54,118-120).</td>
</tr>
<tr>
<td>I</td>
<td>B-NR</td>
<td>In patients treated with DAPT, a daily aspirin dose of 81 mg (range, 75 mg to 100 mg) is recommended (56-60,75-78).</td>
</tr>
<tr>
<td>IIb</td>
<td>B-NR</td>
<td>In patients with SIHD, DAPT (with clopidogrel initiated early postoperatively) for 12 months after CABG may be reasonable to improve vein graft patency (121-125).</td>
</tr>
</tbody>
</table>

Aspirin therapy after CABG improves vein graft patency, particularly during the first postoperative year, and reduces MACE (126-130). In the CURE study (52), the reduction in ischemic events in patients treated with aspirin plus clopidogrel who underwent CABG was consistent with the study population as a whole, although benefit was primarily observed mainly before the procedure (118). A propensity score analysis of a Danish administrative database (120) demonstrated during a mean follow-up of 466±144 days significantly fewer deaths in patients treated with aspirin plus clopidogrel than in those treated with aspirin alone, although there was no reduction in the incidence of recurrent MI.

The impact of clopidogrel on graft occlusion after on-pump CABG has been evaluated in 5 studies (*Data Supplement 10*). Several randomized and nonrandomized trials and a post hoc substudy analysis of patients predominantly undergoing on-pump CABG did not demonstrate any differences in graft patency between antiplatelet monotherapy and DAPT when assessed at follow-up ranging from 1 month to 1 year after CABG (131-134). In the only RCT to demonstrate a benefit of DAPT, vein graft patency 3 months after CABG was significantly higher in patients treated with clopidogrel and aspirin (100 mg) than in those receiving aspirin monotherapy (121).

Two meta-analyses and 1 systematic overview assessed the potential benefits of DAPT after CABG and reported mixed results (122,123,135) (*Data Supplement 10*). In the largest meta-analysis of patients pooled from 5 RCTs and 6 observational studies (122), DAPT was associated with reduced vein graft occlusion and 30-day mortality rate as compared with aspirin monotherapy. A meta-analysis of only the 5 RCTs (123) showed that
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DAPT was associated with a significantly lower vein graft occlusion at 1 year versus antiplatelet monotherapy but with no improvement in arterial graft patency. Major bleeding after surgery was more frequent with DAPT (122,123,135).

The benefits of DAPT in off-pump CABG patients were noted in terms of improved graft patency (124,125) and clinical outcome (136) in single-center observational studies (124,136) and an RCT (125) (Data Supplement 10).

Only data from post hoc analyses are available on the utility of newer P2Y<sub>12</sub> inhibitors in patients with ACS who undergo CABG. In a retrospective analysis of patients in the TRITON-TIMI 38 study (54) who underwent CABG (137), prasugrel treatment was associated with a significantly lower 30-day mortality rate than that of clopidogrel and more postoperative blood loss. A post hoc analysis of patients who underwent CABG in the PLATO study (53) showed that the primary endpoint at 1 year was similar for both treatments, but a significant reduction in cardiovascular mortality was noted with ticagrelor compared with clopidogrel (138,139).

Issues related to the timing of discontinuation of DAPT before CABG are beyond the scope of this update but are addressed in the 2011 CABG guideline (10). Figure 3 summarizes recommendations for the management and duration of P2Y<sub>12</sub> inhibitor therapy in patients undergoing CABG.
Figure 3. Treatment Algorithm for Management and Duration of P2Y₁₂ Inhibitor Therapy in Patients Undergoing CABG

Colors correspond to Class of Recommendation in Table 1. Aspirin therapy is almost always continued indefinitely in patients with coronary artery disease.

*Duration of DAPT therapy can vary from as little as 4 weeks to >12 months, depending on the clinical setting and bleeding risk.

ACS indicates acute coronary syndrome; CABG, coronary artery bypass graft surgery; DAPT, dual antiplatelet therapy; PCI, percutaneous coronary intervention; NSTE-ACS, non–ST-elevation acute coronary syndromes; post-op, postoperatively; SIHD, stable ischemic heart disease; and S/P, status post.
### 6. SIHD: Recommendations

See *Online Data Supplements 1 to 4 and 6 to 11* for evidence supporting these recommendations.

#### Recommendations for SIHD

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
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</thead>
<tbody>
<tr>
<td>I</td>
<td>A</td>
<td>In patients with SIHD treated with DAPT after BMS implantation, P2Y₁₂ inhibitor therapy (clopidogrel) should be given for a minimum of 1 month (94,95).</td>
</tr>
<tr>
<td>I</td>
<td>B-NR SR</td>
<td>In patients with SIHD treated with DAPT after DES implantation, P2Y₁₂ inhibitor therapy (clopidogrel) should be given for at least 6 months (17,18,21,30,96,97).</td>
</tr>
<tr>
<td>I</td>
<td>B-NR</td>
<td>In patients treated with DAPT, a daily aspirin dose of 81 mg (range, 75 mg to 100 mg) is recommended (56-60,75-78).</td>
</tr>
<tr>
<td>IIb</td>
<td>A SR</td>
<td>In patients with SIHD being treated with DAPT for an MI that occurred 1 to 3 years earlier who have tolerated DAPT without a bleeding complication and who are not at high bleeding risk (e.g., prior bleeding on DAPT, coagulopathy, oral anticoagulant use), further continuation of DAPT may be reasonable (28,30,40,41,44).</td>
</tr>
<tr>
<td>IIb</td>
<td>A SR</td>
<td>In patients with SIHD treated with BMS or DES implantation who have tolerated DAPT without a bleeding complication and who are not at high bleeding risk (e.g., prior bleeding on DAPT, coagulopathy, oral anticoagulant use), continuation of DAPT with clopidogrel for longer than 1 month in patients treated with BMS or longer than 6 months in patients treated with DES may be reasonable (16,22,24-26,30,50).</td>
</tr>
<tr>
<td>IIb</td>
<td>C-LD</td>
<td>In patients with SIHD treated with DAPT after DES implantation who develop a high risk of bleeding (e.g., treatment with oral anticoagulant therapy), are at high risk of severe bleeding complication (e.g., major intracranial surgery), or develop significant overt bleeding, discontinuation of P2Y₁₂ inhibitor therapy after 3 months may be reasonable (19,20,34,36,37).</td>
</tr>
<tr>
<td>IIb</td>
<td>B-NR</td>
<td>In patients with SIHD, treatment with DAPT (with clopidogrel initiated early postoperatively) for 12 months after CABG may be reasonable to improve vein graft patency (121-125).</td>
</tr>
<tr>
<td>III: No Benefit</td>
<td>B-R</td>
<td>In patients with SIHD without prior history of ACS, coronary stent implantation, or recent (within 12 months) CABG, treatment with DAPT is not beneficial (28,40-42).</td>
</tr>
</tbody>
</table>

SR indicates systematic review.

For the purposes of this update, patients with a history of ACS >1 year prior who have remained free of recurrent ACS are considered to have transitioned to SIHD.

In the CHARISMA trial, which randomized patients with established atherosclerosis or at high risk of
clinical atherosclerotic disease to either DAPT (with clopidogrel) or aspirin monotherapy, no significant reduction was found in ischemic effects at a median follow-up of 28 months with DAPT, but a 0.4% absolute increase was seen in severe bleeding (40). In a post hoc analysis of patients enrolled in the study with prior MI, a 1.7% absolute decrease in the composite endpoint of cardiovascular death, MI, or stroke events was observed with DAPT, but no benefit was seen in those with CAD without prior MI (Data Supplement 4) (40,41). In the PEGASUS-TIMI 54 trial, in which stable patients 1 to 3 years after MI with additional high-risk features were randomized to either DAPT (with ticagrelor 60 mg or 90 mg twice daily) or continued aspirin monotherapy, a mean of 33 months of DAPT led to a 1.2% to 1.3% absolute reduction in ischemic events and a 1.2% to 1.5% increase in major bleeding (28). In subgroup analysis, the greatest reduction in ischemic events was in patients in whom P2Y₁₂ inhibitor therapy either had not been discontinued or had been discontinued ≤30 days before enrollment in the study (absolute reduction in MACE: 1.9% to 2.5%), and no benefit was seen in patients in whom P2Y₁₂ inhibitor therapy had been discontinued >1 year before enrollment in the study (42). On the basis of all studies of DAPT in post-MI patients, extended DAPT for approximately 18 to 36 months leads to an absolute decrease in ischemic complications of ≈1% to 3% and an absolute increase in bleeding complications of ≈1% (Data Supplement 4) (28,40,41,43,44).

DAPT is not recommended in patients with SIHD without prior stent implantation and no history of ACS or MI. Decisions about treatment with and duration of DAPT in patients with SIHD with a history of MI or coronary stent implantation require a thoughtful assessment of the benefit/risk ratio, integration of study data, and consideration of patient preference.

Figure 4 summarizes recommendations on duration of P2Y₁₂ inhibitor therapy in patients with SIHD.
Figure 4. Treatment Algorithm for Duration of P2Y₁₂ Inhibitor Therapy in Patients With SIHD (Without ACS Within the Past Several Years)

Colors correspond to Class of Recommendation in Table 1. Patients with a history of ACS >1 year prior who have since remained free of recurrent ACS are considered to have transitioned to SIHD. Arrows at the bottom of the figure denote that the optimal duration of prolonged DAPT is not established. Clopidogrel is the only currently used P2Y₁₂ inhibitor studied in patients with SIHD undergoing PCI. Aspirin therapy is almost always continued indefinitely in patients with coronary artery disease.

*High bleeding risk denotes those who have or develop a high risk of bleeding (e.g., treatment with oral anticoagulant therapy) or are at increased risk of severe bleeding complication (e.g., major intracranial surgery).

ACS indicates acute coronary syndrome; BMS, bare metal stent; CABG, coronary artery bypass graft surgery; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; Hx, history; MI, myocardial infarction; PCI, percutaneous coronary intervention; SIHD, stable ischemic heart disease; and S/P, status post.

7. Acute Coronary Syndrome (NSTE-ACS and STEMI)

7.1. Duration of DAPT in Patients With ACS Treated With Medical Therapy Alone (Without Revascularization or Fibrinolytic Therapy): Recommendations

See Online Data Supplements 4 to 6 for evidence supporting these recommendations.

Recommendations for Duration of DAPT in Patients With ACS Treated with Medical Therapy Alone

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>B-R</td>
<td>In patients with ACS who are managed with medical therapy alone (without...</td>
</tr>
</tbody>
</table>
### 7.2. Duration of DAPT in Patients With STEMI Treated With Fibrinolytic Therapy: Recommendations

See *Online Data Supplements 4 and 6* for evidence supporting these recommendations.

#### Recommendations for Duration of DAPT in Patients With STEMI Treated With Fibrinolytic Therapy

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>A</td>
<td>In patients with STEMI treated with DAPT in conjunction with fibrinolytic therapy, P2Y₁₂ inhibitor therapy (clopidogrel) should be continued for a minimum of 14 days (<em>Level of Evidence: A</em>) (140,142) and ideally at least 12 months (<em>Level of Evidence: C-EQ</em>).</td>
</tr>
<tr>
<td>I</td>
<td>B-NR</td>
<td>In patients treated with DAPT, a daily aspirin dose of 81 mg (range, 75 mg to 100 mg) is recommended (56-60,75-78).</td>
</tr>
<tr>
<td>IIb</td>
<td>Aₚᵣ</td>
<td>In patients with ACS treated with medical therapy alone (without revascularization or fibrinolytic therapy) who have tolerated DAPT without bleeding complication and who are not at high bleeding risk (e.g., prior bleeding on DAPT, coagulopathy, oral anticoagulant use), continuation of DAPT for longer than 12 months may be reasonable (28,30,40,41,43,53,71,141).</td>
</tr>
</tbody>
</table>

SR indicates systematic review.

### 7.3. Duration of DAPT in Patients With ACS Treated With PCI: Recommendations

See *Online Data Supplements 1 to 9* for evidence supporting these recommendations.

#### Recommendations for Duration of DAPT in Patients With ACS Treated With PCI

<table>
<thead>
<tr>
<th>COR</th>
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</tr>
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<tbody>
<tr>
<td>I</td>
<td>B-R</td>
<td>In patients with ACS treated with DAPT after BMS or DES implantation, P2Y₁₂ inhibitor therapy (clopidogrel, prasugrel, or ticagrelor) should be given for at least 12 months (16,50-55,72,96-98).</td>
</tr>
<tr>
<td>I</td>
<td>B-NR</td>
<td>In patients treated with DAPT, a daily aspirin dose of 81 mg (range, 75 mg to 100 mg) is recommended (56-60,75-78).</td>
</tr>
</tbody>
</table>
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<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>I</td>
<td>C-LD</td>
<td>In patients with ACS being treated with DAPT who undergo CABG, P2Y&lt;sub&gt;12&lt;/sub&gt; inhibitor therapy should be resumed after CABG to complete 12 months of DAPT therapy after ACS (52-54,118-120).</td>
</tr>
</tbody>
</table>

### 7.4. Duration of DAPT in Patients With ACS Treated With CABG: Recommendation

See [Online Data Supplement 4 and 11](http://circ.ahajournals.org/) for evidence supporting this recommendation.

**Recommendation for Duration of DAPT in Patients With ACS Treated With CABG**

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendation</th>
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</thead>
<tbody>
<tr>
<td>I</td>
<td>C-LD</td>
<td>In patients with ACS being treated with DAPT who undergo CABG, P2Y&lt;sub&gt;12&lt;/sub&gt; inhibitor therapy should be resumed after CABG to complete 12 months of DAPT therapy after ACS (52-54,118-120).</td>
</tr>
</tbody>
</table>

### 7.5. Duration of DAPT in Patients With ACS

Aspirin remains the cornerstone of antiplatelet therapy in patients with ACS. Further platelet inhibition, with an associated reduction in ischemic risk, can be achieved by blocking the P2Y<sub>12</sub> receptor. In the CURE trial of patients with NSTE-ACS, the addition of clopidogrel (for up to 1 year) to aspirin monotherapy resulted in a 2.1% absolute reduction in subsequent ischemic events but also a 1.0% absolute increase in major bleeding (52). The majority of patients in this study were treated without revascularization, though benefit was observed both in those treated with revascularization (PCI or CABG) and in those treated with medical therapy alone (51,52). Available evidence from this trial, as well as from PLATO (53,71,72) and TRITON-TIMI 38 (54,55), supports DAPT duration of at least 12 months for patients with NSTE-ACS.
The results of the CURE trial (52) and PCI-CURE analyses of the CURE trial (51) (Data Supplement 4) have been extrapolated to patients with STEMI on the basis of the consideration that NSTE-ACS and STEMI are both part of the spectrum of ACS and usually caused by coronary plaque rupture. Based on this consideration, as well as the results from the PLATO and TRITON-TIMI 38 trials, it is recommended that patients with STEMI treated with coronary stent implantation or medical therapy alone (without revascularization or reperfusion therapy) be treated with DAPT for at least 12 months (53-55,55,71,72). Ticagrelor is considered a P2Y12 treatment option in patients with STEMI not treated with revascularization (or reperfusion therapy) on the basis of a similar extrapolation of the results of the “medically managed” patients with ACS in the PLATO trial (71). On the basis of CURE, PCI-CURE, PLATO, and TRITON-TIMI 38, clopidogrel, prasugrel, and ticagrelor are all P2Y12 treatment options in patients with ACS treated with PCI.

In the CLARITY-TIMI 28 (Clopidogrel as Adjunctive Reperfusion Therapy—Thrombolysis In Myocardial Infarction 28) trial, short-term treatment (up to 8 days) with clopidogrel (in addition to aspirin) in patients with STEMI undergoing fibrinolytic therapy improved TIMI flow grade in the culprit artery and decreased the composite endpoint of cardiovascular death, reinfarction, or the need for urgent revascularization (142). In COMMIT (Clopidogrel and Metoprolol in Myocardial Infarction Trial) (93% with STEMI not managed with primary PCI), treatment for ≥2 weeks with clopidogrel (in addition to aspirin 162 mg) resulted in a 0.9% absolute reduction of the 28-day composite endpoint of death, reinfarction, or stroke and a 0.6% absolute reduction in death (140). A 1.1% absolute risk reduction in the composite endpoint was seen in the subgroup of patients who received fibrinolytic therapy. On the basis of these trials and extrapolation of the results of CURE, DAPT with aspirin and clopidogrel is recommended for a minimum of 14 days and ideally at least 12 months in patients with STEMI treated with fibrinolytic therapy (Data Supplement 4).

As discussed in Section 3, treatment with prolonged (extended) DAPT beyond a minimum recommended duration necessitates a fundamental tradeoff between decreasing ischemic risk (e.g., MI and stent thrombosis) and increasing bleeding risk (16,24,28,30,34,36,37,46). In post-MI patients, extended DAPT for approximately 18 to 36 months leads to an absolute decrease in ischemic complications of ≥1% to 3% and an absolute increase in bleeding complications of ≥1% (Data Supplement 4) (28,40,41,43,44). An analysis from the PEGASUS-TIMI 54 trial found that the greatest reduction in ischemic events with prolonged DAPT in post-MI patients was in patients in whom P2Y12 inhibitor therapy either had not been discontinued or had been discontinued for ≤30 days (absolute reduction in MACE: 1.9% to 2.5%). No benefit was seen in patients in whom P2Y12 inhibitor therapy had been discontinued >1 year before enrollment in the study (42). Decisions about treatment with and duration of DAPT in patients with ACS require a thoughtful assessment of the benefit/risk ratio, integration of study data, and consideration of patient preference.

In patients treated with DAPT with high bleeding risk (e.g., oral anticoagulation), increased risk of severe bleeding complications (e.g., major intracranial surgery), or significant overt bleeding, the benefit/risk
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ratio may favor shorter-than-recommended duration of DAPT (17-21,34,36).

Recommendations for DAPT in patients with ACS treated with medical therapy alone, fibrinolytic therapy, PCI, and CABG are summarized in Figure 5.
Figure 5. Treatment Algorithm for Duration of P2Y₁₂ Inhibitor Therapy in Patient With Recent ACS (NSTE-ACS or STEMI)

Colors correspond to Class of Recommendation in Table 1. Arrows at the bottom of the figure denote that the optimal duration of prolonged DAPT is not established. Aspirin therapy is almost always continued indefinitely in patients with coronary artery disease.

*High bleeding risk denotes those who have or develop a high risk of bleeding (e.g., treatment with oral anticoagulant therapy) or are at increased risk of severe bleeding complication (e.g., major intracranial surgery).

ACS indicates acute coronary syndrome; BMS, bare metal stent; CABG, coronary artery bypass graft surgery; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; lytic, fibrinolytic therapy; NSTE-ACS, non–ST-elevation acute coronary syndrome; PCI, percutaneous coronary intervention; and STEMI, ST-elevation myocardial infarction.

8. Perioperative Management–Timing of Elective Noncardiac Surgery in Patients Treated With PCI and DAPT: Recommendations

See Online Data Supplement 12 for evidence supporting these recommendations.

Recommendations for Perioperative Management–Timing of Elective Noncardiac Surgery in Patients Treated With PCI and DAPT
<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>I</td>
<td>B-NR</td>
<td>Elective noncardiac surgery should be delayed 30 days after BMS implantation and optimally 6 months after DES implantation (101-103,143-146).</td>
</tr>
<tr>
<td>I</td>
<td>C-EO</td>
<td>In patients treated with DAPT after coronary stent implantation who must undergo surgical procedures that mandate the discontinuation of P2Y₁₂ inhibitor therapy, it is recommended that aspirin be continued if possible and the P2Y₁₂ platelet receptor inhibitor be restarted as soon as possible after surgery.</td>
</tr>
<tr>
<td>IIa</td>
<td>C-EO</td>
<td>When noncardiac surgery is required in patients currently taking a P2Y₁₂ inhibitor, a consensus decision among treating clinicians as to the relative risks of surgery and discontinuation or continuation of antiplatelet therapy can be useful.</td>
</tr>
<tr>
<td>IIb</td>
<td>C-EO</td>
<td>Elective noncardiac surgery after DES implantation in patients for whom P2Y₁₂ inhibitor therapy will need to be discontinued may be considered after 3 months if the risk of further delay of surgery is greater than the expected risks of stent thrombosis.</td>
</tr>
<tr>
<td>III: Harm</td>
<td>B-NR</td>
<td>Elective noncardiac surgery should not be performed within 30 days after BMS implantation or within 3 months after DES implantation in patients in whom DAPT will need to be discontinued perioperatively (101-103,143-146).</td>
</tr>
</tbody>
</table>

The timing of noncardiac surgery in patients treated with coronary stent implantation involves consideration of: (1) the risk of stent thrombosis (particularly if DAPT needs to be interrupted); (2) the consequences of delaying the desired surgical procedure; and (3) increased the intra- and peri-procedural bleeding risk and the consequences of such bleeding if DAPT is continued (15,147,148) (Data Supplement 12). DAPT significantly reduces the risk of stent thrombosis (50,51,94,95,99), and discontinuation of DAPT in the weeks after stent implantation is one of the strongest risk factors for stent thrombosis, with the magnitude of risk and impact on mortality rate inversely proportional to the timing of occurrence after the procedure (145,149,150). Older observational studies found that the risk of stent-related thrombotic complications is highest in the first 4 to 6 weeks after stent implantation but continues to be elevated at least 1 year after DES placement (101-103,149). Data from more recent large observational studies suggest that the time frame of increased risk of stent thrombosis is on the order of 6 months, irrespective of stent type (BMS or DES) (151-153). In a large cohort of patients from the Veterans Health Administration hospitals, the increased risk of surgery for the 6 months after stent placement was most pronounced in those patients in whom the indication for PCI was an MI (146). An additional consideration, irrespective of the timing of surgery, is that surgery is associated with proinflammatory and prothrombotic effects that may increase the risk of coronary thrombosis at the level of the stented vascular segment as well as throughout the coronary vasculature (154,155).
Prior recommendations with regard to duration of DAPT (9,104) and the timing of noncardiac surgery (15,156) in patients treated with DES were based on observations of those treated with first-generation DES. Compared with first-generation DES, currently used newer-generation DES are associated with a lower risk of stent thrombosis and appear to require a shorter minimum duration of DAPT (17,18,21,38,96,97). Several studies of DAPT duration in patients treated with newer-generation DES did not detect any difference in the risk of stent thrombosis between patients treated with 3 to 6 months of DAPT or patients treated with longer durations of DAPT (although these studies were underpowered to detect such differences) (17-21) (Data Supplement 1). Moreover, the safety of treating selected patients with newer-generation DES for shorter durations (3 or 6 months) of DAPT has been shown in a patient-level analysis pooling 4 trials evaluating DAPT durations (34). Furthermore, in the PARIS (Patterns of Nonadherence to Antiplatelet Regimens in Stented Patients) registry, interruption of DAPT according to physician judgment in patients undergoing surgery at any time point after PCI was not associated with an increased risk of MACE (145). On the basis of these considerations, the prior Class I recommendation that elective noncardiac surgery in patients treated with DES be delayed 1 year (15) has been modified to “optimally at least 6 months.” Similarly, the prior Class IIb recommendation that elective noncardiac surgery in patients treated with DES may be considered after 180 days (15) has been modified to “after 3 months.” Figure 6 summarizes recommendations on timing of elective noncardiac surgery in patients with coronary stents.

The magnitude of incremental bleeding risk in patients treated with antiplatelet therapy who undergo surgery is uncertain (157,158). If P2Y₁₂ inhibitor therapy needs to be held in patients being treated with DAPT after stent implantation, continuation of aspirin therapy if possible is recommended, though this is based primarily on expert opinion. If a P2Y₁₂ inhibitor has been held before a surgical procedure, therapy is restarted as soon as possible, given the substantial thrombotic hazard associated with lack of platelet inhibition early after surgery in patients with recent stent implantation. Although several small studies have used intravenous antiplatelet agents as a means of “bridging” in patients requiring temporary discontinuation of DAPT before surgery, there is no convincing clinical evidence demonstrating the efficacy of bridging with either parenteral antiplatelet or anticoagulant therapy (159-163).

Decisions about the timing of surgery and whether to discontinue DAPT after coronary stent implantation are best individualized. Such decisions involve weighing the particular surgical procedure and the risks of delaying the procedure, the risks of ischemia and stent thrombosis, and the risk and consequences of bleeding. Given the complexity of these considerations, decisions are best determined by a consensus of the surgeon, anesthesiologist, cardiologist, and patient.
Figure 6. Treatment Algorithm for the Timing of Elective Noncardiac Surgery in Patients With Coronary Stents
Colors correspond to Class of Recommendation in Table 1.
BMS indicates bare metal stent; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; and PCI, percutaneous coronary intervention.
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Key Words: AHA Scientific Statements ■ acute coronary syndrome ■ aspirin ■ coronary artery disease ■
coronary stents ■ dual antiplatelet therapy (DAPT) ■ focused update ■ P2Y₁₂ inhibitor ■ stable ischemic heart
disease
References

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154. Rajagopalan S, Ford I, Bachoo P, et al. Platelet activation, myocardial ischemic events and postoperative non-


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Appendix 1. Author Relationships With Industry and Other Entities (Relevant)—2016 ACC/AHA Guideline Focused Update on Duration of Dual Antiplatelet Therapy in Patients With Coronary Artery Disease (February 2015)

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<td>Glenn N. Levine</td>
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| Eric R. Bates    | University of Michigan—Professor of Medicine | • AstraZeneca  
• Merck | None | None | None | None | None | All sections |
| John A. Bittl    | Munroe Regional Medical Center—Interventional Cardiologist | None | None | None | None | None | None | None |
| Ralph G. Brindis | University of California, San Francisco—Philip R. Lee Institute for Health Policy Studies—Clinical Professor of Medicine | None | None | None | None | None | None | None |
| Stephan D. Fihn  | Department of Veterans Affairs—Director, Office of Analytics and Business Intelligence | None | None | None | None | None | None | None |
| Lee A. Fleisher  | University of Pennsylvania, Department of Anesthesiology—Professor of Anesthesiology | None | None | None | None | None | None | None |
| Christopher B. Granger | Duke Clinical Research Institute—Director, Cardiac Care Unit; Professor of Medicine | • AstraZeneca  
• Bayer  
• Bristol-Myers Squibb‡  
• Daiichi-Sankyo  
• Janssen | None | None | None | • AstraZeneca‡  
• Bayer‡  
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Focused Update on Duration of Dual Antiplatelet Therapy

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| Peter K. Smith  
| (Vice Chair, CABG) | Duke University Medical Center—Professor of Surgery; Chief, Thoracic Surgery | None | None | None | None | None | None |
| Sidney C. Smith, Jr | University of North Carolina—Professor of Medicine; Center for Cardiovascular Science and Medicine—Director | None | None | None | None | None | None |

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*Writing committee members are required to recuse themselves from voting on sections to which their specific relationships with industry and other entities may apply.
†No financial benefit.
‡Significant relationship.

ACC indicates American College of Cardiology; AHA, American Heart Association; CABG, coronary artery bypass graft surgery; periop, perioperative noncardiac surgery; SIHD, stable ischemic heart disease; STEMI, ST-elevation myocardial infarction; and TIMI, Thrombosis In Myocardial Infarction.
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**Appendix 2. Reviewer Relationships With Industry and Other Entities (Relevant)—2016 ACC/AHA Guideline Focused Update on Duration of Dual Antiplatelet Therapy in Patients With Coronary Artery Disease** (December 2015)

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• Bayer  
• Daiichi-Sankyo  
• Sanofi-Aventis  
• Servier Pharmaceuticals  
• ZS Pharma | None                     | None                                           | • Bayer Pharma (DSMB)†  
• Janssen Pharmaceuticals (DSMB)  
• ZS Pharma* | None | None |
| Joaquin E. Cigarroa       | Official Reviewer—ACC/AHA Task Force on Practice Guidelines | Oregon Health and Science University—Clinical Professor of Medicine | None                                                                                         | None | None | None | None | None |
| Ian C. Gilchrist          | Official Reviewer—AHA| Hershey Medical Center—Physician, Professor of Medicine | • Terumo Interventional Systems | None | None | • Angel Medical Systems†  
• Eli Lilly | None | None |
| Dipti Itchhaporia         | Official Reviewer—ACC Board of Trustees | Newport Coast Cardiology—Robert and Georgia Roth Chair of Cardiac Excellence; Hoag Heart and Vascular Institute—Medical Director, Disease Management | None                                                                                         | None | None | None | None | None |
| Mladen I. Vidovich        | Official Reviewer—ACC Board of Governors | University of Illinois—Associate Professor of Medicine; Jesse Brown VA Medical Center—Chief of Cardiology | None                                                                                         | • Eli Lilly/Daiichi-Sankyo* | None | None | None | None |
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| Dawn J. Abbott | Organizational Reviewer—SCAI | Brown University—Director of Interventional Cardiology Fellowship Training Program | None | None | None | None | None | AstraZeneca† | None |
| Dominick J. Angiolillo | Organizational Reviewer—SCAI | University of Florida College of Medicine—Cardiovascular Research Director | None | None | None | None | None | Eli Lilly* | Daiichi-Sankyo* | AstraZeneca | Janssen Pharmaceuticals* | CSL Behring* | CeloNova (DSMB)* | None | None |
| Herbert D. Aronow | Organizational Reviewer—SVM | Rhode Island Hospital—Director of Cardiac Catheterization Laboratory; The Warren Alpert School of Brown University—Clinical Professor of Cardiology; Lifespan Cardiovascular Institute—Director, Intervention Cardiology | None | None | None | None | None | EndoMax (Steering Committee) | None | None |
| Vinay Badhwar | Organizational Reviewer—STS | University of Pittsburgh Medical Center—Director, Center for Mitral Valve Disease | None | None | None | None | None | Abbott | On-X Life Technologies | None | None |
| Geoffrey D. Barnes | Organizational Reviewer—SVM | University of Michigan—Cardiologist, Vascular Medicine Specialist | None | None | None | None | None | Blue Cross/Blue Shield of Michigan* | None | None |
| Kathy Berra | Organizational Reviewer—PCNA | Stanford Prevention Research Center—Clinical Trial Director | None | None | None | None | None | Abbott Pharmaceuticals | None | None |
| Lola A. Coke | Organizational Reviewer—PCNA | Rush University Medical Center—Cardiovascular Clinical Nurse Specialist | None | None | None | None | None | None | None | None |
| Harold L. Lazar | Organizational Reviewer—AATS | Boston University Medical Center Department of Cardiology—Professor of Cardiothoracic Surgery | None | None | None | None | None | Paraxel International (DSMB) | Eli Lilly | None | None |
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<td>Frederico Gentile</td>
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- Elsai *
- Ethicon *
- FlowCo †
- Forest Laboratories *
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<td>Ajay J. Kirtane</td>
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*Abbott Vascular*
*Eli Lilly*
Levine, GN, et al.
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<th>Medical University of South Carolina—Service Line Medical Director</th>
<th>Indiana School of Nursing—Professor and Sally Reahard Chair; Center of Enhancing Quality of Life in Chronic Illness—Director</th>
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Levine, GN, et al.
Focused Update on Duration of Dual Antiplatelet Therapy

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<th>Squibb*</th>
<th>Eli Lilly/ Daiichi-Sankyo Alliance*</th>
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<th>Institutional, Organizational or Other Financial Benefit</th>
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</table>
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| Eric R. Bates  
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| Ralph G. Brindis                | University of California, San Francisco—Philip R. Lee Institute for Health Policy Studies—Clinical Professor of Medicine | None             | • Volcano Corp  | None                         | • Harvard Clinical Research Institute (DAPT trial (Advisory Board)  
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| Richard A. Lange      | Texas Tech University Health Sciences Center El Paso—President; Paul L. Foster School of Medicine—Dean | • Bristol-Myers Squibb†  
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<tr>
<td>Peter K. Smith (Vice Chair, CABG)</td>
<td>Duke University Medical Center—Professor of Surgery; Chief, Thoracic Surgery</td>
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Peter K. Smith
(Vice Chair, CABG)

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†Significant relationship.

ABIM indicates American Board of Internal Medicine; ACC, American College of Cardiology; ACCF, American College of Cardiology Foundation; ACP, American College of Physicians; AHA, American Heart Association; AMA, American Medical Association; DAPT, dual antiplatelet therapy; DSMB, data safety monitoring board; ECG, electrocardiogram; JAHA, Journal of the American Heart Association; NCDR, National Cardiovascular Data Registry; NHLBI, National Heart, Lung, and Blood Institute; NIH, National Institutes of Health; SCAI, Society for Cardiovascular Angiography and Interventions; and TIMI, Thrombosis In Myocardial Infarction.
# 2016 Duration of Dual Antiplatelet Therapy Guideline Focused Update Data Supplement

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## Data Supplement 1. RCTs of Shorter (3–6 Month) Duration of DAPT in Patients Treated With Stent Implantation

| Study Acronym | Study Author; Year Published | Aim of Study; Study Type; Study Size (N) | Patient Population | Study Intervention (# patients)/ Study Comparator (# patients) | Endpoint Results (Absolute Event Rates, P values; OR or RR; & 95% CI) | Relevant 2° Endpoint (if any); Study Limitations; Adverse Events |
|---------------|-----------------------------|-----------------------------------------|--------------------|---------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------
| **ISAR-SAFE** | Schulz-Schupke S., et al., 2015 (1) | Test if 6 mo DAPT is noninferior to 12 mo DAPT | Inclusion criteria: Pts being treated with DAPT 6 mo after DES | Intervention: 6 additional mo DAPT after initial 6 mo of DAPT (n=2,003) | 1° endpoint: Composite endpoint of death, MI, stent thrombosis, CVA, or TIMI major bleeding 9 mo after randomization (15 mo after stent)  • 1.5% with no additional DAPT (6 mo total) vs. 1.6% with 6 additional mo DAPT (12 mo total) (p<0.001 for noninferiority) • Trial stopped early due to slow recruitment • Lower than expected event rates • Stent thrombosis and TIMI major bleeding rates low and not statistically different |
| **SECURITY** | Colombo A, et al., 2014 (2) | Test noninferiority of 6 vs. 12 mo DAPT after 2nd generation DES | Inclusion criteria: Pts with stable angina, unstable angina, or silent ischemia | Intervention: 6 mo DAPT (n=682) | 1° endpoint: Cardiac death, MI, CVA, stent thrombosis or BARC type 3 or 5 bleeding  • 4.5% with 6 mo DAPT vs. 3.7% with 12 mo DAPT (risk difference 0.8%; 95% CI: -2.4%–1.7%; p=0.469)  • p<0.05 for noninferiority |
| **OPTIMIZE** | Feres, et al., 2013 (3) | Assess whether 3 mo of DAPT is clinically noninferior to 12 mo in pts undergoing PCI with ZES | Inclusion criteria: Stable angina, low-risk ACS | Intervention: 3 mo DAPT (1,605) | 1° endpoint: NACCE. At 1 y follow-up  • 93 pts with 3 mo Rx vs. 90 pts with 12 mo Rx (95% CI: 1.52–1.86)  • p=0.002 for noninferiority | • Stent thrombosis rates low and not significantly different  • Relatively low-risk population enrolled |

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<tr>
<th>Study</th>
<th>Aim</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
<th>Intervention</th>
<th>1st endpoint</th>
<th>Study notes</th>
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<tr>
<td>RESET</td>
<td>Evaluate noninferiority of shorter DAPT after DES</td>
<td>Pts undergoing DES implantation</td>
<td>Contraindication to antiplatelet agents, bleeding, STEMI within 48 h or cardiogenic shock, left main PCI</td>
<td>3 mo DAPT with E-ZES (n=1059)</td>
<td>CV death, MI, stent thrombosis, TVR, bleeding at 1 y. • 4.7% with 3 mo DAPT/E-ZES vs. 4.7% with 12 mo DAPT/other DES (difference 0.0%; 95% CI: -2.5–2.5; p=0.84) • p&lt;0.001 for noninferiority</td>
<td>No significant differences in rates of stent thrombosis, bleeding or TVR • Study underpowered due to low event rates • Same stents not used in the 2 randomization arms</td>
</tr>
<tr>
<td>EXCELLENT</td>
<td>Evaluate whether 6 mo DAPT would be noninferior to 12 mo DAPT after DES</td>
<td>&gt;50% lesion with evidence of myocardial ischemia or &gt;75% lesion (with or without documented ischemia)</td>
<td>MI within 72 h, LVEF&lt;25% or cardiogenic shock, recent major bleeding or surgery</td>
<td>6 mo DAPT after DES (n=722)</td>
<td>Target vessel failure (cardiac death, MI, ischemia-driven TVR) at 12 mo • 4.8% with 6 mo DAPT vs. 4.3% with 12 mo DAPT (p=0.001 for noninferiority)</td>
<td>Stent thrombosis 0.9% with 6 mo DAPT vs. 0.1% with 12 mo DAPT (HR: 6.02; 95% CI: 0.72–49.96; p=0.10) • TIMI major bleeding 0.3% with 6 mo DAPT vs. 0.6% with 12 mo DAPT (HR: 0.50; 95% CI: 0.09–2.73; p=0.42) • Target vessel failure occurred more frequently with 6 mo DAPT in diabetic pts • Study underpowered for death or MI</td>
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<tr>
<td>ITALIC</td>
<td>Evaluate noninferiority of 6 mo DAPT vs. 24 mo DAPT with newer generation (Xience) DES</td>
<td>Pts undergoing PCI</td>
<td>Primary PCI for STEMI, left main PCI, ASA nonresponder</td>
<td>6 mo DAPT (n=926)</td>
<td>Death, MI, urgent TVR, CVA, major bleeding at 12 mo post-stenting • 1.6% with 6 mo vs. 1.5% with 24 mo (p=0.85) • p=0.00002 for noninferiority (absolute risk difference 0.11%; 95% CI: -1.04–1.26%)</td>
<td>Study terminated early due to recruitment problems • No significant differences in stent thrombosis or bleeding complications • Low event rates (lower than expected)</td>
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<tr>
<td>PRODIGY</td>
<td>To evaluate the impact of up 6 or 24 mo DAPT after BMS or DES</td>
<td>SIHD or ACS pts undergoing PCI</td>
<td>Bleeding diathesis, bleeding or stroke within 6 mo, oral anticoagulant therapy</td>
<td>24 mo DAPT (n=987)</td>
<td>Death, MI or CVA at 2 y • 10.1% with 24 mo DAPT vs. 10.0% with 6 mo DAPT (HR: 0.98; 95% CI: 0.74–1.29; p=0.91)</td>
<td>Stent thrombosis rates low and not significantly different between treatment groups</td>
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</table>
ACS indicates acute coronary syndrome; ASA, aspirin; BARC, Bleeding Academic Research Consortium; BMS, bare metal stent; CKD, chronic kidney disease; CVA, cerebrovascular accident; CV, cardiovascular; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; LVEF, left ventricular ejection fraction; MI, myocardial infarction; NACCE, Net Adverse Clinical and Cerebral Events; NSTEMI, non–ST-elevation myocardial infarction; PCI, percutaneous coronary intervention; RCT, randomized controlled trial; Rx, prescription; STEMI, ST-elevation myocardial infarction; SIHD, stable ischemic heart disease; SVG, saphenous vein graft; TIMI, Thrombolysis In Myocardial Infarction; and TVR, target-vessel revascularization.

### Data Supplement 2. RCTs of Prolonged/Extended (>12 Month) Duration of DAPT in Patients Treated With Stent Implantation

<table>
<thead>
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<th>Study Acronym</th>
<th>Author; Year Published</th>
<th>Aim of Study; Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention ( absolute event rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant 2° Endpoint (if any); Study Limitations; Adverse Events</th>
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</table>
| OPTIDUAL      | Helft G, et al., 2015 (8) 26364288 | **Aim:** Evaluate hypothesis that continuing clopidogrel would be superior to stopping clopidogrel at 12 mo following DES  
**Study type:** RCT, open label, superiority trial  
**Size:** 1,966 pts (1385 included in ITT analysis) | Inclusion criteria: Pts (SIHD or ACS) undergoing PCI with DES free of MACCE or major bleeding after 12 mo DAPT  
Exclusion criteria: Need for oral anticoagulation, unprotected left main PCI, life expectancy <2 y | **Intervention:** Additional 36 mo DAPT (n=695)  
**Comparator:** ASA therapy alone (n=690) | 1° endpoint: Net adverse clinical events (death, MI, CVA or major bleeding)  
• 5.8% with additional 36 mo DAPT vs. 7.5% with ASA alone (HR: 0.75; 95% CI: 0.50–1.28; p=0.017)  
• Study terminated early due to slow recruitment  
• Actual median follow-up 33.4 mo  
• Rates of death 2.3% with extended DAPT vs. 3.5% with ASA alone (HR: 0.65; 95% CI: 0.34–1.22; p=0.18)  
• Rates of major bleeding identical at 2.0% (p=0.95)  
• No significant differences in stent thrombosis or bleeding complications  
• Post hoc analysis of MACCE (death, MI or CVA) found rates of 4.2% with extended DAPT vs. 6.4% with ASA alone (HR: 0.64; 95% CI: 0.40–1.02; p=0.06) |

| ITALIC        | Gilard M, et al., 2015 (6) 25461690 | **Aim:** Evaluate noninferiority of 6 mo DAPT vs. 24 mo DAPT with newer generation (Xience) DES  
**Study type:** RCT, open label, noninferiority trial  
**Size:** 2,031 pts (actual 1850 pts) | Inclusion criteria: Pts undergoing PCI  
Exclusion criteria: Primary PCI for STEMI, left main PCI, ASA nonresponder | **Intervention:** 6 mo DAPT (n=926)  
**Comparator:** 24 mo DAPT (n=924) | 1° endpoint: Death, MI, urgent TVR, CVA, major bleeding at 12 mo post-stenting  
• 1.6% with 6 mo vs. 1.5% with 24 mo (p=0.85)  
• p<0.00002 for noninferiority (absolute risk difference 0.11%; 95% CI: -1.04–1.26%)  
• Study terminated early due to recruitment problems  
• No significant differences in stent thrombosis or bleeding complications  
• Low event rates (lower than expected) |
<table>
<thead>
<tr>
<th>Study</th>
<th>Aim</th>
<th>Inclusion criteria</th>
<th>Intervention</th>
<th>Co-1&lt;sup&gt;°&lt;/sup&gt; endpoints (after additional 18 mo Rx)</th>
<th>1&lt;sup&gt;°&lt;/sup&gt; Safety endpoint</th>
<th>&lt;sup&gt;1&lt;/sup&gt;° endpoint: Death, MI, stent thrombosis, CVA or urgent TVR</th>
<th>&lt;sup&gt;1&lt;/sup&gt;° Safety endpoint: STEEPLE major bleeding</th>
<th>Additional endpoints</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAPT</strong></td>
<td>Mauri L, et al., 2014 (9)</td>
<td>To assess benefits and risks of &gt;12 mo DAPT after BMS or DES</td>
<td>Pts treated with BMS or DES, but only DES-treated pts included in this report</td>
<td>Additional 18 mo of DAPT after initial 12 mo</td>
<td>Stent thrombosis: 0.4% with continued DAPT vs. 1.4% with placebo thienopyridine (HR: 0.29; 95% CI: 0.17–0.48; p=0.001)</td>
<td>MACCE (death, MI, CVA): 4.3% with continued DAPT vs. 5.9% with placebo thienopyridine (HR: 0.71; 95% CI: 0.59–0.85; p&lt;0.001)</td>
<td>GUSTO moderate or severe bleeding</td>
<td>2.6% with continued DAPT vs. 1.6% with placebo thienopyridine (p=0.001)</td>
</tr>
<tr>
<td><strong>ARCTIC-\text{Interruption}</strong></td>
<td>Collet JP, et al., 2014 (10)</td>
<td>To demonstrate superiority of continued (&gt;12 mo) vs. interrupted (12 mo) DAPT</td>
<td>Pts prior enrolled in ARCTIC-Monitoring trial without an event at 12 mo</td>
<td>Interruption (cessation) of DAPT after 12 mo Rx (n=624)</td>
<td>Death, MI, stent thrombosis, CVA or urgent TVR</td>
<td>4% of interruption group vs. 4% of continuation group (HR: 1.17; 95% CI: 0.68–2.03; p=0.58)</td>
<td>STEEPLE major bleeding</td>
<td>&lt;0.5% of interruption group vs. 1% of continuation group (HR: 0.15; 95% CI: 0.02–1.20; p=0.073)</td>
</tr>
<tr>
<td><strong>DES-LATE</strong></td>
<td>Lee CW, et al., 2014 (11)</td>
<td>To compare 12 mo DAPT to &gt;12 mo DAPT after DES</td>
<td>Pts treated with DES event-free after 12-18 mo of DAPT</td>
<td>Continued DAPT after 12 mo of Rx (n=2514)</td>
<td>CV death, MI, CVA 24 mo after randomization</td>
<td>2.4% in ASA alone vs 2.6% in continued DAPT (HR: 0.94; 95% CI: 0.66–1.35; p=0.75)</td>
<td>Publications includes pts from ZEST-LATE and REAL-LATE (the results of which were first published by Park SJ in 2010) and an additional 2,344 pts TIMI major bleeding at 24 mo follow-up occurred in 1.1% of ASA alone vs. 1.4% of continued DAPT (HR: 0.71; 95% CI: 0.42–1.20; p=0.20); difference was statistically significant by the end of all follow-up</td>
<td>No significant difference in stent thrombosis</td>
</tr>
</tbody>
</table>
### Data Supplement 3. Meta-Analyses of Duration of DAPT

<table>
<thead>
<tr>
<th>Author; Year Published</th>
<th>Aim of Study; Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention (# patients) / Study Comparator (# patients)</th>
<th>Endpoint Results (Absolute Event Rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant 2° Endpoint (if any); Study Limitations; Adverse Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Udell JA, et al., 2015 (13) 26324537</td>
<td><strong>Aim:</strong> Compare benefits and risks of more than one y of DAPT with ASA alone in high-risk pts with Hx of prior MI&lt;br&gt;<strong>Study type:</strong> Meta-analysis&lt;br&gt;<strong>Size:</strong> 33,435 pts</td>
<td><strong>Inclusion criteria:</strong> RCTs of secondary prevention in pts with MI randomized to extended duration (&gt;12 mo) DAPT compared with ASA alone&lt;br&gt;<strong>Exclusion criteria:</strong> ≤12 mo of follow-up, trials of oral anticoagulant therapies, trials of pts with</td>
<td><strong>Intervention:</strong> &gt;12 mo DAPT&lt;br&gt;<strong>Comparator:</strong> ASA therapy alone</td>
<td><strong>1° endpoint:</strong> MACE (CV death, nonfatal MI, and nonfatal stroke)&lt;br&gt;6.4% with DAPT vs. 7.5% with ASA alone (RR: 0.78; 95% CI: 0.67–0.90; p=0.001)&lt;br&gt;<strong>Studies included in analysis:</strong> CHARISMA, PRODIGY, ARCTIC- Interruption, DAPT, DES-LATE, and PEGASUS-TIMI 54&lt;br&gt;<strong>For all studies except PEGASUS-TIMI 54, a subgroup of the study population was used for the meta-analysis</strong>&lt;br&gt;CV death 2.3% with DAPT vs. 2.6% with ASA alone (RR: 0.85; 95% CI: 0.74–0.98; p= 0.03),</td>
<td><strong>Studies included in analysis:</strong> CHARISMA, PRODIGY, ARCTIC- Interruption, DAPT, DES-LATE, and PEGASUS-TIMI 54&lt;br&gt;<strong>For all studies except PEGASUS-TIMI 54, a subgroup of the study population was used for the meta-analysis</strong>&lt;br&gt;CV death 2.3% with DAPT vs. 2.6% with ASA alone (RR: 0.85; 95% CI: 0.74–0.98; p= 0.03),</td>
</tr>
<tr>
<td>Study</td>
<td>Aim</td>
<td>Design</td>
<td>Patients</td>
<td>Intervention</td>
<td>Comparators</td>
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<tr>
<td>Elmariah S, et al., 2015</td>
<td>Assess the effect of extended duration DAPT on mortality</td>
<td>Hierarchical Bayesian random effects model meta-analysis, trial level data</td>
<td>Pts enrolled in RCTs of extended vs. short duration DAPT or DAPT vs. ASA alone. Clinical settings of studies included post-PCI, post-ACS, atrial fibrillation, lacunar stroke, and documented or high-risk of CV disease</td>
<td>Longer duration DAPT</td>
<td>Shorter duration DAPT or ASA alone</td>
</tr>
<tr>
<td>Palmerini T, et al., 2015</td>
<td>To compare clinical outcomes between short- (≤6 mo) and long-term (1 y) DAPT in pts treated with DES</td>
<td>Individual pts data pairwise and network meta-analysis of RCTs</td>
<td>RCTs comparing short-duration (3 or 6 mo) with longer-duration DAPT (≥1 y).</td>
<td>Short-term (≤6 mo) DAPT</td>
<td>Long-term (1 y) DAPT</td>
</tr>
<tr>
<td>Giustino G, et al., 2015</td>
<td>Evaluate the efficacy and safety of DAPT after DES</td>
<td>Meta-analysis of RCT, trial level data</td>
<td>Pts treated with DES enrolled in RCTs of shorter vs. longer duration DAPT</td>
<td>Shorter duration vs. Longer duration DAPT</td>
<td>Stent thrombosis: 0.9% with shorter vs. 0.5% with longer (OR: 1.71; 95% CI:1.26–2.32, p=0.001)</td>
</tr>
<tr>
<td>Study</td>
<td>Aim</td>
<td>Patients</td>
<td>Comparator</td>
<td>Outcome Measures</td>
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</table>
| Navarese, et al., 2015 (17) | To assess the benefits and risks of short term (<12 mo) or extended (>12 mo) DAPT vs. 12 mo DAPT after DES. | Pts treated with DES enrolled in RCT of shorter vs. longer duration DAPT | Shorter or longer duration DAPT compared to 12 mo DAPT | MI:  
- Short vs. 12 mo: 1.65% vs. 1.50% (OR: 1.11; 95% CI: 0.87–1.43; p=0.40)  
- Extended vs. 12 mo: 1.55% vs. 2.89% (OR: 0.53; 95% CI: 0.42–0.66; p<0.001)  
- Stent thrombosis:  
  - Short vs. 12 mo: 0.53% vs. 0.40% (OR:1.32; 95% CI: 0.83–2.08; p=0.24)  
  - Extended vs. 12 mo: 0.32% vs. 0.98% (OR: 0.33; 95% CI: 0.21–0.51; p<0.001)  
- Major bleeding:  
  - Short vs. 12 mo: 0.35% vs. 0.61% (OR:0.58; 95% CI: 0.36–0.92; p=0.02)  
  - Extended vs. 12 mo: 1.95% vs. 1.21% (OR:1.62; 95% CI: 1.26–2.09; p<0.001)  
- CV mortality:  
  - Short vs. 12 mo: 1.13% vs. 1.20% (OR: 0.95; 95% CI: 0.68–1.33; p=0.76)  
  - Extended vs. 12 mo: 1.03% vs. 0.95% (OR:1.09; 95% CI: 0.79–1.50; p=0.62)  
- All-cause mortality:  
  - Short vs. 12 mo: 1.43% vs. 1.56% (OR: 0.91; 95% CI: 0.781–1.18; p=0.49)  
  - Extended vs. 12 mo: 1.84% vs. 1.42% (OR: 1.30; 95% CI: 1.02–1.66; p=0.03)  |
| Palmerini T, et al., 2015 (18) | Investigate mortality and other clinical outcomes with different DAPT strategies | Pts treated with DES enrolled in RCT of shorter vs. longer duration DAPT | Shorter duration vs. longer duration DAPT | All-cause mortality: Shorter vs. longer DAPT; HR: 0.82; 95% CI: 0.69–0.98; p=0.02; NNT=325 |

| Size: 10 RCT; total n=32,287 |  |

- Trial level data used  
- Authors concluded that compared with standard 12 mo DAPT, shorter duration reduced bleeding with no apparent increase in ischemic complications and could be considered for most pts. In selected pts with low bleeding risk and very high ischemic risk, extended DAPT could be considered.
Spencer FA, et al., 2015 (19)

**Study Acronym**  | **Author; Year Published** | **Aim** | **Study Type** | **Study Size (N)** | **Patient Population** | **Study Intervention (# patients) / Study Comparator (# patients)** | **Endpoint Results (Absolute Event Rates, P values; OR or RR; & 95% CI)** | **Relevant 2^ Endpoint (if any); Study Limitations; Adverse Events** |
---|---|---|---|---|---|---|---|---|
**Aim**  | To summarize data on clinical outcome with longer vs. shorter duration DAPT after DES  | *Meta-analysis of RCT, trial level data*  |  | 10 RCT; total n=31,666 pts  |  |  |  |  |
**Comparators**  |  |  |  |  |  |  |  |  |
**Spencer FA, et al., 2015 (19) 26005909**  | **Size:** 9 RCT; total n=28,808  | **Aim:** Pts treated with DES enrolled in RCT of shorter vs. longer duration DAPT  | **Study type:** Meta-analysis of RCT, trial level data  |  |  |  |  |  |
**Comparators:**  | Shorter duration vs. longer duration DAPT  |  |  |  |  |  |  |  |
**MI:**  | 1.7% with longer vs. 2.6% with shorter (RR: 0.73; CI: 0.58–0.92)  |  |  |  |  |  |  |  |
**Major Bleeding:**  | 1.4% with longer vs. 0.8% with shorter (RR: 1.66; 95% CI: 1.34–1.99)  |  |  |  |  |  |  |  |
**Total Mortality:**  | 2.0% with longer vs. 1.7% with shorter (RR=1.19; 95% CI: 1.04–1.36)  |  |  |  |  |  |  |  |

ACS indicates acute coronary syndrome; ASA, aspirin; CV, cardiovascular; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; HR, hazard ratio; Hx, history; MACE, major adverse cardiac events; MI, myocardial infarction; NNT, number need to treat; PCI, percutaneous coronary intervention; RCT, randomized controlled trial; SIHD, stable ischemic heart disease; and TIMI, Thrombolysis In Myocardial Infarction.
### DAPT (MI subgroup analysis)
Yeh RW, et al., 2015 (20)

**Aim:** Assess benefits and risks of extended DAPT in subgroups of pts in the DAPT study with MI and stable presentations

**Study type:** Post-hoc analysis of the DAPT trial

**Size:** 11,648 pts

**Inclusion criteria:** Pts enrolled in DAPT trial treated with either BMS or DES

**Exclusion criteria:** N/A

**Intervention:** Additional 18 mo DAPT after initial 12 mo

**Comparator:** Placebo thienopyridine after initial 12 mo DAPT

**Subgroup analysis:** Pts with MI (n=3,576) and without MI (n=8,072)

**Co-1° endpoints (after additional 18 mo Rx):**
- **Stent thrombosis in MI group:** 0.5% with extended DAPT vs. 1.9% with placebo thienopyridine (HR: 0.27; CI: 0.13–0.57, p<0.001)
- **MACCE (death, MI, CVA) in MI group:** 3.9% with continued DAPT vs. 6.8% with placebo thienopyridine (HR: 0.56; CI: 0.42–0.76; p<0.001)

**1° Safety endpoint:** GUSTO moderate or severe bleeding
- In pts with MI: 1.9% with continued DAPT vs. 0.8% with placebo thienopyridine (HR: 2.38; CI: 1.28–4.43, p=0.005)
- All cause death 1.4% with extended DAPT vs. 1.6% with placebo thienopyridine (HR: 0.87; CI: 0.50–1.50, p=0.61)

### PEGASUS-TIMI 54
Bonaca MP, et al., 2015 (21)

**Aim:** To investigate the efficacy and safety of ticagrelor beyond 1 y after a MI

**Study type:** RCT, placebo controlled

**Size:** 21,162 pts

**Inclusion criteria:** MI 1-3 y prior, age ≥50, and an additional high-risk feature

**Exclusion criteria:** Bleeding disorder, Hx of ischemic stroke of ICH, CNS tumor, GI bleeding within 6 mo, major surgery within 30 d, oral anticoagulant use

**Intervention:** Ticagrelor 90 mg (n=7050) or ticagrelor 60 mg (n=7045)

**Comparator:** Placebo (n=7067)

**1° endpoint:** CV death, MI or stroke at median 33 mo follow-up
- 7.85% with 90 mg ticagrelor, 7.77% with 60 mg ticagrelor, and 9.04% with placebo •HR for 90 mg vs. placebo: 0.85; 95% CI: 0.75–0.96; p=0.008
- HR for 60 mg vs. placebo: 0.84; 95% CI: 0.74–0.95; p=0.004

**1° Safety endpoint:** TIMI major bleeding
- 2.60 with 90 mg ticagrelor, 2.30 with 60 mg ticagrelor, and 1.06% with placebo (p<0.001 for each dose vs. placebo)

• All pts treated with ASA
• No differences in death between the either dose of ticagrelor and placebo
| **TRILOGY** | **Aim:** To compare prasugrel with clopidogrel in pts with NSTE-ACS not undergoing revascularization | **Inclusion criteria:** Pts with NSTE-ACS selected for medical management without revascularization | **Intervention:** Prasugrel | 1st **endpoint:** MACE (CV death, MI or CVA) in pts <75 y at 30 mo  
• 13.9% with prasugrel vs. 16.0% with clopidogrel (HR: 0.91; 95% CI: 0.79–1.05; p=0.21)  
**Safety endpoint:** GUSTO severe or life-threatening bleeding  
• 0.9% with prasugrel vs. 0.6% with clopidogrel (HR: 0.94; 95% CI: 0.44–1.99; p=0.87)  
• All pts treated with ASA |
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<tbody>
<tr>
<td><strong>Study type:</strong> RCT</td>
<td><strong>Exclusion criteria:</strong> Hx CVA or TIA, PCI or CABG within prior 30 d, renal failure requiring dialysis, concomitant oral anticoagulation treatment</td>
<td><strong>Comparator:</strong> Clopidogrel</td>
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<tr>
<td><strong>Size:</strong> 7,243 pts</td>
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</table>

| **PLATO** | **Aim:** To evaluate efficacy and safety outcomes in pts in PLATO who at randomization were planned for a noninvasive treatment strategy. | **Inclusion criteria:** Pts with ACS admitted to hospital with planned noninvasive management | **Intervention:** Ticagrelor (90 mg bid) | 1st **endpoint:** Vascular death, MI or CVA  
• 12.0% with ticagrelor compared to 14.3% with clopidogrel (HR: 0.85; 95% CI: 0.73–1.00; p=0.04)  
**Safety endpoint:** Total major bleeding:  (11.9% with ticagrelor vs. 10.3% with clopidogrel (HR: 1.17; 95% CI: 0.98–1.39; p=0.08)  
• Non–CABG major bleeding: 4.0% with ticagrelor vs. 3.1% with clopidogrel (HR: 1.30, 95% CI:0.95–1.77; p=0.10)  
• N/A |
| **Study type:** Pre-specified subgroup analysis of the PLATO RCT | **Exclusion criteria:** Pts in PLATO with planned invasive management | **Comparator:** Clopidogrel (75 mg qD) |  |  |
| **Size:** 5,216 pts |  |  |  |  |

| **PLATO** | **Aim:** To examine the efficacy and safety of ticagrelor compared with clopidogrel in pts with STE-ACS intended for reperfusion with primary PCI. | **Inclusion criteria:** Pts enrolled in PLATO with STEMI | **Intervention:** Ticagrelor | 1st **endpoint:** MACE (CV death, MI, CVA)  
• 9.4% with ticagrelor vs. 10.8% with clopidogrel;  (HR: 0.87; 95% CI: 0.75–1.01; p=0.07)  
**Safety endpoint:** major bleeding  
• No difference in major bleeding (HR: 0.98; p=0.76).  
• 72% of pts with STEMI underwent primary PCI  
• Definite stent thrombosis lower with ticagrelor (HR: 0.66; p=0.03).  
• Risk of stroke higher with ticagrelor (1.7% vs. 1.0%; HR: 1.63; 95% CI: 1.07–2.48; p=0.02).  
• N/A |
| **Study type:** Pre specified subgroup analysis of PLATO; RCT | **Exclusion criteria:** Same as PLATO study | **Comparator:** Clopidogrel |  |  |
| **Size:** 7,544 pts |  |  |  |  |
| **TRITON-TIMI 38** | **Aim:** To assess prasugrel vs. clopidogrel in pts undergoing PCI for STEMI enrolled in TRITON-TIMI 38  
**Study type:** Double-blind RCT  
**Size:** 3,534 pts |
|---|---|
| **Inclusion criteria:** Pts undergoing PCI for STEMI  
**Exclusion criteria:** Increased risk of bleeding, anemia, recent fibrinolytic administration, need from chronic oral anticoagulants, cardiogenic shock, or thienopyridine treatment within 5 d of randomization. |
| **Intervention:** Prasugrel (n=1,769)  
**Comparator:** Clopidogrel (n=1,765) |
| **1° endpoint:** CV death, nonfatal MI, nonfatal stroke at 15 mo.  
- 10.0% with prasugrel vs. 12.4% with clopidogrel (HR: 0.79; 95% CI: 0.65–0.97; p=0.0221) |
| **Safety endpoint:**  
- No significant different in non–CABG related TIMI major bleeding at 30 d or 15 mo  
- Secondary endpoint of CV death, nonfatal MI or target vessel revascularization at 30 d 6.5% with prasugrel vs. 9.5% with clopidogrel (HR: 0.75; 95% CI: 0.59–0.96; p=0.0205) |

| **TRITON** | **Wiviott SD, et al., 2007 (26)  
17982182** | **Aim:** To compare prasugrel with clopidogrel in pts with ACS scheduled for PCI  
**Study type:** RCT, double-blind, double-dummy design  
**Size:** 13,608 pts |
|---|---|
| **Inclusion criteria:** ACS (NSTE-ACS or STEMI) pts undergoing planned PCI  
**Exclusion criteria:** Increased risk of bleeding, anemia, thrombocytopenia |
| **Intervention:** Prasugrel (10 mg qD) (n=6,813)  
**Comparator:** Clopidogrel (75 mg qD) (n=6,795) |
| **1° endpoint:** CV death, MI, CVA  
- 9.9% with prasugrel vs. 12.1% with clopidogrel (HR: 0.81; CI: 0.73–0.90; p<0.001)  
1° Safety endpoint: Non–CABG related TIMI major bleeding  
- 2.4% with prasugrel vs. 1.8% with clopidogrel (HR: 1.32; 95% CI: 1.03–1.68, p=0.03)  
- Stent thrombosis rate lower with prasugrel (1.1% vs. 2.4%, p=0.001)  
- Life-threatening bleeding higher with prasugrel (1.4% vs. 0.9%, p=0.01)  
- Fatal bleeding higher with prasugrel (0.4% vs. 0.1%, p=0.002)  
- Increased rate of ICH in those treated with prasugrel with Hx of CVA or TIA  
- Increased risk of bleeding in those with Hx CVA or TIA, elderly (≥75 y) and body weight <60 kg |

| **CHARISMA** | **Bhatt DL, et al., 2006, 2007 (27,28)  
7498584  
16531616** | **Aim:** Assess effect of DAPT in a broad population of pts at high risk for atherothrombotic events  
**Study type:** RCT, placebo controlled  
**Size:** 15,603 pts |
|---|---|
| **Inclusion criteria:** Age ≥45 with multiple atherothrombotic risk factors and/or documented CAD, cerebrovascular disease, or PAD  
**Exclusion criteria:** Long-term use of oral antithrombotic medications of NSAID, recent ACS |
| **Intervention:** ASA + clopidogrel (n=7,802)  
**Comparator:** ASA + placebo (n=7,801) |
| **1° endpoint:** CV death, MI or CVA (median follow-up 28 mo)  
- 6.8% with ASA+clopidogrel vs. 7.4% with ASA+placebo (RR: 0.93; 95% CI: 0.83–1.05; p=0.22)  
1° Safety endpoint: GUSTO severe bleeding  
- 1.7% with ASA+clopidogrel vs. 1.3% with ASA+placebo (RR: 1.25; 95% CI: 0.97–1.61; p=0.09)  
- In a post hoc subgroup analysis of those with Hx of prior MI, composite endpoint of CV death, MI and CVA occurred in 8.3% of placebo-treated pts and 6.6% of clopidogrel-treated pts (HR: 0.774; 95% CI: 0.613–0.978; p=0.031) |

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<table>
<thead>
<tr>
<th>COMMIT-CCS 2</th>
<th><strong>Aim</strong>: To compare ASA alone to ASA + clopidogrel in pts with STEMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chen ZM, et al., 2005 (29)</td>
<td></td>
</tr>
<tr>
<td><strong>Study type</strong>: RCT</td>
<td></td>
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<tr>
<td><strong>Size</strong>: 45,852 pts</td>
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<tr>
<td><strong>Inclusion criteria</strong>: Pts with suspected MI within 24 H</td>
<td></td>
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<tr>
<td><strong>Exclusion criteria</strong>: Pts undergoing primary PCI, high-risk of adverse event with study treatments</td>
<td></td>
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<tr>
<td><strong>Intervention</strong>: ASA + clopidogrel</td>
<td></td>
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<tr>
<td><strong>Comparator</strong>: ASA alone</td>
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<tr>
<td><strong>Co-1° endpoints (during scheduled treatment – discharge or d 28)</strong>:</td>
<td></td>
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<tr>
<td>• MACE (death, reinfarction, CVA): 9.2% with DAPT vs. 10.1% with ASA (RRR: 9%; 95% CI: 3%–14%; p=0.002)</td>
<td></td>
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<tr>
<td>• Death: 7.5% with DAPT vs. 8.1% with ASA (RRR: 7%; 95% CI: 1%–13%; p=0.03)</td>
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<tr>
<td><strong>Safety endpoint</strong>: Life-threatening bleeding</td>
<td></td>
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<tr>
<td>• 0.58% with DAPT vs. 0.55% with ASA (p=0.59)</td>
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</table>

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<tr>
<th>PCI-CLARITY</th>
<th><strong>Aim</strong>: Determine if clopidogrel pretreatment before PCI in pts with recent STEMI is superior to clopidogrel treatment initiated at the time of PCI in preventing MACE</th>
</tr>
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<tbody>
<tr>
<td>Sabatine MS, et al., 2005 (30)</td>
<td></td>
</tr>
<tr>
<td><strong>Study type</strong>: RCT; prespecified subgroup analysis of pts in CLARITY-TIMI 28 who underwent PCI</td>
<td></td>
</tr>
<tr>
<td><strong>Size</strong>: 1,863 pts</td>
<td></td>
</tr>
<tr>
<td><strong>Inclusion criteria</strong>: Pts receiving fibrinolytics for STEMI undergoing subsequent angiography and PCI enrolled in CLARITY</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion criteria</strong>: Planned treatment with clopidogrel or a GPI before angiography, cardiogenic shock, prior CABG</td>
<td></td>
</tr>
<tr>
<td><strong>Intervention</strong>: Clopidogrel pretreatment</td>
<td></td>
</tr>
<tr>
<td><strong>Comparator</strong>: Standard therapy (clopidogrel at the time of PCI)</td>
<td></td>
</tr>
<tr>
<td><strong>1° endpoint</strong>: MACE at 30 d</td>
<td></td>
</tr>
<tr>
<td>• 3.6% with pretreatment vs. 6.2% with standard Rx; (adjusted OR=0.54; 95% CI: 0.35–0.85; p=0.008)</td>
<td></td>
</tr>
<tr>
<td><strong>Safety endpoint</strong>: TIMI major or minor bleeding</td>
<td></td>
</tr>
<tr>
<td>• 2.0% with pretreatment vs. 1.9% with standard Rx (p=0.99)</td>
<td></td>
</tr>
</tbody>
</table>

| Sabatine MS, et al., 2005 (31)  |
| **Aim**: To assess benefit of addition of clopidogrel to ASA in pts with STEMI treated with fibrinolytic therapy  |
| **Study type**: RCT  |
| **Size**: 3,491 pts  |
| **Inclusion criteria**: Pts with STEMI being treated with fibrinolytic therapy and ASA  |
| **Exclusion criteria**: recent clopidogrel treatment or GPI, planned performance of angiography within 48 h, prior CABG, cardiogenic shock  |
| **Intervention**: Clopidogrel + ASA  |
| **Comparator**: Placebo + ASA  |
| **1° endpoint**: Composite of occluded infarct-related artery (TIMI flow grade 0 or 1) at angiography, or death or recurrent MI before angiography  |
| • 15.0% with DAPT vs. 21.7% with ASA (absolute reduction 6.7%; RRR: 36%; 95% CI: 24%–47%; p<0.001)  |
| **Safety endpoint**: TIMI major bleeding  |
| • 1.3% with DAPT vs. 1.1% with ASA (p=0.64)  |

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<table>
<thead>
<tr>
<th>Study</th>
<th>Aim</th>
<th>Inclusion criteria</th>
<th>Intervention</th>
<th>1st endpoint: MACE (CV death, MI or stroke)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURE</td>
<td>To assess benefits and risks of ASA plus clopidogrel in pts undergoing CABG for NSTE-ACS</td>
<td>NSTE-ACS within &lt;24 h</td>
<td>Clopidogrel + ASA</td>
<td>14.5% with DAPT vs. 16.2% with ASA (RR: 0.89; 95% CI: 0.71–1.11)</td>
<td>Benefits of DAPT with CABG were deemed “consistent” (test for interaction among strata 0.53) with the benefits in pts undergoing PCI (9.6% with DAPT vs. 13.2% with ASA; RR: 0.72; 95% CI: 0.47–0.90) and in those treated with medical therapy alone (8.1% with DAPT vs. 10.0% with ASA; RR: 0.80; 95% CI: 0.69–0.92)</td>
</tr>
<tr>
<td>CURE</td>
<td>Compare efficacy and safety of DAPT in pts with NSTE-ACS hospitalized within 24 h of symptom onset</td>
<td>Pts with NSTE-ACS hospitalized within 24 h of symptom onset</td>
<td>ASA + clopidogrel (DAPT)</td>
<td>9.3% with DAPT vs. 11.4% with ASA alone (RR: 0.80; 95% CI: 0.72–0.90; p&lt;0.01)</td>
<td>Mean duration of treatment was 9 mo</td>
</tr>
<tr>
<td>PCI-CURE</td>
<td>To assess whether pretreatment with clopidogrel followed by long-term Rx after PCI is superior to no pretreatment and 4 wk Rx</td>
<td>Pts enrolled in CURE undergoing PCI</td>
<td>ASA + clopidogrel (DAPT)</td>
<td>4.5% with ASA+clopidogrel vs. 6.4% with ASA+placebo (RR: 0.70; 95% CI: 0.50–0.97; p=0.03)</td>
<td>CV death or MI rate between PCI and end of follow-up: 6.0% with ASA+clopidogrel vs. 8.0% with ASA+placebo (RR: 0.75; 95% CI: 0.56–1.00; p=0.047)</td>
</tr>
</tbody>
</table>

**Notes:**
- ACS indicates acute coronary syndrome; ASA, aspirin; bid, two times per day; BMS, bare metal stent; CABG, coronary artery bypass graft; CAD, coronary artery disease; CI, confidence interval; CNS, central nervous system; CVA, cerebrovascular accident; CV, cardiovascular; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; Dx, diagnosis; GI, gastrointestinal; GPI, glycoprotein inhibitor; HR, hazard ratio; Hx, history; ICH, intracerebral hemorrhage; MACE, major adverse cardiac and cerebrovascular events; MI, myocardial infarction; NSTE-ACS, non–ST-elevation acute coronary syndrome; NSAID, nonsteroidal anti-inflammatory drug; NYHA, New York Heart Association; PAD, peripheral artery disease; PCI, percutaneous coronary intervention; RCT, randomized clinical trial.
controlled trial; RR, relative risk; Rx, prescription; TIA, transient ischemic attack; TIMI, Thrombolysis In Myocardial Infarction; SIHD, stable ischemic heart disease; STE-ACS, ST-elevation acute coronary syndrome; STEMI, ST-elevation myocardial infarction; and TVR, target-vessel revascularization.

### Data Supplement 5. RCTs and RCT Subgroup Analyses Comparing Clopidogel With Prasugrel or Ticagrelor In Patients With ACS

<table>
<thead>
<tr>
<th>Study Acronym</th>
<th>Author; Year Published</th>
<th>Aim of Study; Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention (# patients) / Study Comparator (# patients)</th>
<th>Endpoint Results (Absolute Event Rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant 2° Endpoint (if any); Study Limitations; Adverse Events</th>
</tr>
</thead>
</table>
| TRILOGY       | Row MT, et al., 2012 (22) 22920930 | **Aim:** To compare prasugrel with clopidogrel in pts with NSTE-ACS not undergoing revascularization  
**Study type:** RCT  
**Size:** 7,243 pts | **Inclusion criteria:** Pts with NSTE-ACS selected for medical management without revascularization  
**Exclusion criteria:** Hx CVA or TIA, PCI or CABG within prior 30 d, renal failure requiring dialysis, concomitant oral anticoagulation treatment | **Intervention:** Prasugrel  
**Comparator:** Clopidogrel | **1° endpoint:** MACE (CV death, MI or CVA) in pts <75 y at 30 mo  
- 13.9% with prasugrel vs. 16.0% with clopidogrel (HR: 0.91; 95% CI: 0.79–1.05; p=0.21)  
**Safety endpoint:** GUSTO severe or life-threatening bleeding  
- 0.9% with prasugrel vs. 0.6% with clopidogrel (HR: 0.94; 95% CI: 0.44–1.99; p=0.87)  
*All pts treated with ASA* |
| PLATO         | James SK, et al., 2011 (23) 21685437 | **Aim:** To evaluate efficacy and safety outcomes in pts in PLATO who at randomization were planned for a noninvasive treatment strategy.  
**Study type:** Prespecified subgroup analysis of the PLATO RCT  
**Size:** 5,216 pts | **Inclusion criteria:** Pts with ACS admitted to hospital with planned noninvasive management  
**Exclusion criteria:** Pts in PLATO with planned invasive management | **Intervention:** Ticagrelor (90 mg bid)  
**Comparator:** Clopidogrel (75 mg qD) | **1° endpoint:** Vascular death, MI or CVA  
- 12.0% with ticagrelor compared to 14.3% with clopidogrel (HR: 0.85; 95% CI: 0.73–1.00; p=0.04)  
**Safety endpoint:**  
- Total major bleeding: (11.9% with ticagrelor vs. 10.3% with clopidogrel (HR: 1.17; 95% CI: 0.98–1.39; p=0.08)  
- Non–CABG major bleeding: 4.0% with ticagrelor vs. 3.1% with clopidogrel (HR: 1.30, 95% CI: 0.95–1.77; p=0.10)  
*N/A* |
<table>
<thead>
<tr>
<th>Study</th>
<th>Aim</th>
<th>Inclusion criteria</th>
<th>Intervention</th>
<th>1st endpoint</th>
<th>Safety endpoint: major bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLATO Steg PG, et al., 2010 (24)</td>
<td>To examine the efficacy and safety of ticagrelor compared with clopidogrel in pts with STE-ACS intended for reperfusion with primary PCI.</td>
<td>Pts enrolled in PLATO with STEMI</td>
<td>Ticagrelor</td>
<td>MACE (CV death, MI, CVA)</td>
<td>No difference in major bleeding (HR: 0.98; p=0.76).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion criteria: Same as PLATO study</td>
<td>Comparator: Clopidogrel</td>
<td>9.4% with ticagrelor vs. 10.8% with clopidogrel; HR: 0.87; 95% CI: 0.75–1.01; p=0.07</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Study type: Prespecified subgroup analysis of PLATO; RCT</td>
<td>Size: 7,544 pts</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PLATO Wallentin L, et al., 2009 (35)</td>
<td>To compare ticagrelor and clopidogrel in pts with ACS</td>
<td>Ticagrelor (90 mg bid) (n=9,333)</td>
<td>Vascular death, MI or CVA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inclusion criteria: ACS with symptom onset within 24 h</td>
<td>Comparator: Clopidogrel (75 mg qD) (n=9,291)</td>
<td>9.8% with ticagrelor vs. 11.7% with clopidogrel (HR: 0.84; 95% CI: 0.77–0.92; p&lt;0.001</td>
<td>11.6% with ticagrelor vs. 11.2% with clopidogrel (p=0.43)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion criteria: Fibrinolytic therapy within 24 h, oral anticoagulant therapy, increased risk of bradycardia, concomitant therapy with a strong cytochrome P-450 3A inhibitor or inducer</td>
<td>1st Safety endpoint: Trial-defined major bleeding</td>
<td>No significant different in non–CABG related TIMI major bleeding at 30 d or 15 mo</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Study type: RCT, double-blind, double dummy design</td>
<td>Size: 18,624 pts</td>
<td>7.3% with ticagrelor vs. 7.6% with clopidogrel (p=0.22)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TRITON-TIMI 38 Montalescot, et al., 2009 (25)</td>
<td>To assess prasugrel vs. clopidogrel in pts undergoing PCI for STEMI enrolled in TRITON-TIMI 38</td>
<td>Prasugrel (n=1,769)</td>
<td>CV death, nonfatal MI, nonfatal stroke at 15 mo.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inclusion criteria: Pts undergoing PCI for STEMI</td>
<td>Comparator: Clopidogrel (n=1,765)</td>
<td>10.0% with prasugrel vs. 12.4% with clopidogrel (HR: 0.79; 95% CI: 0.65–0.97; p=0.0221)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusion criteria: Increased risk of bleeding, anemia, recent fibrinolytic administration, need from chronic oral anticoagulants, cardiogenic shock, or thienopyridine treatment within 5 d of randomization.</td>
<td>1st endpoint: CV death, nonfatal MI or TVR at 30 d 6.5% with prasugrel vs. 9.5% with clopidogrel (HR: 0.75; 95% CI: 0.59–0.96; p=0.0205)</td>
<td>No significant different in non–CABG related TIMI major bleeding at 30 d or 15 mo</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Study type: Double-blind RCT</td>
<td>Size: 3,534 pts</td>
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</tbody>
</table>

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Aim: To compare prasugrel with clopidogrel in pts with ACS scheduled for PCI

Study type: RCT, double-blind, double-dummy design

Size: 13,608 pts

Inclusion criteria: ACS (NSTE-ACS or STEMI) pts undergoing planned PCI

Exclusion criteria: Increased risk of bleeding, anemia, thrombocytopenia

Intervention: Prasugrel (10 mg qD) (n=6,813)

Comparator: Clopidogrel (75 mg qD) (n=6,795)

1st endpoint: CV death, MI, CVA

- 9.9% with prasugrel vs. 12.1% with clopidogrel (HR: 0.81; 95% CI: 0.73–0.90; p<0.001)

Safety endpoint: Non–CABG related TIMI major bleeding

- 2.4% with prasugrel vs. 1.8% with clopidogrel (HR: 1.32; CI: 1.03–1.68; p=0.03)

- Stent thrombosis rate lower with prasugrel (1.1% vs. 2.4%, p=0.001)

- Life-threatening bleeding higher with prasugrel (1.4% vs. 0.9%, p=0.01)

- Fatal bleeding higher with prasugrel (0.4% vs. 0.1%, p=0.002)

- Increased rate of ICH in those treated with prasugrel with Hx of CVA or TIA

- Increased risk of bleeding in those with Hx CVA or TIA, elderly (≥75 y) and body weight <60 kg

ACS indicates acute coronary syndrome; ASA, aspirin; bid, two times per day; CABG, coronary artery bypass graft; CI, confidence interval; CVA, cerebrovascular accident; CV, cardiovascular; DAPT, dual antiplatelet therapy; HR, hazard ratio; Hx, history; MACE, major adverse cardiac events; MI, myocardial infarction; NSTE-ACS, non–ST-elevation acute coronary syndrome; NSTEMI, non–ST-elevation myocardial infarction; PCI, percutaneous coronary intervention; RCT, randomized controlled trial; RR, relative risk; Rx, prescription; TIA, transient ischemic attack; TIMI, Thrombolysis In Myocardial Infarction; SIHD, stable ischemic heart disease; STEMI, ST-elevation myocardial infarction; and TVR, target-vessel revascularization.

Data Supplement 6. Studies and Comparisons of Short-Term or Chronic Aspirin Dose in Patients With Coronary Artery Disease

<table>
<thead>
<tr>
<th>Study Acronym</th>
<th>Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention</th>
<th>Study Comparator</th>
<th>Endpoint Results (Absolute Event Rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant 2nd Endpoint (if any); Study Limitations; Adverse Events</th>
</tr>
</thead>
</table>
| TRANSLATE-ACS | Aim: Compare outcome of pts in TRANSLATE-ACS treated with high-dose (325 mg) or low-dose (81 mg) ASA | Study type: Analysis of data in the TRANSLATE-ACS observational study | Intervention: ASA dose (nonrandomized) | Comparator: Higher or lower ASA dose | 1st endpoint: MACE
- MACE not statistically significantly different between treatment groups
- 8.2% with high dose vs. 9.2% with low-dose (adjusted HR: 0.99; 95% CI: 0.85–1.17). |
- Safety endpoint: bleeding (BARC)
- BARC (1-5) bleeding higher with high-dose ASA (unadjusted 24.2% with high-dose vs. 22.7% with low-dose; adjusted HR: 1.19; 95% CI:1.06–1.33) |
- High-dose ASA was 325 mg; low-dose ASA was 81 mg |
| CURRENT-OASIS 7 | Aim: To assess the efficacy and safety of standard vs. double-dose clopidogrel and of high- vs. low-dose ASA in pts with ACS undergoing PCI | Inclusion criteria: Pts with ACS (STEMI or non–STEMI) undergoing PCI | Intervention 1: High-dose ASA (300-325 mg) | | 1st endpoint: CV death, MI, or stroke at 30 d
- 4.1% with high-dose ASA vs. 4.2% with low-dose ASA (HR: 0.98; 95% CI: 0.84–1.13; p=0.76) |
- Safety endpoint: Major bleeding |

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<table>
<thead>
<tr>
<th>Study type</th>
<th>Inclusion criteria</th>
<th>Intervention</th>
<th>1° endpoint</th>
<th>Safety endpoint</th>
<th>Odds reduction in vascular events</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCI-CURE</td>
<td>Evaluate the safety of different doses of ASA after PCI in PCI-CURE</td>
<td>ASA dose (nonrandomized)</td>
<td>N/A</td>
<td>Major bleeding at 30 d and long term (mean 8 mo)</td>
<td>ASA doses were categorized as low-dose (≤100 mg), moderate dose (101–199 mg), and high-dose (≥200 mg)</td>
</tr>
<tr>
<td>Jolly SS, et al., 2009</td>
<td>NSTE-ACS pts in CURE who underwent PCI (PCI-CURE cohort)</td>
<td>Comparator: Higher or lower ASA dose</td>
<td></td>
<td>• Major bleeding increased with high-dose ASA</td>
<td></td>
</tr>
<tr>
<td>(38)</td>
<td></td>
<td></td>
<td></td>
<td>• 1.9% with low-dose, 1.5% with moderate dose, and 3.9% with high-dose</td>
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<td>• For high vs. low-dose HR: 2.05 (95% CI: 1.20–3.50; p=0.009)</td>
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<td></td>
<td></td>
<td>• ASA doses were categorized as low-dose (≤100 mg), moderate dose (101–199 mg), and high-dose (≥200 mg)</td>
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<td></td>
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<td></td>
<td>• Net adverse clinical events (death, MI, stroke, major bleeding) favored Low-dose over high-dose ASA (8.4% vs. 11.0%; HR: 1.31; 95% CI: 1.00–1.73; p=0.056)</td>
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<td></td>
<td></td>
<td></td>
<td>• ASA doses were categorized as low-dose (≤100 mg), moderate dose (101–199 mg), and high-dose (≥200 mg)</td>
<td></td>
</tr>
<tr>
<td>CHARISMA</td>
<td>Assess MACE based on ASA dose in CHARISMA</td>
<td>ASA dose (nonrandomized)</td>
<td></td>
<td>Severe or life-threatening bleeding</td>
<td></td>
</tr>
<tr>
<td>Steinhubl, et al., 2009</td>
<td>Pts enrolled in CHARISMA</td>
<td>Comparator: Higher or lower ASA dose</td>
<td></td>
<td>• Hazard similar regardless of dose</td>
<td></td>
</tr>
<tr>
<td>(39)</td>
<td></td>
<td></td>
<td></td>
<td>• Adjusted HR: 0.85; 95% CI: 0.57–1.26, for &gt;100 mg vs. &lt;100 mg</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Adjusted HR: 1.0; 95% CI: 0.85–1.18; for &gt;100 mg vs. &lt;100 mg</td>
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<td></td>
<td></td>
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<td></td>
<td>• ASA doses were categorized as &lt;100 mg (75 mg or 81 mg), 100 mg or &gt;100 mg (150 mg or 162 mg)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• In pts also receiving clopidogrel, daily ASA doses &gt;100 mg seemed to be nonstatistically significantly associated with reduced efficacy (adjusted HR: 1.16; CI: 0.93–1.44) and increased harm (adjusted HR: 1.30; CI: 0.83–2.04).</td>
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<td></td>
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<td></td>
<td></td>
<td>• ASA doses were categorized as &lt;100 mg (75 mg or 81 mg), 100 mg or &gt;100 mg (150 mg or 162 mg)</td>
<td></td>
</tr>
<tr>
<td>Patrono C, et al., 2008</td>
<td>Comparison of OR in vascular events with different ASA doses</td>
<td>ASA dose (nonrandomized)</td>
<td></td>
<td>Severe or life-threatening bleeding</td>
<td></td>
</tr>
<tr>
<td>(40)</td>
<td>Studies of ASA in high-risk pts</td>
<td>Comparator: Different ASA dosing ranges</td>
<td></td>
<td>• Hazard similar regardless of dose</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Adjusted HR: 0.85; 95% CI: 0.57–1.26, for &gt;100 mg vs. &lt;100 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Adjusted HR: 1.0; 95% CI: 0.85–1.18; for &gt;100 mg vs. &lt;100 mg</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• ASA doses were categorized as &lt;100 mg (75 mg or 81 mg), 100 mg or &gt;100 mg (150 mg or 162 mg)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• In pts also receiving clopidogrel, daily ASA doses &gt;100 mg seemed to be nonstatistically significantly associated with reduced efficacy (adjusted HR: 1.16; CI: 0.93–1.44) and increased harm (adjusted HR: 1.30; CI: 0.83–2.04).</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Study</th>
<th>Aim</th>
<th>Inclusion criteria</th>
<th>Intervention</th>
<th>1st endpoint</th>
<th>Comparator</th>
<th>Size</th>
<th>Comparator</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serebruany, et al., 2005 (41)</td>
<td>To compare the risk of bleeding with low, moderate and high-doses of ASA</td>
<td>Clinical trials with follow-up of ≥1 month and contained a detailed description of hemorrhagic complications, pts characteristics, therapy duration and concomitant agents used.</td>
<td>ASA dose (nonrandomized)</td>
<td>None specifically defined</td>
<td>Higher or lower ASA dose</td>
<td>68 trials; &gt;50,000 pts</td>
<td>Low-dose ASA defined as &lt;100 mg; moderate-dose ASA 100–200 mg; high-dose ASA &gt;200 mg</td>
<td></td>
</tr>
<tr>
<td>CURE</td>
<td>To study the benefits and risks of adding clopidogrel to different doses of ASA in the treatment of pts with ACS</td>
<td>Pts with NSTE-ACS enrolled in the CURE study</td>
<td>ASA dose (nonrandomized)</td>
<td>MACE</td>
<td>Higher or lower ASA dose</td>
<td>12,562 pts</td>
<td>Incidence of MACE not heterogeneous in pts receiving ASA alone when examined by dose (highest and medium ASA dose groups compared with the low-dose group: adjusted OR, 1.0 (95% CI: 0.82–1.23) and 1.2 (95% CI: 1.08–1.51), respectively</td>
<td></td>
</tr>
<tr>
<td>Antithrombotic Trialists' Collaboration, 2002 (43)</td>
<td>To determine the effects of antiplatelet therapy among pts at high-risk of occlusive vascular events.</td>
<td>Randomized trials of an antiplatelet regimen vs. control or one regimen vs. another regimen</td>
<td>ASA</td>
<td>Series vascular event (nonfatal MI, nonfatal stroke, vascular death)</td>
<td>Control or placebo</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

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Table: Data Supplement 7. RCTs Comparing Antiplatelet Therapy With Anticoagulant Therapy in Patients Undergoing Coronary Stenting

<table>
<thead>
<tr>
<th>Study Acronym</th>
<th>Author; Year Published</th>
<th>Aim of Study; Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention (# patients) / Study Comparator (# patients)</th>
<th>Endpoint Results (Absolute Event Rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant 2° Endpoint (if any); Study Limitations; Adverse Events</th>
</tr>
</thead>
</table>
| STARS         | Leon MB, et al., 1998 (45) 9834303 | Aim: To compared the efficacy and safety of three antithrombotic-drug regimens — ASA alone, ASA and warfarin, and ASA and ticlopidine — after coronary stenting (BMS)  
**Study type:** RCT  
**Size:** 1,653 pts | **Inclusion criteria:** Pts undergoing successful coronary stent implantation  
**Exclusion criteria:** Left main or bifurcation stenting, AMI, bleeding diathesis | **Intervention 1:** ASA alone  
**Intervention 2:** ASA + warfarin  
**Intervention 3:** ASA + ticlopidine | **1° endpoint:** Death, TLR, Angiographically-evident thrombosis, or MI within 30 d  
- 3.6% with ASA alone; 2.7% with ASA + warfarin; 0.5% with ASA + ticlopidine (p=0.001 for the comparison of all 3 groups).  
**Safety endpoint:** bleeding complications  
- 1.8% with ASA alone; 6.2% with ASA + warfarin; 5.5% with ASA + ticlopidine (p<0.001 for the comparison of all 3 groups) | ● Compared to ASA alone, ASA + ticlopidine reduced incidence of primary endpoint (RR: 0.15; CI: 0.05–0.43; p<0.001) |

ACS indicates acute coronary syndrome; ASA, aspirin; CI, confidence interval; CVA, cerebrovascular accident; CV, cardiovascular; HR, hazard ratio; MACE, major adverse cardiac events; MI, myocardial infarction; N/A, not available; NSTE-ACS, non–ST-elevation acute coronary syndrome; PCI, percutaneous coronary intervention; OR, odds ratio; RCT, randomized controlled trials; and RR, relative risk.
**Schomig A, et al., 1996 (46)**

- **Aim:** To compare antiplatelet therapy with conventional anticoagulant therapy with respect to clinical outcomes 30 d after coronary-artery stenting (BMS)
- **Study type:** RCT
- **Size:** 517 pts
- **Inclusion criteria:** Pts undergoing coronary stent implantation (BMS)
- **Exclusion criteria:** Stent placed as a bridge to CABG, cardiogenic shock, need for mechanical ventilation
- **Intervention:** ASA + ticlopidine (antiplatelet therapy)
- **Comparator:** anticoagulant therapy (intravenous heparin, phenprocoumon, and ASA)
- **1° endpoint:** Primary cardiac endpoint a composite of CV death, MI, CABG or repeated angioplasty.
  - 1.6% with antiplatelet therapy vs. 6.2% with anticoagulation therapy (RR: 0.25; 95% CI: 0.06–0.77)
- **Safety endpoint:** Bleeding events
  - 0% with antiplatelet therapy vs. 6.5% with anticoagulant therapy (RR: 0.00; p<0.001)

ASA indicates aspirin; BMS, bare metal stent; CABG, coronary artery bypass graft; CI, confidence interval; CV, cardiovascular; HR, hazard ratio; MI, myocardial infarction; N/A, not available; OR, odds ratio; RCT, randomized controlled trial; RR, relative risk; and TLR, target-lesion revascularization.

### Data Supplement 8. Nonrandomized Studies of DAPT Duration After BMS or DES

<table>
<thead>
<tr>
<th>Study Acronym; Author; Year Published</th>
<th>Aim of Study; Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention (# patients) / Study Comparator (# patients)</th>
<th>Endpoint Results (Absolute Event Rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant 2° Endpoint (if any); Study Limitations; Adverse Events</th>
</tr>
</thead>
</table>
| Brar SS, et al., 2008 (47) 18534267   | **Aim:** To assess long term clinical outcomes with BMS or DES by duration of clopidogrel use in pts with DM  
**Study type:** Retrospective, observational  
**Size:** 749 pts | **Inclusion criteria:** Pts with DM who underwent stent implantation with either BMS or DES  
**Exclusion criteria:** Pts with CABG, pts who received both a BMS and DES, pts with valvular disease, nonhealth plan members | **Intervention:** Clopidogrel >6 mo  
**Comparator:** No clopidogrel >6 mo | **1° endpoint:** All-cause death and nonfatal MI  
- 3.2% with >9 mo clopidogrel; 9.4% with 6–9 mo clopidogrel; and 16.5% with <6 mo clopidogrel (p=0.001) | • For pts treated with DES adjusted HR: 0.48; 95% CI: 0.16–1.47; p=0.48 for >6 mo clopidogrel vs. no clopidogrel >6 mo |
| Eisenstein, et al., 2007 (48) 17148711 | **Aim:** Assess the association between clopidogrel use and long-term clinical outcomes of pts receiving DES and BMS  
**Study type:** Observational study | **Inclusion criteria:** Consecutive pts treated at 1 institution undergoing BMS or DES | **Comparators:** Duration of self-reported clopidogrel use | **1° endpoints in DES-treated pts at 24 mo follow-up:**  
- Death: 2.2% with clopidogrel vs. 5.3% without clopidogrel (difference -3.3%; CI: -6.3% -- 0.3%; p=0.03)  
- Death or MI: 3.1% with clopidogrel vs. 7.2% without clopidogrel (difference -4.1%; | • Results based on landmark analysis of those event-free at 6 or 12 mo follow-up (6 mo results included in this table) |
ASA indicates aspirin; BMS, bare metal stent; CABG, coronary artery bypass graft; CI confidence interval; DES, drug-eluting stent; DM, diabetes mellitus; HR, hazard ratio; MI, myocardial infarction; N/A, not available; OR, odds ratio; RCT, randomized controlled trial; and RR, relative risk.

ASA indicates aspirin; BMS, bare metal stent; CI, indicates confidence interval; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; DM, diabetes mellitus; HR, hazard ratio; MACE, major adverse cardiac events; MI, myocardial infarction; N/A, not available; OR, odds ratio; PCI, percutaneous coronary intervention; RCT, randomized controlled trial; RR, relative risk; and STEMI, ST-elevation myocardial infarction.

### Data Supplement 9. Randomized Studies of 1 Versus 12 Months of DAPT After BMS

<table>
<thead>
<tr>
<th>Study Acronym; Author; Year Published</th>
<th>Aim of Study; Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention (# patients) / Study Comparator (# patients)</th>
<th>Endpoint Results (Absolute Event Rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant Z² Endpoint (if any); Study Limitations; Adverse Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steinhubl SR, et al., 2002 (49) 12435254</td>
<td><strong>Aim:</strong> To evaluate the benefit of long-term (12 mo) treatment with clopidogrel (in addition to ASA) after PCI in pts treated with BMS</td>
<td><strong>Inclusion criteria:</strong> Pts referred for planned PCI <strong>Exclusion criteria:</strong> Contraindications to antiplatelet or antithrombotic therapy, recent STEMI, recent use of GPI, clopidogrel, or thrombolytic therapy</td>
<td><strong>Intervention:</strong> ASA + clopidogrel <strong>Comparator:</strong> ASA + placebo</td>
<td><strong>1st endpoint:</strong> 1 y incidence of MACE (death, MI or stroke) • RRR: 26.9% (CI: 3.9%–44.4%; p=0.02) <strong>Safety endpoint:</strong> Major bleeding • 8.8% with DAPT vs. 6.7% with ASA (p=0.07)</td>
<td>• All study pts treated with DAPT for the first 28 d • Absolute risk reduction 3% with DAPT</td>
</tr>
</tbody>
</table>

### Data Supplement 10. Studies and Meta-Analyses Comparing Graft Patency Post–CABG in Patients Treated With Either Antiplatelet Monotherapy or DAPT

<table>
<thead>
<tr>
<th>Study Acronym; Author; Year Published</th>
<th>Aim of Study; Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention (# patients) / Study Comparator (# patients)</th>
<th>Endpoint Results (Absolute Event Rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant Z² Endpoint (if any); Study Limitations; Adverse Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mannacio VA, et al., 2012 (50) 22942294</td>
<td><strong>Aim:</strong> To determine the individual variability in the response to ASA and/or clopidogrel and its impact on graft patency after off-pump CABG</td>
<td><strong>Inclusion criteria:</strong> Consecutive pts undergoing off-pump CABG <strong>Exclusion criteria:</strong> Additional surgical procedures, emergency</td>
<td><strong>Intervention:</strong> ASA + clopidogrel <strong>Comparator:</strong> ASA</td>
<td><strong>1st endpoint:</strong> Platelet resistance and inhibition • In the ASA group 32.6% were ASA resistant and, in the ASA-clopidogrel group, 12.6% were ASA and clopidogrel resistant.</td>
<td>• Secondary endpoint of SVG graft occlusion at 12 mo as assessed by CTA: 7.4% with DAPT vs. 13.1% with ASA (p=0.04)</td>
</tr>
<tr>
<td>Study type:</td>
<td>Single center RCT</td>
<td>Study type:</td>
<td>RCT, pilot study</td>
<td>Study type:</td>
<td>RCT</td>
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<tr>
<td><strong>Size:</strong></td>
<td>300 pts</td>
<td><strong>Size:</strong></td>
<td>100 pts (79 of whom underwent follow-up CTA)</td>
<td><strong>Size:</strong></td>
<td>113 pts (92 underwent follow-up IVUS)</td>
</tr>
<tr>
<td><strong>Inclusion criteria:</strong></td>
<td>Operations, active bleeding or bleeding diathesis</td>
<td><strong>Inclusion criteria:</strong></td>
<td>Pts undergoing on-pump CABG treated with ≥1 free bypass graft</td>
<td><strong>Inclusion criteria:</strong></td>
<td>Pts referred for isolated CABG, with or without cardiopulmonary bypass</td>
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<tr>
<td><strong>Exclusion criteria:</strong></td>
<td>Indication for anticoagulation, Hx of GI or intracranial bleeding</td>
<td><strong>Exclusion criteria:</strong></td>
<td>Concomitant valve surgery, need for oral anticoagulation</td>
<td><strong>Exclusion criteria:</strong></td>
<td>Thrombocytopenia, previous CABG, concomitant valve surgery or aneurysm resection</td>
</tr>
<tr>
<td><strong>Intervention:</strong></td>
<td>ASA+clopidogrel</td>
<td><strong>Comparator:</strong></td>
<td>ASA+placebo</td>
<td><strong>Intervention:</strong></td>
<td>Clopidogrel (in addition to ASA)</td>
</tr>
<tr>
<td><strong>Comparator:</strong></td>
<td>ASA+placebo</td>
<td><strong>1st endpoint:</strong></td>
<td>Proportion of pts with ≥ occluded grafts at 1 mo as assessed by CTA</td>
<td><strong>1st endpoint:</strong></td>
<td>Mean SVG intimal area per pts at 1 y follow-up</td>
</tr>
<tr>
<td><strong>Safety endpoint:</strong></td>
<td>Major bleeding • 1.3% with DAPT vs. 1.3% with ASA (p=1.00)</td>
<td><strong>Safety endpoint:</strong></td>
<td>Major bleeding complication • 6.1% with ASA+clopidogrel vs. 6.0% with ASA+placebo (p=1.00)</td>
<td><strong>Safety endpoint:</strong></td>
<td>Major bleeding • 1.8% with clopidogrel vs. 0.0% with placebo (p=0.50)</td>
</tr>
<tr>
<td><strong>Aim:</strong></td>
<td>Assess graft patency 1 mo after CABG in pts treated with ASA alone or ASA+clopidogrel</td>
<td><strong>Aim:</strong></td>
<td>Assess if addition of clopidogrel to ASA after CABG inhibits SVG disease at 1 y as assessed by IVUS</td>
<td><strong>Aim:</strong></td>
<td>Assess 3 mo graft patency after CABG in those treated with or without clopidogrel (in addition to baseline ASA)</td>
</tr>
<tr>
<td><strong>Author:</strong></td>
<td>Sun JCJ, et al., 2010 (51)</td>
<td><strong>Author:</strong></td>
<td>CASCADE Kulik A, et al., 2010 (52)</td>
<td><strong>Author:</strong></td>
<td>Gao G, et al., 2010 (53)</td>
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<tr>
<td><strong>Journal:</strong></td>
<td>21146675</td>
<td><strong>Journal:</strong></td>
<td>21135365</td>
<td><strong>Journal:</strong></td>
<td>21050973</td>
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<table>
<thead>
<tr>
<th>Study</th>
<th>Size</th>
<th>Inclusion criteria</th>
<th>Intervention</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; endpoint</th>
<th>Comparator</th>
<th>Endpoint</th>
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<tbody>
<tr>
<td>ROOBY</td>
<td>197 pts</td>
<td>Pts who were enrolled in the ROOBY trial with complete data on clopidogrel use and with 1 y angiographic data</td>
<td>Clopidogrel use at discharge (nonrandomized) (n=345)</td>
<td>1 y graft patency rates at angiography</td>
<td>No clopidogrel use at discharge (n=608)</td>
<td>• No significant difference in graft patency found in those who underwent on-pump CABG nor in those who underwent off-pump CABG</td>
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<td>Inclusion criteria (for substudy): No data on clopidogrel use, no 1 y angiographic follow-up</td>
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<tr>
<td>Ibrahim K, et al., 2006</td>
<td>94 consecutively treated pts; 62 pts underwent angiographic follow-up</td>
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<td>6 mo angiographic follow-up</td>
<td>Antiplatelet monotherapy</td>
<td>Overall graft patency at 6 mo angiographic follow-up</td>
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<td>• 42/45 (93%) with ASA + clopidogrel vs. 31/37 (84%) with ASA alone (p=NS)</td>
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<td>• LIMA patency: 28/29 (96%) with DAPT vs. 23/35 (92%) with ASA (p=NS)</td>
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<td>• SVG patency: 14/16 (87%) with DAPT vs. 7/11 (66%) with ASA (p=NS)</td>
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<tr>
<td>Meta-Analyses and Systematic Overviews</td>
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Nocerino AG, et al., 2013 (58) 24035160

**Aim:** Assess whether DAPT is superior to antiplatelet monotherapy to improve graft patency early after CABG  
**Study type:** Meta-analysis of 5 RCT  
**Size:** 958 pts; 2,919 grafts  
**Inclusion criteria:** RCT of single vs. dual antiplatelet therapy for ≥30 d  
**Exclusion criteria:** Nonrandomized studies  
**Intervention:** DAPT  
**Comparator:** Antiplatelet monotherapy  
**1° endpoint:** Overall graft patency  
• Early graft occlusion 5.0% with DAPT vs. 7.7% with monotherapy (p=0.005)  
• OR=1.59 for graft occlusion with monotherapy (95% CI: 1.16–2.1)  
**Follow-up in studies ranged from 3 d to 12 mo**  
• For SVG only, monotherapy, when compared to DAPT, associated with increased graft loss rate (10.8% vs. 6.6%; OR: 1.70; p=0.03)  
• No significant reduction in arterial graft occlusion with DAPT found  

de Leon N, et al., 2012 (59) 22570427  

**Aim:** Evaluate the evidence for DAPT post–CABG  
**Study type:** Systematic overview  
**Size:** 4 RCT evaluating surrogate endpoints and 9 studies evaluating clinical endpoints  
**Inclusion criteria:** Peer-reviewed studies that evaluated DAPT after CABG  
**Intervention:** DAPT after CABG  
**Comparator:** Antiplatelet monotherapy  
**Primary relevant finding:**  
• 3 clinical trials assessing surrogate endpoints failed to demonstrate an improvement in graft patency with DAPT use, while 1 clinical trial found an increase in graft patency.  

ASA indicates aspirin; CABG, coronary artery bypass graft; CI, confidence interval; CTA, computed tomography angiography; DAPT, dual antiplatelet therapy; GI, gastrointestinal; HR, hazard ratio; Hx, history; N/A, not available; LIMA, left internal mammary artery; OR, odds ratio; RCT, randomized controlled trials; RR, relative risk; and SVG, saphenous vein graft.

### Data Supplement 11. Studies Comparing Outcome Post–CABG in Patients Treated With Either Aspirin or DAPT

<table>
<thead>
<tr>
<th>Study Acronym; Author; Year Published</th>
<th>Aim of Study; Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention (# patients) / Study Comparator (# patients)</th>
<th>Endpoint Results (Absolute Event Rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant 2° Endpoint (if any); Study Limitations; Adverse Events</th>
</tr>
</thead>
</table>
| Sorenson, et al., 2001 (60) 21371637 | **Aim:** To study efficacy of post–op clopidogrel treatment in pts with MI undergoing CABG  
**Study type:** Registry study  
**Size:** 3,545 pts | **Inclusion criteria:** Pts surviving ≥ 30 d after CABG, pts observed 18 mo. after CABG  
**Exclusion criteria:** Those not meeting above inclusion criteria | **Intervention:** Clopidogrel (n=957)  
**Comparator:** No clopidogrel (n=2,588) | **1° endpoint:** Death or recurrent MI  
• 4.1% with clopidogrel vs. 7.8% without clopidogrel (HR: 0.59; 95% CI: 0.42–0.85; p=0.0003)  
• By propensity score (total n=945) 4.0% with clopidogrel vs. 6.0% without clopidogrel (HR: 0.67; 95% CI: 0.44–1.00; p=0.05) | **N/A** |
<table>
<thead>
<tr>
<th>Aim</th>
<th>Study type</th>
<th>Inclusion criteria</th>
<th>Intervention</th>
<th>1st endpoint</th>
<th>Safety endpoint</th>
<th>CURE Fox KA, et al., 2004 (32) 15313956</th>
</tr>
</thead>
<tbody>
<tr>
<td>To determine benefit and risk of ASA + clopidogrel use (vs. ASA alone) postoperatively following on-pump or off-pump CABG.</td>
<td>Observational</td>
<td>Pts undergoing CABG treated in the early post-operative period with ASA or clopidogrel + ASA</td>
<td>ASA + clopidogrel (n=3,268)</td>
<td>In-hospital mortality ● 0.95% with DAPT vs. 1.78% with ASA (adjusted OR: 0.50; 95% CI: 0.25–0.99)</td>
<td>in-hospital bleeding events ● 4.19% with DAPT vs. 5.17% with ASA (adjusted OR: 0.70; 95% CI: 0.51–0.97)</td>
<td>To assess benefits and risks of ASA plus clopidogrel in pts undergoing CABG for NSTE-ACS</td>
</tr>
<tr>
<td>Study type: Observational</td>
<td>Size: 15,067 pts</td>
<td>Exclusion criteria: Pre-op and late post-op clopidogrel use, prolonged hospitalization &gt;1 wk before surgery, valvular procedure, warfarin use</td>
<td>Comparator: ASA (n=11,799)</td>
<td>▶ Adjusted HR: 0.83 (CI: 0.61–1.12) for in-hospital mortality or 30 d readmission with DAPT compared to ASA</td>
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</table>

ASA indicates aspirin; CABG, coronary artery bypass graft; CI, confidence interval; DAPT, dual antiplatelet therapy; HF, heart failure; HR, hazard ratio; MI, myocardial infarction; N/A, not available; NSTE-ACS, non–ST-elevation acute coronary syndrome; NYHA, New York Heart Association; OR, odds ratio; PCI, percutaneous coronary intervention and RR, relative risk.
<table>
<thead>
<tr>
<th>Study Acronym; Author; Year Published</th>
<th>Aim of Study; Study Type; Study Size (N)</th>
<th>Patient Population</th>
<th>Study Intervention (# patients) / Study Comparator (# patients)</th>
<th>Endpoint Results (Absolute Event Rates, P values; OR or RR; &amp; 95% CI)</th>
<th>Relevant 2° Endpoint (if any); Study Limitations; Adverse Events</th>
</tr>
</thead>
</table>
| Kaluza, et al., 2000 (62) 10758971 | **Aim:** To assess the clinical course of pts who have undergone coronary stent placement >6 wk before noncardiac surgery.  
**Study type:** Retrospective cohort  
**Size:** 40 pts | **Inclusion criteria:** Consecutive pts who underwent coronary stent placement >6 wk before noncardiac surgery requiring a general anesthesia were included in the study  
**Exclusion criteria:** N/A | Intervention: N/A  
Comparator: N/A | **1° endpoint:**  
- MI: 7 pts  
- Major Bleeds: 11 pts  
- Deaths: 8  
- All deaths/MI and 8/11 bleeds occurred if surgery <14 d from stent placement | • DAPT not well described  
• Single center |
| Wilson, et al., 2003 (63) 12875757 | **Aim:** To determine the frequency and timing of complications at our institution when surgery was performed within 2 mo of coronary stent placement.  
**Study type:** Retrospective cohort  
**Size:** 207 pts | **Inclusion criteria:** Analysis of the PCI database and the General Surgery database at Mayo Clinic for pts who underwent noncardiac surgery within 60 d of coronary stent placement. Surgical procedures included in this analysis were those that required a significant incision and had the potential for perioperative bleeding.  
**Exclusion criteria:** Procedures such as joint aspirations, endoscopy, and skin biopsies, among others, were not included in this analysis | Intervention: N/A  
Comparator: N/A | **1° endpoint:**  
- MACE: 8/207  
**1° Safety endpoint:**  
- Excessive bleeding: 2/207 | • Single center |
<table>
<thead>
<tr>
<th>Study</th>
<th>Aim</th>
<th>Inclusion criteria</th>
<th>Intervention</th>
<th>Comparator</th>
<th>1st endpoint</th>
<th>Other notes</th>
</tr>
</thead>
</table>
| Nuttal, et al., 2008 (64) 10813036 | To address the hypothesis that the risk of MACEs and bleeding events is related to the time interval between PCI with BMS and NCS | Analysis of pts who underwent NCS within 1 y after PCI with BMS at Mayo Clinic (Rochester, Minnesota) between January 1, 1990, and January 1, 2005. Pts were identified using the Mayo Clinic PCI registry and the Mayo Clinic Surgical database. | N/A | N/A | • MACE- 47 (5.2%; 95% CI: 3.8–6.7%)  
• Frequency of MACEs was 10.5% (95% CI: 6.7–14.3%) when NCS was performed 30 or fewer d after PCI with BMS, 3.8% (95% CI: 1.5–6.2%) when NCS was 31–90 d after PCI with BMS, and 2.8% (95% CI: 1.2–4.5%) when NCS was 91 or more d after PCI with BMS | • DAPT not well described  
• Single center |
| Wijeysundera, et al., 2012 (65) 22893606 | To evaluate the outcomes of pts who underwent elective intermediate- to high-risk noncardiac surgery in Ontario, Canada after stent implantation. | All Ontario residents who were ≥40 y, underwent any 1 of 16 prespecified elective noncardiac surgeries between April 1, 2003 and March 31, 2009, and underwent coronary stent implantation within 10 y before their index surgery. The included surgeries were abdominal aortic aneurysm repair, carotid endarterectomy, peripheral vascular bypass, total hip replacement, total knee replacement, large bowel resection, partial liver resection, Whipple procedure, pneumonectomy, pulmonary lobectomy, gastrectomy, esophagectomy, total abdominal hysterectomy, radical prostatectomy, nephrectomy, and cystectomy. | N/A | N/A | • Overall risk of 30 d MACE was relatively low at 2.1% (n=170), whereas the risk of 1 y MACE was 9.8% (n=798).  
• The rate of postoperative mortality was 1.2% (n=100) at 30 d and 5.2% (n=419) at 1 y.  
• BMS: 1-45 d OR: 2.35 (95% CI: 0.98–5.64); 46–180 d OR: 1.06 (95% CI: 0.58–2.01); 181–365 d OR: 1.89 (1.08–3.32)  
• DES: 1-45 d OR: 11.58 (95% CI: 4.08-32.80); 46-180 d OR: 1.71 (95% CI: 0.73–4.01); 181-365 d OR: 0.64 (95% CI: 0.20–2.04) | • Administrative database |
| EVENT Registry Berger, et al., 2010 (66) 20860090 | To determine the frequency of noncardiac surgery and adverse postoperative events among pts who recently underwent attempted stent placement at 42 hospitals between July 2004 and September 2005 were enrolled | The EVENT registry, consecutive pts who underwent attempted stent placement | Pts who underwent major surgery | N/A | • In the 7 d after surgery, 4 pts had a cardiac death, myocardial infarction, or stent thrombosis (1.9%; 95%) | • DAPT status and bleeding endpoint not well described |
received a DES following noncardiac surgery and followed for 1 y. Major noncardiac surgical procedures in which a significant surgical incision was required from which bleeding would result were included in this analysis.

**Exclusion criteria:** Pts who underwent CABG or valve surgery (n=67), pacemaker and defibrillator placement (n=46), and pts who underwent surgery whose nature could not be determined (n=50) were prospectively excluded from this analysis. Pts who underwent minor surgical procedures (n=27), such as minor dermatological procedures, endoscopic procedures, joint aspirations, and cataract surgery were excluded. Pts who did not undergo major surgery were included.

**Study type:** Registry

**Size:** 206 pts

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**PARIS**

Mehran, et al., 2013 (67) 24004642

<table>
<thead>
<tr>
<th>Aim</th>
<th>To determine the association between different modes of DAPT cessation and cardiovascular risk after PCI in the PARIS Registry</th>
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<tbody>
<tr>
<td><strong>Study type:</strong></td>
<td>Retrospective analysis of a prospective registry</td>
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<tr>
<td><strong>Size:</strong></td>
<td>5,031 pts undergoing PCI</td>
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</tbody>
</table>

**Inclusion criteria:** Adult pts (≥18 y) undergoing successful stent implantation in ≥1 native coronary artery and discharged on DAPT were eligible for enrolment.

**Exclusion criteria:** Pts participating in an investigational device or drug study or with evidence of stent thrombosis at the index procedure were excluded.

**DAPT Cessation 1:** physician recommended discontinuation

**DAPT Cessation 2:** brief interruption (for surgery)

**DAPT Cessation 3:** disruption (noncompliance or because of bleeding)

**Findings:**
- Overall incidence DAPT cessation 57.3% (discontinuation 40.8%, interruption 10.5%, disruption 14.4%)
- Compared with those on DAPT, the adjusted HR for MACE due to discontinuation was 0.63 (95% CI: 0.46–0.86); for interruption was 1.41 (95% CI: 0.94–2.12; p=0.10) and for disruption was 1.50 (95% CI: 1.14–1.97; p=0.004).
- Within 7 d, 8–30 d, and more than 30 d after disruption, adjusted HRs were 7.04 (95% CI: 3.31–14.95), 2.17 (95% CI: 0.97–4.88), and 1.3 (95% CI: 0.97–1.76), respectively.

**CI=0.5%–4.9%).**

• The risk of the composite outcome was increased 27-fold in the wk following noncardiac surgery compared with any other wk after stent implantation (HR: 27.3; 95% CI: 10.0–74.2; p <0.001).

**N/A**
| Holcomb, et al., 2015 (68) 26720292 | **Aim:** To better understand the factors contributing to cardiac risk in pts who have undergone recent PCI and require noncardiac surgery, we comparatively examined the postoperative MACE associated with 3 distinct subgroups of stent indication: (1) MI; (2) unstable angina; and (3) non–ACS revascularization.  
**Study type:** Retrospective cohort  
**Size:** 26,661 pts | **Inclusion criteria:** All pts with coronary stents implanted in the VA between January 1, 2000, and December 31, 2010  
**Exclusion criteria:** Minor operations such as endoscopic procedures and minor musculoskeletal procedures such as application of a cast and joint aspiration. Operations performed under local or monitored anesthesia were excluded from analyses.  
**Intervention:** N/A  
**Comparator:** N/A | **1st endpoint:**  
• Postoperative MACE rates were significantly higher in the MI group (7.5%) compared with the unstable angina (2.7%) and non–ACS (2.6%) groups (p<0.001).  
• When surgery was performed within 3 mo of PCI, adjusted odds of MACE were significantly higher in the MI group compared with the non–ACS group (OR: 5.25; 95% CI: 4.08–6.75). This risk decreased overtime, although it remained significantly higher at 12–24 mo from PCI (OR: 1.95; 95% CI: 1.58–2.40).  
• The adjusted odds of MACE for the unstable angina group were similar to those for the non–ACS group when surgery was performed within 3 mo (OR: 1.11; CI: 0.80–1.53) or between 12 and 24 mo (OR: 1.08; CI: 0.86–1.37) from stent placement.  
Primarily older white males  
Unknown medication regimen  
Stent type was not significantly associated with MACE regardless of indication.  
ACS indicates acute coronary syndrome; BMS, bare metal stent; CABG, coronary artery bypass graft; CI, confidence interval; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; HR, hazard ratio; MACE, major adverse cardiac events; MI, myocardial infarction; N/A, not available; NCS, noncardiac surgery; OR, odds ratio; PCI, percutaneous coronary intervention; RCT, randomized controlled trials; RR, relative risk; and VA, US Veterans Affairs Hospital.

ARCTIC indicates Assessment by a Double Randomisation of a Conventional Antiplatelet Strategy Versus a Monitoring-Guided Strategy for Drug-Eluting Stent Implantation and of Treatment Interruption Versus Continuation 1 Year AfterS; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; DES-LATE, Optimal Duration of Clopidogrel Therapy With Drug Eluting Stents to Reduce Late Coronary Arterial Thrombotic Events; EXCELLENT, Efficacy of Xience/Promus Versus Cypher to Reduce Late Loss After Stenting; ISAR-SAFE, Intracoronary Stenting and Antithrombotic Regimen: Safety and Efficacy of 6 Months Dual Antiplatelet Therapy After Drug-Eluting Stenting; ITALIC, Is There A Life for DES After Discontinuation of Clopidogrel; MACCE, major adverse cardiac and cerebrovascular events (death, MI, or stroke); MI, myocardial infarction; OPTIDUAL, Optimal Dual Antiplatelet Therapy; OPTIMIZE, Optimized Duration of Clopidogrel Therapy Following Treatment With the Zotarolimus-Eluting Stent in Real-World Clinical Practice; NACCE, net adverse cardiac and cerebrovascular events (death, MI, stroke or major bleeding); PRODIGY, Prolonging Dual Antiplatelet Treatment After Grading Stent-Induced Intimal Hyperplasia; REAL-LATE, REAL-world patients treated with drug-eluting stent implantation and Late coronary Arterial Thrombotic Events; RESET, Real Safety and Efficacy of 3-month Dual Antiplatelet Therapy Following Endeavor Zotarolimus-Eluting Stent Implantation; revasc, revascularization; SECURITY, Second Generation Drug-Eluting Stent Implantation Followed by Six- Versus Twelve-Month Dual Antiplatelet Therapy; ST, stent thrombosis; TIMI, Thrombolysis In Myocardial Infarction; TVF, target-vessel failure; TVR, target-vessel revascularization; and ZEST-LATE, Zotarolimus-Eluting Stent, Sirolimus-Eluting Stent, or Paclitaxel-Eluting Stent Implantation for Coronary Lesions-Late coronary Arterial Thrombotic Events.
References


