PCI in Patients with AF
Optimizing Oral Anticoagulation Regimen

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AF and CAD often occur together because of the strong association of both conditions with aging and overlapping risk factors.

20%-30% of AF patients with indication for OAC have coexisting CAD and therefore may require PCI.

5%-20% of ACS patients undergoing PCI have concomitant AF.

An estimated 1–2 million anticoagulated patients are candidates for PCI procedures.
1. Antiplatelet therapy is needed to prevent stent thrombosis
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2. Oral anticoagulants are needed to prevent stroke
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2. Oral anticoagulants are needed to prevent stroke
3. Combining OAC and APT increases bleeding

Combination therapy increases risk of fatal and non-fatal bleeding

Hansen et al. Arch Int Med 2010; 170: 1433-1441
1. Antiplatelet therapy is needed to prevent stent thrombosis
2. Oral anticoagulants are needed to prevent stroke
3. Combining OAC and APT increases bleeding
4. Bleeding is associated with an increased mortality

In the CathPCI registry, analysing data from 3.3 million PCI procedures (2004–11):

\[
\text{risk difference} = 3.39\% \\
\text{(95\% CI: 3.20–3.59)} \\
P<0.001
\]

5.26\% in-hospital mortality rate: major bleeding

1.87\% in-hospital mortality rate: non-bleeding

Compared with patients without bleeding, patients who experience bleeding are more likely to die, not only early (in hospital) but also late (after discharge) regardless of bleeding site

Background risk

- Bleeding
- Shock
- Anaemia
- Transfusion
- Discontinuation of APT
- Ischaemia
- Inflammation
- Stent thrombosis

Mortality

Chhatriwala AK et al. JAMA 2013;309:1022–9
Steg et al. Eur Heart J 2011;32:1854–64
1. Antiplatelet therapy is needed to prevent stent thrombosis
2. Oral anticoagulants are needed to prevent stroke
3. Combining OAC and APT increases bleeding
4. Bleeding is associated with an increased mortality
5. Therefore there is a need to clarify the optimal combination regimen in terms of choice of agents, dose and duration of therapy
What combination of therapy is optimal for patients with AF undergoing PCI?

AF
- Anticoagulant therapy
  - VKA
  - NOAC

PCI
- Antiplatelet therapy (DAPT)
  - ASA
  - Clopidogrel, Prasugrel
  - Ticagrelor, Cangrelor

AF and PCI
- DUAL THERAPY: anticoagulant and single antiplatelet?
- OR
- TRIPLE THERAPY: anticoagulant and dual antiplatelet therapy?

Management of patients with AF undergoing PCI must balance stroke and bleeding risk.

- **APT**
  - Dual therapy ▲ CV events ▲ mortality
  - Triple therapy High bleeding event rates, bleeding complications, MACE, and mortality

- **OAC** VKA NOAC
  - Dual therapy ▼ stent thrombosis ▼ major bleeding ≈ coronary events
  - Dual therapy ▲ MI ▲ stent thrombosis

- **ASA**

Open-label study (N=573)
Safety outcomes with triple therapy (VKA + clopidogrel 75+ ASA 80) vs. dual therapy (VKA + clopidogrel)
(69% of WOEST patients had AF, included prosthetic heart valves)

Safety outcomes
Any bleeding episode within 1 year of PCI

Efficacy outcomes

Management of patients with AF undergoing PCI must balance stroke and bleeding risk


APT

Dual therapy ▼ stent thrombosis ▼ major bleeding ≈ coronary events

Dual therapy ▲ CV events ▲ mortality

Triple therapy High bleeding event rates, bleeding complications, MACE, and mortality

Dual therapy ▲ MI ▲ stent thrombosis

WOEST RE-DUAL PCI PIONEER AF PCI AUGUSTUS ENTRUST AF PCI

OAC VKA NOAC

ASA
For patients requiring OAC, new ESC focused update recommends dual or triple therapy after PCI with stent depending on individual patient risk factors.

When a NOAC is used, the lowest dose effective for stroke prevention in AF should be applied.

Dabigatran 110 mg is the only reduced-dose NOAC to be fully tested for effectiveness in stroke prevention in AF.

*High ischaemic risk is considered as an acute clinical presentation or anatomical/procedural features, which might increase the risk for MI; †Dabigatran 110 mg BID (Class IIa C), rivaroxaban 15 mg OD (Class IIb B), or apixaban 2.5 mg BID (Class IIa C) according to selected study population in pivotal studies; ASA, acetylsalicylic acid; Valgimigli et al. Eur Heart J 2017
PIONEER AF-PCI
Patients With Atrial Fibrillation Undergoing Coronary Stent Placement
PIONEER AF-PCI

Multicentre, randomized, open-label trial

Paroxysmal, persistent or permanent AF, undergoing PCI (with stent placement)
N=2124

No prior stroke/TIA, Gl bleeding Hb<10, G3GI<30

Primary endpoint: TIMI major + minor + bleeding requiring medical attention
Secondary endpoint: CV death, MI, and stroke (Ischemic, Hemorrhagic, or Uncertain Origin)

PIONEER AF-PCI demonstrated a lower rate of the primary endpoint in both rivaroxaban groups vs the triple therapy group

Composite of bleeding events*

*Composite of major bleeding or minor bleeding according to TIMI criteria or bleeding requiring medical attention;
†Trial not powered to definitively establish superiority or noninferiority.

PIONEER AF-PCI showed similar rates of thromboembolic events across treatment groups, with low power to demonstrate efficacy.

The study was not powered to show superiority or non-inferiority between treatments in efficacy endpoints.
PIONEER AF-PCI study: Efficacy

Q Are patients receiving regimens of low-dose rivaroxaban plus antiplatelets protected against stroke?

- This trial did not establish non-inferiority of Rivaroxaban based strategies vs. VKA+DAPT for stroke prevention (Stroke rate were low overall)

*15 mg OD recommended for patients with moderate renal impairment
Questions about the PIONEER AF-PCI study

Q Are patients receiving regimens of low-dose rivaroxaban plus antiplatelets protected against stroke?

Q How would you translate results for these non-approved rivaroxaban regimens into clinical practice?

- Cardioversion of Afib
  - X-VERT Trial: Rivaroxaban (20 mg) vs. VKA

- Safety and Efficacy in
  - Patients with prior stroke
  - Patients with a history of ICH or GI bleeding

(excluded from the study*)
Questions about the PIONEER AF-PCI study

Q Are patients receiving regimens of low-dose rivaroxaban plus antiplatelets protected against stroke?

Q How would you translate results for these non-approved rivaroxaban regimens into clinical practice?

Q No comparison to the WOEST VKA+Clopidogrel arm
Both strategies reduce bleeding compared to VKA + DAPT

**WOEST**  
VKA + clopidogrel

**PIioneer AF-PCI**  
RVRX reduced dose + APT

Dewilde W et al. *Lancet* 2013  
Gibson CM et al. *NEJM* 2016
PIONEER AF-PCI was an exploratory trial, comparing the safety of low-dose rivaroxaban regimens plus single or dual antiplatelet therapy vs warfarin-based triple therapy.

1. The rate of bleeding events (composite endpoint) was lower in both rivaroxaban groups vs the triple therapy group.

2. The rivaroxaban doses used have either not been approved for stroke prevention (2.5 mg BID) or have been tested in only a small number of patients with AF (15/10 mg OD in 639 Japanese patients in J-ROCKET).
RE-DUAL PCI trial
RE-DUAL PCI tested the safety and efficacy of 2 regimens of dual therapy with dabigatran without ASA vs triple therapy with warfarin

RE-DUAL PCI was a multicentre, randomized, open-label trial

Patients with AF undergoing PCI with stenting

N=2725

Randomization ≤120 hours post-PCI

Primary endpoint: ISTH major or CRNM bleeding

Dabigatran 150 mg BID + P2Y12 inhibitor

Dabigatran 110 mg BID + P2Y12 inhibitor

Warfarin (INR 2.0–3.0) + P2Y12 inhibitor + ASA†

6-month minimum treatment duration, maximum treatment duration 30 months (mean follow-up ~14 months)

Primary endpoint was time to first ISTH major or clinically relevant non-major bleeding event

Composite efficacy Endpoint: Time to first event of death, TE event (MI, stroke, systemic embolism) and unplanned revascularization

RE-DUAL PCI key inclusion and exclusion criteria

**Inclusion**
- Patients aged ≥18 years with paroxysmal, persistent or permanent NVAF
- ACS successfully treated by PCI and stenting (BMS or DES)
- Stable CAD with ≥1 lesion eligible for PCI that was successfully treated by elective PCI and stenting (BMS or DES)

**Exclusion**
- Cardiogenic shock during current hospitalization
- Use of fibrinolytics within 24 hours of randomization that, in the investigator’s opinion, will put patient at high risk of bleeding
- Stroke or major bleeding event within 1 month prior to screening visit
- Severe renal impairment (CrCl <30mL/min)

ACS, acute coronary syndrome; BMS, bare-metal stent; CAD, coronary artery disease; DES, drug-eluting stent; PCI, percutaneous coronary intervention; Cannon et al. Clin Cardiol 2016
### Baseline characteristics

<table>
<thead>
<tr>
<th></th>
<th>Dabigatran 110 mg dual therapy (n=981)</th>
<th>Warfarin triple therapy (n=981)</th>
<th>Dabigatran 150 mg dual therapy (n=763)</th>
<th>Warfarin triple therapy (n=764)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years, mean</td>
<td>71.5</td>
<td>71.7</td>
<td>68.6</td>
<td>68.8</td>
</tr>
<tr>
<td>≥80 (USA, ROW), ≥70 (Japan), %</td>
<td>22.9</td>
<td>22.9</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>&lt;80 (USA, ROW), &lt;70 (Japan), %</td>
<td>77.1</td>
<td>77.1</td>
<td>99.0</td>
<td>99.0</td>
</tr>
<tr>
<td>Male, %</td>
<td>74.2</td>
<td>76.5</td>
<td>77.6</td>
<td>77.7</td>
</tr>
<tr>
<td>Baseline CrCl, mL/min, mean</td>
<td>76.3</td>
<td>75.4</td>
<td>83.7</td>
<td>81.3</td>
</tr>
<tr>
<td>Diabetes mellitus, %</td>
<td>36.9</td>
<td>37.9</td>
<td>34.1</td>
<td>39.7</td>
</tr>
<tr>
<td>CHA₂DS₂–VASc score (mean)</td>
<td>3.7</td>
<td>3.8</td>
<td>3.3</td>
<td>3.6</td>
</tr>
<tr>
<td>Modified HAS-BLED score at baseline (mean)</td>
<td>2.7</td>
<td>2.8</td>
<td>2.6</td>
<td>2.7</td>
</tr>
<tr>
<td>ACS indication for PCI, %</td>
<td>51.9</td>
<td>48.4</td>
<td>51.2</td>
<td>48.3</td>
</tr>
<tr>
<td>DES placed only, %</td>
<td>82.0</td>
<td>84.2</td>
<td>81.4</td>
<td>83.5</td>
</tr>
</tbody>
</table>

ROW, rest of world; ACS, acute coronary syndrome; DES, drug-eluting stent; PCI, percutaneous coronary intervention; Cannon et al. N Engl J Med 2017; Cannon et al. ESC 2017
Primary Endpoint
Significantly lower rates of ISTH major bleeding or CRNMBE with dabigatran dual therapy

For the dabigatran 150 mg vs warfarin comparison, elderly patients outside the USA (≥80 years) and Japan (≥70 years) are excluded. Full analysis set presented CRNMBE, clinically relevant non-major bleeding event; ISTH, International Society on Thrombosis and Haemostasis; Cannon et al. ESC 2017; Cannon et al. N Engl J Med 2017
TIMI major or minor bleeding: significantly lower rate for dabigatran dual therapy

TIMI major bleeding definition: fatal, ICH, clinically overt bleeding with fall in Hb ≥5 g/dL; TIMI minor bleeding definition: Clinically overt bleeding (including imaging), resulting in Hb drop of 3 to <5 g/dL; TIMI, Thrombolysis in Myocardial Infarction; Cannon et al. N Engl J Med 2017
Intracranial haemorrhage: fewer events with dabigatran dual therapy

HR: 0.30 (95% CI: 0.08–1.07)  
P=0.06

HR: 0.12 (95% CI: 0.02–0.98)  
P=0.047
Dabigatran dual therapy was non-inferior to warfarin triple therapy in the composite efficacy endpoint

Composite endpoint of death or thromboembolic event (MI, stroke or systemic embolism) or unplanned revascularization (PCI/CABG)

Dabigatran (combined dose) dual therapy
- Patients with outcome event (%): 13.7%
- Warfarin triple therapy
- Patients with outcome event (%): 13.4%

HR: 1.04 (95% CI: 0.84–1.29)
Non-inferiority P=0.005

CABG, coronary artery bypass grafting; PCI, percutaneous coronary intervention; Cannon et al. N Engl J Med 2017; Cannon et al ESC 2017
There are no significant differences in efficacy outcomes

<table>
<thead>
<tr>
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<th>Dabigatran 110 mg dual therapy (n=981)</th>
<th>Warfarin triple therapy (n=981)</th>
<th>D110 DT vs warfarin TT</th>
<th>Dabigatran 150 mg dual therapy (n=763)</th>
<th>Warfarin triple therapy (n=764)</th>
<th>D150 DT vs warfarin TT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>HR (95% CI) P value</td>
<td>n (%)</td>
<td>n (%)</td>
<td>HR (95% CI) P value</td>
</tr>
<tr>
<td>DTE or unplanned</td>
<td>149 (15.2)</td>
<td>131 (13.4)</td>
<td>1.13 (0.90–1.43) 0.30</td>
<td>90 (11.8)</td>
<td>98 (12.8)</td>
<td>0.89 (0.67–1.19) 0.44</td>
</tr>
<tr>
<td>revascularization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>All-cause death</td>
<td>55 (5.6)</td>
<td>48 (4.9)</td>
<td>1.12 (0.76–1.65) 0.56</td>
<td>30 (3.9)</td>
<td>35 (4.6)</td>
<td>0.83 (0.51–1.34) 0.44</td>
</tr>
<tr>
<td>Stroke</td>
<td>17 (1.7)</td>
<td>13 (1.3)</td>
<td>1.30 (0.63–2.67) 0.48</td>
<td>9 (1.2)</td>
<td>8 (1.0)</td>
<td>1.09 (0.42–2.83) 0.85</td>
</tr>
<tr>
<td>Unplanned revascularization</td>
<td>76 (7.7)</td>
<td>69 (7.0)</td>
<td>1.09 (0.79–1.51) 0.61</td>
<td>51 (6.7)</td>
<td>52 (6.8)</td>
<td>0.96 (0.65–1.41) 0.83</td>
</tr>
<tr>
<td>MI</td>
<td>44 (4.5)</td>
<td>29 (3.0)</td>
<td>1.51 (0.94–2.41) 0.09</td>
<td>26 (3.4)</td>
<td>22 (2.9)</td>
<td>1.16 (0.66–2.04) 0.61</td>
</tr>
<tr>
<td>Systemic embolism</td>
<td>2 (0.3)</td>
<td>3 (0.4)</td>
<td>0.62 (0.10–3.71) 0.60</td>
<td>1 (0.1)</td>
<td>3 (0.4)</td>
<td>0.30 (0.03–2.93) 0.30</td>
</tr>
</tbody>
</table>

RE-DUAL PCI was not powered to show differences in individual thromboembolic endpoints

Results presented are times to event.
DT, dual therapy; TT, triple therapy; Cannon et al. N Engl J Med 2017; Cannon et al. ESC 2017; BI, data on file
Summary of RE-DUAL PCI results

Time to first ISTH major or CRNM bleeding event

Time to first ISTH major bleeding event

Intracranial haemorrhage

Composite endpoint of thromboembolic events, death, or unplanned revascularization

P value

<0.001
0.002

<0.001
0.02

0.06
0.047

0.005*
0.30
0.44

Favours dabigatran dual therapy
Favours warfarin triple therapy

HR (95% CI)

Dual therapy with full-dose dabigatran (110 mg BID and even 150 mg BID) significantly reduced the risk of all classifications of major bleeding vs warfarin triple therapy.

Dabigatran dual therapy was as effective as warfarin triple therapy for the composite efficacy endpoint (thromboembolism, death, and unplanned revascularization).

Dabigatran dual therapy provides an alternative for managing post-PCI patients with both doses approved for stroke prevention in atrial fibrillation.
# How do RE-DUAL PCI and PIONEER AF-PCI compare?

<table>
<thead>
<tr>
<th></th>
<th>RE-DUAL PCI&lt;sup&gt;1&lt;/sup&gt;</th>
<th>PIONEER AF-PCI&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trial design</td>
<td>Multicentre, randomized, open-label trial</td>
<td>Multicentre, randomized, open-label trial</td>
</tr>
<tr>
<td>NOAC dose</td>
<td>Both doses of <strong>Dabigatran (110 &amp; 150 bid)</strong> approved for stroke prevention in AF (RELY)</td>
<td><strong>Rivaroxaban 2.5 mg BID</strong> has not been tested or approved for stroke prevention in AF</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Rivaroxaban 15/10 mg OD</strong> regimen has been tested in 639 Japanese patients for stroke prevention in AF (J-ROCKET, exploratory study); non-inferiority for efficacy vs warfarin not shown&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>DAPT duration</td>
<td>DAPT duration predefined in protocol</td>
<td>DAPT duration defined by investigator</td>
</tr>
<tr>
<td>Bleeding risk</td>
<td>Excluded if major bleeding episode or ICH in past month, or GI bleeding within 1 month, unless cause has been eliminated</td>
<td>Excluded if any history of ICH or if GI bleeding in past year</td>
</tr>
<tr>
<td>Stroke risk</td>
<td>Excluded if stroke in past month</td>
<td>Excluded if any prior stroke/TIA</td>
</tr>
<tr>
<td>Primary endpoint</td>
<td>ISTH major or CRNM bleeding event</td>
<td>Composite of major bleeding or minor bleeding according to TIMI criteria, or bleeding requiring medical attention</td>
</tr>
<tr>
<td>Adjudication</td>
<td>Primary safety endpoint fully adjudicated</td>
<td>Primary safety endpoint not fully adjudicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bleeding requiring medical attention: 15% of events were adjudicated, remainder classified by algorithm</td>
</tr>
</tbody>
</table>
Primary study hypothesis

- Apixaban is non-inferior to warfarin on (ISTH) major or clinically relevant non-major bleeding in patients with AF who develop ACS and/or undergo PCI with planned antiplatelet therapy.

ClinicalTrials.gov Identifier: NCT02415400
ENTRUST-AF-PCI: Edoxaban

PROBE design: prospective, randomized, open label, blinded evaluation of Edoxaban based regimen vs VKA based regimen in N=1500 AF patients

Inclusion Criteria:
- OAC indication for AF for at least 12 months
- Successful PCI with stent placement (goal of at least 25% ACS)

Randomize
- 4 hours
- 5 days after sheath removal

Edoxaban 60 mg/day*
- P2Y12 antagonist**
  (without ASA)

Vitamin K Antagonist***
- P2Y12 antagonist
  (ASA 1 - 12 months)****

Primary outcome:
- ISTH major and clinically relevant non-major bleeding

*Edoxaban dose reduction to 30 mg OD
**Clopidogrel 75mg once-daily or if documented need prasugrel 5 or 10mg once-daily or ticagrelor 90mg twice-daily
***VKA, target INR 2-3
****ASA 100mg OD for 1-12 months guided by clinical presentation (ACS or stable CAD), CHA2DS-VASc2, and HAS-BLED

ClinicalTrials.gov Identifier: NCT02866175
Recommendation

AF patient in need of OAC after an ACS

- Bleeding risk low compared to risk for ACS or stent thrombosis
  - Triple therapy (IIaB)
  - Dual therapy (IIaC)
  - OAC monotherapy (IB)

- Bleeding risk high compared to risk for ACS or stent thrombosis
  - Triple therapy (IIaB)
  - Dual therapy (IIaC)
  - OAC monotherapy (IB)

Time from ACS
- 0
- 1 month
- 3 months
- 6 months
- 12 months
- Lifelong

AF patient in need of OAC after elective PCI with stent

- Bleeding risk low compared to risk for ACS or stent thrombosis
  - Triple therapy (IIaB)
  - Dual therapy (IIaC)
  - OAC monotherapy (IB)

- Bleeding risk high compared to risk for ACS or stent thrombosis
  - Triple therapy (IIaB)
  - Dual therapy (IIaC)
  - OAC monotherapy (IB)

Time from PCI
- 0
- 1 month
- 3 months
- 6 months
- 12 months
- Lifelong

Flowchart indicating the recommended treatments based on bleeding risk and time from ACS or PCI.
Are we Ready to change strategy and use a non VKA based regimen in combination with antiplatelet for the treatment of PCI patients with AF indicated OAC?

- Dabigatran vs. Xarelto

- Awaiting further studies
Thank You
In RE-LY, the effects of dabigatran 110 mg BID vs warfarin were consistent regardless of whether patients were taking antiplatelets.

**Dabigatran 110 mg BID**

- **Stroke/embolism**
  - No antiplatelet: 0.87 (0.66–1.15), 0.93 (0.70–1.25)
  - Antiplatelet (ASA, clopidogrel, or both): 0.93 (0.75–1.16), 0.87 (0.69–1.10)
  - Interaction P value: 0.74

- **CV death**
  - No antiplatelet: 0.93 (0.75–1.16), 0.87 (0.69–1.10)
  - Antiplatelet (ASA, clopidogrel, or both): 0.79 (0.64–0.96), 0.82 (0.67–1.00)
  - Interaction P value: 0.67

- **Major bleed**
  - No antiplatelet: 0.79 (0.64–0.96), 0.82 (0.67–1.00)
  - Antiplatelet (ASA, clopidogrel, or both): 0.78 (0.72–0.85), 0.78 (0.71–0.85)
  - Interaction P value: 0.79

- **All bleeds**
  - No antiplatelet: 0.78 (0.72–0.85), 0.78 (0.71–0.85)
  - Antiplatelet (ASA, clopidogrel, or both): 0.82 (0.67–1.00)
  - Interaction P value: 0.85

- **Intracranial bleed**
  - No antiplatelet: 0.35 (0.20–0.61), 0.23 (0.12–0.47)
  - Antiplatelet (ASA, clopidogrel, or both): 0.92 (0.74–1.15), 0.95 (0.77–1.18)
  - Interaction P value: 0.37

- **Extracranial bleed**
  - No antiplatelet: 0.78 (0.64–0.96), 0.78 (0.67–0.96)
  - Antiplatelet (ASA, clopidogrel, or both): 0.78 (0.72–0.85), 0.78 (0.71–0.85)
  - Interaction P value: 0.84

ASA, acetylsalicylic acid; Dans et al. Circulation 2013
### Recommendations for combination therapy with oral anticoagulants and antiplatelets

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Classa</th>
<th>Levelb</th>
<th>Refc</th>
</tr>
</thead>
<tbody>
<tr>
<td>After elective coronary stenting for stable coronary artery disease in AF patients at risk of stroke, combination triple therapy with aspirin, clopidogrel and an oral anticoagulant should be considered for 1 month to prevent recurrent coronary and cerebral ischaemic events.</td>
<td>IIa</td>
<td>B</td>
<td>522, 524</td>
</tr>
<tr>
<td>After an ACS with stent implantation in AF patients at risk of stroke, combination triple therapy with aspirin, clopidogrel and an oral anticoagulant should be considered for 1–6 months to prevent recurrent coronary and cerebral ischaemic events.</td>
<td>IIa</td>
<td>C</td>
<td>520</td>
</tr>
<tr>
<td>After an ACS without stent implantation in AF patients at risk of stroke, dual treatment with an oral anticoagulant and aspirin or clopidogrel should be considered for up to 12 months to prevent recurrent coronary and cerebral ischaemic events.</td>
<td>IIa</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>The duration of combination antithrombotic therapy, especially triple therapy, should be kept to a limited period, balancing the estimated risk of recurrent coronary events and bleeding.</td>
<td>IIa</td>
<td>B</td>
<td>520</td>
</tr>
<tr>
<td>Dual therapy with any oral anticoagulant plus clopidogrel 75 mg/day may be considered as an alternative to initial triple therapy in selected patients.</td>
<td>IIb</td>
<td>C</td>
<td>524, 525</td>
</tr>
</tbody>
</table>