Quelle monotherapie antiplaquettaire chez le coronarien?

Hôpital Pitié-Salpêtrière AP-HP

CARDIO RUN 2025

ACTION Group

Paris, France

www.action-groupe.org

Oral antiplatelets

It is **DOUBLE**, **ALWAYS** and,

it is **MANDATORY !**

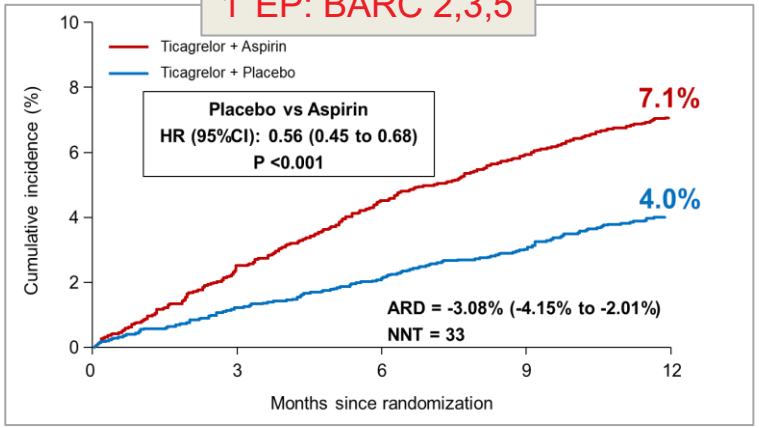
… but for how long?

Short DAPT in HBR

TWILIGHT

(**3m^{ths}** post-PCI)

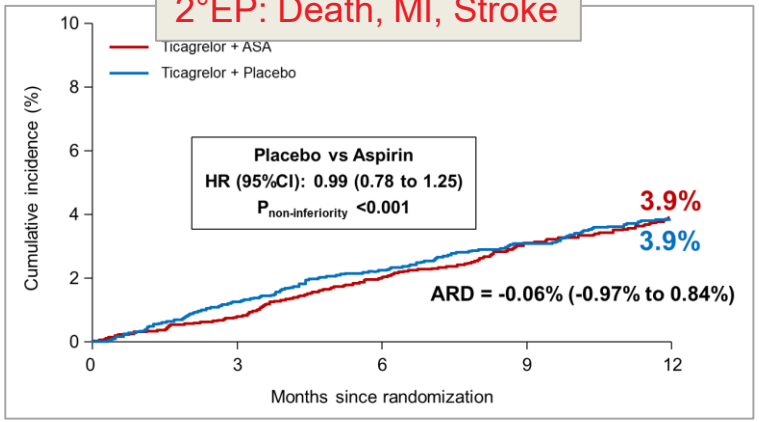
1°EP: BARC 2,3,5



N=7119
HBR/HBI
DB

Mehran R. NEJM 2019

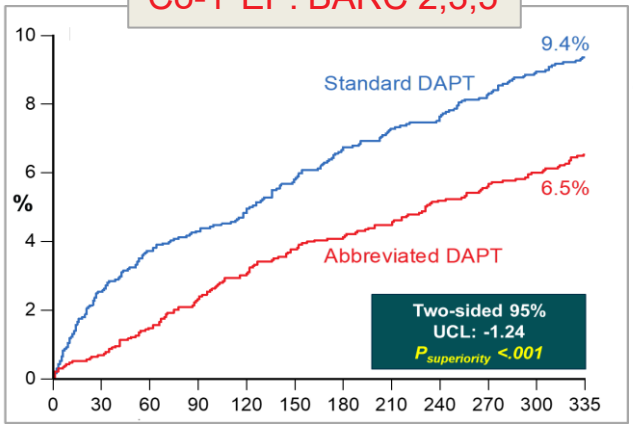
2°EP: Death, MI, Stroke



MASTER-DAPT

(**1mth** post-PCI)

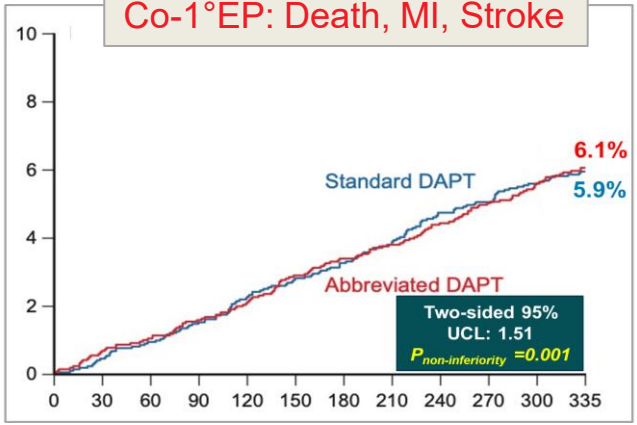
Co-1°EP: BARC 2,3,5



N=4579
HBR
OL

Valgimigli M. NEJM 2021

Co-1°EP: Death, MI, Stroke



Short DAPT in ACS

DAPT to SAPT after PCI+ACS

SAPT ASA: GUIDELINES

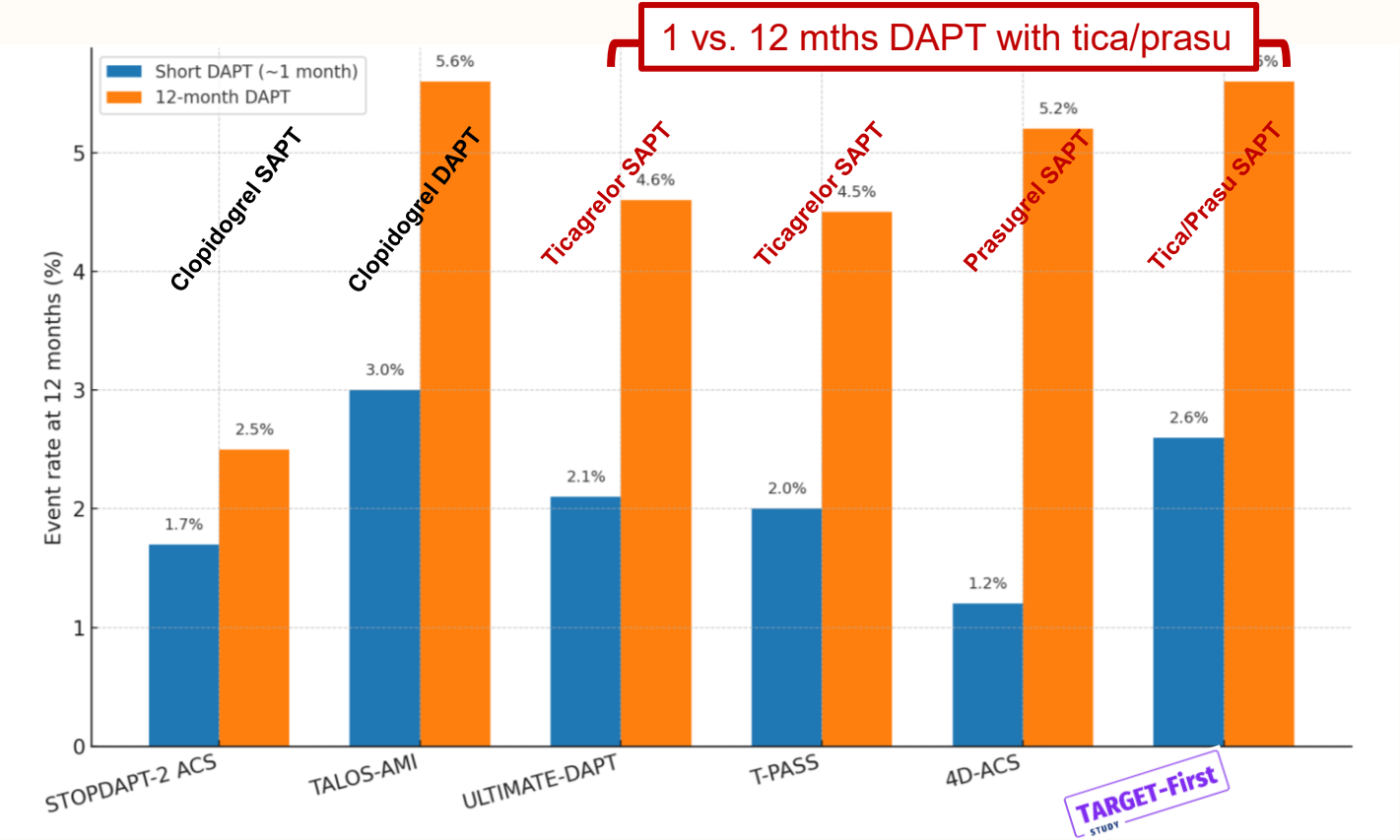
SAPT TICAGRELOR: TICO

TWILIGHT
(HBR/HIR)

SAPT TICAGRELOR: T-PASS // ULTIMATE
SAPT PRASUGREL: 4D
SAPT TICA/PRASU: **TARGET-FIRST**

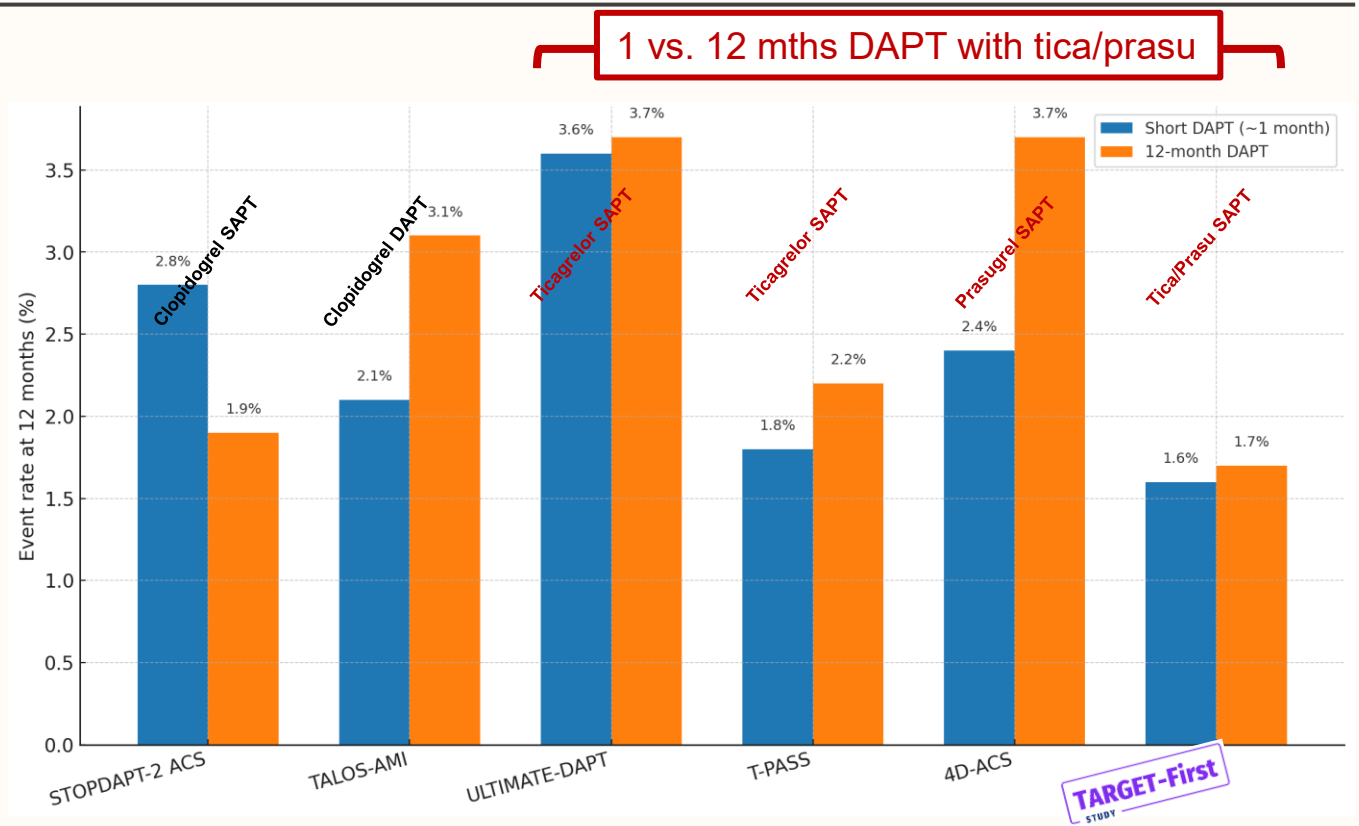
MASTER-DAPT
(HBR)
TALOS-AMI
(↘ DAPT with ASA+clopi)
HOST-REDUCE
(↘ DAPT with SAPT prasu^{5mg})
ONE-MONTH DAPT
(↘ DAPT with SAPT ASA in elective PCI)

BARC 2,3,5 at 12 months after PCI for ACS/MI and de-escalation at 1 month



TALOS-AMI, ULTIMATE and TARGET-first randomized 1 month after PCI

MACE at 12 months after PCI for ACS/MI and de-escalation at 1 month

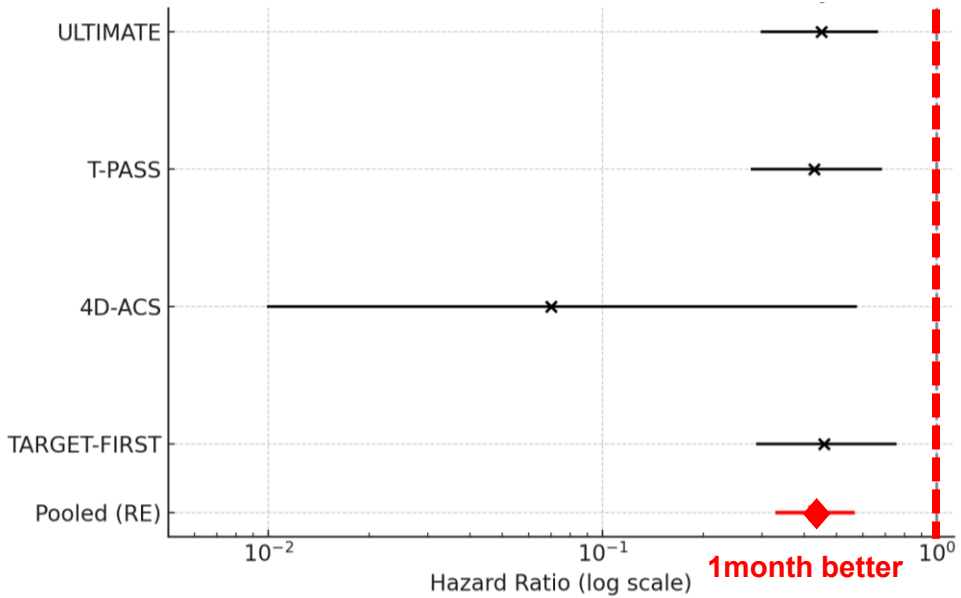


TALOS-AMI, ULTIMATE and TARGET-first randomized 1 month after PCI

Meta-analysis of the 4 studies in PCI of ACS/MI

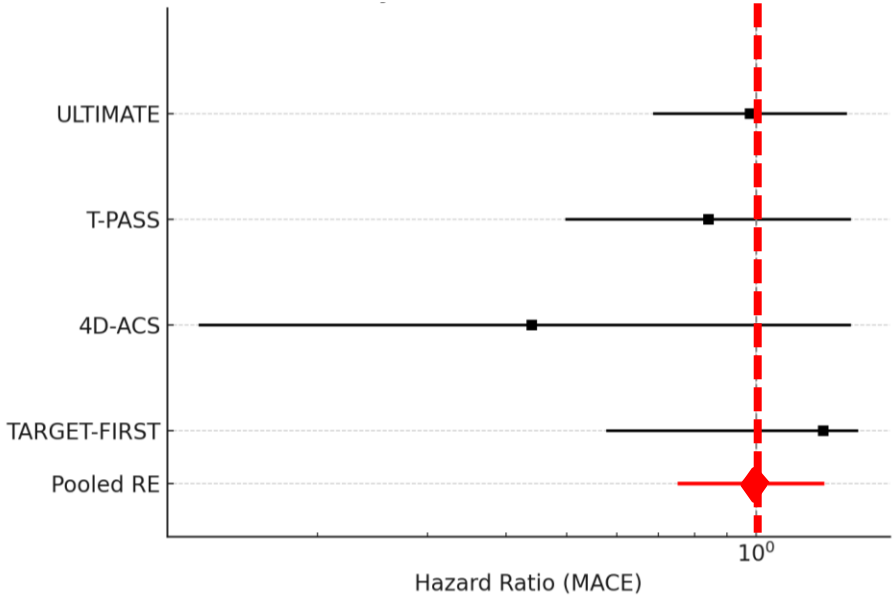
N=8848

BARC 2-5



Pooled (Random-effects): HR 0.43 (95% CI 0.33–0.56)
Heterogeneity: I^2 = 6.9%

MACE



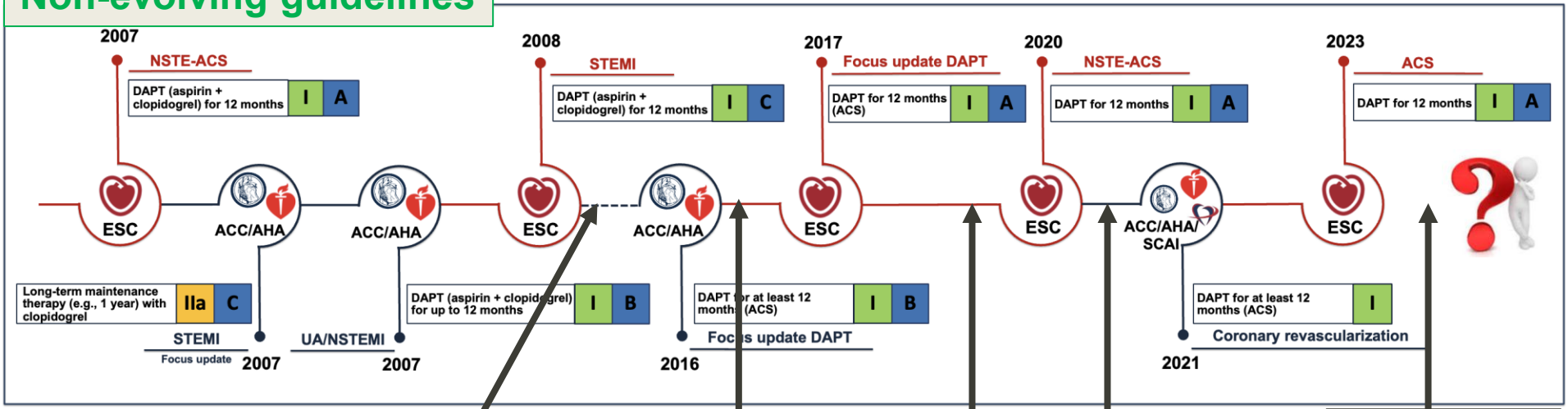
Pooled (Random-effects): HR=0.98 (95% CI 0.76–1.28)
Heterogeneity: I^2 = 11%

Metaanalysis of PCI trials in MI/ACS for 1-month versus 12-month DAPT. Gilles Montalescot – ESC 2025, Madrid.

Events from 1 to 12 months (except for T-PASS from PCI to 12 months)

Guidelines vs. Evidence

Non-evolving guidelines



Evolving evidence

2012: ACS
EXCELLENT
RESET
3-6 mth DAPT
(Rx DAPT)

2015: HBR
LEADERS-FREE
ZEUS
SENIOR
1-mth DAPT
(Rx stents)

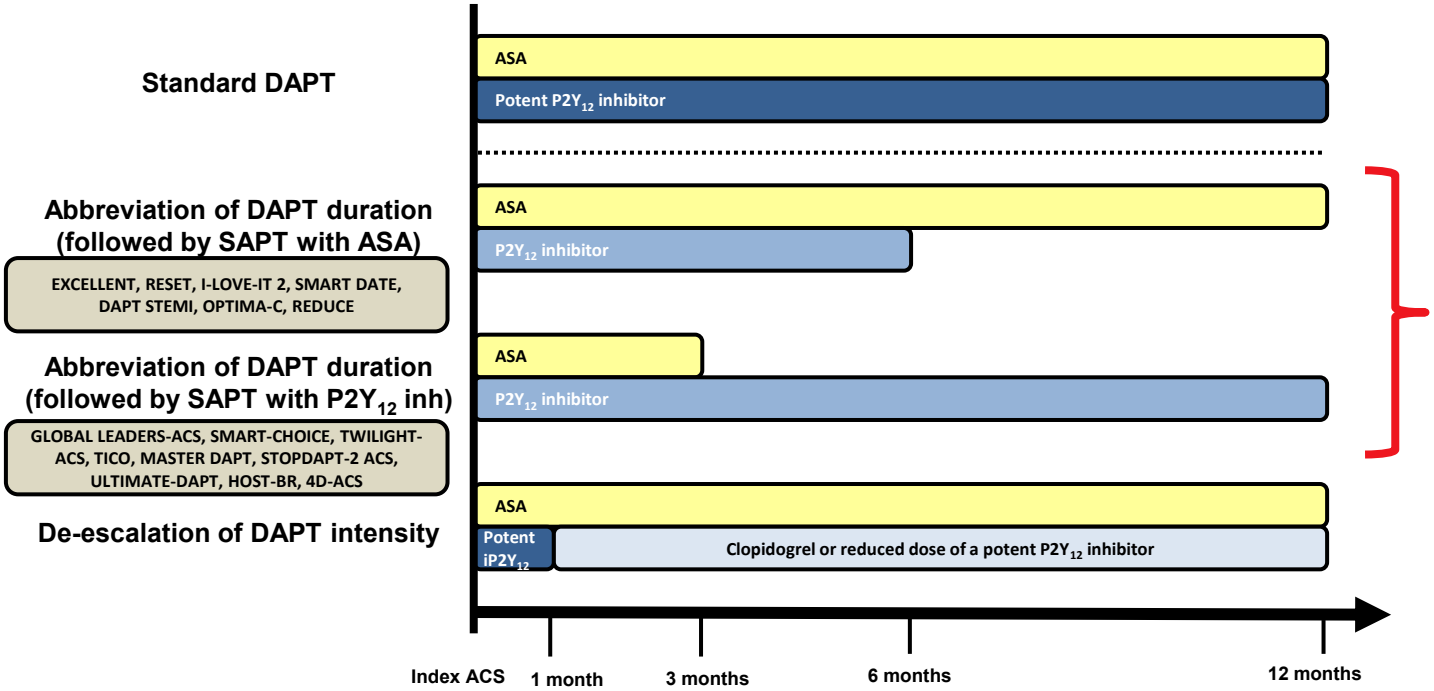
2019: HBR/HIR/ACS
STOP-DAPT
SMART-CHOICE
TWILIGHT
TICO
1-3 mth DAPT
(Rx DAPT)

2021: HBR
MASTER-DAPT
1 mth DAPT
(Rx DAPT)

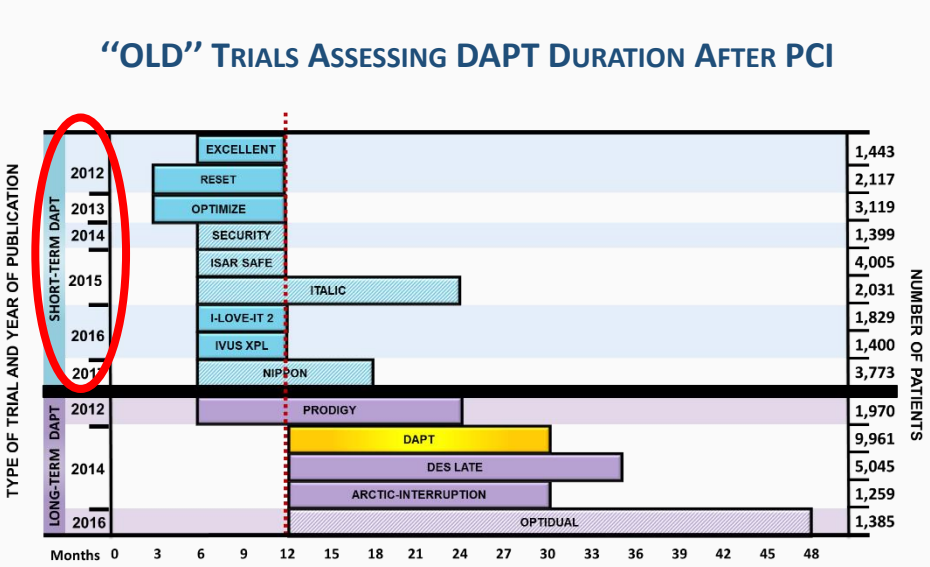
2024:ACS/MI
T-PASS
ULTIMATE
4D-ACS
TARGET-FIRST
1 mth DAPT
(Rx DAPT)

What SAPT (after DAPT)?

DAPT abreviation

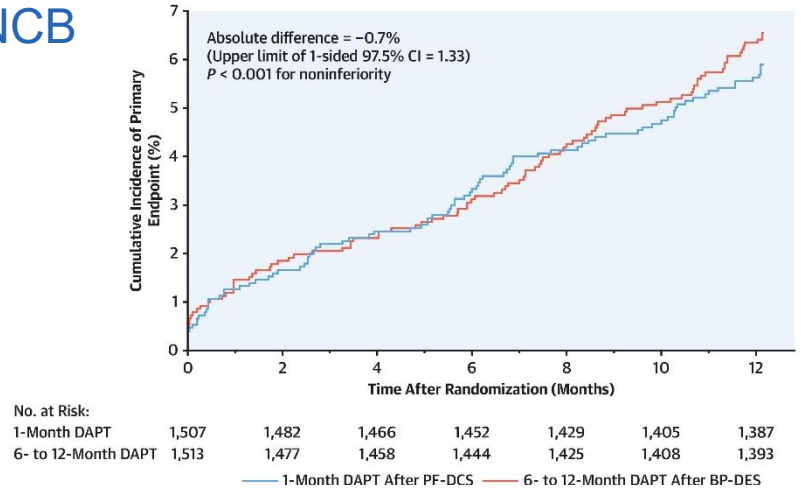


DAPT abbreviation followed by ASA monotherapy



Lugo LM and Ferreiro JL. J Cardiol. 2018;72:94-104

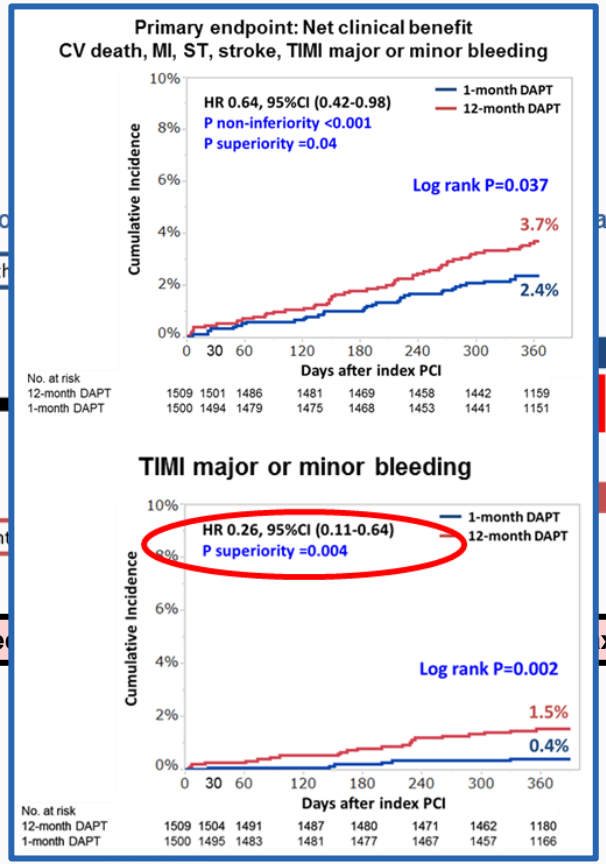
NCB

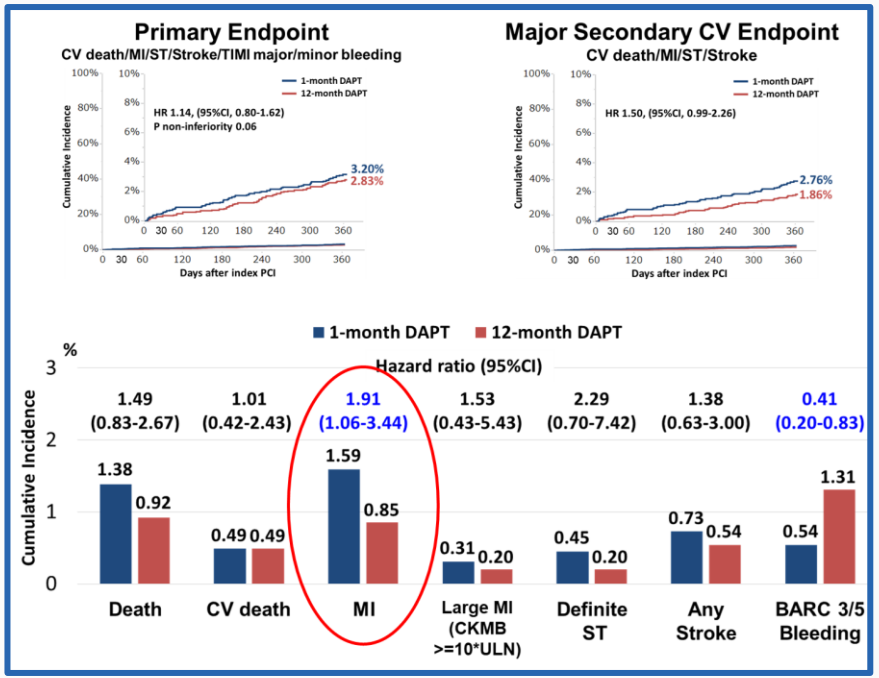


Major bleeding was not different (1.7% vs 2.5%; *P* = 0.136)
Stent thrombosis was not different (0.7% vs 0.8%; *P* = 0.842).

Hong, S.-J. et al. J Am Coll Cardiol Intv. 2021;14(16):1801-1811.

DAPT abbreviation followed by clopidogrel monotherapy



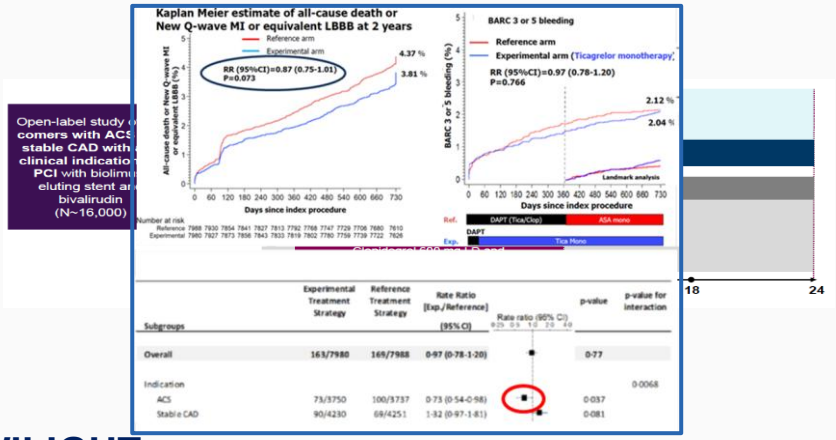


Watanabe H et al. JAMA. 2019;321:2414-27

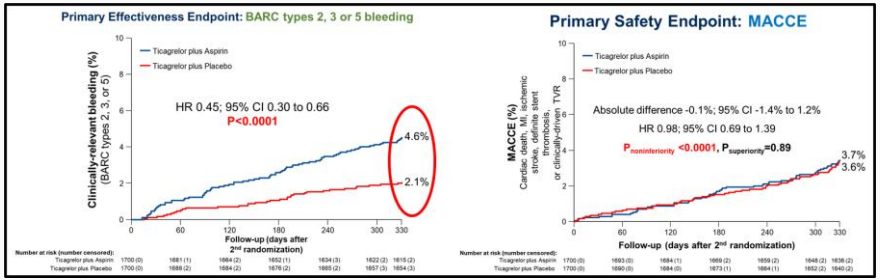
Watanabe H et al. JAMA Cardiol. 2022;7:407-17

DAPT abbreviation followed by ticagrelor monotherapy

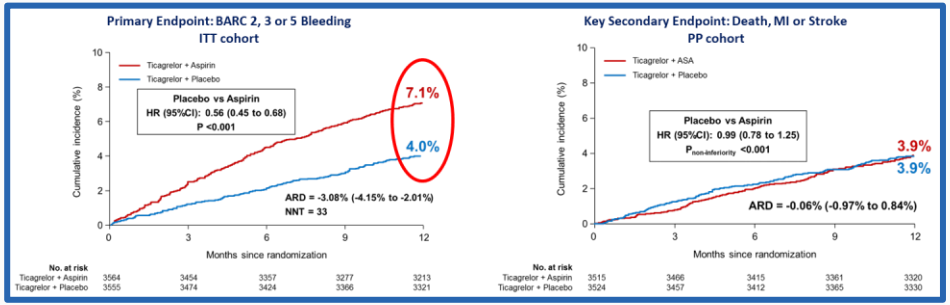
GLOBAL LEADERS



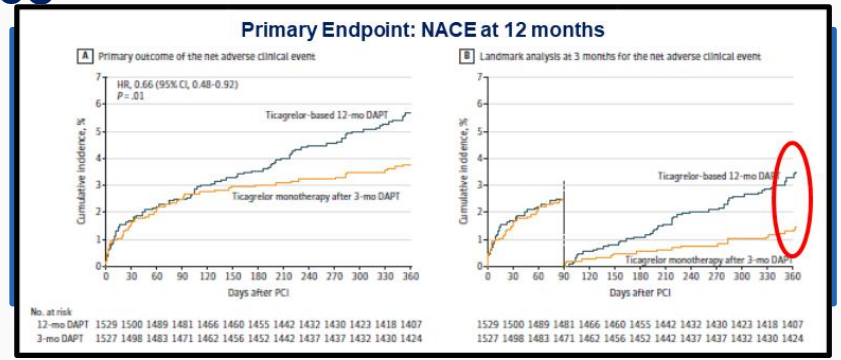
ULTIMATE-DAPT



TWILIGHT

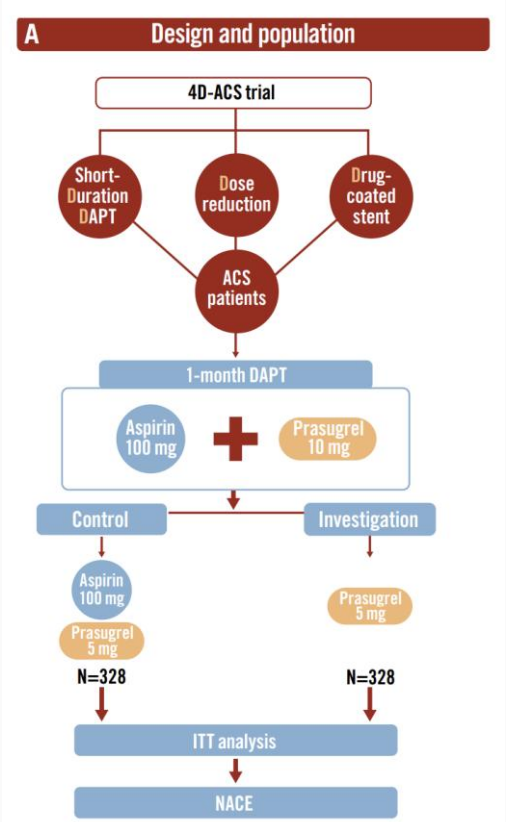


TICO

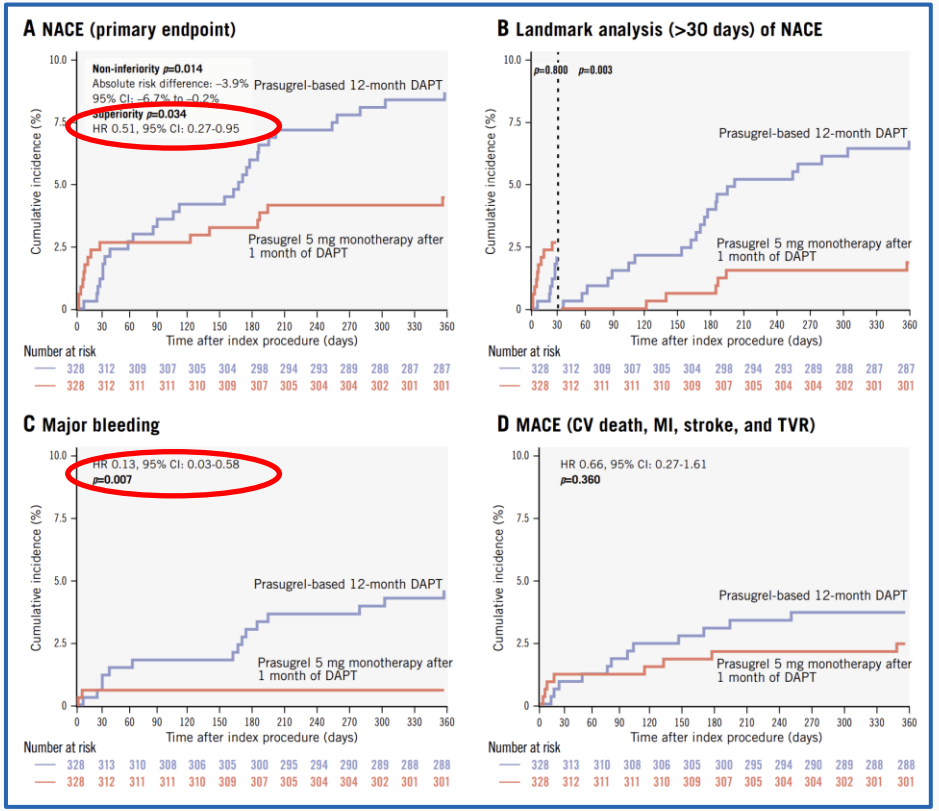


Vranckx P et al. Lancet. 2018;392:940-9
Mehran R et al. N Engl J Med. 2019;381:2032-42
Ge Z et al. Lancet. 2024;403:1866-78
Kim BK et al. JAMA. 2020;323:2407-16.

DAPT abbreviation followed by prasugrel monotherapy



"Dual de-escalation" strategy?



Jang Y et al. EuroIntervention. 2025;21:e1-e14

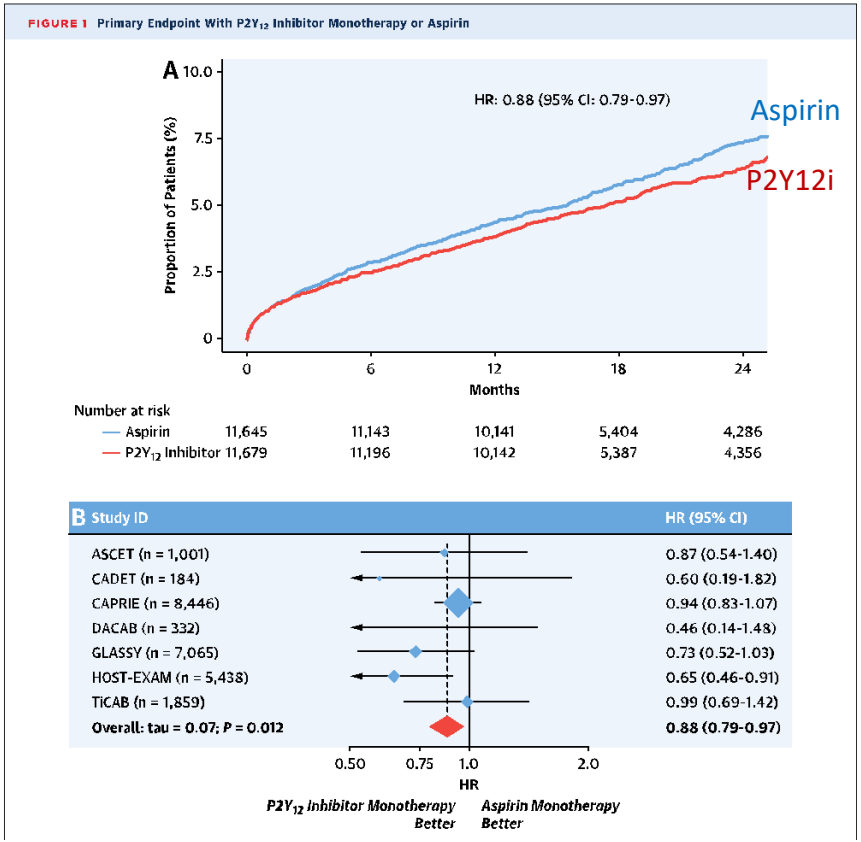
SAPT if prior ACS or PCI

Antiplatelet therapy long after PCI

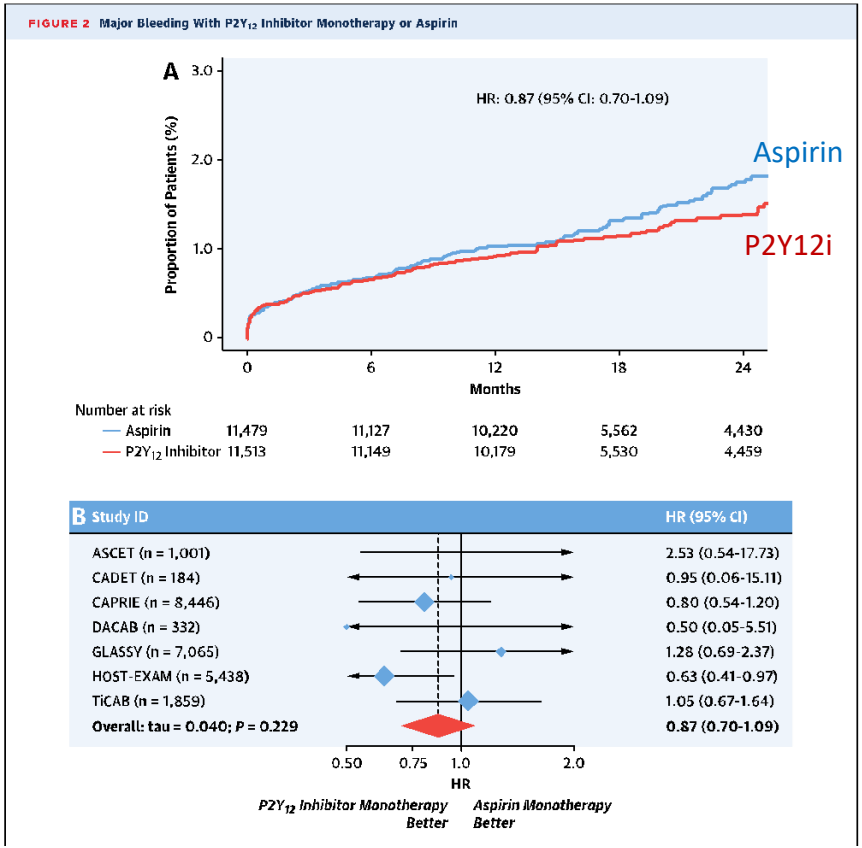
Long-term antithrombotic therapy in patients with chronic coronary syndrome and no clear indication for oral anticoagulation		
In CCS patients with a prior MI or remote PCI, aspirin 75–100 mg daily is recommended lifelong after an initial period of DAPT.[558,559]	I	A
In CCS patients with a prior MI or remote PCI, clopidogrel 75 mg daily is recommended as a safe and effective alternative to aspirin monotherapy.[562,564–566,649]	I	A

Head-to-head comparisons

CV death, myocardial infarction, and stroke



Major bleeding



Gragnano et al. P2Y12 Inhibitors vs Aspirin for CAD. JACC 2023

SAPT without prior ACS or PCI

Antiplatelet therapy for CAD without MI or revascularisation

Long-term antithrombotic therapy in patients with chronic coronary syndrome and no clear indication for oral anticoagulation		
In patients *without* prior MI or revascularization but with evidence of significant obstructive CAD, aspirin 75–100 mg daily is recommended lifelong.[557–559]	I	B

Antiplatelet therapy for CAD without MI or revascularisation

Aspirin in the primary and secondary prevention of vascular disease: collaborative meta-analysis of individual participant data from randomised trials

*Antithrombotic Trialists' (ATT) Collaboration**

Meta-analyses of MACE (MI, stroke, or CV death) and **major bleeds**

6 primary prevention trials (95000 individuals at low average risk, 660000 person-years, 3554 serious vascular events)

16 secondary prevention trials (17000 individuals at high ave rage risk, 43000 person-years, 3306 serious vascular events)

that compared **long-term aspirin versus control**.

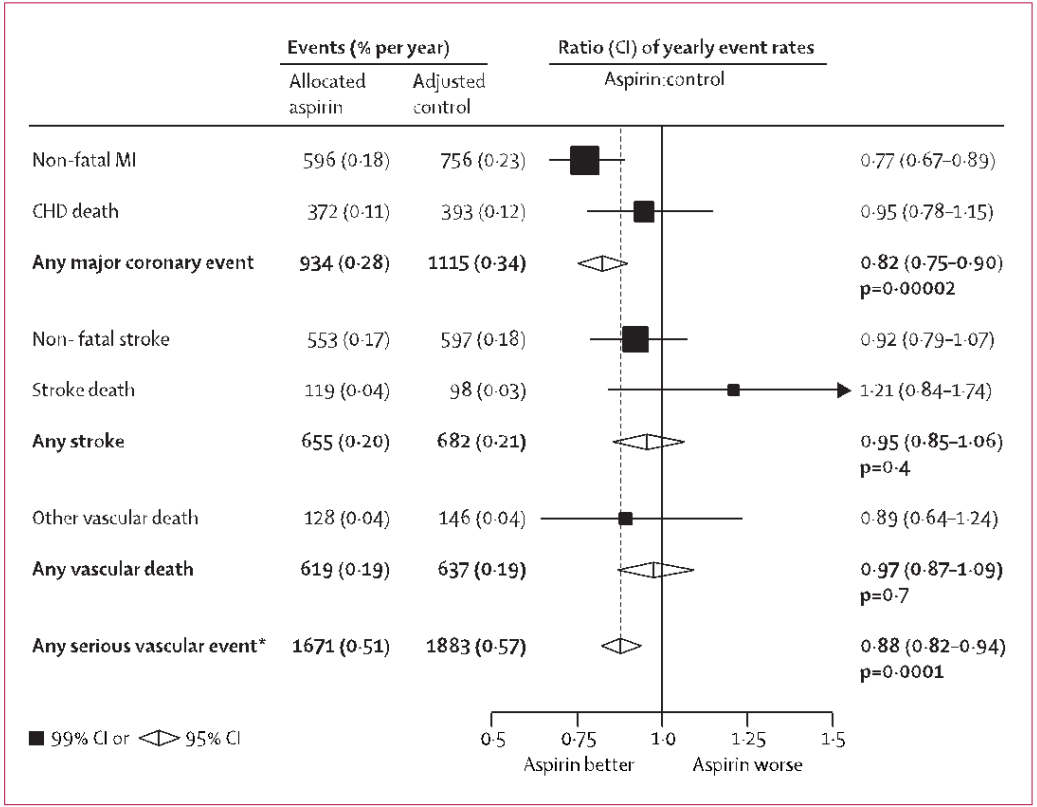
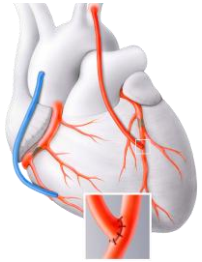


Figure 1: Serious vascular events in primary prevention trials—proportional effects of aspirin allocation

Lancet 2009

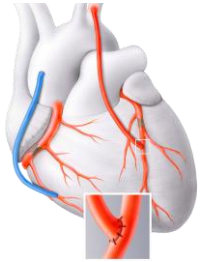
Antiplatelet therapy after CABG



Antithrombotic therapy post-coronary artery bypass grafting		
It is recommended to initiate aspirin post-operatively as soon as there is no concern over bleeding.[629,630]	I	B
DAPT may be considered after CABG in selected patients at greater risk of graft occlusion[f] and at low risk of bleeding.[635]	IIb	B

Long-term antithrombotic therapy in patients with chronic coronary syndrome and no clear indication for oral anticoagulation		
After CABG, aspirin 75–100 mg daily is recommended lifelong.[558,559,629]	I	A

Antiplatelet therapy after CABG



ESC European Society of Cardiology
European Heart Journal (2020) 41, 1653–1661
doi:10.1093/eurheartj/ehz714

CLINICAL RESEARCH
Coronary artery disease

Secondary prevention medications after coronary artery bypass grafting and long-term survival: a population-based longitudinal study from the SWEDEHEART registry

All patients who underwent isolated CABG in Sweden from 2006 to 2015 and survived at least 6 months after discharge (n=28 812)

Table 2 Crude mortality rates with 95% confidence interval based on time-updated exposure and adjusted effects of time-updated use of secondary prevention therapy on mortality evaluated by Cox regression

	Crude mortality rate without treatment	Crude mortality rate with treatment	Model 1	Model 2	Model 3
Platelet inhibitors	5.57 (5.21–5.94)	2.33 (2.25–2.42)	0.55 (0.51–0.60)	0.67 (0.62–0.72)	0.74 (0.69–0.81)
			<0.001	<0.001	<0.001

Platelet inhibitors were associated with lower mortality risk after adjustment

Björklund et al. EHJ 2020

After PCI in ACS patients:

- 1 month DAPT is mandatory (*STOPDAPT-3 trial*)
- Duration of DAPT has decreased progressively from 12 → 6 → 3 → 1 month to reduce bleeding
- ASA-free strategies are possible after 1 month
- Any P2Y12 inhibitor can be chosen and the dose can be discussed according to the patient situation
- There is also (but less) evidence for ASA-SAPT strategies after 1 month of DAPT (*One-Month DAPT trial*)

For long-term secondary prévention

- SAPT is the rule
- Clopidogrel > Aspirin if prior ACS or PCI
- However, management of daily life is more complex with clopidogrel (biopsies, operations, endoscopies, etc...)