GRACIAS
STENTS CON DROGAS

DOBLE ANTIAGREGACION PLAQUETARIA

¿DURANTE CUANTO TIEMPO Y CON QUE DROGAS?
¿DE DONDE VENIMOS?
Cumulative Hazard Rates for the First Primary Outcome (Death from Cardiovascular Causes, Nonfatal Myocardial Infarction, or Stroke) during the 12 Months of the Study.

END POINT  DEATH INFARCT STROKE  1 MONTH  11.4%  12 MONTHS  9.3%  p < 0.001
Effects of pretreatment with clopidogrel and aspirin followed by long-term therapy in patients undergoing percutaneous coronary intervention: the PCI-CURE study

END POINT DEATH CV INFARCTION 1 MONTH 12.6% 12 MONTH 8.8% p < 0.001
¿DONDE ESTAMOS?
Are at Least 12 Months of Dual Antiplatelet Therapy Needed for All Patients With Drug-Eluting Stents?
Six-Month Versus 12-Month Dual Antiplatelet Therapy After Implantation of Drug-Eluting Stents: The Efficacy of Xience/Promus Versus Cypher to Reduce Late Loss After Stenting (EXCELLENT) Randomized, Multicenter Study

Kaplan-Meier curves for the primary end point of target vessel failure.

A. A composite of cardiac death, myocardial infarction, or target vessel revascularization by intention-to-treat analysis.

B. Six-month landmark analysis among patients who were event-free at 6 months. DAPT indicates dual antiplatelet therapy.
From: Three vs Twelve Months of Dual Antiplatelet Therapy After Zotarolimus-Eluting Stents: The OPTIMIZE Randomized Trial


Time to Event for the Primary Composite End Point (NACCE) Among Patients Receiving Short- and Long-term Dual Antiplatelet Therapy—0-360 Days, 0-90 Days, and 91-360 Days

Numbers of events listed under the x-axes are not cumulative but rather incremental numbers of events; numbers of events listed under the x-axes on day 0 represent periprocedural events. HR indicates hazard ratio; NACCE, net adverse clinical and cerebral events (a composite of all-cause death, myocardial infarction, stroke, or major bleeding).
Cumulative incidence of the primary end point and selected secondary end points, according to treatment group. Cumulative incidence curves are shown for the primary end point of death of any cause, myocardial infarction, or cerebrovascular accident (A), death of any cause (B), myocardial infarction (C), any cerebrovascular accident (D), definite or probable stent thrombosis (E), and cumulative type 5, 3, or 2 bleeding events according to the Bleeding Academic Research Consortium classification (F). Probability values were calculated with log-rank test.
Twelve or 30 Months of Dual Antiplatelet Therapy after Drug-Eluting Stents


**Figure 3. Cumulative Incidence of Major Adverse Cardiovascular and Cerebrovascular Events, According to Study Group.** Cumulative incidence curves are shown for the primary effectiveness outcome of major adverse cardiovascular and cerebrovascular events (a composite of death, myocardial infarction, or stroke) in the intention-to-treat population. P values were calculated with the use of the stratified log-rank test. The number at risk was defined as the number of subjects who had not had the event of interest and who were available for subsequent follow-up. The numbers at risk at the start of final 33-month visit (i.e., 20 months after randomization) were 4336 in the group that had been assigned to continued thienopyridine therapy and 4217 in the group that had been assigned to placebo. The inset shows the same data on an enlarged y axis.
Figure 2. Cumulative Incidence of Stent Thrombosis, According to Study Group. Cumulative incidence curves are shown for the primary efficacy end point of probable or definite stent thrombosis, as assessed according to the criteria of the Academic Research Consortium, in the intention-to-treat population. Randomization occurred at 12 months after stenting. The primary-analysis period was the period from month 12 to month 30 after percutaneous coronary intervention (i.e., the 18 months after randomization, during which subjects received the randomized study drug). Patients were followed for an observational period of an additional 3 months after discontinuation of the study drug (i.e., to 33 months after enrollment and 21 months after randomization). P values were calculated with the use of a stratified log-rank test. The number at risk was defined as the number of patients who had not had the event of interest and who were available for subsequent follow-up. The final 33-month assessment visit took place between 20 and 21 months after randomization. The figure shows the numbers at risk at the end of that period (i.e., 21 months after randomization). The numbers at risk at the start of that period (i.e., 20 months after randomization) were 4438 in the group that had been assigned to continued thienopyridine therapy versus 4362 in the group that had been assigned to placebo. The inset shows the same data on an enlarged y axis.
Stent thrombosis (ST) and related myocardial infarction (MI).

¿QUE NOS PREOCUPA?
STENT THROMBOSIS
Overview of principal characteristics of selected current generation durable polymer and biodegradable polymer drug-eluting stents and fully bioresorbable drug-eluting stents with published large-scale randomized controlled trial data. BES, biolimus-eluting stent; CoCr, cobalt chromium; CoNi, cobalt Nickel; EES, everolimus-eluting stent; PtCr, platinum chromium; SES, sirolimus-eluting stent; ZES, zotarolimus-eluting stent.

Robert A. Byrne et al. Eur Heart J 2015;eurheartj.ehv511
© The Author 2015. Published by Oxford University Press on behalf of the European Society of Cardiology.
Incidence of definite or probable stent thrombosis according to Kaplan–Meier estimates over 4 years of follow-up.


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From: 2-Year Follow-Up of a Randomized Controlled Trial of Everolimus- and Paclitaxel-Eluting Stents for Coronary Revascularization in Daily Practice: COMPARE (Comparison of the everolimus eluting XIENCE-V stent with the paclitaxel eluting TAXUS LIBERTÉ stent in all-comers: a randomized open label trial)


ST THROMBOSIS
EVEROLIMUS 0.9%
PACLITAXEL 3.9%

Figure Legend:
Kaplan-Meier Cumulative Event Curves for ST at 2-Year Follow-Up
Kaplan-Meier cumulative event curves for definite and probable stent thrombosis (ST) at 2-year follow-up as defined by the Academic Research Consortium. The absolute difference in rates of definite and probable ST between stent groups was 1.9% at 1 year, which significantly increased to 3.9% at 2 years. Red line indicates PES; blue line indicates EES. Abbreviations as in Figure 2.
Stent thrombosis and restenosis: what have we learned and where are we going?
The Andreas Grüntzig Lecture ESC 2014

Stent thrombosis: central illustration of histopathology, risk factors, incidence, and intravascular imaging features

Robert A. Byrne et al. Eur Heart J 2015;eurheartj.ehv511

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Are at Least 12 Months of Dual Antiplatelet Therapy Needed for All Patients With Drug-Eluting Stents?

All Patients With Drug-Eluting Stents Need at Least 12 Months of Dual Antiplatelet Therapy

Sorin J. Brener, MD

Circulation. 2015;131:2001-2009
¿ HACIA DONDE VAMOS ?

NUEVAS DROGAS
Landmark Analyses of Safety and Net Clinical Benefit
Landmark analyses (survival method) of the Kaplan-Meier estimates of Thrombolysis In Myocardial Infarction major noncoronary artery bypass grafting bleeding and net clinical benefit during the first 3 days after randomization (left side of each panel) and from 3 days to the end of the study (right side of each panel) are shown for the prasugrel and clopidogrel groups. There was no significant increase in major bleeding with prasugrel during the first 3 days, but there was a significant increase from 3 days to the end of the study. Net clinical benefit favored prasugrel during both the early and late phases of the study. HR = hazard ratio.
Ticagrelor versus Clopidogrel in Patients with Acute Coronary Syndromes

End Point  Clopidogrel 11.7%  Ticagrelor 9.5%

Cumulative Kaplan–Meier Estimates of the Time to the First Adjudicated Occurrence of the Primary Efficacy End Point.

Ticagrelor versus Clopidogrel in Patients with Acute Coronary Syndromes

Bleeding  Clopidogrel 11.2%  Ticagrelor 11.2%

Cumulative Kaplan–Meier Estimates of the Time to the First Major Bleeding End Point, According to the Study Criteria.

Meta-Analysis of Comparison of the Newer Oral P2Y$_{12}$ Inhibitors (Prasugrel or Ticagrelor) to Clopidogrel in Patients With Non—ST-Elevation Acute Coronary Syndrome

Chirag Bavishi, MD, MPH$^a$, Sadik Panwar, MD$^b$, Franz H. Messerli, MD$^{b,c}$, and Sripal Bangalore, MD, MHA$^{d,*}$

<table>
<thead>
<tr>
<th>Clinical Outcomes</th>
<th>P2Y$_{12}$ Inhibitor</th>
<th>Clopidogrel</th>
<th>RR (95% CI)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MACE*</td>
<td>1,648/15,951 (10.3%)</td>
<td>1,860/15,519 (12.0%)</td>
<td>0.87 (0.80 - 0.95)</td>
<td>0.002</td>
</tr>
<tr>
<td>All-cause mortality</td>
<td>622/10,907 (5.7%)</td>
<td>703/10,489 (6.7%)</td>
<td>0.87 (0.71 - 1.07)</td>
<td>0.19</td>
</tr>
<tr>
<td>Cardiovascular death</td>
<td>604/15,951 (3.8%)</td>
<td>673/15,519 (4.3%)</td>
<td>0.89 (0.78-1.01)</td>
<td>0.07</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>1,092/15,951 (6.8%)</td>
<td>1,259/15,519 (8.1%)</td>
<td>0.85 (0.75-0.96)</td>
<td>0.01</td>
</tr>
<tr>
<td>Stroke</td>
<td>182/15,951 (1.1%)</td>
<td>187/15,519 (1.2%)</td>
<td>0.96 (0.78-1.18)</td>
<td>0.71</td>
</tr>
<tr>
<td>TIMI major bleeding†</td>
<td>349/15,868 (2.2%)</td>
<td>250/15,423 (1.6%)</td>
<td>1.27 (1.07-1.50)</td>
<td>0.007</td>
</tr>
<tr>
<td>TIMI major and minor bleeding</td>
<td>1,039/15,868 (6.5%)</td>
<td>863/15,423 (5.6%)</td>
<td>1.20 (1.02-1.42)</td>
<td>0.03</td>
</tr>
</tbody>
</table>

* MACE included CV death/MI/Stroke.
† TIMI major bleeding included non-CABG TIMI major bleeding except in DISPERSE trial which included any major bleeding.

MACE NEWER 10.3% CLOPIDOGREL 12%
INFACTION NEWER 6.8% CLOPIDOGREL 8.1%
TIMI MAYOR NON RELATED CABG BLEEDING NEWER 2.6% CLOPIDOGREL 1.6%

AM J CARDIOL 2015 116: 809 - 817
Meta-Analysis of Comparison of the Newer Oral P2Y<sub>12</sub> Inhibitors (Prasugrel or Ticagrelor) to Clopidogrel in Patients With Non–ST-Elevation Acute Coronary Syndrome

Chirag Bavishi, MD, MPH<sup>a</sup>, Sadik Panwar, MD<sup>b</sup>, Franz H. Messerli, MD<sup>b,c</sup>, and Sripal Bangalore, MD, MHA<sup>d,*</sup>

Figure 5. Univariate meta-regression exploring the role of PCI use on (A) MACE and (B) myocardial infarction. The size of the data marker represents the weight of each trial. The regression fit (solid line) is shown.
CONCLUSIONES

DURACION DEL TRATAMIENTO

A) En pacientes con cuadros estables en los que se implantan un stent metalico no liberador: 30 dias (preferencialmente 3 a 6 meses)

B) En pacientes con sindrome coronario agudo o con implante de DES de primera generacion: 12 meses

C) En pacientes con cuadros estables y DES de nuevas generaciones: 3 a 6 meses
CONCLUSIONES
CONSENSO CACI

DROGAS

A) En cuadros coronarios estables o SCA de bajo riesgo: Clopidogrel 600mg 75mg/dia

B) En SCA de alto riesgo o con supra ST
   Clopidogrel 1c
   Prasugrel lb 60mg 10mg/dia
   Ticagrelor lb 180mg 90mg c/12hs
GRACIAS
Biodegradable polymer drug-eluting stents reduce the risk of stent thrombosis at 4 years in patients undergoing percutaneous coronary intervention: a pooled analysis of individual patient data from the ISAR-TEST 3, ISAR-TEST 4, and LEADERS randomized trials.

Efficacy endpoint: target lesion revascularization. (A) Kaplan–Meier curves for the pooled population in each of the stent groups. (B) Forest plot with hazard ratios with biodegradable polymer stents vs. permanent polymer stents for individual trials and the pooled population. Hazard ratios are shown on a logarithmic scale. The size of the square is proportional to the weight of the individual studies, measured as the inverse of the estimated variance of the log hazard ratio. BP, biodegradable polymer drug-eluting stent; DP, durable polymer sirolimus-eluting stent. (C) Kaplan–Meier curves for the pooled population in each of the stent groups with the landmark analysis at 1 year.

Giulio G. Stefanini et al. Eur Heart J 2012;33:1214-1222
Endeavour zotarolimus-eluting stent reduces stent thrombosis and improves clinical outcomes compared with cypher sirolimus-eluting stent: 4-year results of the PROTECT randomized trial.

Incidence of definite or probable stent thrombosis according to Kaplan–Meier estimates over 4 years of follow-up.


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Table 2 Cardiac and bleeding event rates in randomized trials of dual antiplatelet therapy after drug-eluting stents implantation

<table>
<thead>
<tr>
<th>Trial</th>
<th>No. of DAPT duration patients</th>
<th>Ischaemic endpoint</th>
<th>Stent type</th>
<th>Ischaemic event (%)</th>
<th>Bleeding event (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long DAPT</td>
<td>Short DAPT</td>
<td>Long DAPT</td>
<td>Short DAPT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXCELLENT</td>
<td>1443</td>
<td>6 VS 12</td>
<td>Death, MI, TVR</td>
<td>Everolimus, Sirolimus</td>
<td>1.9</td>
</tr>
<tr>
<td>OPTIMIZE</td>
<td>3119</td>
<td>3 VS 12</td>
<td>Death, MI, stroke</td>
<td>Zotarolimus</td>
<td>5.1</td>
</tr>
<tr>
<td>PRODIGY</td>
<td>1970</td>
<td>6 VS 24</td>
<td>Death, MI, stroke</td>
<td>BMS, Zotarolimus, Paclitaxel, Everolimus</td>
<td>10.0</td>
</tr>
<tr>
<td>RESET</td>
<td>2117</td>
<td>3 VS 12</td>
<td>Death, MI, ST</td>
<td>Zotarolimus, Others</td>
<td>1.3</td>
</tr>
<tr>
<td>ITALIC</td>
<td>2031</td>
<td>6 VS 24</td>
<td>Death, MI, urgent TVR stroke, major bleeding</td>
<td>Everolimus</td>
<td>1.0</td>
</tr>
<tr>
<td>ISAR-SAFE</td>
<td>6000</td>
<td>6 VS 12</td>
<td>Death, MI, ST, stroke</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
Dual antiplatelet therapy: optimal timing, management, and duration

Pierre Sabouret, Sophie K. Rushton-Smith, Mathieu Kernéis, Johanne Silvain, Jean-Philippe Collet, Gilles Montalescot

Table 2 Cardiac and bleeding event rates in randomized trials of dual antiplatelet therapy after drug-eluting stents implantation

<table>
<thead>
<tr>
<th>Long-term Dapt Trial</th>
<th>No. Of patients</th>
<th>DAPT duration (months)</th>
<th>Ischaemic endpoint</th>
<th>Stent type</th>
<th>Ischaemic event (%)</th>
<th>Bleeding event (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Long DAPT</td>
<td>Short DAPT</td>
</tr>
<tr>
<td>DAPT 20</td>
<td>9961</td>
<td>12 vs. 30</td>
<td>Death, MI, stroke</td>
<td>Sirolimus, Paclitaxel, Zotarolimus, Everolimus</td>
<td>4.3</td>
<td>5.9 (P&lt;0.001)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.5</td>
<td>1.6 (P=0.001)</td>
</tr>
<tr>
<td>DES-LATE 19</td>
<td>5045</td>
<td>12–18 vs 36-42.</td>
<td>Cardiac death MI, stroke</td>
<td>Sirolimus, Zotarolimus Paclitaxel, Everolimus, Others</td>
<td>2.6</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.4</td>
<td>1.1</td>
</tr>
</tbody>
</table>

DOI: http://dx.doi.org/10.1093/ehjcvp/pvv015 198-204 First published online: 23 March 2015
Biodegradable polymer drug-eluting stents reduce the risk of stent thrombosis at 4 years in patients undergoing percutaneous coronary intervention: a pooled analysis of individual patient data from the ISAR-TEST 3, ISAR-TEST 4, and LEADERS randomized trials.

Safety endpoint: definite stent thrombosis. (A) Kaplan–Meier curves for the pooled population in each of the stent groups. (B) Forest plot with hazard ratios for biodegradable polymer stents vs. permanent polymer stents for individual trials and the pooled population. Hazard ratios are shown on a logarithmic scale. The size of the square is proportional to the weight of the individual studies, measured as the inverse of the estimated variance of the log hazard ratio. BP, biodegradable polymer drug-eluting stent; DP, durable polymer sirolimus-eluting stent. (C) Kaplan–Meier curves for the pooled population in each of the stent groups with the landmark analysis at 1 year.

Giulio G. Stefanini et al. Eur Heart J 2012;33:1214-1222
Major adverse cardiac and cerebrovascular events (MACCEs).

Prasugrel Plus Aspirin Beyond 12 Months Is Associated With Improved Outcomes After Taxus Liberté Paclitaxel-Eluting Coronary Stent Placement

Bleeding event rates.

Kaplan–Meier estimates of primary and secondary endpoints at the end of follow-up (FU). Shown are the cumulative incidences of the primary endpoint of death resulting from cardiac causes, myocardial infarction (MI), or stroke (A); death resulting from any cause (B); definite stent thrombosis (C); and Thrombolysis in Myocardial Infarction (TIMI) major bleeding (D). The dual-therapy group is shown in blue and aspirin-alone group in red. HR indicates hazard ratio.
Figure Legend:

Landmark Analyses of Efficacy

Landmark analyses (survival method) of the Kaplan-Meier estimates of myocardial infarction (MI), stent thrombosis, and urgent target vessel revascularization (uTVR) during the first 3 days after randomization (left side of each panel) and from 3 days to the end of the study (right side of each panel) are shown for the prasugrel and clopidogrel groups. There were significant reductions in the hazard ratio (HR) for each end point both during the first 3 days and from 3 days to the end of the study that were consistent with independent superiority of the loading and maintenance doses of prasugrel compared with clopidogrel.
From: Three vs Twelve Months of Dual Antiplatelet Therapy After Zotarolimus-Eluting Stents: The OPTIMIZE Randomized Trial


Time to Event for Individual Components of the Primary Composite End Point (All-Cause Death, Myocardial Infarction) Among Patients Receiving Short- and Long-term Dual Antiplatelet Therapy at 0-360 Days, 0-90 Days, and 91-360 DaysNumbers of events listed under the x-axes are not cumulative but rather incremental numbers of events; numbers of events listed under the x-axes on day 0 represent periprocedural events. HR indicates hazard ratio.

Figure Legend:

Six-month landmark analysis for the key secondary end points.

A, A composite of death or myocardial infarction (MI)

B, Stent thrombosis

C, Major adverse cardiocerebral events (MACCE; a composite of death, MI, stroke, or any revascularization)

D, Safety end point (a composite of death, MI, stroke, stent thrombosis, or Thrombolysis in Myocardial Infarction major bleeding).
From: Three vs Twelve Months of Dual Antiplatelet Therapy After Zotarolimus-Eluting Stents: The OPTIMIZE Randomized Trial


**Figure Legend:**

Time to Event for Individual Components of the Primary Composite End Point (Stroke, Major Bleeding) Among Patients Receiving Short- and Long-term Dual Antiplatelet Therapy at 0-360 Days, 0-90 Days, and 91-360 Days

Numbers of events listed under the x-axes are not cumulative but rather incremental numbers of events; numbers of events listed under the x-axes on day 0 represent periprocedural events. HR indicates hazard ratio.
Short-Versus Long-Term Duration of Dual-Antiplatelet Therapy After Coronary Stenting: A Randomized Multicenter Trial for the Prolonging Dual Antiplatelet Treatment After Grading Stent-Induced Intimal Hyperplasia Study (PRODIGY) Investigators

2,697 Assessed for Eligibility

694 Excluded
  353 Not Meeting Inclusion Criteria
  232 Refused to Participate
  109 Operator's choice

2,013 randomly allocated to receive one of the four study stent type

501 randomized to EES
  499 received EES
  10 received POBA for ≥1 lesion
  4 had ≥1 failed treated lesion
  5 died before 30 days
  1 withdrew at 30 days

505 randomized to PES
  498 received PES
  13 received POBA for ≥1 lesion
  2 had ≥1 failed treated lesion
  11 died before 30 days
  4 withdrew at 30 days

502 randomized to ZES
  500 received ZES
  12 received POBA for ≥1 lesion
  4 had ≥1 failed treated lesion
  7 died before 30 days
  2 withdrew at 30 days

505 randomized to BMS
  502 received BMS
  14 received POBA for ≥1 lesion
  2 had ≥1 failed treated lesion
  10 died before 30 days
  3 withdrew at 30 days

1970 eligible for randomization at 30 days

987 randomly allocated to 24 month Clopidogrel
  2 Lost to follow-up after 6 month visit
  1 Lost to follow-up after 12 month visit
  984 available for primary endpoint assessment

983 randomly allocated to 6 month Clopidogrel
  3 Lost to follow-up after 6 month visit
  1 Lost to follow-up after 12 month visit
  979 available for primary endpoint assessment


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TIPO DE STENT (SCAFOLD POLIMERO DROGA)
TIPO DE PLACA (ESTABLE, TROMBOTICA, RUPTURA)
SINDROME CORONARIO (SCA, ANGINA ESTABLE)
CONDICION CLINICA (INSUFICIENCIA RENAL DIABETES)
Endeavour zotarolimus-eluting stent reduces stent thrombosis and improves clinical outcomes compared with cypher sirolimus-eluting stent: 4-year results of the PROTECT randomized trial
Cumulative Incidence of Stent Thrombosis at 4 Years after Implantation of FDA-Approved Drug-Eluting Stents, According to Definitions Used in Trial Protocol versus ARC Definite or Probable Categories.

Panels A and B show comparisons of the incidence of stent thrombosis in patients with sirolimus-eluting stents and paclitaxel-eluting stents, as compared with bare-metal stents, according to the definition of stent thrombosis used in the original cohort trials. Panels C and D show data from the same trials with the definition of definite or probable stent thrombosis recommended by the Academic Research Consortium (ARC). P values were calculated by the log-rank test. I bars indicate 95% confidence intervals.

Cumulative incidence of the primary end point and selected secondary end points, according to treatment group. Cumulative incidence curves are shown for the primary end point of death of any cause, myocardial infarction, or cerebrovascular accident (A), death of any cause (B), myocardial infarction (C), any cerebrovascular accident (D), definite or probable stent thrombosis (E), and cumulative type 5, 3, or 2 bleeding events according to the Bleeding Academic Research Consortium classification (F). Probability values were calculated with log-rank test.
Twelve or 30 Months of Dual Antiplatelet Therapy after Drug-Eluting Stents


Table 2. Stent Thrombosis and Major Adverse Cardiovascular and Cerebrovascular Events.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Continued Thienopyridine (N = 5020)</th>
<th>Placebo (N = 4941)</th>
<th>Hazard Ratio, Thienopyridine vs. Placebo (95% CI)†</th>
<th>P Value‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stent thrombosis‡</td>
<td>19 (0.4)</td>
<td>65 (1.4)</td>
<td>0.29 (0.17–0.48)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Definite</td>
<td>15 (0.3)</td>
<td>58 (1.2)</td>
<td>0.26 (0.14–0.45)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Probable</td>
<td>5 (0.1)</td>
<td>7 (0.1)</td>
<td>0.71 (0.22–2.23)</td>
<td>0.55</td>
</tr>
<tr>
<td>Major adverse cardiovascular and cerebrovascular events§</td>
<td>211 (4.3)</td>
<td>285 (5.9)</td>
<td>0.71 (0.59–0.85)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Death</td>
<td>98 (2.0)</td>
<td>74 (1.5)</td>
<td>1.36 (1.00–1.85)</td>
<td>0.05</td>
</tr>
<tr>
<td>Cardiac</td>
<td>45 (0.9)</td>
<td>47 (1.0)</td>
<td>1.00 (0.66–1.52)</td>
<td>0.98</td>
</tr>
<tr>
<td>Vascular</td>
<td>5 (0.1)</td>
<td>5 (0.1)</td>
<td>0.98 (0.28–3.39)</td>
<td>0.98</td>
</tr>
<tr>
<td>Noncardiovascular</td>
<td>48 (1.0)</td>
<td>22 (0.5)</td>
<td>2.23 (1.32–3.78)</td>
<td>0.002</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>99 (2.1)</td>
<td>198 (4.1)</td>
<td>0.47 (0.37–0.61)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Stroke</td>
<td>37 (0.8)</td>
<td>43 (0.9)</td>
<td>0.80 (0.51–1.25)</td>
<td>0.32</td>
</tr>
<tr>
<td>Ischemic</td>
<td>24 (0.5)</td>
<td>34 (0.7)</td>
<td>0.68 (0.40–1.17)</td>
<td>0.16</td>
</tr>
<tr>
<td>Hemorrhagic</td>
<td>13 (0.3)</td>
<td>9 (0.2)</td>
<td>1.20 (0.50–2.91)</td>
<td>0.68</td>
</tr>
<tr>
<td>Type uncertain</td>
<td>0</td>
<td>1 (&lt;0.1)</td>
<td>—</td>
<td>0.32</td>
</tr>
</tbody>
</table>

* At 12 months after placement of a drug-eluting stent, patients were randomly assigned to receive either continued thienopyridine therapy plus aspirin or placebo plus aspirin for 18 months. Data are presented for the intention-to-treat population. The primary analysis was performed on data from the period of 12 to 30 months after enrollment, and the study coprimary efficacy end points were stent thrombosis and major adverse cardiovascular and cerebrovascular events. Percentages are Kaplan–Meier estimates.

† The hazard ratios and P values were stratified according to geographic region (North America, Europe, or Australia and New Zealand), thienopyridine drug received at the time of randomization, and presence or absence of risk factors for stent thrombosis. P values were calculated with the use of a log-rank test.

‡ Definite and probable stent thrombosis were determined according to the criteria of the Academic Research Consortium.

§ The end point of major adverse cardiovascular and cerebrovascular events was a composite of death, myocardial infarction, or stroke.