PLATELET BLOCKADE FROM ACUTE CARE TO SECONDARY PREVENTION: CLOSING THE QUALITY GAP ACROSS THE ACS TREATMENT SPECTRUM
Session 11: Platelet Blockade From Acute Care to Secondary Prevention: Closing the Quality Gap Across the ACS Treatment Spectrum

Learning Objectives

- Identify the evidence base for acute and long-term oral antiplatelet therapy in acute coronary syndrome (ACS) patients, across different treatment paradigms and comorbidities.
- Improve short- and long-term outcomes for patients with ACS via the implementation of consistent and effective guideline-based management strategies.

Faculty

Deepak L. Bhatt, MD, FACC, FSCAI, FAHA, FESC
Chief of Cardiology
VA Boston Healthcare System
Director, Integrated Cardiovascular Intervention Program
Brigham and Women’s Hospital
Boston, Massachusetts

Deepak L. Bhatt, MD, FACC, FSCAI, FAHA, FESC, is the chief of cardiology in the VA Boston Healthcare System and director of the integrated cardiovascular intervention program at Brigham and Women’s Hospital and the VA system. He was formerly director of the Interventional Cardiology Fellowship and the associate director for the Cardiovascular Medicine Fellowship at the Cleveland Clinic Foundation. He is board certified by the American Board of Internal Medicine in internal medicine, cardiovascular diseases, and interventional cardiology.

Dr Bhatt’s research interests include the study of oral and intravenous antithrombotic medications, as well as the optimal management of patients with acute coronary syndromes, including myocardial infarction. He also has research interests in advanced techniques for cardiac, cerebral, and peripheral intervention.

Dan J. Fintel, MD
Professor of Medicine
Feinberg School of Medicine
Northwestern University
Attending Physician
Director, Coronary Care Unit
Northwestern Memorial Hospital
Chicago, Illinois

Dan Fintel, MD, is associate professor of medicine at the Feinberg School of Medicine, Northwestern University, and is an attending physician at Northwestern Memorial Hospital, as well as director of the coronary care unit. He graduated magna cum laude from Yale University and Harvard Medical School. He performed his internship and residency in medicine at the Mt. Sinai Hospital in New York City, and completed a fellowship in cardiology at Johns Hopkins University.

Dr Fintel’s principal research interests include antithrombotic therapies for ACS and nuclear imaging in cardiology. He has been a principal investigator at Northwestern University for several fibrinolytic, anti-ischemic, and antithrombotic therapy clinical trials, and has served on the Acute Cardiac Care Subcommittee of the American Heart Association and the Cardiovascular Network of the American College of Chest Physicians.

Faculty Financial Disclosure Statement

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Dr Bhatt receives research grants (directly to the institution) from Bristol-Myers Squibb, Eisai, Ethicon, HeartScape, sanofi-aventis U.S., and The Medicines Company. He receives honoraria from AstraZeneca LP; Bristol-Myers Squibb; Centocor; Daiichi-Sankyo, Inc.; Eisai; Eli Lilly and Company; GlaxoSmithKline; Millennium; Paringenix; PDL; sanofi-aventis U.S.; Schering-Plough Pharmaceuticals; The Medicines Company; and tns Healthcare.
Dr Fintel receives research grants, honoraria, and/or consulting fees from Merck & Co., Inc.; Novartis Pharmaceuticals Corporation; Pfizer Inc.; sanofi-aventis U.S.; and Schering-Plough Corporation.

Education Partner Financial Disclosure Statement

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### Drug List

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<td>ReoPro</td>
<td>sirolimus</td>
<td>Rapamune</td>
</tr>
<tr>
<td>aspirin</td>
<td>various</td>
<td>warfarin</td>
<td>Coumadin, Jantoven</td>
</tr>
<tr>
<td>bivalirudin</td>
<td>Angiomax</td>
<td>prasugrel (Effient)</td>
<td></td>
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<tr>
<td>clopidogrel</td>
<td>Plavix</td>
<td>cangrelor</td>
<td></td>
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<tr>
<td>hydrochlorothiazide</td>
<td>various</td>
<td>AZD6140</td>
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<tr>
<td>lisinopril</td>
<td>Prinivil, Zestril</td>
<td>E5555</td>
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<tr>
<td>metoprolol</td>
<td>Lopressor, Toprol-XL</td>
<td>SCH530348</td>
<td></td>
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<tr>
<td>paclitaxel</td>
<td>Taxol</td>
<td></td>
<td></td>
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<tr>
<td>simvastatin</td>
<td>Zocor</td>
<td></td>
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</tr>
</tbody>
</table>

### Investigational

- prasugrel (Effient)
- cangrelor
- AZD6140
- E5555
- SCH530348

### Suggested Reading List


Platelet Blockade from Acute Care to Secondary Prevention: Closing the Quality Gap Across the ACS Treatment Spectrum

Deepak L. Bhatt, MD, FACC
VA Boston Healthcare System
Boston, Massachusetts

Dan J. Fintel, MD
Feinberg School of Medicine
Chicago, Illinois

Learning Objectives
- Identify the evidence base for acute and long-term oral antiplatelet therapy in ACS patients, across different treatment paradigms and co-morbidities
- Improve short- and long-term outcomes for patients with ACS via the implementation of consistent and effective guideline-based management strategies

2007 ACC/AHA Guideline Updates
- NSTEMI – August 2007
- STEMI – December 2007
- PCI – December (ACC/AHA/SCAI) 2007

CRUSADE: Lower Guideline Adherence in NSTEMI Management Is Associated with Worse Outcomes

No. of events (%) by hospital adherence quartile

<table>
<thead>
<tr>
<th>Population (N=64,775)</th>
<th>1 (lowest) (n=12,329)</th>
<th>2 (n=15,255)</th>
<th>3 (n=18,364)</th>
<th>4 (highest) (n=18,827)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>784 (6.36)</td>
<td>772 (5.06)</td>
<td>786 (4.17)</td>
<td>786 (4.17)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Death/MI</td>
<td>1119 (9.08)</td>
<td>1280 (8.39)</td>
<td>1201 (6.38)</td>
<td>1201 (6.38)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Stroke</td>
<td>96 (0.78)</td>
<td>146 (0.96)</td>
<td>171 (0.93)</td>
<td>134 (0.71)</td>
<td>.31</td>
</tr>
<tr>
<td>CHF</td>
<td>908 (7.36)</td>
<td>1747 (11.45)</td>
<td>1541 (8.19)</td>
<td>1727 (8.40)</td>
<td>.24</td>
</tr>
</tbody>
</table>


Guideline-based Management of Oral Antiplatelet Therapy for the STEMI Patient

Deepak L. Bhatt, MD, FACC
Chief of Cardiology
VA Boston Healthcare System
Director, Integrated Cardiovascular Intervention Program
Brigham and Women’s Hospital
Boston, Massachusetts

Case 1
- 69-year-old Caucasian female is brought by ambulance to the emergency department (ED) in a community hospital without on-site interventional cardiology. The closest facility with on-site interventional cardiology is a 2-hour drive.
  - 5’2’’; 94 lbs
  - Symptoms began 2 hours ago and include epigastric distress, nausea, vomiting, shortness of breath at rest, pre-syncope, dizziness
Case 1 cont’d

- History
  - Non-smoker
  - History of hypertension
  - Family history of heart disease
  - Medications
    - hydrochlorothiazide (25 mg/d)
    - lisinopril (10 mg/d)
- 12-lead electrocardiogram (ECG): > 1 mm ST-segment elevation in leads V2-V4

What is the optimal antiplatelet choice for this patient if she undergoes pharmacologic reperfusion?

1. ASA only
2. ASA + clopidogrel
3. ASA + clopidogrel + GP IIb/IIIa inhibitor
4. Unsure

ACC/AHA 2007 Focused Update of the STEMI Guidelines: Oral Antiplatelet Therapy

ASA 162 to 325 mg should be given on day 1 of STEMI and in the absence of contraindications should be continued indefinitely on a daily basis thereafter at a dose of 75 to 162 mg.

New recommendation

Benefit of ASA Therapy in High Risk Patients*

<table>
<thead>
<tr>
<th>Category of trial</th>
<th>No. of trials with data</th>
<th>No. (%) of vascular events/Adjusted control</th>
<th>Odds Ratio (CI)</th>
<th>% Odds Reduction (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA alone (mg/d)</td>
<td>35</td>
<td>1,621/15,215 (14.5)</td>
<td>1.030/11.238 (17.2)</td>
<td>19 (3)</td>
</tr>
<tr>
<td>100-225</td>
<td>19</td>
<td>1,520/14,640 (10.3)</td>
<td>1.016/11.272 (14.6)</td>
<td>26 (3)</td>
</tr>
<tr>
<td>75-150</td>
<td>12</td>
<td>366/3,370 (10.8)</td>
<td>1.077/11.406 (12.6)</td>
<td>32 (6)</td>
</tr>
<tr>
<td>&lt;75</td>
<td>3</td>
<td>316/1,827 (17.2)</td>
<td>1.051/1.028 (11.6)</td>
<td>13 (8)</td>
</tr>
<tr>
<td>Any ASA</td>
<td>65</td>
<td>3,028/20,652 (14.8)</td>
<td>1.074/12.743 (16.6)</td>
<td>23 (2)</td>
</tr>
</tbody>
</table>

Treatment effect P<0.001

*Patients with previous or acute MI, previous stroke/TIA, or other high risk

| Vascular events = MI, stroke, or vascular death. Some trials contributed to more than 1 comparison.

COMMIT: Primary Efficacy Endpoints

<table>
<thead>
<tr>
<th>Treatment arm</th>
<th>Placebo 10.1%</th>
<th>Clopidogrel 9.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days since randomization</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Death, reinfarction, or stroke (%)</td>
<td>0</td>
<td>9% (SE:3) RRR (2P=0.002)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment arm</th>
<th>Placebo 8.1%</th>
<th>Clopidogrel 7.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days since randomization</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Mortality (%)</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

COMMIT: Bleeding Endpoints

<table>
<thead>
<tr>
<th>Event</th>
<th>Clopidogrel n=22,961</th>
<th>Placebo n=22,891</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intracranial hemorrhage</td>
<td>55 (0.2)</td>
<td>56 (0.2)</td>
<td>NS</td>
</tr>
<tr>
<td>Major bleeding</td>
<td>134 (0.6)</td>
<td>125 (0.5)</td>
<td>NS</td>
</tr>
</tbody>
</table>

Would you administer a loading dose of clopidogrel to this patient?

1. Yes, 300 mg
2. Yes, 600 mg
3. No
4. Unsure

ACC/AHA 2007 Focused Update of the STEMI Guidelines: Oral Antiplatelet Therapy

In patients <75 years who receive fibrinolytic therapy or who do not receive reperfusion therapy, it is reasonable to administer an oral loading dose of clopidogrel 300 mg. (No data are available to guide decision making in patients ≥75 years of age.)

New recommendation

CLARITY-TIMI 28: Primary Endpoint

Patients received a loading dose of clopidogrel 300 mg followed by 75 mg daily.

Composite Endpoint of CV Death, MI, or Recurrent MI Leading to the Need for Revascularization

CLARITY-TIMI 28:

Primary Safety Endpoint

Bleeding outcomes by day after angiography, or day 8/hospital discharge

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Clopidogrel n=1733</th>
<th>Placebo n=1719</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major or minor bleeding</td>
<td>40 (2.3)</td>
<td>28 (1.6)</td>
<td>.18</td>
</tr>
<tr>
<td>Major bleeding</td>
<td>23 (1.3)</td>
<td>13 (1.1)</td>
<td>.64</td>
</tr>
<tr>
<td>Minor bleeding</td>
<td>17 (1.0)</td>
<td>9 (0.5)</td>
<td>.17</td>
</tr>
</tbody>
</table>

How long would you continue dual antiplatelet therapy in this patient?

1. Through hospital discharge
2. 2 weeks
3. 1 month
4. 6 months
5. 1 year
6. Unsure
ACC/AHA 2007 Focused Update of the STEMI Guidelines: Oral Antiplatelet Therapy

For patients treated medically or with balloon PTCA, treatment with clopidogrel for AT LEAST 14 days (1 year if stent is placed).

New recommendation

Long-term maintenance therapy (e.g., 1 year) with clopidogrel (75 mg daily) is reasonable in ALL STEMI patients.

New recommendation


Impact of Clopidogrel Discontinuation in Medically Managed Patients with ACS

The patient is to be transferred for primary PCI. What antiplatelet therapy would you initiate before transfer in addition to ASA?

1. Clopidogrel 300 mg
2. Clopidogrel 600 mg
3. GP IIb/IIIa inhibitor
4. Neither
5. Unsure

ACC/AHA/SCAI 2007 Focused Update of the PCI Guidelines: Oral Antiplatelet Therapy

A loading dose of clopidogrel, generally 600 mg, should be administered before or when PCI is performed.

Modified recommendation

In patients undergoing PCI within 12 to 24 hrs of receiving fibrinolytic therapy, a clopidogrel oral loading dose of 300 mg may be considered.

Modified recommendation


PCI-CLARITY: Effect of Clopidogrel Pretreatment Prior to PCI in STEMI Patients Treated with Fibrinolytics

Rates and ORs for CV death, recurrent MI, and stroke following PCI up to 30 days


CHARISMA: Benefit of Dual Antiplatelet Therapy in the Subgroup with Prior MI

Primary endpoint: CV death, MI or stroke

OR = Odds ratio.

TRITON-TIMI 38: Efficacy and Safety of Prasugrel vs. Clopidogrel

TRITON-TIMI 38: TIMI Bleeding Endpoints in the Overall Cohort at 15 Months

Assuming this patient received a DES, how long would you continue dual antiplatelet therapy?

1. 2 weeks
2. 1 month
3. 6 months
4. 1 year
5. Indefinitely
6. Unsure

TRITON-TIMI 38: Effect of Prasugrel vs. Clopidogrel on Probable or Definite Stent Thrombosis

ACC/AHA/(SCAI) 2007 Focused Updates of the STEMI (PCI) Guidelines

ACC/AHA/(SCAI) 2007 Focused Update of the STEMI (PCI) Guidelines: Oral Antiplatelet Therapy
PREMIER Registry: Association of Thienopyridine Discontinuation with Increased All-Cause Mortality in PCI Patients

Continued vs. Discontinued

$$P<0.001$$

Mortality (%)

HR 9.02

(95% CI: 1.3-60.6; $$P=0.02$$)

Incidence of Thrombosis after DES: Predictors of Thrombosis

Prevention of Premature Discontinuation of Dual Antiplatelet Therapy in DES Patients

- AHA/ACC/SCAI/ACS/ADA Science Advisory Recommendations
  - 12 months dual antiplatelet therapy after DES
  - Patient and HCP education about hazards of premature discontinuation
  - Postpone elective surgery for 1 year
    - If not possible, consider continuing ASA during post-operative period
  - Avoid DES in patients unlikely to comply with 12 months of thienopyridine therapy

What if this patient were 79 yrs old with a history of a TIA? Which antiplatelet therapy would you choose?

1. ASA only
2. ASA + clopidogrel
3. Unsure

COMMIT: Effect of Clopidogrel on Death, Reinfarction, or Stroke Based on Patient Age

<table>
<thead>
<tr>
<th>Age at entry (yrs)</th>
<th>Clopidogrel (22,961)</th>
<th>Placebo (22,891)</th>
<th>Odds ratio (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;60</td>
<td>485 (5.0)</td>
<td>512 (5.4)</td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>745 (10.1)</td>
<td>835 (11.2)</td>
<td></td>
</tr>
<tr>
<td>&gt;70</td>
<td>891 (14.9)</td>
<td>963 (16.2)</td>
<td></td>
</tr>
</tbody>
</table>

Hazard Ratio for Prasugrel Efficacy (95% CI)

<table>
<thead>
<tr>
<th>Total No. Of Patients</th>
<th>Pras. (%): Clop. (%): Reduction in Risk (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>13,608: 9.9: 12.1: 19</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>&lt;65 yr</td>
<td>8,322: 8.1: 10.6: 25</td>
</tr>
<tr>
<td>65-74 yr</td>
<td>3,477: 10.7: 12.3: 14</td>
</tr>
<tr>
<td>≥75 yr</td>
<td>1,808: 17.2: 18.3: 6</td>
</tr>
</tbody>
</table>

TRITON-TIMI 38: Age Subgroup Analysis for Rate of Primary Efficacy Endpoint at 15 Months

**P** values for interaction were not significant
**TRITON-TIMI 38: Efficacy and Safety of Prasugrel vs. Clopidogrel in Subgroups**

Age ≥75 yrs, Body Weight <60 kg, or with Prior Stroke or TIA

<table>
<thead>
<tr>
<th>End Point</th>
<th>Prasugrel</th>
<th>Clopidogrel</th>
<th>Hazard Ratio for Prasugrel (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death from cardiovascular causes, nonfatal MI, or nonfatal stroke</td>
<td>199/1320 (15.1)</td>
<td>199/1347 (14.9)</td>
<td>1.02 (0.84-1.24)</td>
<td>0.83</td>
</tr>
<tr>
<td>Non-CABG-related TIMI major bleeding</td>
<td>52/1305 (4.3)</td>
<td>38/1328 (2.9)</td>
<td>1.42 (0.93-2.15)</td>
<td>0.10</td>
</tr>
<tr>
<td>Death from any cause, nonfatal MI, nonfatal stroke, or non-CABG-related nonfatal TIMI major bleeding</td>
<td>249/1320 (20.2)</td>
<td>239/1347 (19.0)</td>
<td>1.07 (0.90-1.28)</td>
<td>0.43</td>
</tr>
</tbody>
</table>

**Conclusions**

- Oral antiplatelet therapy improves outcomes in a broad range of STEMI patients
- Data support loading dose before routine PCI; no randomized data in primary PCI but guidelines recommend loading dose
- No safety data on loading dose in elderly
- Recommendations for long-term maintenance therapy based on extrapolation from NSTEMI data and indications for patients receiving DES

**Case 2 NSTEMI**

- 67 yo male, no cardiac Hx. Hx of hypertension, hypercholesterolemia, and former smoker. Presents to ER with intermittent chest discomfort that began ~6 hours earlier. Experienced 4 episodes, longest ~15 minutes. All at rest. Resolved spontaneously.
- Meds: ASA 81 mg daily
  - Lisinopril/HCTZ 20/12.5 mg daily
  - Simvastatin 20 mg daily at bedtime
- ECG: NSR. Lateral T-wave flattening with 0.5 mm horizontal ST depression
- Labs: Initial troponin I 0.3 (ULN 0.04)

**Antiplatelet Agents: Future Options**

- Thienopyridine Prasugrel
- Cangrelor
- AZD6140 E5555
- SCH530348

**Guideline-based Management of Oral Antiplatelet Therapy for the NSTEMI Patient**

Dan J. Fintel, MD
Professor of Medicine
Director, Coronary Care Unit
Feinberg School of Medicine
Northwestern University
Chicago, Illinois

**What is the optimal antiplatelet choice for this patient?**

1. ASA only
2. ASA + clopidogrel
3. ASA + clopidogrel + GP IIb/IIIa inhibitor
4. Unsure
8
Would you preload this patient who is intended for the cath lab with clopidogrel?

1. Yes, 300 mg
2. Yes, 600 mg
3. Yes, but the dose depends on the time interval before the patient is taken to the cath lab
4. No

**PCI-CURE: 30-day Outcomes Following PCI with Both Loading and Maintenance Doses of Clopidogrel**

![Graph showing cumulative hazard rates for PCI-CURE study](image)

- **Placebo**: 6.4%
- **Clopidogrel**: 4.5%

*Primary endpoint: CV death, MI, or urgent target vessel revascularization.*


**ARMYDA-2: Comparison of Low and High Loading Dose of Clopidogrel Prior to PCI**

- Increased Loading Dose Improves Primary Outcomes (Death, MI, TVR) at 30 Days

![Graph showing event rates for ARMYDA-2 study](image)

- Event Rates (%)
  - 600 mg: 4%
  - 300 mg: 12%

*P* = .041


**CURRENT-OASIS 7: Study Design**

- **Objective**: To clarify the optimal dosing regimens of clopidogrel and ASA in ACS patients undergoing an early invasive procedure
- **Methods**:
  - 2x2 factorial design experiment to investigate the optimal clopidogrel dose (600 mg LD + 150 mg/d for 1 week + 75 mg/d vs. 300 mg LD + 75 mg/d) and ASA dose (≥300 mg/d vs ≤100 mg/d) for 30 days
- **Primary endpoint events**:
  - Efficacy: 30 d CV death, MI, or recurrent ischemia
  - Safety: major bleeding


**Assuming this patient receives a DES, in addition to ASA, what duration of clopidogrel would you recommend at discharge?**

1. 6 months
2. 1 year
3. 2 years
4. Lifelong

**2007 ACC/AHA UA/NSTEMI Guidelines: Long-term Antiplatelet Therapy for Patients Treated with an Invasive Strategy**

- Patients who receive a BMS should be administered ASA 162-325 mg daily for at least 1 month.
- ASA 75-162 mg per day should be continued indefinitely.
- Clopidogrel 75 mg per day should be administered for a minimum of 1 month and ideally up to 1 year (unless patient is at increased risk of bleeding, then it should be given for a minimum of 2 weeks).
- For patients who receive a DES, ASA 162-325 mg per day should be prescribed for at least 3 months after SES and 6 months after PES and continued indefinitely at a dose of 75-162 mg per day.
- Clopidogrel 75 mg per day should be given for at least 12 months to all patients receiving a DES.

**What if this DES patient has atrial fibrillation. What course of therapy would you recommend following PCI?**

1. ASA only
2. ASA + clopidogrel
3. ASA + clopidogrel + warfarin
4. Unsure

**2006 ACC/AHA/ESC Atrial Fibrillation Guidelines: Patients Undergoing PCI**

Following PCI, low dose ASA (<100 mg/d) and/or clopidogrel (75 mg/d) may be given concurrently with anticoagulation to prevent MI, but this strategy is associated with increased bleeding risk.

Anticoagulation may be interrupted and replaced with ASA during PCI, but should be resumed as soon as possible after the procedure. Maintenance regimen should then consist of clopidogrel (75 mg/d) plus warfarin (INR 2.0-3.0). Maintain clopidogrel for recommended duration, then continue warfarin as monotherapy in the absence of subsequent coronary event.

**2007 ACC/AHA UA/NSTEMI Guidelines: Patients with Indication for Anticoagulant Therapy**

For patients who have an indication for anticoagulation, add warfarin* to maintain an international normalization ratio (INR) of 2.0 to 3.0

*Continue ASA indefinitely and warfarin longer term as indicated for such conditions as atrial fibrillation. INR of 2.0 to 3.5 is preferable while given with ASA and clopidogrel, especially in older patients and those with other risk factors for bleeding.

**CHARISMA: Lack of Efficacy of Dual Antiplatelet Therapy in Patients with Atrial Fibrillation**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Clot + ASA (n=298)</th>
<th>ASA (n=265)</th>
<th>Hazard Ratio</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All stroke</td>
<td>15 (2.5%/yr)</td>
<td>14 (2.1%/yr)</td>
<td>1.02 (0.69-1.53)</td>
<td>.94</td>
</tr>
<tr>
<td>Ischemic stroke</td>
<td>14 (2.5%/yr)</td>
<td>14 (2.1%/yr)</td>
<td>0.99 (0.65-1.53)</td>
<td>.91</td>
</tr>
<tr>
<td>MI</td>
<td>5</td>
<td>6</td>
<td>1.43 (0.31-5.48)</td>
<td>.50</td>
</tr>
<tr>
<td>Vascular death</td>
<td>21</td>
<td>12</td>
<td>1.68 (0.82-3.42)</td>
<td>.15</td>
</tr>
<tr>
<td>All-cause mortality</td>
<td>29</td>
<td>25</td>
<td>1.12 (0.63-1.93)</td>
<td>.69</td>
</tr>
<tr>
<td>Stroke, MI, or vascular death</td>
<td>35</td>
<td>27</td>
<td>1.34 (0.75-2.40)</td>
<td>.40</td>
</tr>
<tr>
<td>Rehospitalization</td>
<td>41</td>
<td>43</td>
<td>1.89 (0.56-6.73)</td>
<td>.60</td>
</tr>
<tr>
<td>Stroke, MI, vascular death or rehospitalization</td>
<td>70</td>
<td>66</td>
<td>0.99 (0.75-1.38)</td>
<td>.33</td>
</tr>
</tbody>
</table>

Conclusions

- Oral antplatelet therapy has efficacy in a broad range of NSTE MI patients
- Therapy should be initiated immediately upon presentation
- Loading dose followed by maintenance dose should be administered regardless of reperfusion strategy
- Long-term maintenance therapy is warranted for secondary prevention of events
- Increased potency of emerging oral antplatelet therapies improve outcomes but carry increased bleeding risk
- Patients receiving oral antplatelet therapy who have an indication for warfarin should be closely monitored

Questions?