ПРОДЪЛЖИТЕЛНОСТ НА ПЕРОРАЛНАТА ДАТ – С КАКВИ ДОКАЗАТЕЛСТВА РАЗПОЛАГАМЕ ?

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European Heart Journal Advance Access published August 30, 2013

European Heart Journal
doi:10.1093/eurheartj/eht296

ESC GUIDELINES

2013 ESC guidelines on the management of stable coronary artery disease

The Task Force on the management of stable coronary artery disease of the European Society of Cardiology

Recommendations	Class [a]	Level [b]	Ref. [c]
DES is recommended in SCAD patients undergoing stenting if there is no contraindication to prolonged DAPT.	I	A	172
Aspirin is recommended for elective stenting.	I	B	172
Clopidogrel is recommended for elective stenting.	I	A	172
Prasugrel or ticagrelor should be considered in patients with stent thrombosis on clopidogrel without treatment interruption.	IIa	C	-
GP IIbIIIa antagonists should be considered for bailout situation only.	IIa	C	172
Platelet function testing or genetic testing may be considered in specific or high risk situations (e.g. prior history of stent thrombosis; compliance issue; suspicion of resistance; high bleeding risk) if results may change the treatment strategy.	IIb	C	-
Prasugrel or ticagrelor may be considered in specific high risk situations of elective stenting (e.g. left main stenting; high risk of stent thrombosis; diabetes).	IIb	C	-

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doi:10.1093/eurheartj/eht296

ESC GUIDELINES

2013 ESC guidelines on the management of stable coronary artery disease

The Task Force on the management of stable coronary artery disease of the European Society of Cardiology

Antiplatelet therapy			
SAPT, usually aspirin, is recommended indefinitely.	I	A	172, 333, 501-503
DAPT is indicated after BMS for at least 1 month.	I	A	501, 502, 504, 505
DAPT is indicated for 6 to 12 months after 2nd generation DES.	I	B	
DAPT may be used for more than 1 year in patients at high ischaemic risk (e.g. stent thrombosis, recurrent ACS on DAPT, post MI/diffuse CAD) and low bleeding risk.	IIb	B	334, 504, 505
DAPT for 1 to 3 months may be used in patients at high bleeding risk or with undeferrable surgery or concomitant anticoagulant treatment.	IIb	C	-

European Heart Journal (2011) 32, 2999–3054
doi:10.1093/eurheartj/ehr236

ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

The Task Force for the management of acute coronary syndromes (ACS) in patients presenting without persistent ST-segment elevation of the European Society of Cardiology (ESC)

Recommendations for oral antiplatelet agents

Recommendations	Class[a]	Level[b]	Ref[c]
Aspirin should be given to all patients without contraindications at an initial loading dose of 150–300 mg, and at a maintenance dose of 75–100 mg daily long-term regardless of treatment strategy.	I	A	107, 108
A $P2Y_{12}$ inhibitor should be added to aspirin as soon as possible and maintained over 12 months, unless there are contraindications such as excessive risk of bleeding.	I	A	110, 130, 132
Ticagrelor (180-mg loading dose, 90 mg twice daily) is recommended for all patients at moderate-to-high risk of ischaemic events (e.g. elevated troponins), regardless of initial treatment strategy and including those pre-treated with clopidogrel (which should be discontinued when ticagrelor is commenced).	I	B	132
Prasugrel (60-mg loading dose, 10-mg daily dose) is recommended for $P2Y_{12}$-inhibitor-naïve patients (especially diabetics) in whom coronary anatomy is known and who are proceeding to PCI unless there is a high risk of life-threatening bleeding or other contraindications.[d]	I	B	130
Clopidogrel (300-mg loading dose, 75-mg daily dose) is recommended for patients who cannot receive ticagrelor or prasugrel.	I	A	110, 146, 147

Aspirin	Continue life long
$P2Y_{12}$ inhibitor	Continue for 12 months (unless at high risk of bleeding)

European Heart Journal (2012) **33**, 2569–2619
doi:10.1093/eurheartj/ehs215

ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation

The Task Force on the management of ST-segment elevation acute myocardial infarction of the European Society of Cardiology (ESC)

Table 22 Routine therapies in the acute, subacute and long term phase of ST-segment elevation myocardial infarction

Antiplatelet therapy with low dose aspirin (75–100 mg) is indicated indefinitely after STEMI.	I	A	237
In patients who are intolerant to aspirin, clopidogrel is indicated as an alternative to aspirin.	I	B	243
DAPT with a combination of aspirin and prasugrel or aspirin and ticagrelor is recommended (over aspirin and clopidogrel) in patients treated with PCI.	I	A	109, 110
DAPT with aspirin and an oral ADP receptor antagonist must be continued for up to 12 months after STEMI, with a strict minimum of:	I	C	245–247, 283
• 1 month for patients receiving BMS	I	C	
• 6 months for patients receiving DES	IIb	B	
DAPT should be used up to 1 year in patients with STEMI who did not receive a stent.	IIa	C	-

European Heart Journal (2010) **31**, 2501–2555
doi:10.1093/eurheartj/ehq277

ESC/EACTS GUIDELINES

Guidelines on myocardial revascularization

The Task Force on Myocardial Revascularization of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS)

Recommended duration of dual antiplatelet therapy

After percutaneous coronary intervention

- 1 month after BMS implantation in stable angina;[55,60,94]
- 6–12 months after DES implantation in all patients;[60,94]
- 1 year in all patients after ACS, irrespective of revascularization strategy.

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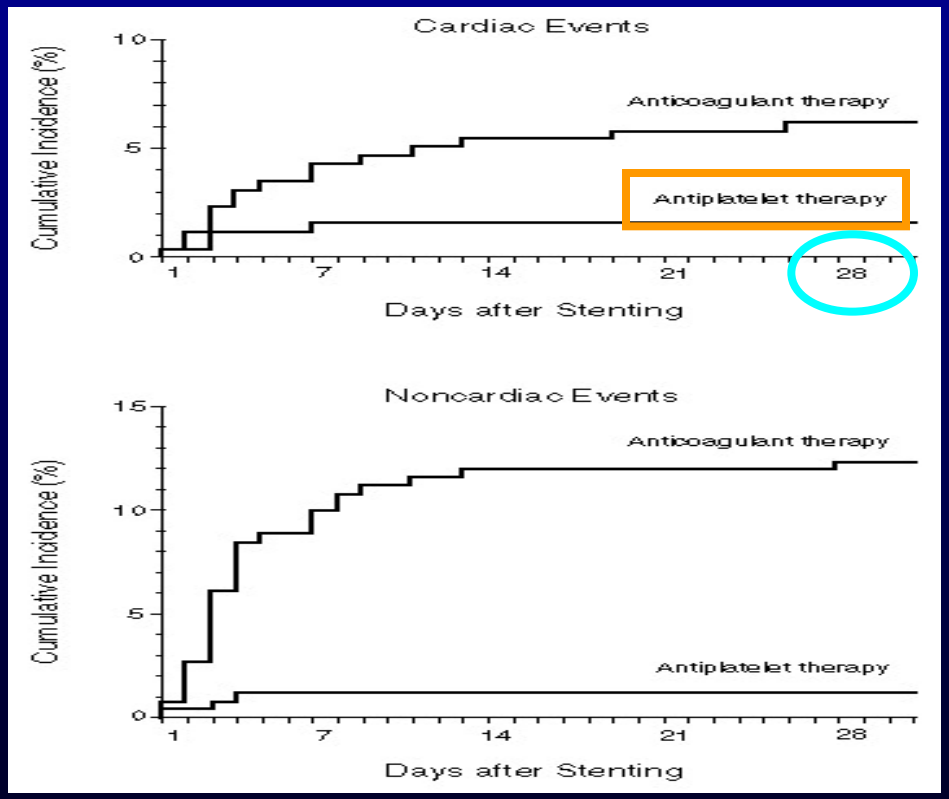
ORIGINAL ARTICLE

A Randomized Comparison of Antiplatelet and Anticoagulant Therapy after the Placement of Coronary-Artery Stents

Albert Schömig, M.D., Franz-Josef Neumann, M.D., Adnan Kastrati, M.D., Helmut Schühlen, M.D., Rudolf Blasini, M.D., Martin Hadamitzky, M.D., Hanna Walter, M.D., Eva-Maria Zitzmann-Roth, M.D., Gert Richardt, M.D., Eckhard Alt, M.D., Claus Schmitt, M.D., and Kurt Ulm, Ph.D.

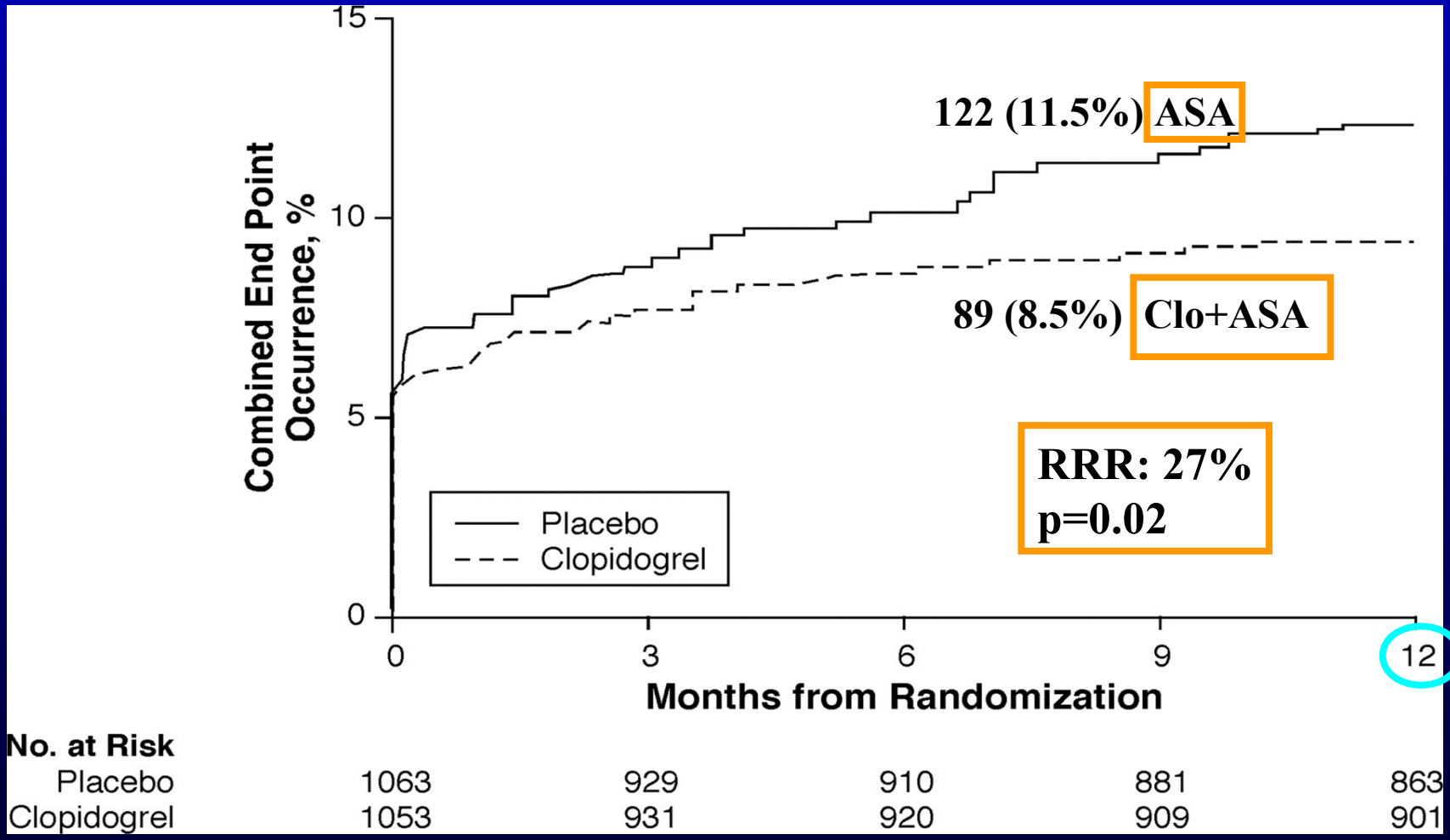
N Engl J Med 1996; 334:1084-1089 | April 25, 1996 | DOI: 10.1056/NEJM199604253341702

Честота на сърдечни и несърдечни събития в двете проучвани групи: на антикоагулант (i.v. Heparin.VKA) vs DAPT (ASA + Ticlopidine)



Schömig A et al. N Engl J Med 1996;334:1084-1089

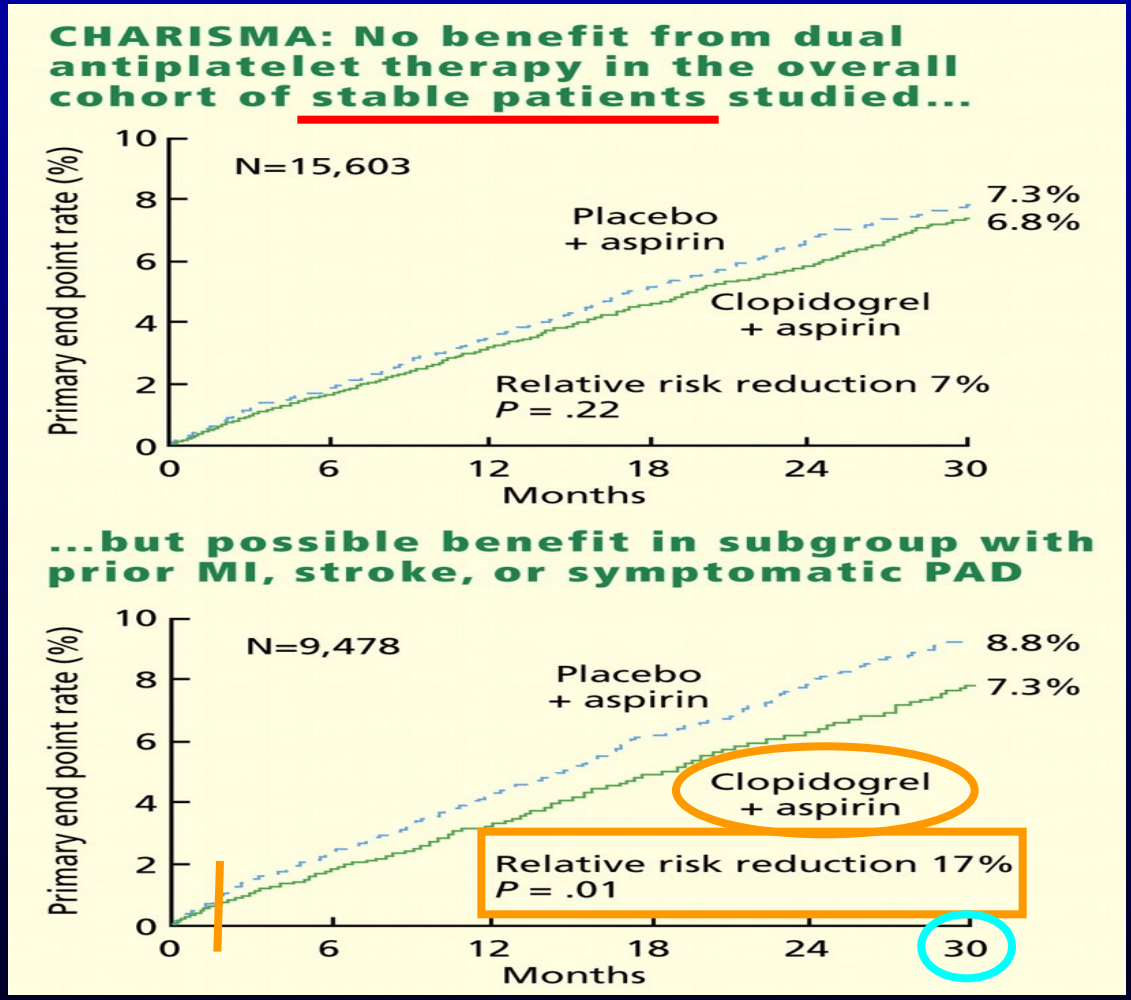
CREDO Trial: Честота на смърт / МИ / инсулт на 1-та година (след планова ПКИ)



Сигнификантна редукция на комбинирания краен показател между 29-тия ден и 1-та година

Chhatriwalla AK and Bhatt DL. *Circ Cardiovasc Interv*. 2008;1:217-225

CHARISMA Trial: Първична крайна цел (МИ / инсулт / СС смърт) в цялата кохорта (**със ССЗ или РФ**) и в подгрупата високорискови пациенти с предшестващ МИ / инсулт или симптоматична PAD: **консервативно поведение**



Bakhru MR and Bhatt DL. Cleveland Clinic Journal of Medicine 2008;75:289-295

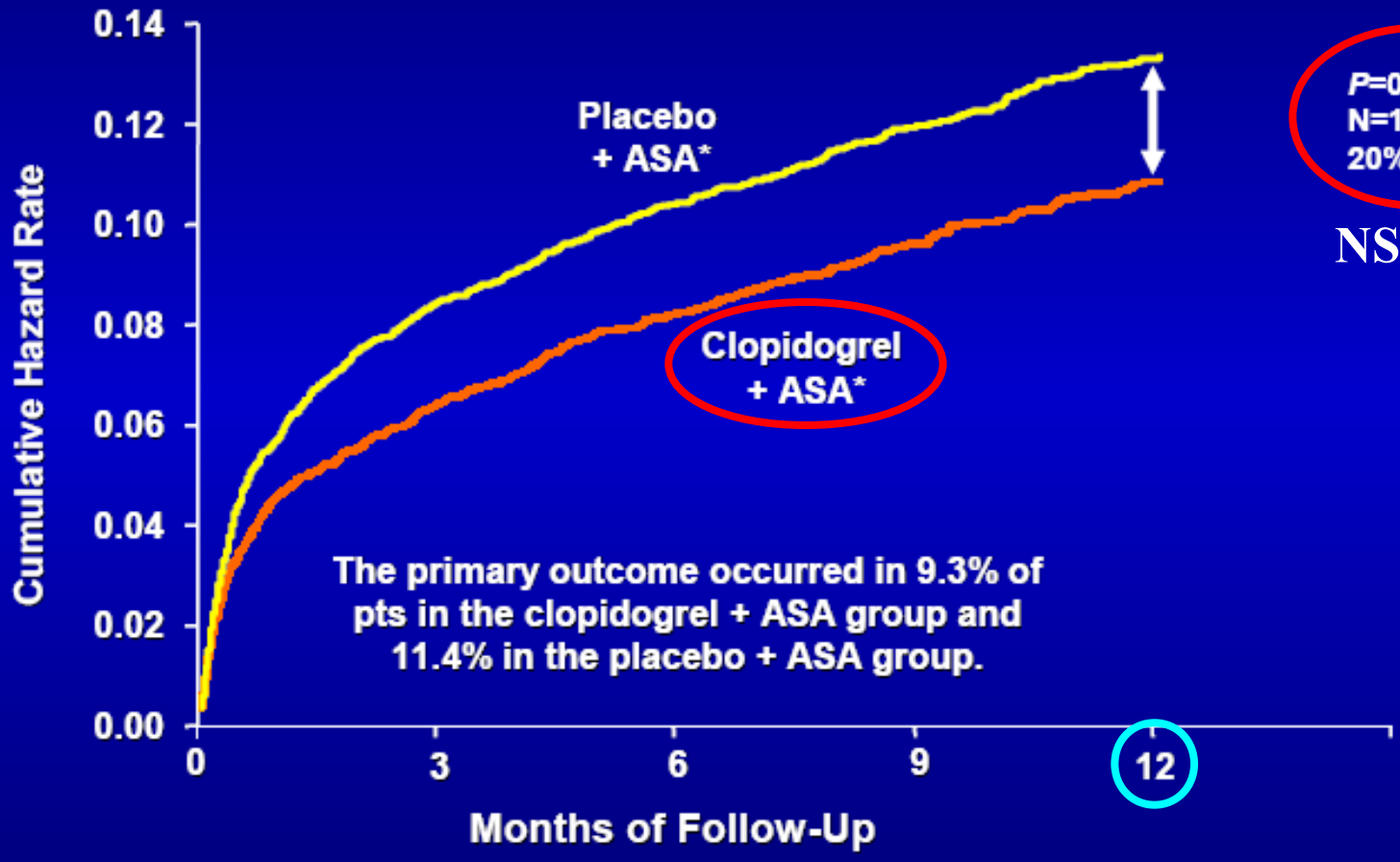
Продължителност на DAPT след ОКС

What are we treating?

The patient or the stent?

CURE

Primary Endpoint—MI/Stroke/CV Death



P=0.00009
N=12,562
20% RRR

NSTEMI

*Other standard therapies were used as appropriate.

Yusuf S et al. *N Engl J Med*. 2001;345:494-502.

Безопасност на продължителния прием на DAPT след ОКС

CURE

Bleeding Results

NSTEMI

End Point	Placebo + ASA* N = 6303	Clopidogrel + ASA* N = 6259
Major bleeding	2.7%	3.7%**
Life-threatening bleeding (ICH)	1.8%	2.2% † (NS)
Non-life-threatening bleeding	0.9%	1.5% ‡
Minor bleeding	2.4%	5.1% §

* In combination with standard therapy

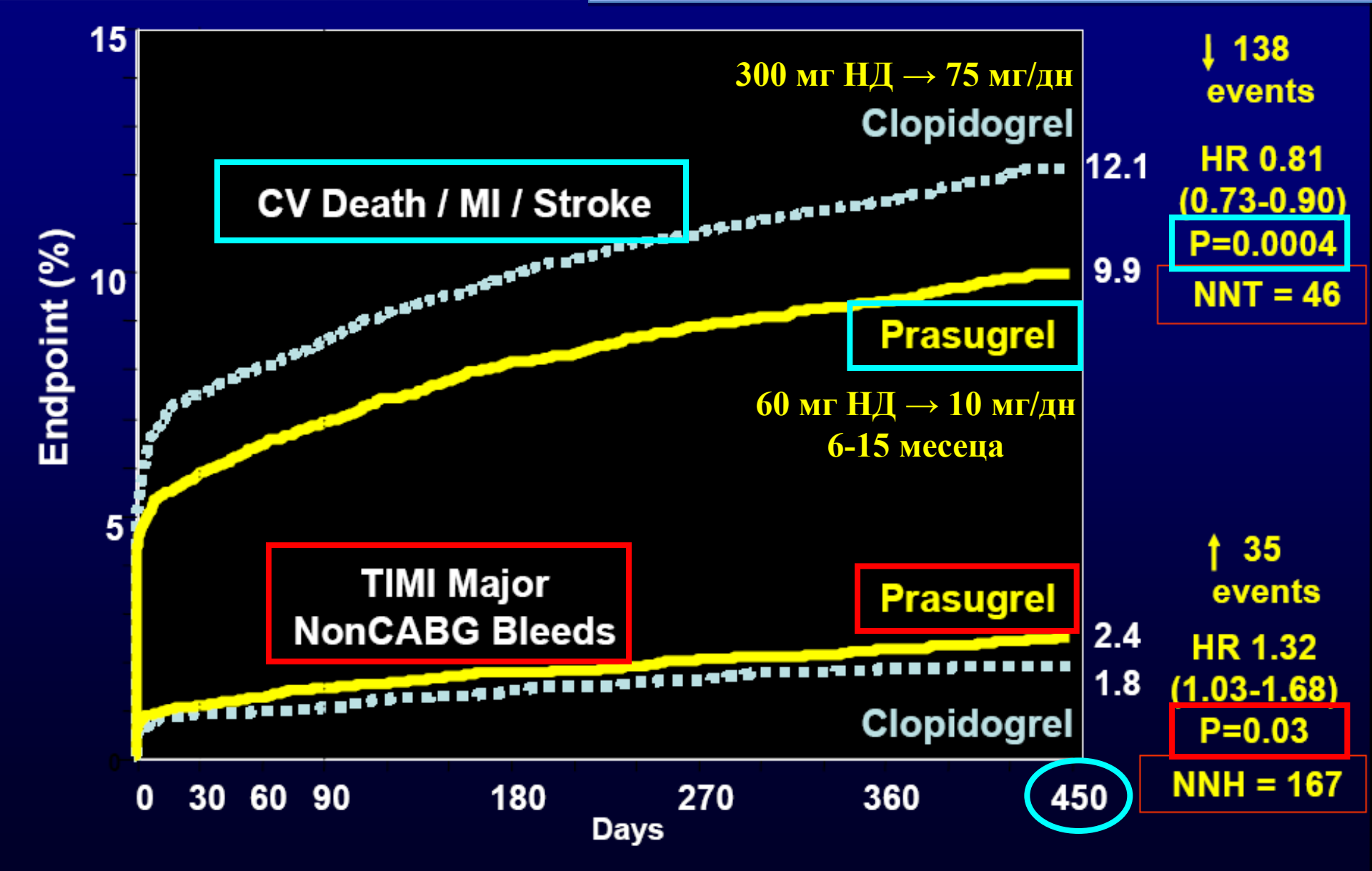
** $P = 0.001$; † P = NS; ‡ $P = 0.002$; § $P < 0.001$

The CURE Trial Investigators. *N Engl J Med.* 2001;345:494-502.

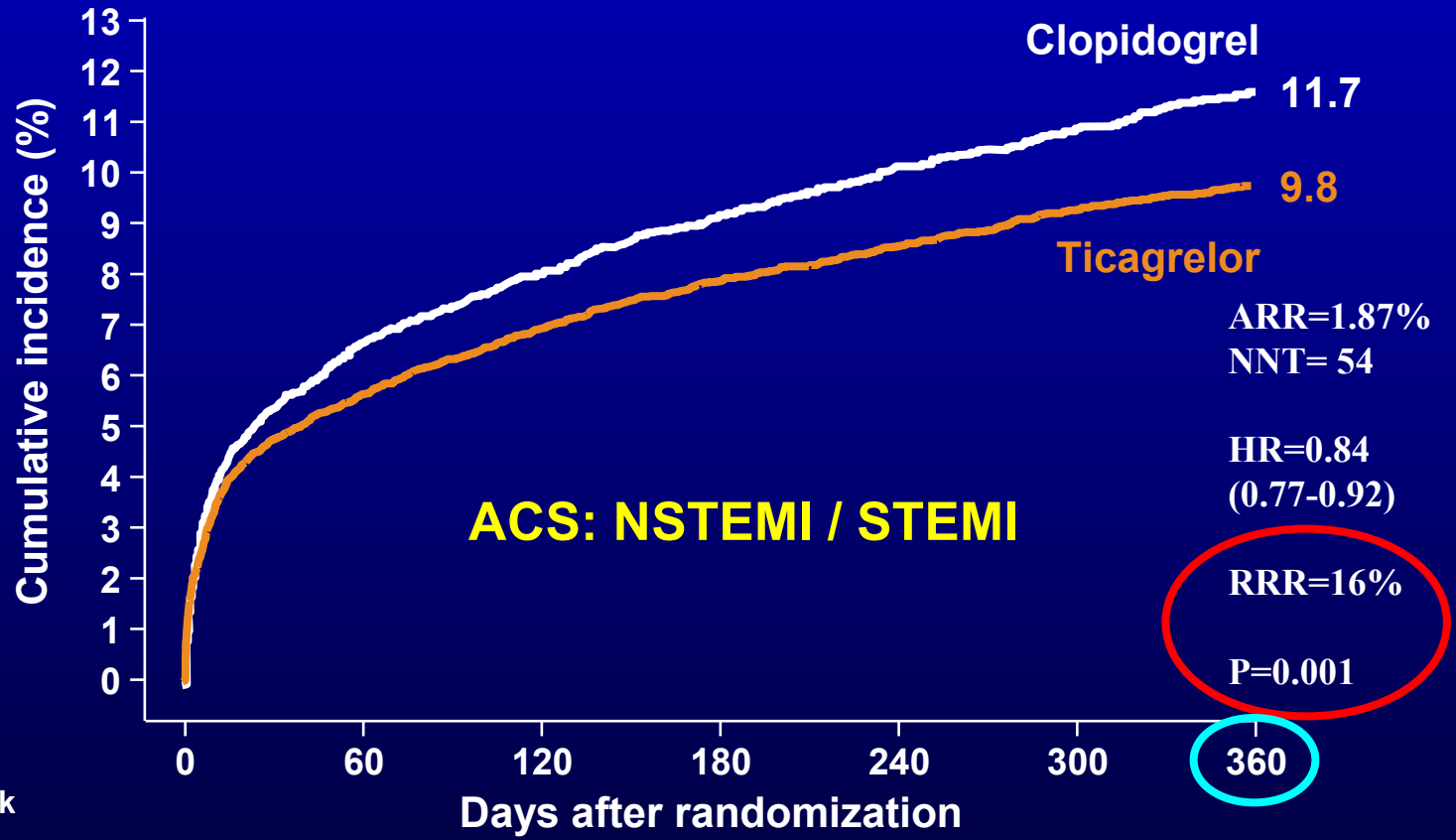
TRITON TIMI-38

Пациенти с ОКС → ПКИ

Баланс между ефикасност и безопасност



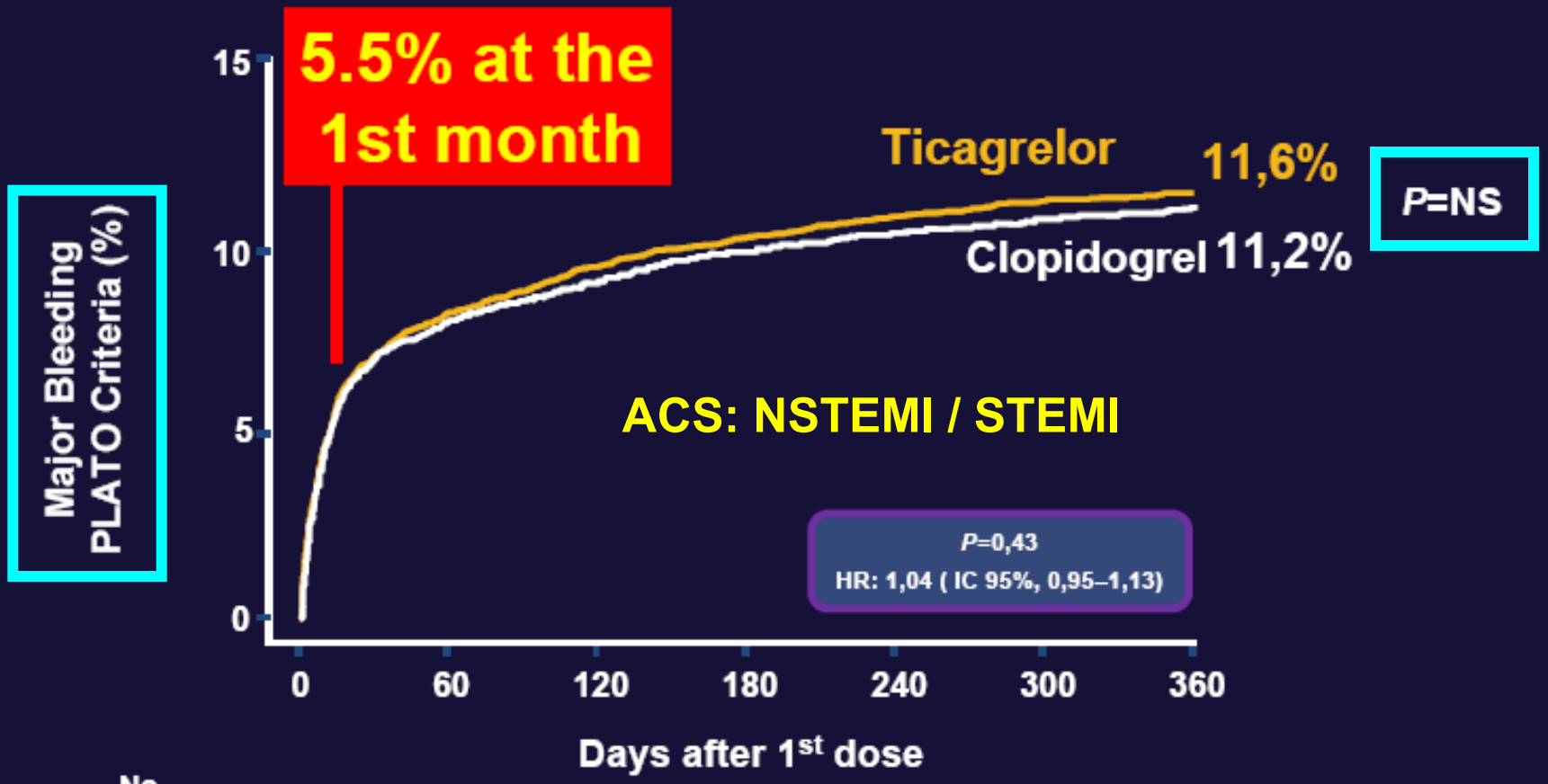
PLATO – Първична крайна цел: (СС смърт, МИ или инсулт)



No. at risk							
Ticagrelor	9333	8628	8460	8219	6743	5161	4147
Clopidogrel	9291	8521	8362	8124	6743	5096	4047

K-M = Kaplan-Meier; HR = hazard ratio; CI = confidence interval

PLATO: Safety of Long -Term DAPT

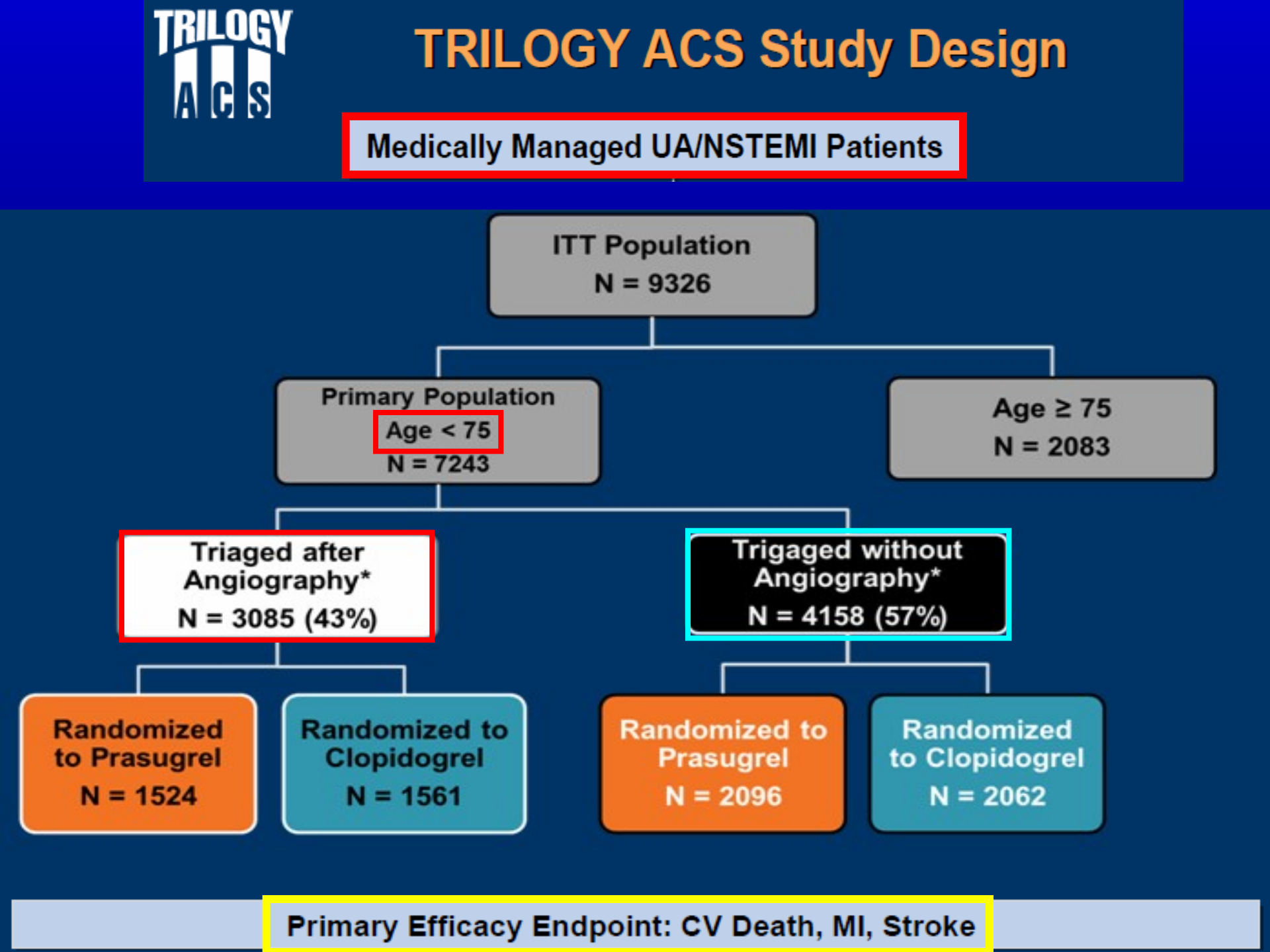


No							
Ticagrelor	9.235	7.246	6.826	6.545	5.129	3.783	3.433
Clopidogrel	9.186	7.305	6.930	6.670	5.209	3.841	3.479

Ambos os grupos incluiram AAS

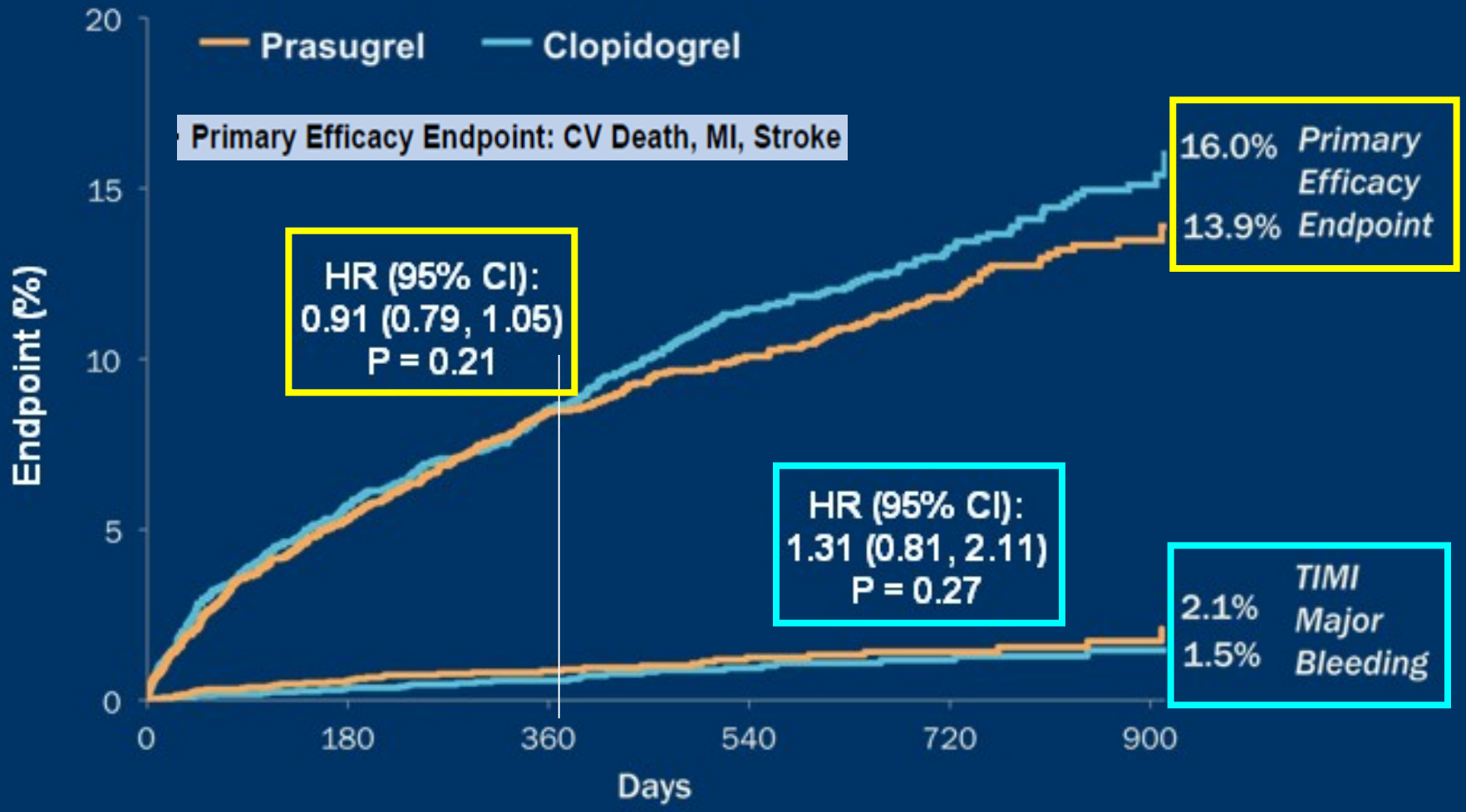
Wallentin L, et al. *N Engl J Med*. 2009;361:1045–1057.

TRILOGY ACS Study Design



Primary Efficacy Endpoint and TIMI Major Bleeding Through 30 Months

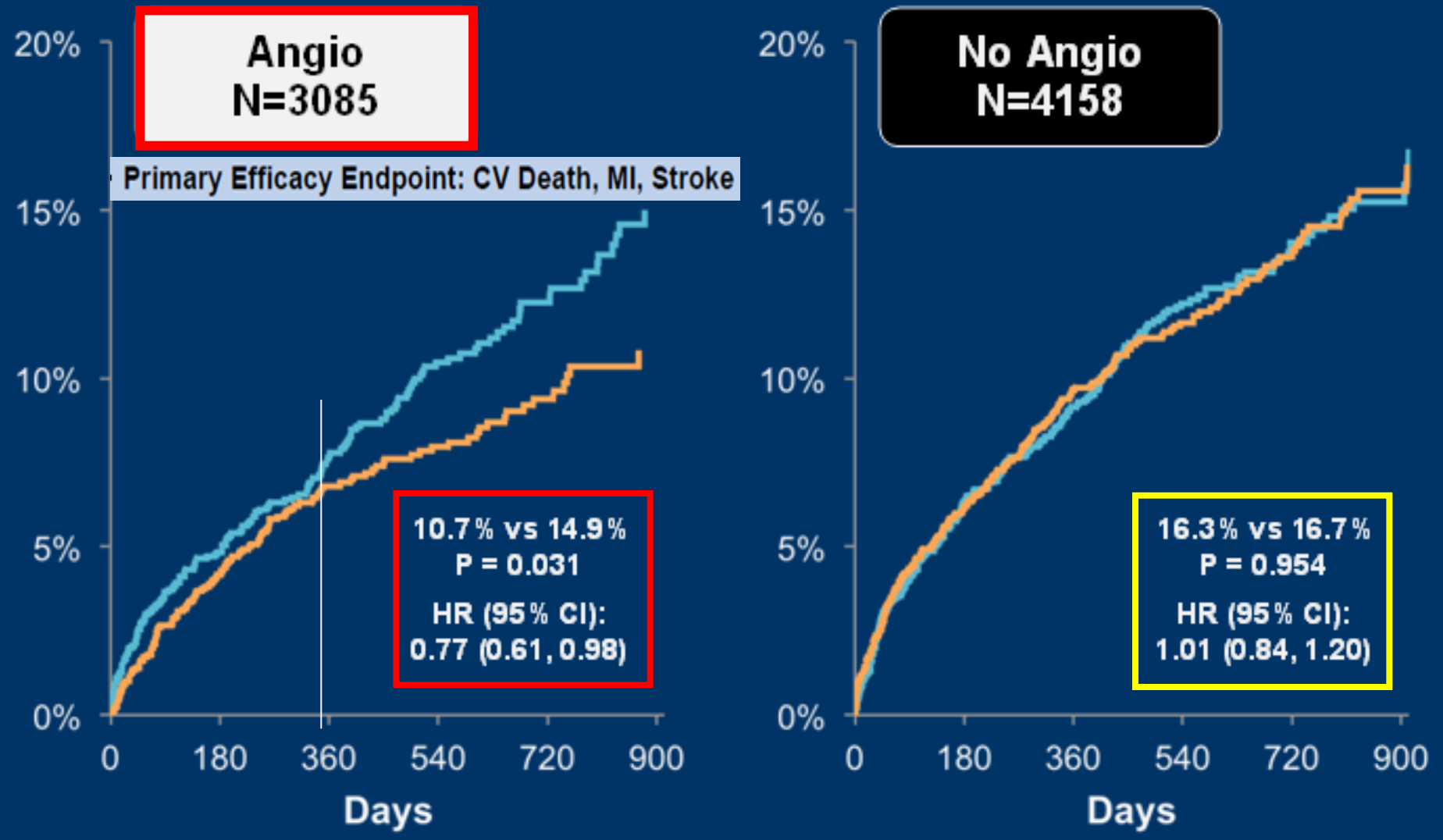
(Age < 75 years, N = 7243)



Roe MT NEJM 2012

Primary Efficacy Endpoint to 30 Months

(Age < 75 years) — Prasugrel — Clopidogrel



P interaction = 0.08

Продължителност на DAPT след ОКС

What are we treating?

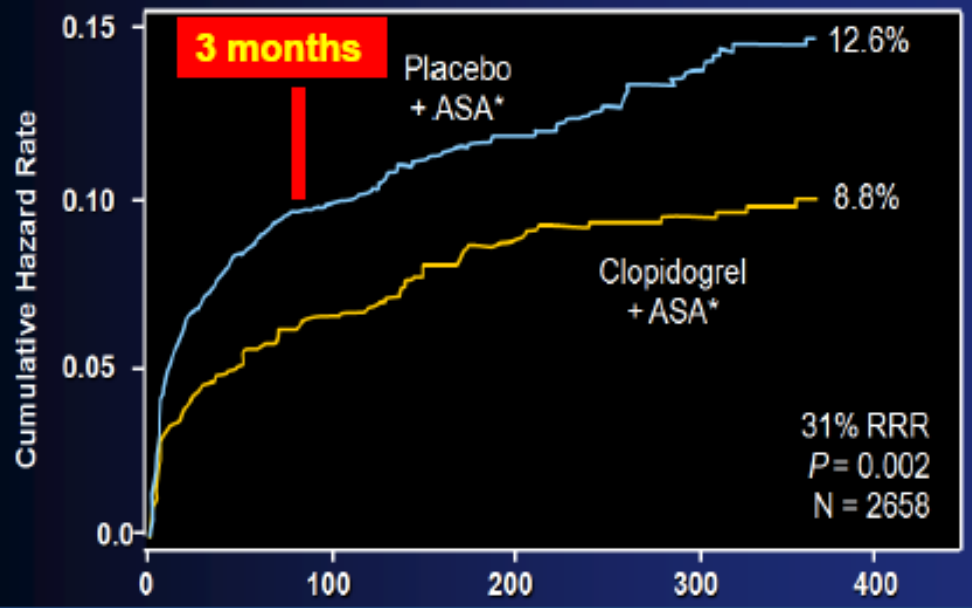
The patient or the stent?

PCI-CURE

BMS

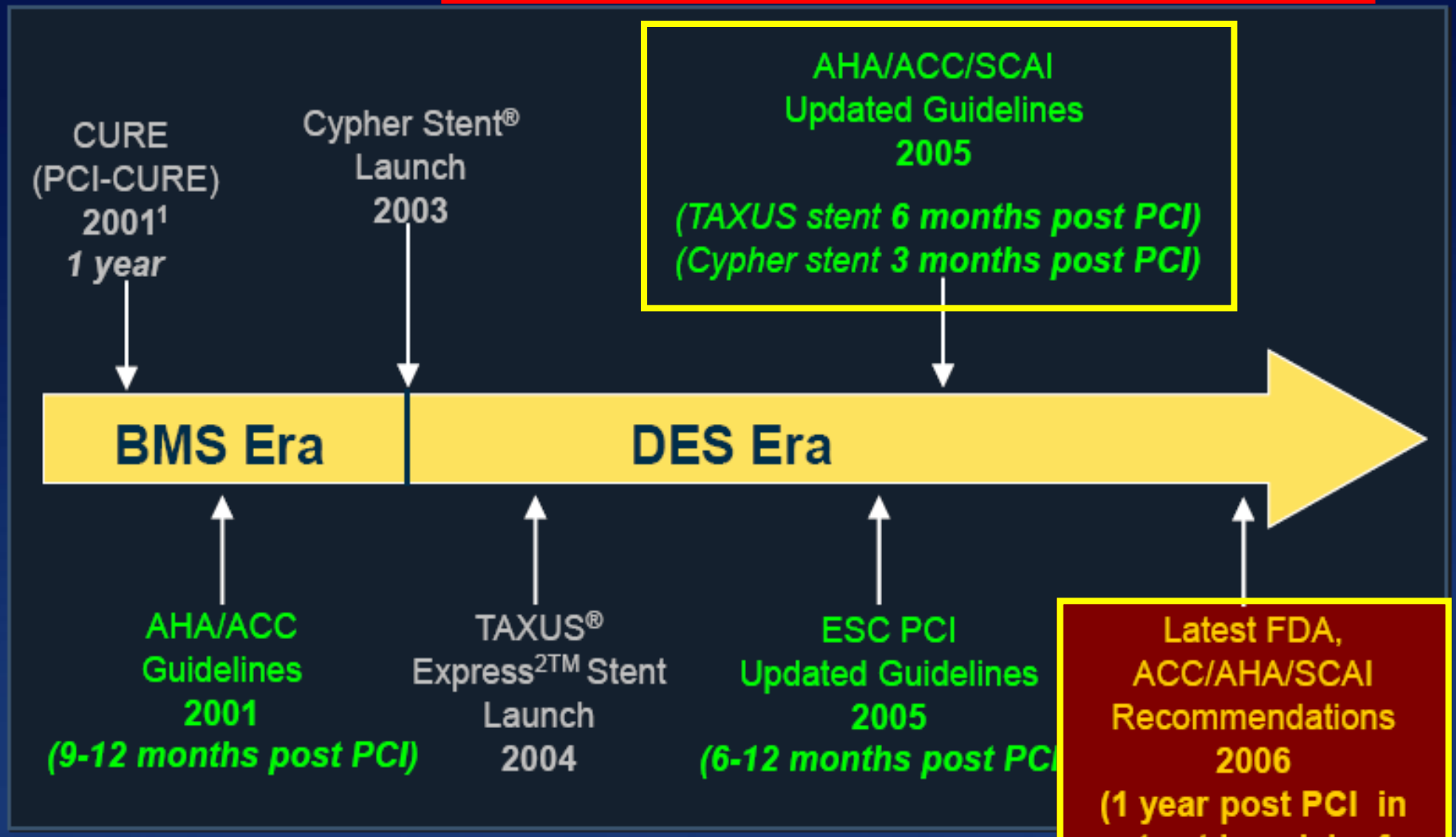
Overall Long-Term Results

Composite of cardiovascular death or MI from randomization to end of follow-up

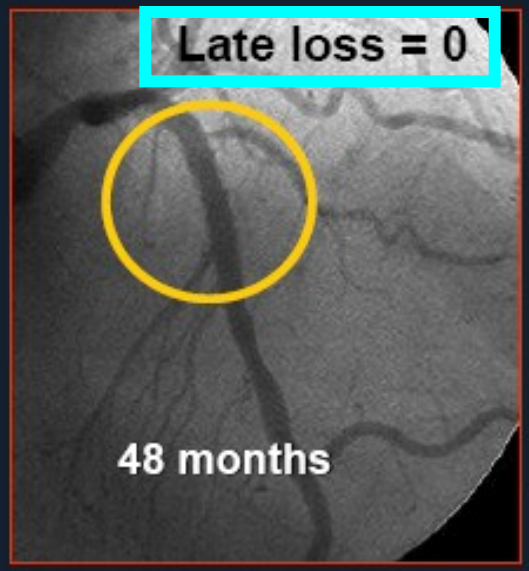


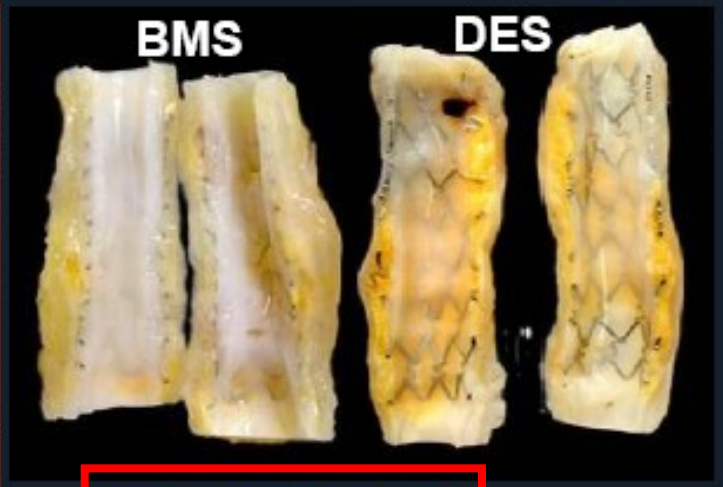
- *DAPT prevented 22CV events/1000 Pts during the 12 months*
- 50% (11CV events/1000) in the first 30 days
- *50% of the benefit ocurred from 1 month to 12 months*
- 9 of the 11 prevented CV events ocurred between 1 & 3 months
- *Only 2 CV events/1000 pts were prevented between 3 & 12 months*
- That works out to a NNT of 500 for the time period 3-12 months

Optimal Duration of Anti-platelet Therapy Post DES Still Unclear

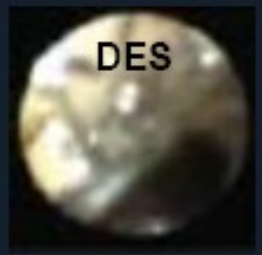


Drug-Eluting Stents…. the good, the bad, and the ugly!

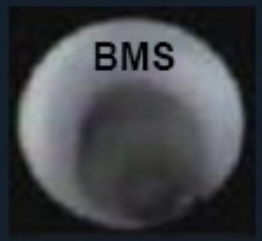




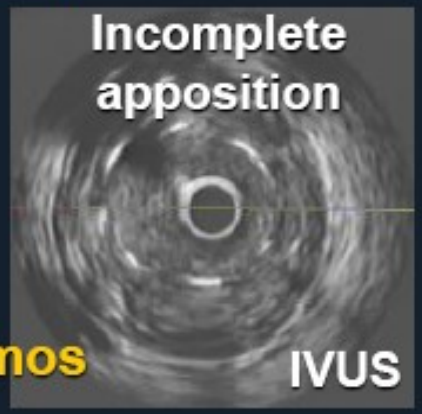
Delayed Healing!

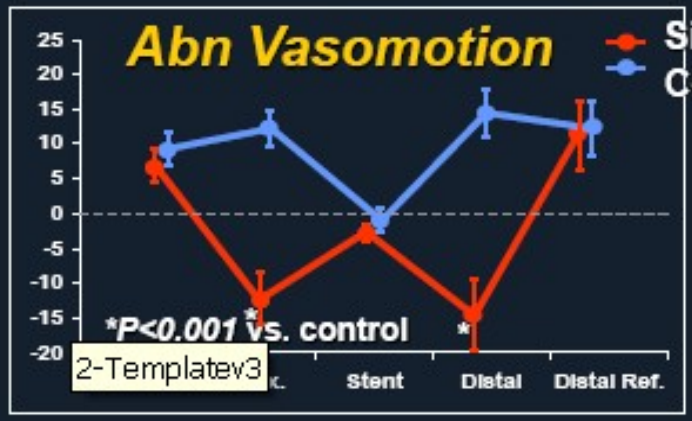


Angioscopy

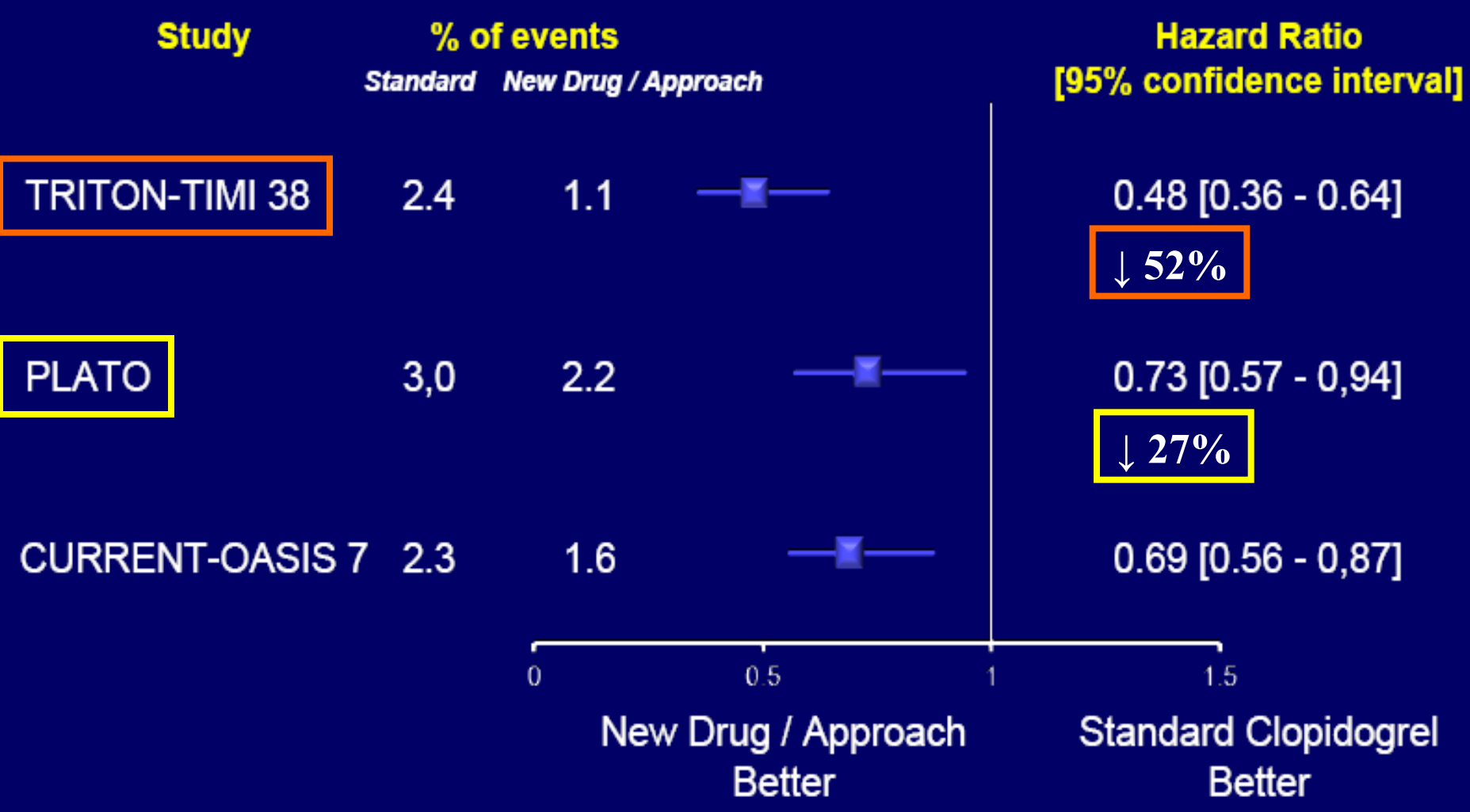


Inflammation





NEW APPROACHES: STENT THROMBOSIS



Ferreiro JL, Angiolillo DJ. Circ Cardiovasc Interv 2012

Стент–тромбоза и прекъсване на DAPT

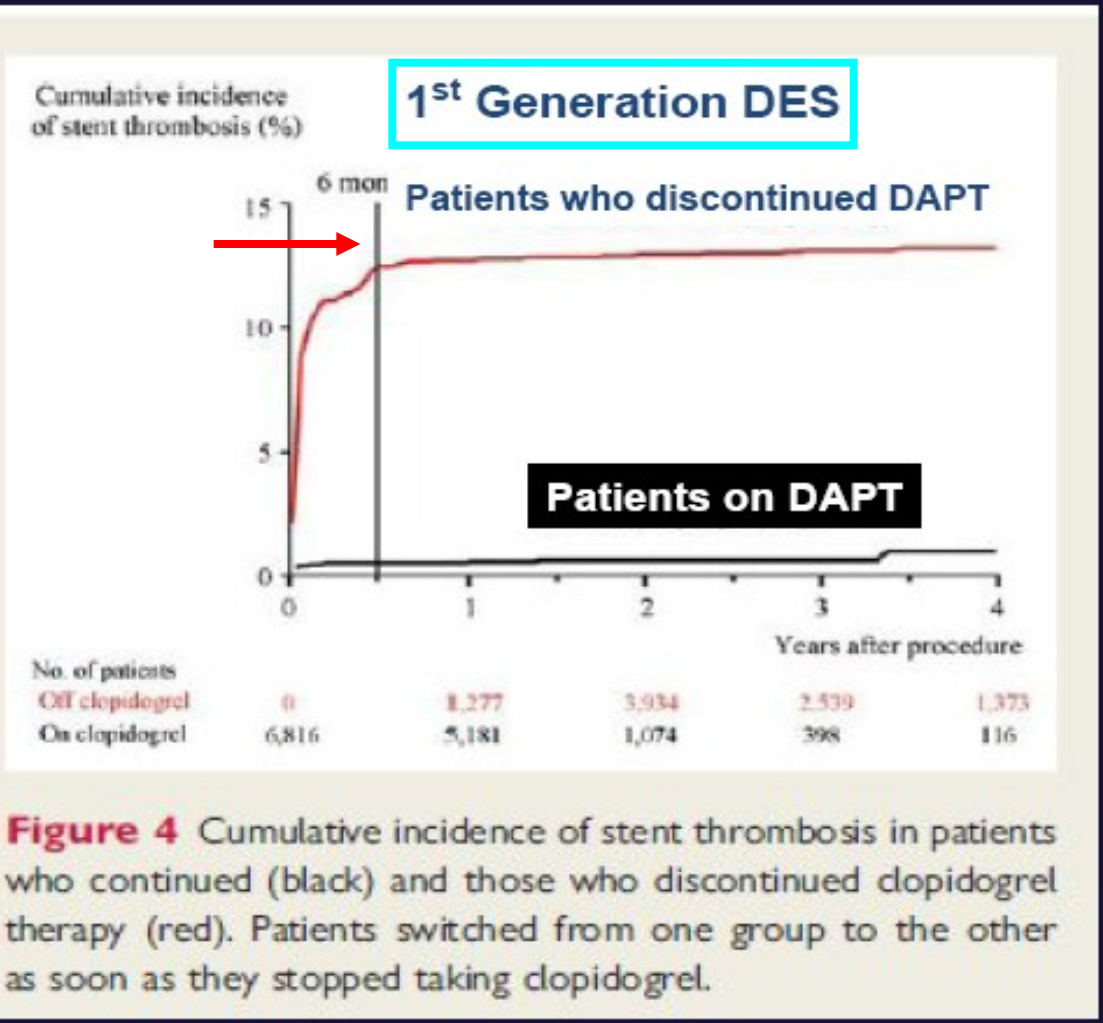


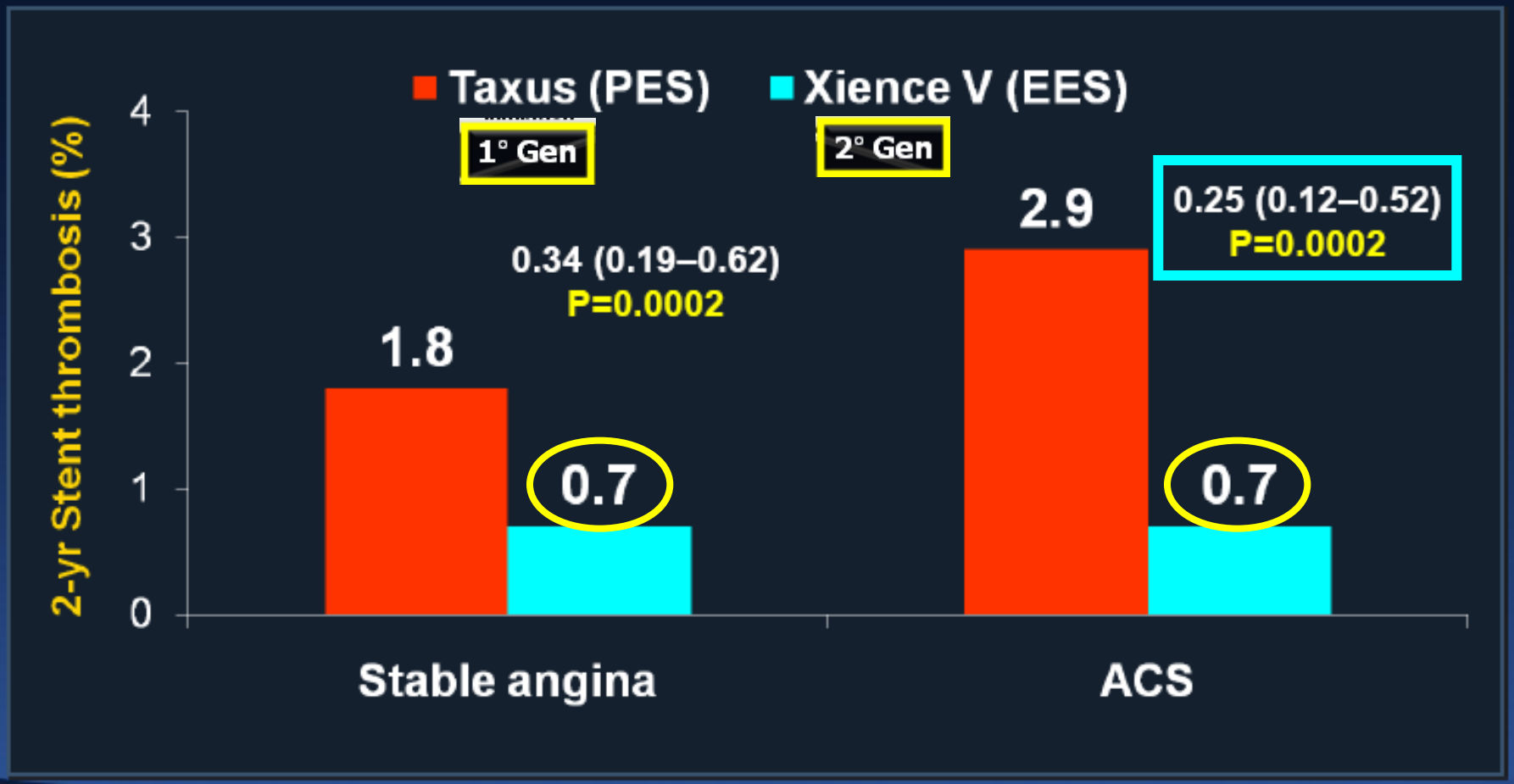
Figure 4 Cumulative incidence of stent thrombosis in patients who continued (black) and those who discontinued clopidogrel therapy (red). Patients switched from one group to the other as soon as they stopped taking clopidogrel.

Schultz S, et al., *EHJ* 2009

SPIRIT II, III, IV and COMPARE trials

Pooled database analysis (n=6,789)

Stent thrombosis (ARC def/prob) at 2 years



Planer D et al. JACC Cardiovasc Interv. 2011;4:1104-15

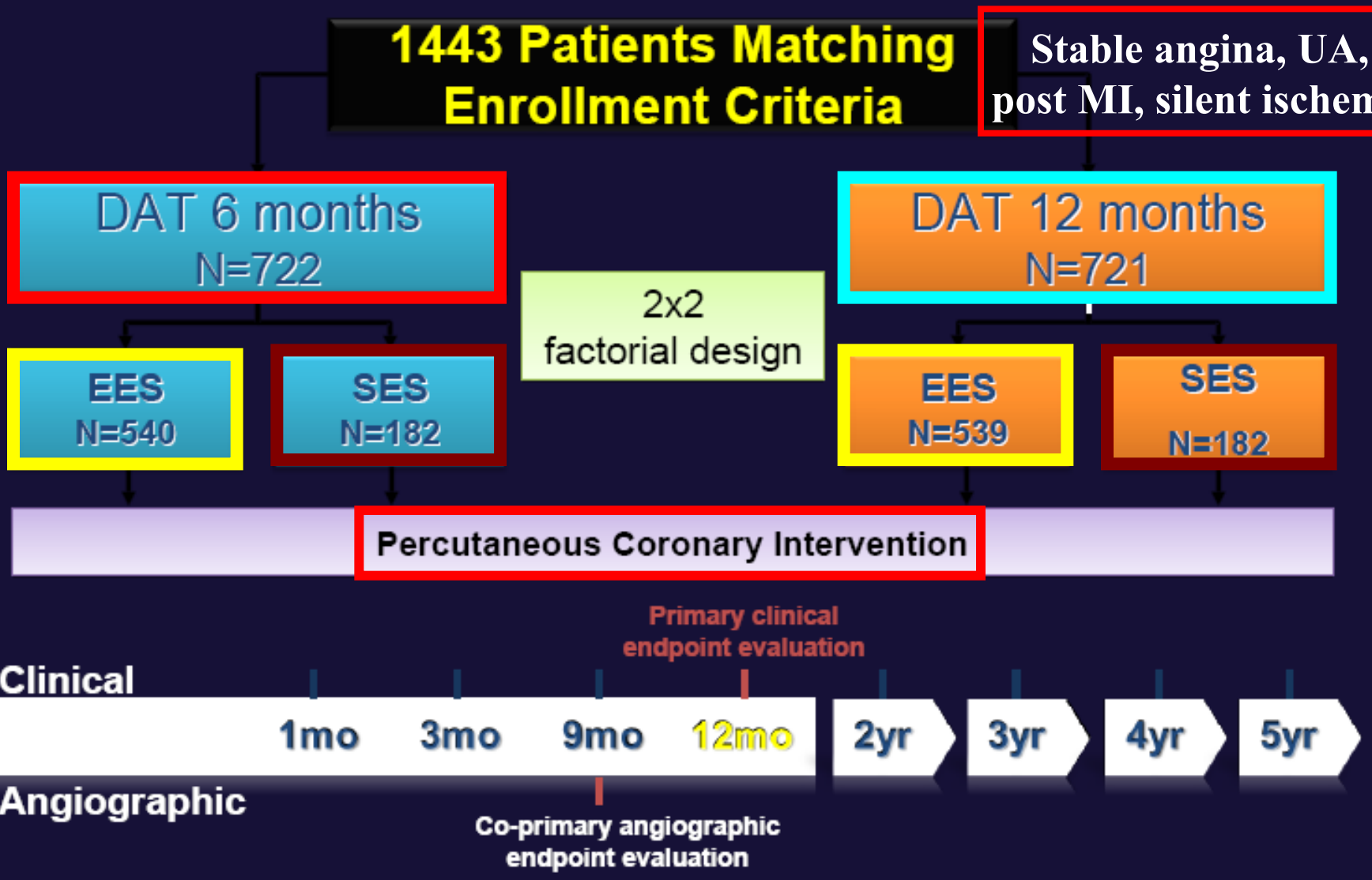
DAPT Duration and Clinical Outcomes at *3 years* Following Endeavor Stent

1414 event- free pts on DAPT at 6 months

Zotarolimus-Eluting Stents	6 months on DAPT	12 months on DAPT	p Value
Death	2.7%	2.2%	0.48
MI	0.3%	1.1%	0.24
Stroke	1.0%	0.8%	0.42
Stent Thrombosis	0.3%	0	0.19
Death/MI/ Stroke	3.9%	3.9%	0.75

Kandzari D et al, JACC Intv 2011;4:1119 –28

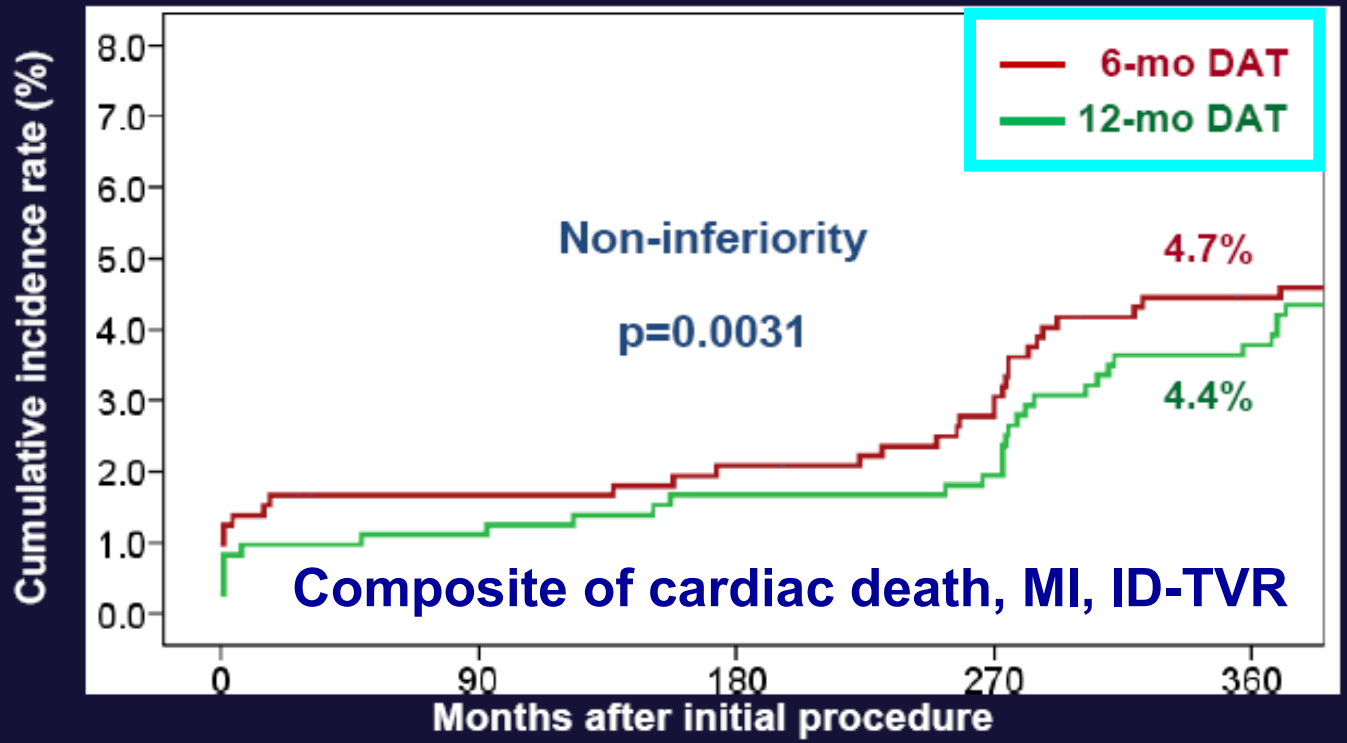
EXCELLENT Trial



Am Heart J 2009 May;157:811-817.e1
Gwon HC et al ACC 2011

EXCELLENT Trial

Target Vessel Failure



Patient Number at Risks

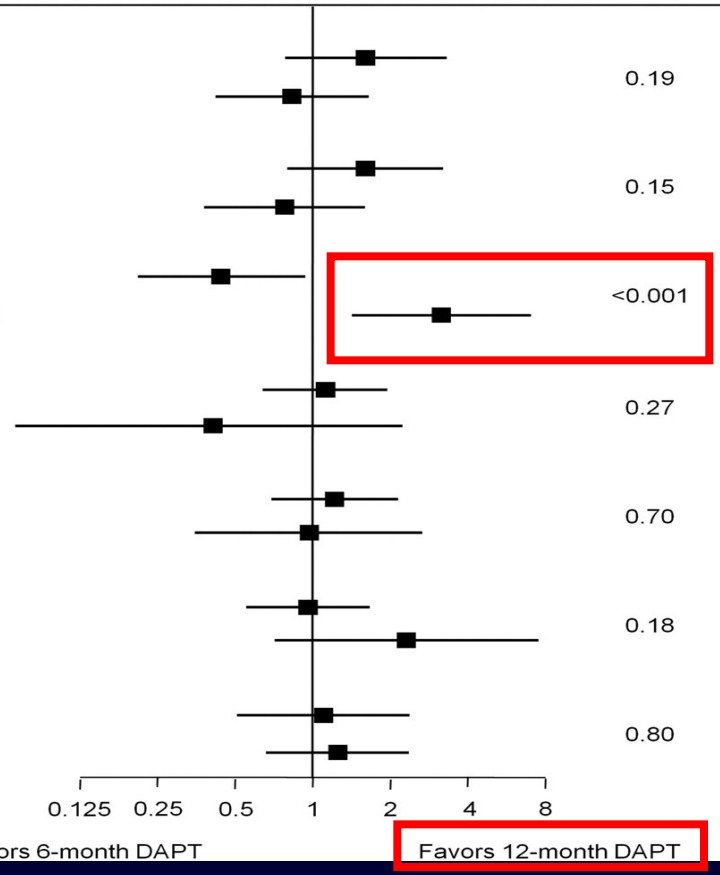
6-month	722	707	701	697	681
12-month	721	710	699	698	680

Am Heart J 2009 May;157:811-817.e1

Gwon HC et al ACC 2011

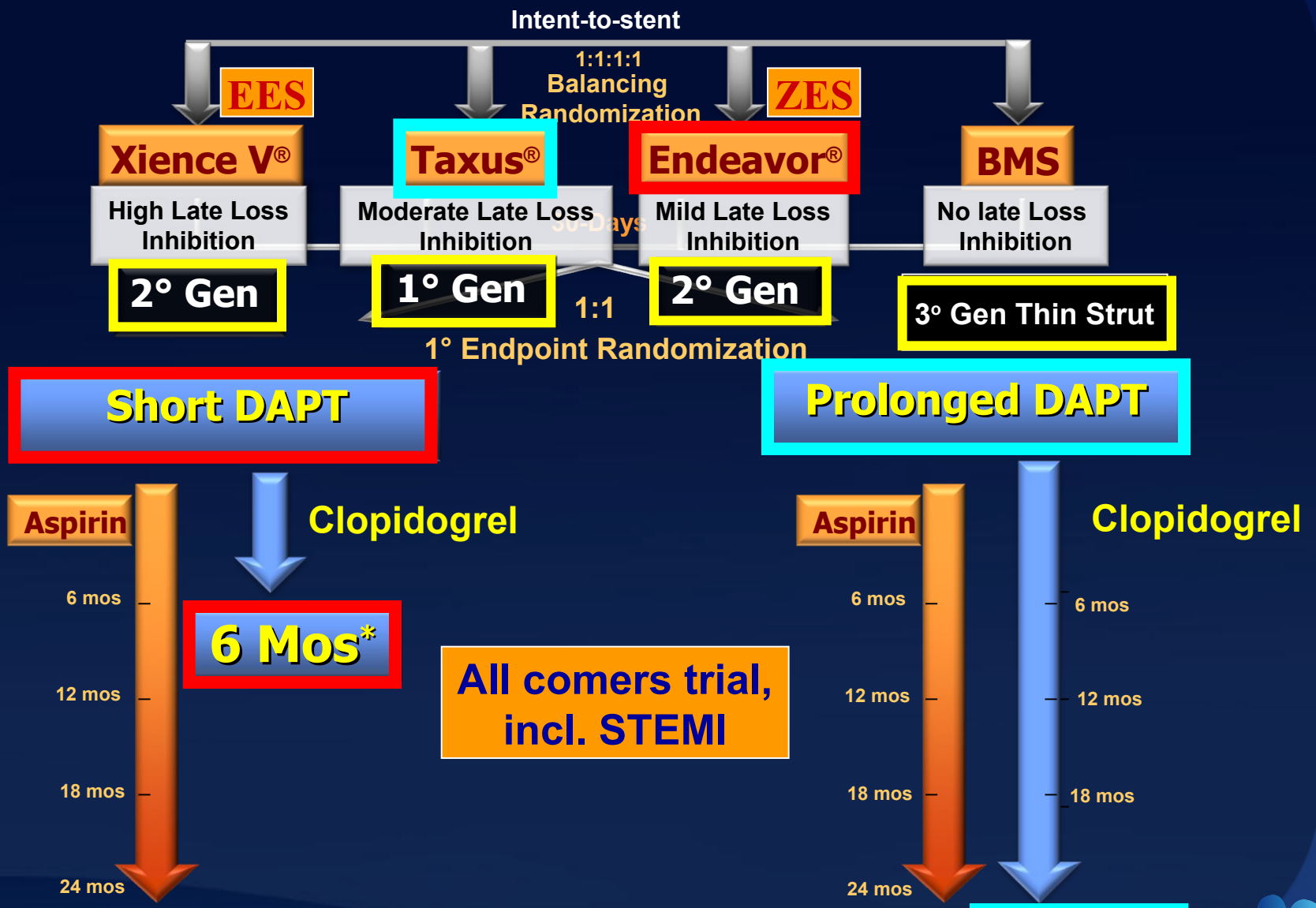
EXCELLENT trial:
Подгрупов анализ на първичната крайна цел

	Total	6-mo DAPT n (%)	12-mo DAPT n (%)	HR (95% CI)	*P* value	Interaction *P* value
Age						
<65	767	19 (5.1)	12 (3.2)	1.61 (0.78-3.31)	0.20	0.19
≥65	676	15 (4.5)	18 (5.5)	0.83 (0.42-1.65)	0.59	
ACS						
No	699	21 (6.03)	13 (3.82)	1.61 (0.8-3.21)	0.18	0.15
Yes	744	13 (3.65)	17 (4.69)	0.78 (0.38-1.60)	0.50	
Diabetes						
No	893	10 (2.27)	22 (5.08)	0.44 (0.21-0.94)	0.03	<0.001
Yes	550	24 (9.09)	8 (2.96)	3.16 (1.42-7.03)	0.005	
LV ejection fraction						
≥50%	1097	26 (4.91)	24 (4.42)	1.12 (0.64-1.95)	0.69	0.27
<50%	124	2 (3.08)	4 (7.41)	0.41 (0.07-2.23)	0.30	
Bifurcation						
No	1243	27 (4.41)	22 (3.65)	1.22 (0.69-2.14)	0.49	0.70
Yes	200	7 (7.61)	8 (7.96)	0.97 (0.35-2.67)	0.95	
Type of stent						
EES	1079	25 (4.72)	26 (4.94)	0.96 (0.55-1.66)	0.89	0.18
SES	364	9 (5.14)	4 (2.27)	2.31 (0.71-7.5)	0.16	
Multi-stent						
No	866	14 (3.18)	12 (2.91)	1.1 (0.51-2.38)	0.81	0.80
Yes	567	20 (7.68)	18 (6.2)	1.25 (0.66-2.37)	0.49	



Gwon H et al. Circulation 2012;125:505-513

PRODIGY Study Flow Chart

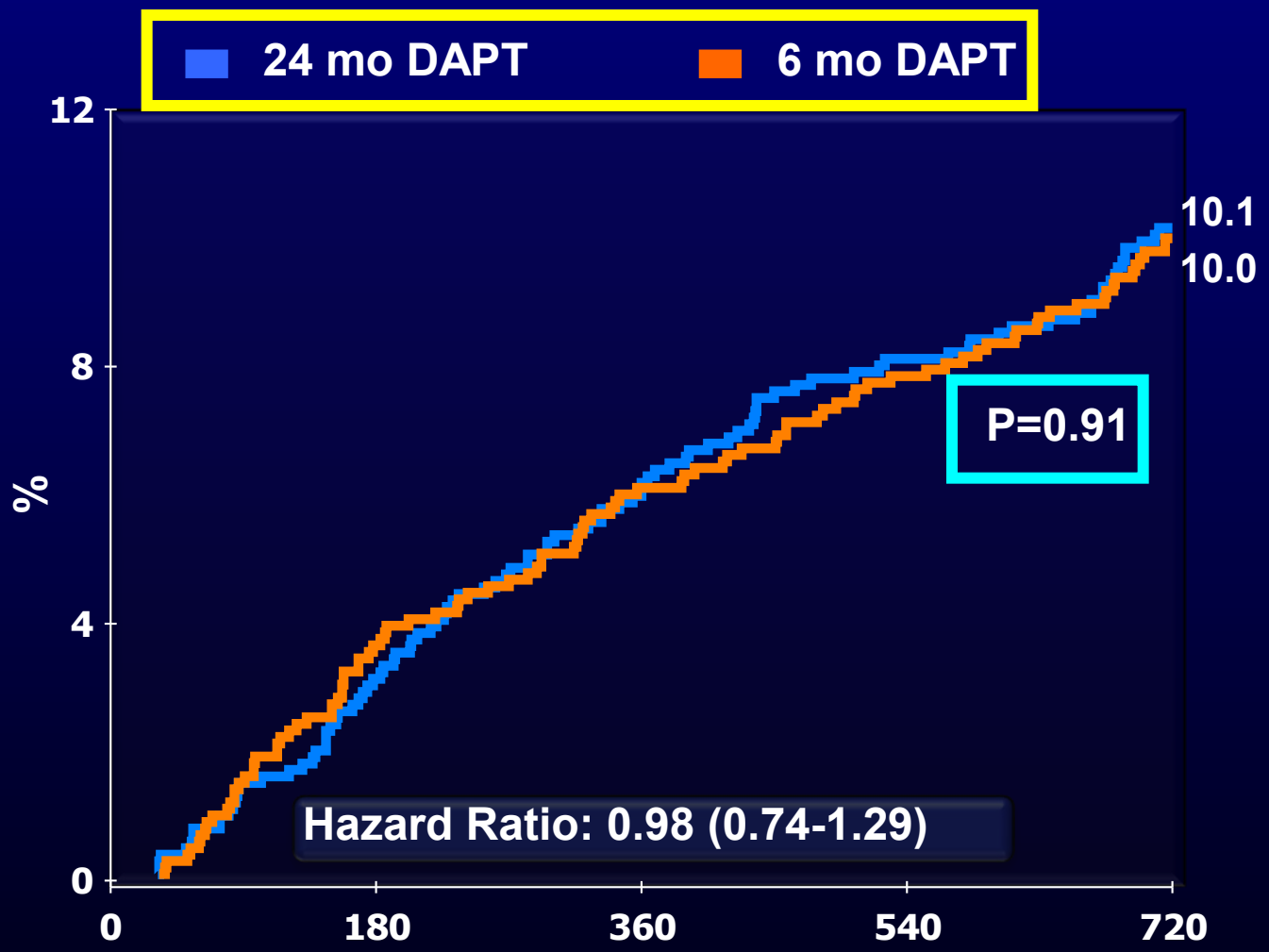


*: <6 months clopidogrel was allowed in BMS pts with stable CAD at the time of PCI

Primary Endpoint

Overall Death, MI or CVA

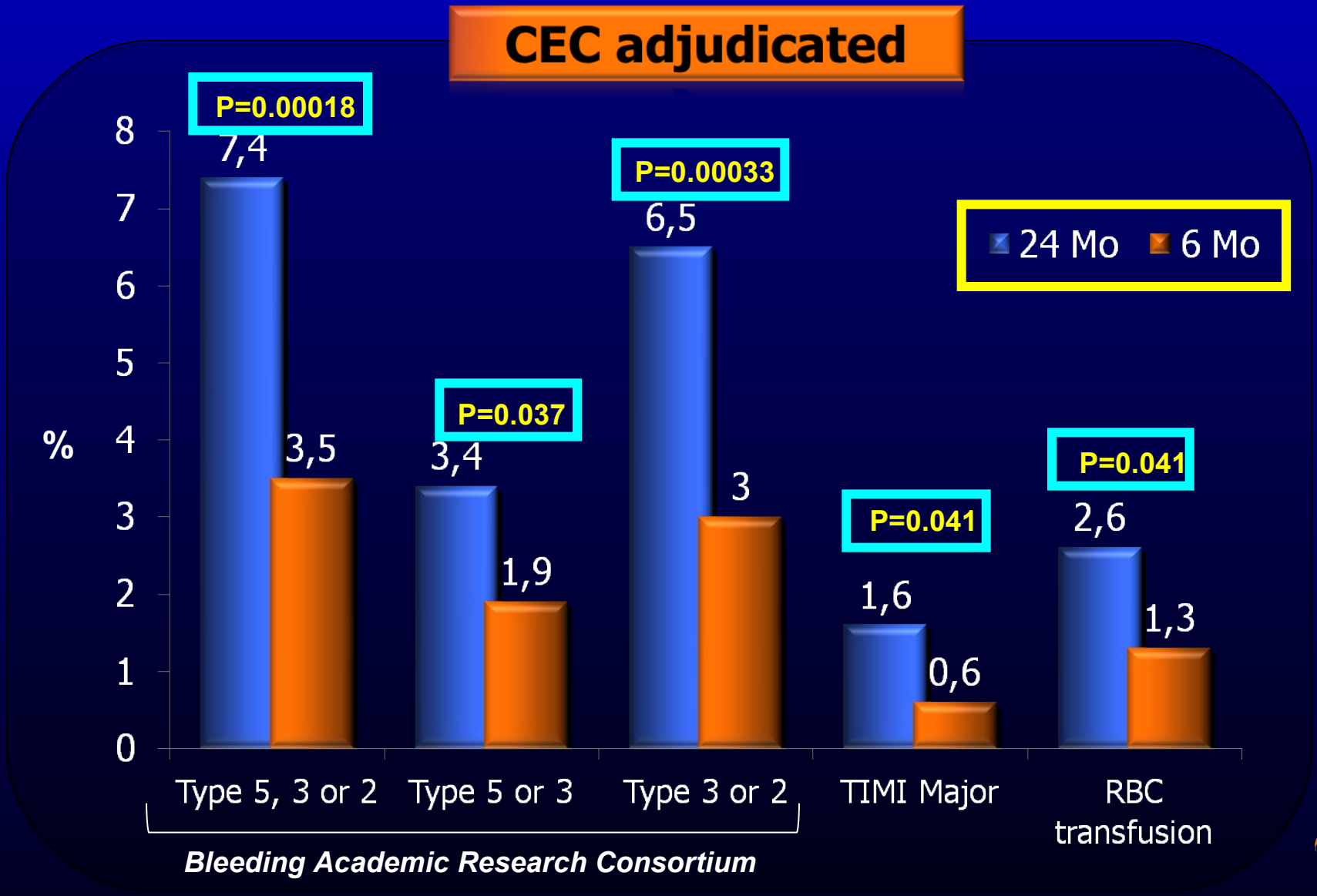
CEC adjudicated



No. at Risk				
24-Month Clopidogrel	987	925	884	
6-Month Clopidogrel	983	919		881

PRODIGY

Bleeding Events and RBC Transfusion



PRODIGY

European Heart Journal (2013) 34, 909–919
doi:10.1093/eurheartj/ehs460

Should duration of dual antiplatelet therapy depend on the type and/or potency of implanted stent? A pre-specified analysis from the PROlonging Dual antiplatelet treatment after Grading stent-induced Intimal hyperplasia studY (PRODIGY)

Marco Valgimigli[1,2*], Marco Borghesi[1], Matteo Tebaldi[1], Pascal Vranckx[3], Giovanni Parrinello[4], and Roberto Ferrari[1,2], for the PROlonging Dual antiplatelet treatment after Grading stent-induced Intimal hyperplasia studY (PRODIGY) Investigators

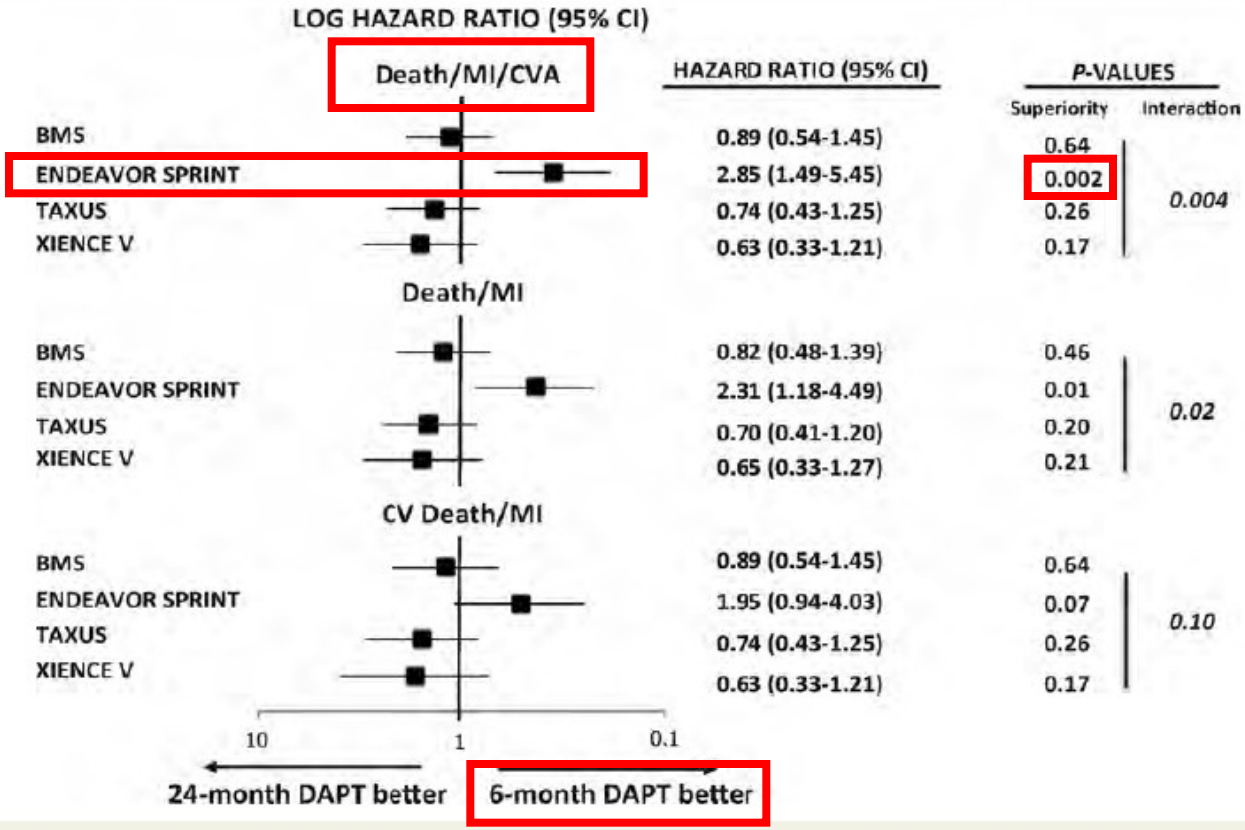


Figure 1 Stent analyse… are shown, with hazard ratios and 95% confiden… erebrovascular accident (CVA), death or MI, and… 24-month clopidogrel therapy. The *P*-value for interaction represents the likelihood of interaction between the variable and the relative treatment effect.

Implications: Optimal duration of dual antiplatelet therapy may be stent specific.

European Heart Journal (2013) 34, 909–919
doi:10.1093/eurheartj/ehs460

Should duration of dual antiplatelet therapy depend on the type and/or potency of implanted stent? A pre-specified analysis from the PROlonging Dual antiplatelet treatment after Grading stent-induced Intimal hyperplasia studY (PRODIGY)

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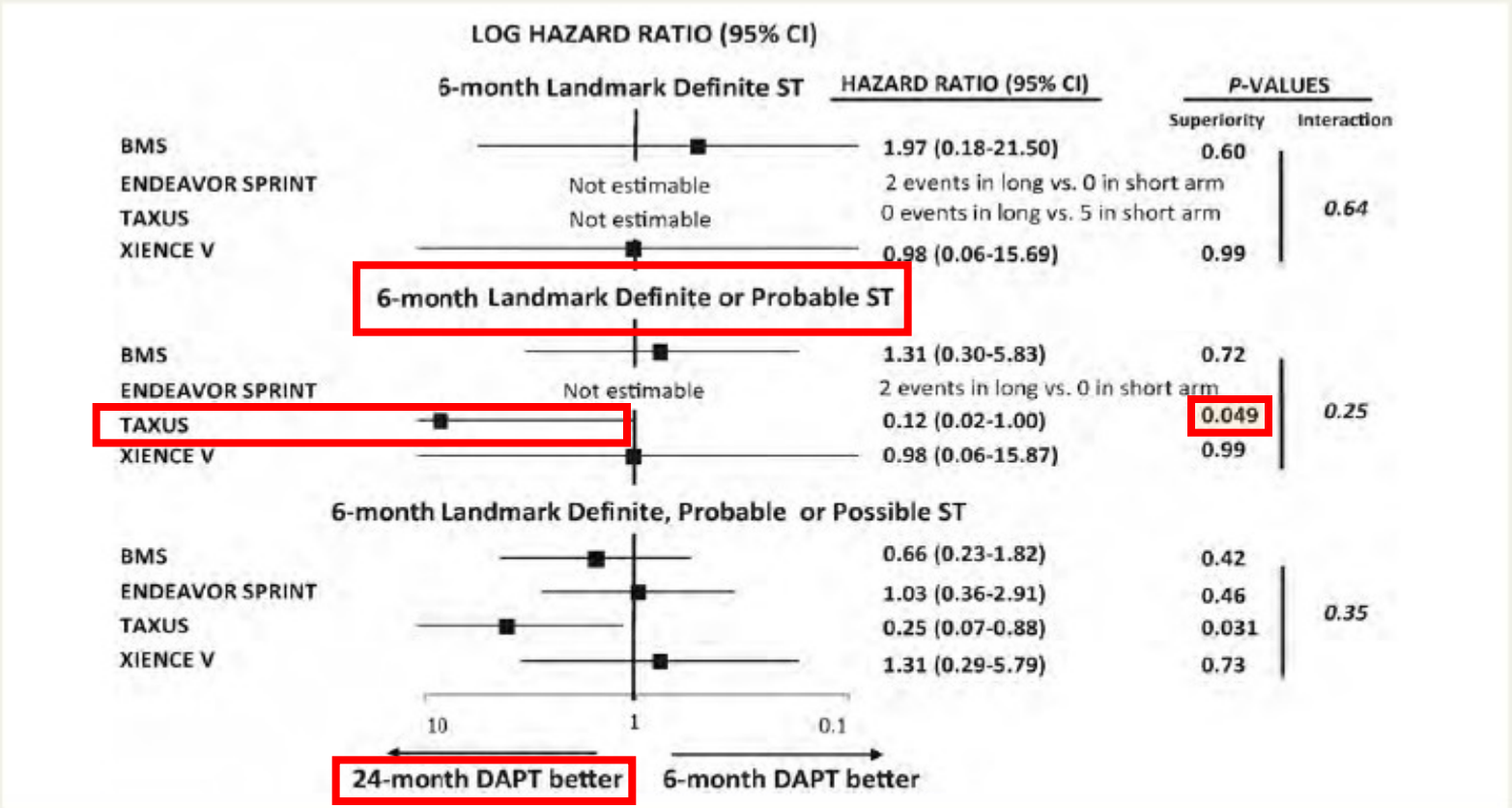


Figure 4 Stent a … h hazard ratios and 95% confidence interva … e stent thrombosis (ST) among patients ran … epresents the likelihood of interaction between the variable and the relative treatment effect.

Implications: Optimal duration of dual antiplatelet therapy may be stent specific.

JAMA
The Journal of the American Medical Association

F Feres and coauthors for the OPTIMIZE Trial Investigators

Three vs Twelve Months of Dual Antiplatelet Therapy After Zotarolimus-Eluting Stents: The OPTIMIZE Randomized Trial

Published online **October 31, 2013**

OPTIMIZE:
A Prospective, Randomized Trial of *3 Months Versus 12 Months* of Dual Antiplatelet Therapy with the *Endeavor Zotarolimus-Eluting Stent*

Fausto Feres, MD, PhD

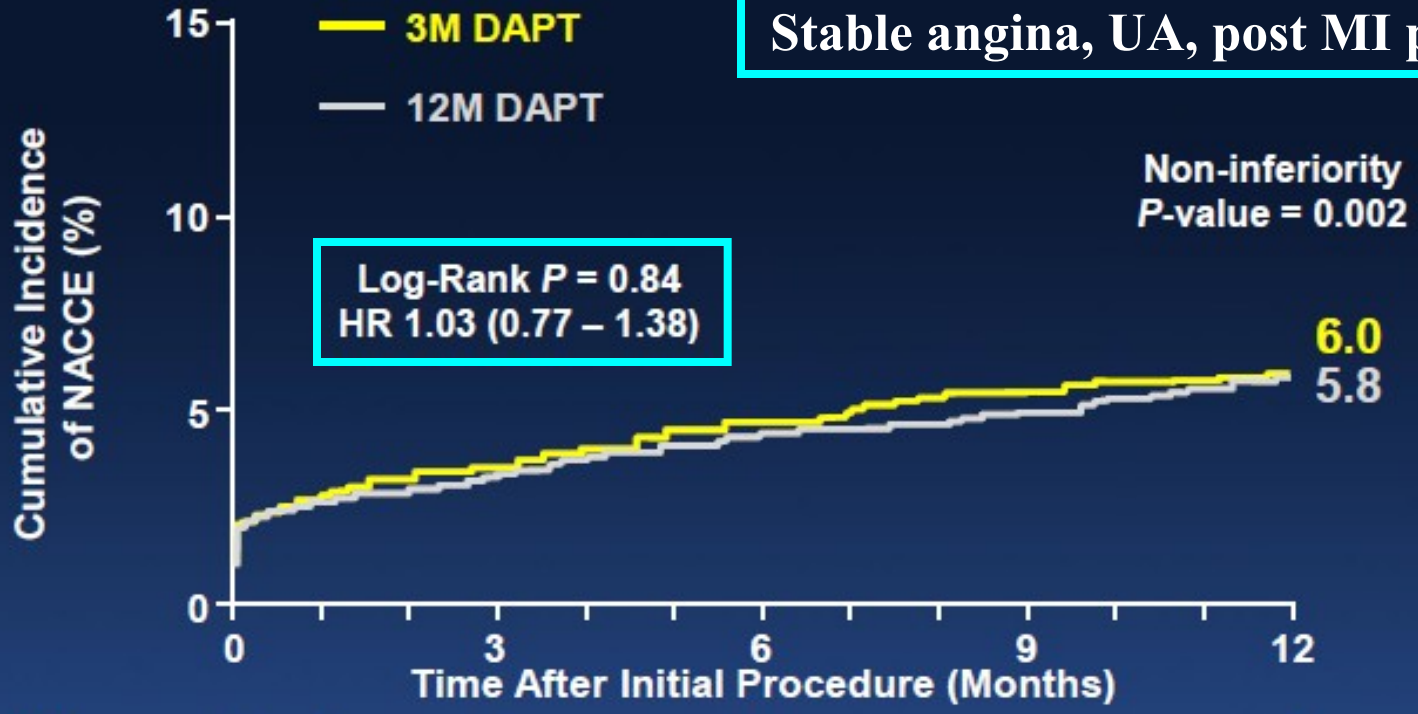
On behalf of the OPTIMIZE Trial Investigators

Instituto Dante Pazzanese de Cardiologia

São Paulo, Brazil

Primary Endpoint: NACCE at 1 Year
(All-Cause Death, MI, Stroke, Major Bleeding)

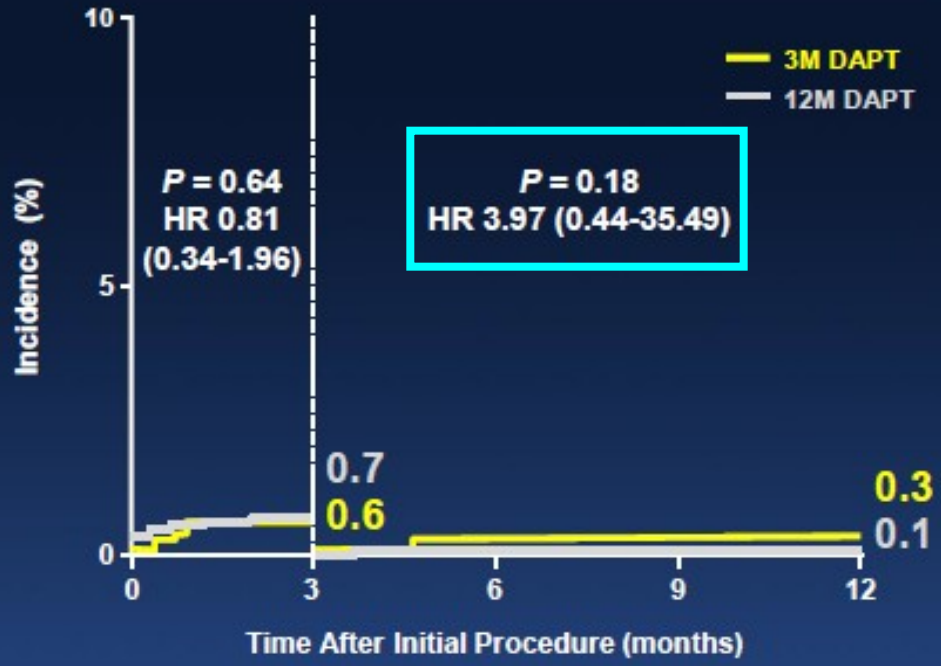
Stable angina, UA, post MI pts



Month	0	1	3	6	12
No. at risk	1563	1520	1504	1468	1384
No. events	18	25	11	18	21
No. at risk	1556	1514	1497	1466	1381
No. events	16	25	11	16	22

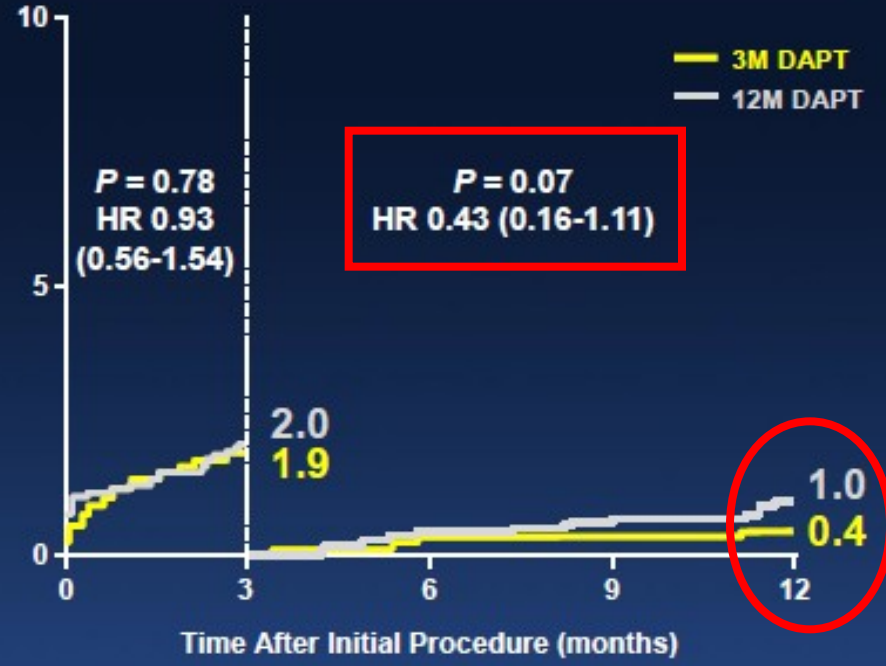
Stent Thrombosis *vs.* Bleeding

ARC Def./Prob. Stent Thrombosis



Month	0	1	3	6	12
No at risk	1563	1555	1540	1506	1505
No events	0	6	3	4	0
No at risk	1556	1541	1525	1501	1500
No events	5	3	3	1	0

Any Bleeding*

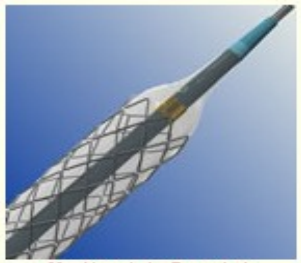


Month	0	1	3	6	12
No at risk	1563	1538	1516	1482	1439
No events	4	15	10	4	2
No at risk	1556	1528	1501	1472	1387
No events	11	8	12	6	8

*Any bleeding according to the combined REPLACE-2 and GUSTO criteria.

With Resolute Stent, Interrupting DAPT After One Month Showed No Increased Risk

ACC.13 presentation features unprecedented data on nearly 5,000 patients, including "all comers," from global RESOLUTE clinical program



Medtronic's Resolute Integrity Drug-Eluting Stent

Resolute™ zotarolimus-eluting stent

March 4, 2013 5:06 PM ET

Interruption or Discontinuation After One Month Following Implant Procedure Posed 'Low and No Increased Risk' of Stent Thrombosis at One Year in Clinical Studies

MINNEAPOLIS — March 4, 2013 — Of relevance to the clinical practice of interventional cardiology, Medtronic, Inc. (NYSE: MDT) announced today that it has received regulatory approval to update the CE *(Conformité Européenne)* mark labeling for the Resolute Integrity drug-eluting stent with new information on one month of dual antiplatelet therapy (DAPT), the shortest minimum duration referenced on the label for any device of its kind.

The updated labeling states: *"One year data from the RESOLUTE Clinical Program indicates low stent thrombosis rates for those who interrupted or discontinued DAPT any time after one month. While physicians should continue to adhere to current ESC or ACC/AHA/SCAI guidelines for PCI, patients who interrupt or discontinue DAPT medication one month or more after stent implantation are considered at low risk and showed no increased risk for stent thrombosis."*

Тройна антитромботична терапия

European Heart Journal Advance Access published May 6, 2010

European Heart Journal
doi:10.1093/eurheartj/ehq117

REVIEW

Novel therapeutic concepts

Antithrombotic management of atrial fibrillation patients presenting with acute coronary syndrome and/or undergoing coronary stenting: executive summary—a Consensus Document of the European Society of Cardiology Working Group on Thrombosis, endorsed by the European Heart Rhythm Association (EHRA) and the European Association of Percutaneous Cardiovascular Interventions (EAPCI)

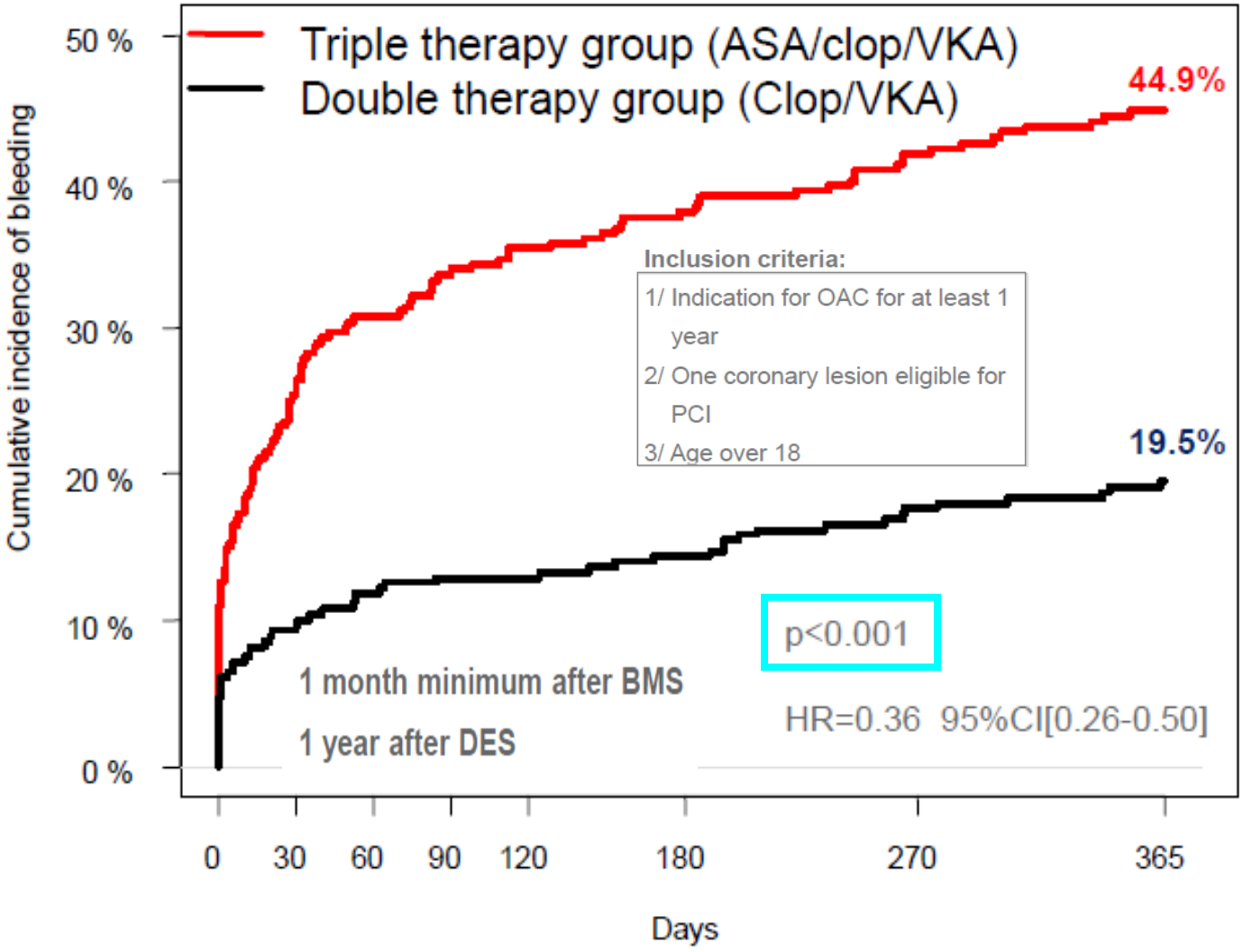
Gregory Y.H. Lip[1]*, Kurt Huber[2], Felicita Andreotti[3], Harald Arnesen[4], Juhani K. Airaksinen[5], Thomas Cuisset[6], Paulus Kirchhof[7], and Francisco Marín[8]

Висок хеморагичен риск

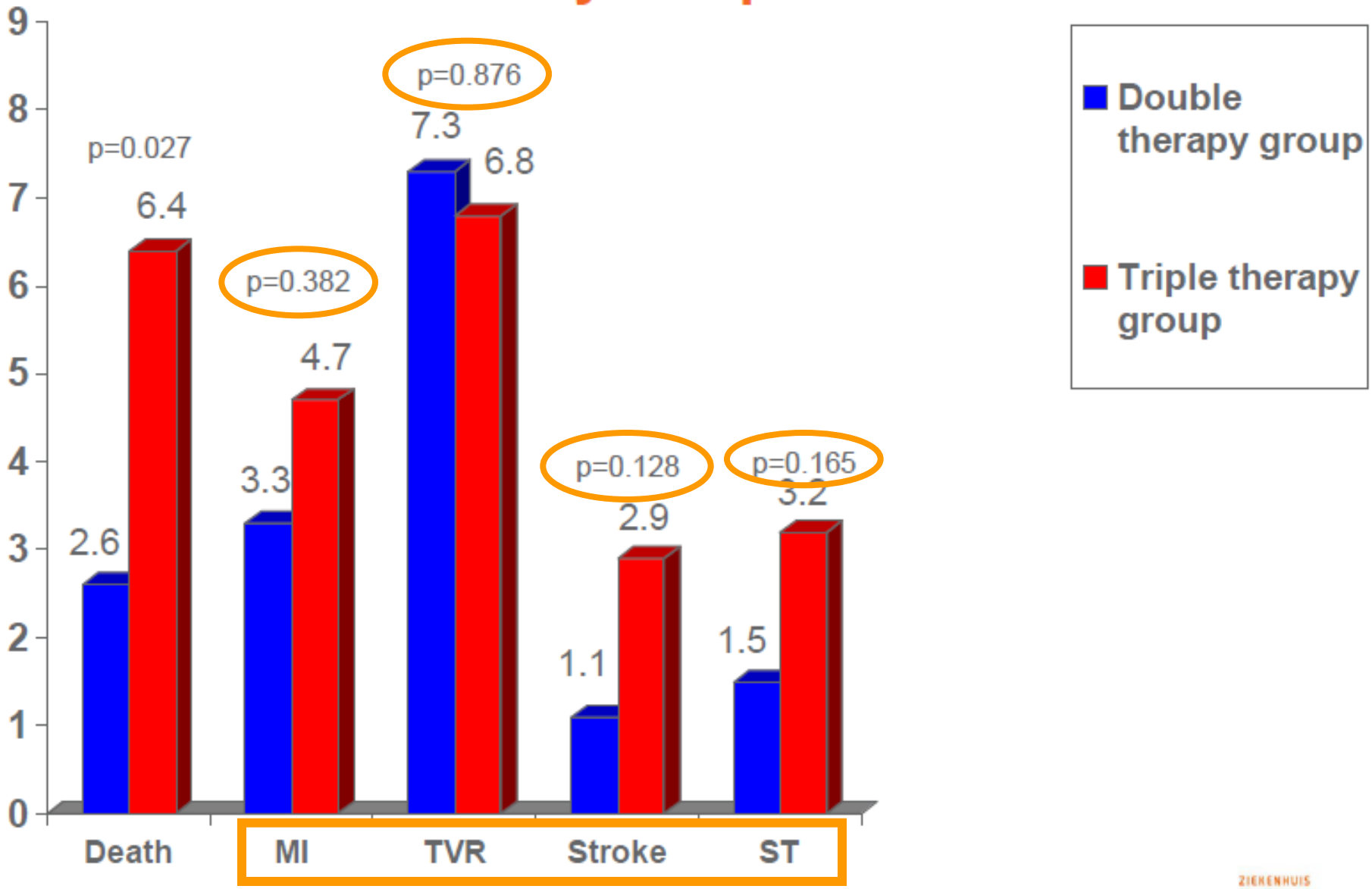
Клиника	Стент	Препоръки (Experts, level C)
1. Планова PCI	BMS	• 2–4 седм: ТАТ – ОАК (INR 2.0–2.5) + ASA 100 mg + clopidogrel 75 mg • за цял живот: ОАК (INR 2.0–3.0) самостоятелно
2. ОКС	BMS	• 4 седм.: ТАТ - ОАК (INR 2.0 –2.5) + ASA 100 mg + clopidogrel 75 mg • До 12 мес: ДАТ - ОАК (INR 2.0–2.5) + clopidogrel 75 mg (или ASA 100 mg) • за цял живот: ОАК (INR 2.0–3.0) самостоятелно

Thromb Haemost 2010;103:13–28

Primary Endpoint: Total number of TIMI bleeding events



Secondary Endpoint



MI=any myocardial infarction; TVR= target vessel revascularisation (PCI + CABG); ST= stent thrombosis

ПОСЛАНИЯ

1. Продължителността на **ДАТ след ПКИ при стабилна стенокардия** се определя основно от **вида на стента**:

   (1) BMS: поне 1 месец (I A)

   (2) DES 2-ра ген.: 6-12 месеца (I B)

   Endeavor (ZES) - 3 мес. ДАТ ?
   Resolute™ (ZES) - 1 мес. ДАТ ?

2. Цел на продължителната ДАТ след планова ПКИ с имплантиране на DES: **предотвратяване на късна стент-тромбоза**

ПОСЛАНИЯ

3. При всички пациенти с:

(1) NSTEMI / STEMI + DES / BMS

(2) ОКС без стент (IIa C)

↓

1 година ДАТ: Лекувай пациента !

4. Цел на продължителната ДАТ след ОКС:

- профилактика на СС събития

- предотвратяване на късна стент-тромбоза


Qatar
Foundation
bwin

Trial Schema

PEGASUS TIMI 54

N ~ 21,000

Stable pts with history of MI 1-3 yrs prior + ≥1 additional atherothrombosis risk factor*

** Age >65 yrs, diabetes, 2nd prior MI, multivessel CAD, or chronic non-end stage renal dysfunction*

RANDOMIZE DOUBLE BLIND

Planned treatment with ASA 75 – 150 mg & Standard background care

- **Ticagrelor 90 mg bid**
- **Ticagrelor 60 mg bid**
- **Placebo**

Follow-up Visits Q4 mos for 1st yr, then Q6 mos

Min 12 mos and median 26 mos follow-up
Event-driven trial

Primary Efficacy Endpoint: CV Death, MI, or Stroke
Primary Safety Endpoint: TIMI Major Bleeding

Нисък и умерен хеморагичен риск

Клиника	Стент	Препоръки (Experts, level C)
1. Планова PCI	BMS	• **1 мес.: ТАТ - ОАК (INR 2.0–2.5) + ASA 100 mg + clopidogrel 75 mg** • **за цял живот: ОАК (INR 2.0–3.0) самостоятелно**
	DES	• 3 (sirolimus) и 6 (paclitaxel) месеца: ТАТ - ОАК (INR 2.0–2.5) + ASA 100 mg + clopidogrel 75 mg • До 12 мес: ДАТ - ОАК (INR 2.0–2.5) + clopidogrel 75 mg (или ASA 100 mg) • за цял живот: ОАК (INR 2.0–3.0) самостоятелно
2. ОКС	BMS / DES	• **6 мес.: ТАТ - ОАК (INR 2.0–2.5) + ASA 100 mg + clopidogrel 75 mg** • **До 12 мес: ДАТ - ОАК (INR 2.0–2.5) + clopidogrel 75 mg (или ASA 100 mg)** • **за цял живот: ОАК (INR 2.0–3.0) самостоятелно**

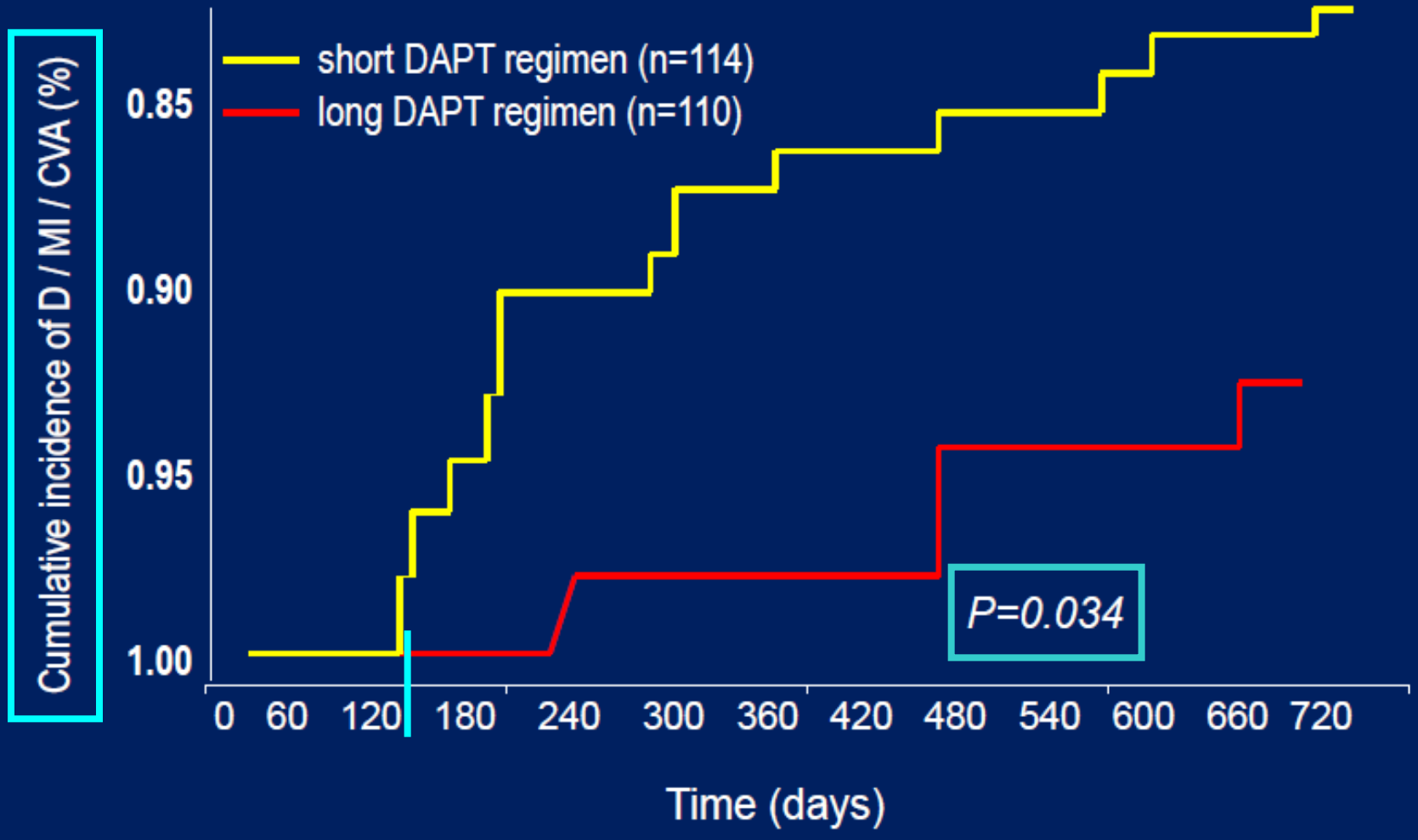
Thromb Haemost 2010;103:13–28

North American Consensus Statement Regarding Antithrombotic Therapy in Atrial Fibrillation Requiring a Stent

- Low dose aspirin (<100 mg per day)
- Clopidogrel is preferred in combination with aspirin and warfarin.
- Prasugrel and ticagrelor cannot be recommended
- Warfarin dose adjusted INR between 2 and 2.5.
- Not unreasonable to use dabigatran in place of warfarin based on the PETRO trial (dabigatran 50, 150, 300 mg BID with or without aspirin vs warfarin)

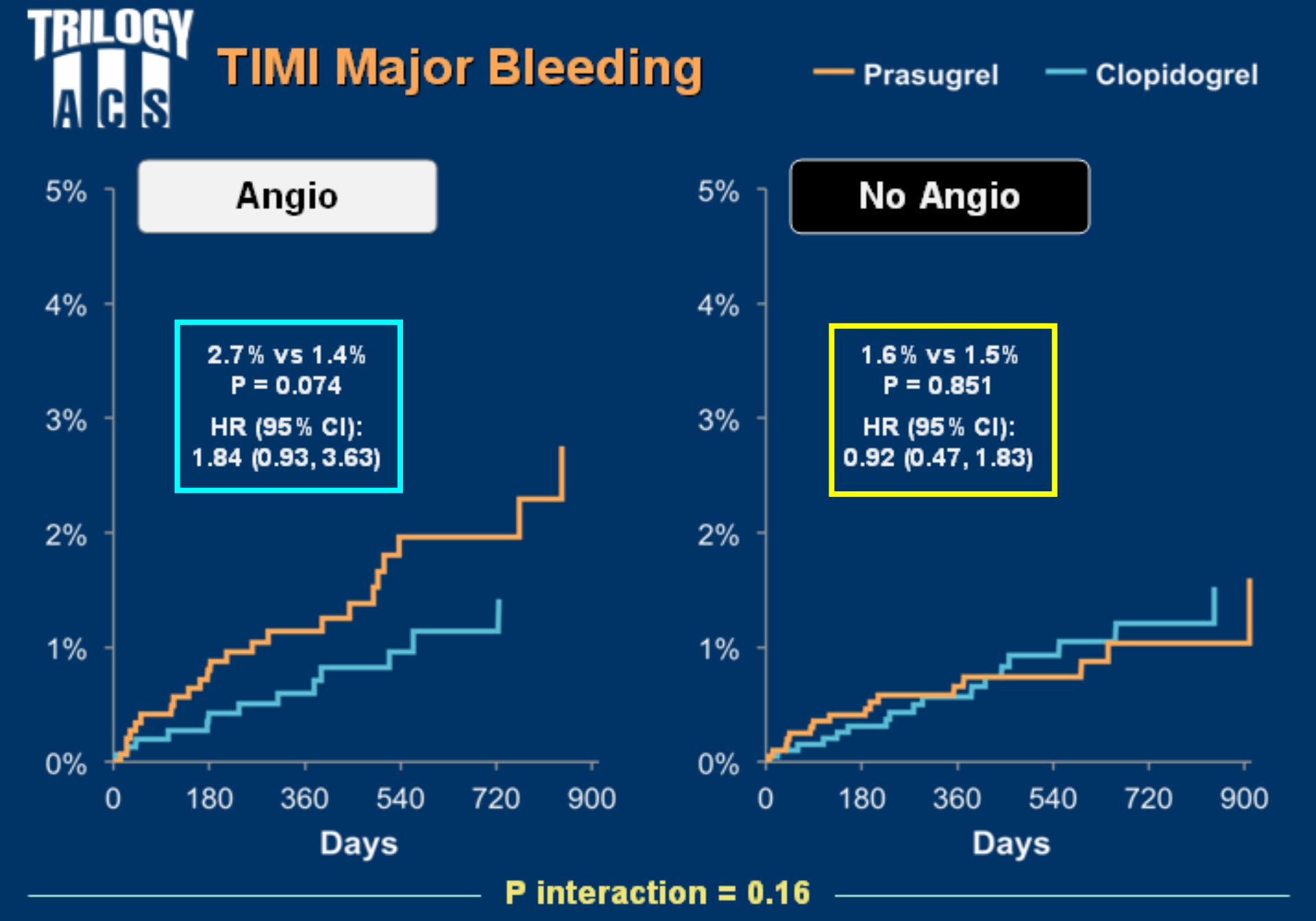
Faxson D, Thrombosis & Hemostasis 2011;106(3):522-

Stenting for ISR: PRODIGY Substudy



Campo et al. JACC 2013

TIMI Major Bleeding



P interaction = 0.16

Meta-analysis: Clinical Impact of Extended DAPT After PCI in the DES Era

4 RCTs (8,231 patients) comparing extended (50.2%; median 16.8 months) or control (49.8%; median 6.2 months) durations of DAPT.

Clinical Outcomes: Extended vs. Control DAPT	OR (95% CI)	*P* Value
All-cause Death	1.15 (0.85-1.54)	0.36
Stent Thrombosis	0.88 (0.43-1.81)	0.73
TIMI Major Bleeding	2.64 (1.31-5.30)	0.006

Conclusion: Extending the duration of dual antiplatelet therapy after PCI may increase the risk of bleeding without reducing ischemic events.

Cassese S, et al. *Eur Heart J.* 2012;Epub ahead of print.

EXCELLENT
PRODIGY
REAL/ZEST-LATE
RESET