

Assessment of Platelet REACTivity After Transcatheter Aortic Valve Replacement



The REAC-TAVI Trial

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ABSTRACT

OBJECTIVES The REAC-TAVI (Assessment of platelet REACTivity after Transcatheter Aortic Valve Implantation) trial enrolled patients with aortic stenosis (AS) undergoing transcatheter aortic valve replacement (TAVR) pre-treated with aspirin + clopidogrel, aimed to compare the efficacy of clopidogrel and ticagrelor in suppressing high platelet reactivity (HPR) after TAVI.

BACKGROUND Current recommendations support short-term use of aspirin + clopidogrel for patients with severe AS undergoing TAVR despite the lack of compelling evidence.

METHODS This was a prospective, randomized, multicenter investigation. Platelet reactivity was measured at 6 different time points with the VerifyNow assay (Accriva Diagnostics, San Diego, California). HPR was defined as (P2Y₁₂ reaction units (PRU) \geq 208. Patients with HPR before TAVR were randomized to either aspirin + ticagrelor or aspirin + clopidogrel for 3 months. Patients without HPR continued with aspirin + clopidogrel (registry cohort). The primary endpoint was non-HPR status (PRU <208) in \geq 70% of patients treated with ticagrelor at 90 days post-TAVR.

RESULTS A total of 68 patients were included. Of these, 48 (71%) had HPR (PRU 273 \pm 09) and were randomized to aspirin + ticagrelor (n = 24, PRU 277 \pm 08) or continued with aspirin + clopidogrel (n = 24, PRU 269 \pm 49). The remaining 20 patients (29%) without HPR (PRU 133 \pm 12) were included in the registry. Overall, platelet reactivity across all the study time points after TAVR was lower in patients randomized to ticagrelor compared with those treated with clopidogrel, including those enrolled in the registry (p < 0.001). The primary endpoint was achieved in 100% of patients with ticagrelor compared with 21% with clopidogrel (p < 0.001). Interestingly, 33% of clopidogrel responder patients at baseline developed HPR status during the first month after TAVR.

CONCLUSIONS HPR to clopidogrel is present in a considerable number of patients with AS undergoing TAVR. Ticagrelor achieves a better and faster effect, providing sustained suppression of HPR to these patients. (Platelet Reactivity After TAVI: A Multicenter Pilot Study [REAC-TAVI]; [NCT02224066](https://doi.org/10.1016/j.jcin.2018.10.005)) (J Am Coll Cardiol Intv 2019;12:22-32)
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Trascatheter aortic valve replacement (TAVR) for degenerative aortic stenosis (AS), the most common valvular heart disease in the elderly (1), has become an established treatment for patients of high or intermediate surgical risk because it offers superior quality of life and similar mortality rates at 2 years follow-up, with less invasiveness than surgical aortic valve replacement (2,3). Application of this technique in younger patients and those of lower surgical risk is currently being explored.

SEE PAGE 33

In patients undergoing TAVR, thrombotic and hemorrhagic complications remain a concern, and are associated with increased mortality and morbidity (4-6). Although the immediate procedural risk relates to vascular access and valvular debris embolization, a significant percentage of thrombotic complications takes place in the first days after the procedure and during follow-up, remaining raised for up to 6 months (4-7). These are non-procedural-related events and implies the presence of a prothrombotic environment in these patients. Therefore, antiplatelet treatment plays an important role in trying to maintain the balance between the suppression of thrombotic complications without increasing the risk of bleeding.

Presently, antithrombotic therapy in patients with AS undergoing TAVR is not standardized. Various combinations of antithrombotic regimens (single-antiplatelet, dual antiplatelet therapy [DAPT], or oral anticoagulants) have been used, but evidence-based guidance is limited. Current guidelines (8,9) for the management of patients with valvular heart disease recommend DAPT combining low-dose aspirin and a thienopyridine (clopidogrel) for up to 6 months after TAVR. However, the evidence for this recommendation is weak and has no support from dedicated randomized clinical trials. Therefore, there is heterogeneity in antithrombotic treatment regimens following TAVR in real-world practice (10,11).

Studies have demonstrated a broad variability in individual response profiles to clopidogrel therapy resulting in adverse clinical outcomes, particularly among those who persist with high platelet reactivity (HPR) (12-14). However, most of these studies have been conducted in patients undergoing coronary

stenting, and there are limited data on profiles of platelet reactivity in AS patients undergoing TAVR treated with clopidogrel. Moreover, the impact of newer generation P2Y₁₂ inhibitor such as ticagrelor characterized by more potent and less heterogeneous antiplatelet effects has never been prospectively tested in AS patients undergoing TAVR.

Therefore, we aimed to analyze profiles of platelet reactivity among patients with AS undergoing TAVR treated with clopidogrel, on a background of aspirin therapy, and to assess the effects of ticagrelor among patients presenting with HPR.

METHODS

STUDY DESIGN AND PATIENT POPULATION. The REAC-TAVI trial (Assessment of platelet REACTivity after Transcatheter Aortic Valve Implantation, NCT02224066) was a prospective, open-label, investigator-initiated, randomized, multicenter, parallel-group, phase IV pharmacodynamic clinical trial, designed to investigate the incidence of HPR with aspirin and clopidogrel in patients with severe symptomatic AS undergoing TAVR and to test the hypothesis that ticagrelor is superior to clopidogrel in suppression of HPR after TAVR. An outline of the study design is provided in the [Online Appendix](#).

In brief, patients with severely symptomatic degenerative AS undergoing TAVR by transfemoral access were included at 7 centers in Spain (see the [Online Appendix](#) for the participating centers). Patients were excluded if they had any of the following: stroke during the 14 days before TAVR, bleeding diathesis, need for long-term oral anticoagulation treatment, contraindications to DAPT for 3 months, platelet count <50,000/ μ l, severe hepatic dysfunction, use of potent CYP3A inhibitors or inducers. All patients were on a background of aspirin (100 mg/day) in adjunct to clopidogrel. Patients need to be on clopidogrel maintenance dosing (75 mg/day) for \geq 4 days before TAVR. Clopidogrel-naive patients were pretreated with a 300-mg loading dose.

Patients with HPR at baseline were randomized in a 1:1 ratio using computerized random-number generation in an interactive web response system by an independent investigator to either continue

ABBREVIATIONS AND ACRONYMS

ARU = aspirin reaction unit(s)

AS = aortic stenosis

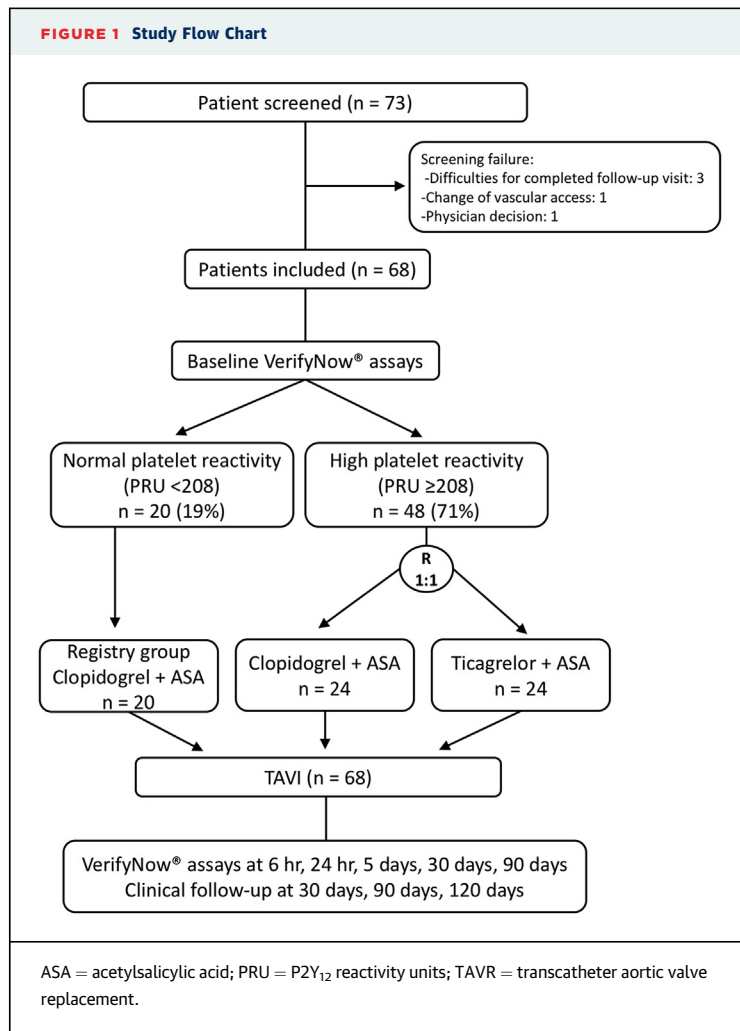
DAPT = dual antiplatelet therapy

HPR = high platelet reactivity

PRU = P2Y₁₂ reaction unit(s)

TAVR = transcatheter aortic valve replacement

entry, database maintenance, statistical analysis, and drafting and submission of the final manuscript was exclusively performed by the investigators. AstraZeneca played no role in the design of the study, data analysis, data interpretation, writing of the report, or in the decision to submit for publication. The authors have reported that they have no relationships relevant to the contents of this paper to disclose.



clopidogrel (75 mg/day) or switch to ticagrelor (90 mg/twice daily). Patients randomized to the ticagrelor group received at least 3 maintenance doses before undergoing TAVR. Patients without HPR were included in a registry cohort and maintained on clopidogrel therapy.

The TAVR procedure was performed according to the standards of each participating center. Patients received intravenous heparin (100 U/kg), with additional doses if the activated clotting time was <250 s. Compliance to antiplatelet therapy was assessed by the 4-item Morisky Green Levine Medication Adherence Scale (15) at 30 and 90 days after TAVR and by accountability of the study drugs in both treatment arms. Onsite monitoring and source data verification were conducted by an independent contract research organization in 100% of patients and in all study procedures, with a final follow-up visit at 4 months after TAVR. Adverse events were adjudicated by an independent clinical events committee, according the

Valve Academic Research Consortium-2 classification (16). The study flow chart is shown in Figure 1. The study complied with the Declaration of Helsinki, the International Conference on Harmonization/Good Clinical Practice guidelines, and applicable regulatory requirements. Informed consent was obtained and documented for all patients before conducting any study-related procedures.

PLATELET REACTIVITY ASSESSMENT. Platelet function was assessed using the VerifyNow point-of-care assay (Accriva Diagnostics, San Diego, California). Measurements were conducted in all patients at baseline (before TAVR) and at 6 different time points following TAVR: 6 h ± 30 min, 24 ± 2 h, 5 ± 1 day, 30 ± 3 days, and 90 ± 5 days. HPR was defined as a P2Y₁₂ reaction unit (PRU) value ≥208, in line with consensus recommendations (17,18). Response to aspirin was also assessed; an aspirin reaction unit (ARU) value ≥550 defined patients as nonresponders to aspirin. All patients were included in the per protocol safety analysis, whereas the pharmacodynamic analysis at 30 days consisted of 61 patients: 1 patient in the registry was excluded from the analyses due to missing platelet reactivity data results; 2 patients (1 in the ticagrelor group and 1 in the clopidogrel group) were excluded due to development of new-onset atrial fibrillation during hospitalization and were switched to oral anticoagulation; and 4 patients died during hospitalization (2 in the clopidogrel group and 2 in the registry group). At 90 days, 2 patients died in the clopidogrel group. The final pharmacodynamic population at 90 days, therefore, comprised 59 patients (ticagrelor n = 23; clopidogrel n = 19; registry n = 17).

STUDY ENDPOINTS. The primary endpoint was to obtain non-HPR status (PRU <208) in ≥70% of patients treated with ticagrelor, or a net difference of ≥40% in the number of patients with PRU <208 between treatment groups at 90 ± 5 days of antiplatelet treatment following TAVR. A key secondary efficacy endpoint was the net difference in the incidence of HPR 6 h post-TAVR of ≥30% between groups.

The secondary safety endpoints are constituted by the incidence of cerebrovascular accident or hemorrhagic complications (according to Valve Academic Research Consortium-2 criteria) at 4-month follow-up following TAVR. Exploratory endpoints included the analysis of patients with HPR after 24 h, 5 days, and 30 days of antiplatelet treatment, and pre-specified subanalyses by sex, age, comorbidities (diabetes mellitus, renal failure), type of bioprosthetic valve implanted, and HPR to both antiplatelet agents.

SAMPLE-SIZE CALCULATION AND STATISTICAL METHODS. Statistical inference was based on comparison of the

incidence of the primary endpoint between treatment groups. To achieve 80% power to detect differences in the contrast of the null hypothesis $H_0: p_1 = p_2$ using a chi-square test for 2 independent samples with $\alpha = 0.05$, a treatment arm allocation ratio of 1:1, under the assumption that the proportion of patients achieving adequate antiplatelet therapy at 3 months post-TAVR (PRU <208) in the aspirin + clopidogrel group is 28% and the proportion expected in the aspirin + ticagrelor group is 70%, it was necessary to enroll 21 patients in each treatment group. Given an expected dropout rate of 10%, 24 patients in each treatment group (total $n = 48$) would be required.

Conformity to the normal distribution was evaluated for continuous variables with the Shapiro-Wilk test. Categorical variables are expressed as frequencies and percentages. For baseline characteristics, continuous variables are expressed as mean \pm SD; PRU and ARU as mean \pm SE. Chi-square tests or Fisher exact tests were used, where appropriate, to compare categorical variables between 2 groups. Primary analysis of the difference between ticagrelor and clopidogrel in PRU at 90 days was analyzed using a 2-sample Student's *t*-test. Two-sample Student's *t*-tests were also used to evaluate other intergroup comparisons and to evaluate the impact of the 2 different treatments on platelet reactivity across time points.

RESULTS

PATIENT POPULATION. Between November 2015 and May 2017, of 73 patients screened, 68 patients met study entry criteria (3 patients had difficulties completing the follow-up visit, 1 patient was switched to non-transfemoral TAVR, and 1 patient was excluded due to physician decision). Most patients were on long-term use (≥ 4 days) of clopidogrel (84%), whereas the remaining patients received a loading dose. A total of 48 patients (71%) had HPR at baseline (PRU 273 ± 09) and were randomized to continue treatment with clopidogrel ($n = 24$, PRU 269 ± 49) or to switch to ticagrelor ($n = 24$, PRU 277 ± 08). The remaining 20 patients (29%) without HPR (PRU 133 ± 12) were included in the registry (Figure 1). Baseline ARU was 456 ± 15 in the randomized group and 451 ± 18 in the registry group; an ARU >550 was present in 9 patients (13%) (ARU 587 ± 10). Of these, 5 patients were in the registry group. Thus, 4 patients had HPR to both aspirin and clopidogrel, and were distributed equally in both randomized groups.

Baseline characteristics of the study population are displayed in Table 1. Compared with the randomized group, patients in the registry cohort had a lower

prevalence of chronic kidney disease and higher hemoglobin levels. Baseline characteristics were similar between randomized groups, except for lower body mass index and mean aortic valve area, and higher STS-PROM score in the clopidogrel group compared with the ticagrelor group. The majority of patients had pre-existing cardiovascular risk factors, nearly one-half of the population were women, had diabetes, or had prior percutaneous coronary intervention, and more than one-quarter of patients had a history of myocardial infarction or chronic kidney disease.

All patients were treated by transfemoral access, with a predominance of a conscious sedation strategy in the randomized group and general anesthesia in the registry. Procedural success was achieved in $>90\%$, and a balloon-expandable valve was used in 48% of cases (Table 2).

PHARMACODYNAMIC RESULTS. Overall, platelet reactivity across all the study time points after TAVR was lower in patients receiving ticagrelor compared with those receiving clopidogrel, including the registry group ($p < 0.001$). The primary endpoint of patients with PRU <208 was achieved in 100% of patients with ticagrelor compared with 21% with clopidogrel (PRU 240 ± 15 ; $p < 0.001$), with a net difference of responders between groups of 79% ($p < 0.001$) and an overall mean difference of -170 PRU in the ticagrelor group compared to clopidogrel group at the end of the treatment. Analysis of PRU levels at the different time-points also showed a significant reduction of platelet reactivity at 6 h, 24 h, 5 days, and 30 days with ticagrelor, compared with clopidogrel ($p < 0.001$) (Figure 2). The percentage of responders to ticagrelor was significantly higher throughout the entire treatment period compared with responders to clopidogrel (Figure 3). Interestingly, important variations in PRU levels throughout the treatment period was observed in the registry group, with an increase of 53 ± 26 PRU (Figure 2) and a decrease of 33% responders during the first month after TAVR (Figure 3). A total of 23 patients had at least 1 PRU value ≤ 70 during the treatment period: 1 in the clopidogrel group, 18 in the ticagrelor group, and 4 in the registry group. Mean ARU values were maintained in ranges of adequate response during the treatment period in the 3 groups, but significant variations in the degree of response to aspirin between groups were noticed at 5 and 30 days post-TAVR (Figure 4). The proportion of patients responding to aspirin did not vary significantly during the treatment phase.

SAFETY RESULTS. There was a total of 55 adverse events adjudicated by the clinical events committee

TABLE 1 Baseline Characteristics of the Study Population

| | Normal Platelet Reactivity Registry (n = 20) | *p Value Registry vs. Randomized | †p Value Registry vs. Clopidogrel + Aspirin | ‡p Value Registry vs. Ticagrelor + Aspirin | High On-Treatment Platelet Reactivity | | §p Value |
|---|--|----------------------------------|---|--|---------------------------------------|-------------------------------|----------|
| | | | | | Clopidogrel + Aspirin (n = 24) | Ticagrelor + Aspirin (n = 24) | |
| Demographic characteristics | | | | | | | |
| Age, yrs | 75.8 ± 19.6 | 0.31 | 0.25 | 0.31 | 81.2 ± 5.5 | 80.3 ± 8.6 | 0.67 |
| Women | 9 (45.0) | 0.58 | 0.95 | 0.54 | 11 (45.8) | 13 (54.2) | 0.56 |
| BMI, kg/m ² | 26.3 ± 4.5 | 0.10 | 0.48 | 0.004 | 27.3 ± 4.77 | 30.6 ± 4.6 | 0.02 |
| Cardiovascular risk factors | | | | | | | |
| Current smokers | 5 (25.0) | 0.56 | 0.92 | 0.43 | 6 (25.0) | 3 (12.5) | 0.46 |
| Hypertension | 16 (80.0) | 0.96 | 0.67 | 0.64 | 19 (79.2) | 22 (91.7) | 0.41 |
| Diabetes mellitus | 8 (40.0) | 0.12 | 0.10 | 0.43 | 16 (66.7) | 13 (54.2) | 0.37 |
| Insulin-treated | 2 (10.0) | 0.19 | 0.08 | 1.00 | 8 (33.3) | 3 (12.5) | 0.08 |
| Dyslipidemia | 11 (55.0) | 0.29 | 0.55 | 0.13 | 16 (66.7) | 19 (79.2) | 0.33 |
| History of cardiovascular disease and procedures | | | | | | | |
| PVD | 0 (0.0) | 0.18 | 0.24 | 1.00 | 3 (12.5) | 1 (4.2) | 0.29 |
| CKD | 2 (10.0) | 0.03 | 0.14 | 0.07 | 8 (33.3) | 9 (37.5) | 0.76 |
| COPD | 2 (10.0) | 0.71 | 0.36 | 0.56 | 5 (20.8) | 4 (16.7) | 0.71 |
| Chronic liver disease | 1 (5.0) | 0.84 | 1.00 | 1.00 | 2 (8.3) | 1 (4.2) | 1.00 |
| Stroke | 1 (5.0) | 0.63 | 0.61 | 1.00 | 3 (12.5) | 1 (4.2) | 0.29 |
| TIA | 1 (5.0) | 0.89 | 1.00 | 0.45 | 2 (8.3) | 0 (0) | 0.48 |
| Myocardial infarction | 5 (25.0) | 0.56 | 0.47 | 0.72 | 4 (16.7) | 5 (20.8) | 0.71 |
| PCI | 10 (50.0) | 0.52 | 0.47 | 0.54 | 10 (41.7) | 10 (41.7) | 1.00 |
| CABG | 0 (0.0) | 0.16 | 0.24 | 0.24 | 3 (12.5) | 3 (12.5) | 1.00 |
| Clinical data | | | | | | | |
| Dyspnea | 16 (80.0) | 0.96 | 1.00 | 0.64 | 19 (79.2) | 22 (91.7) | 0.41 |
| Angina | 4 (20.0) | 0.53 | 1.00 | 0.50 | 5 (20.8) | 8 (33.3) | 0.33 |
| Syncope | 3 (15.0) | 0.41 | 0.64 | 0.64 | 2 (8.3) | 2 (8.3) | 1.00 |
| NYHA II to III | 14 (70.0) | 0.07 | 0.29 | 0.29 | 22 (95.7) | 23 (95.8) | 1.00 |
| Echocardiographic data | | | | | | | |
| Maximum aortic gradient, mm Hg | 80.6 ± 24.5 | 0.42 | 0.94 | 0.33 | 81.1 ± 17.5 | 70.7 ± 23.0 | 0.10 |
| Mean aortic gradient, mm Hg | 51.8 ± 17.8 | 0.06 | 0.45 | 0.06 | 47.9 ± 11.6 | 41.1 ± 13.3 | 0.08 |
| Mean aortic valve area, cm ² | 0.61 ± 0.17 | 0.29 | 0.93 | 0.04 | 0.62 ± 0.20 | 0.73 ± 0.13 | 0.05 |
| Aortic regurgitation ≥moderate | 3 (15.0) | 0.11 | 0.29 | 0.28 | 1 (5.3) | 1 (4.8) | 1.00 |
| LVEF | 60.5 ± 12.7 | 0.52 | 0.30 | 0.96 | 55.9 ± 12.9 | 60.8 ± 15.3 | 0.28 |
| Systolic PAP | 52.3 ± 15.6 | 0.08 | 0.29 | 0.04 | 41.7 ± 13.2 | 36.2 ± 8.1 | 0.34 |
| Blood analysis | | | | | | | |
| Hemoglobin, mg/dl | 13.4 ± 1.6 | 0.01 | 0.009 | 0.02 | 12.0 ± 1.8 | 12.2 ± 1.8 | 0.62 |
| Platelets, 10 ⁹ /l | 203.1 ± 71 | 0.95 | 0.78 | 0.67 | 197.3 ± 62 | 211.7 ± 60 | 0.42 |
| NT-proBNP | 1,901 ± 1,496 | 0.41 | 0.27 | 0.83 | 4,226 ± 5,178 | 2,104 ± 2,103 | 0.33 |
| Risk scores | | | | | | | |
| Logistic EuroScore | 8.9 ± 6.11 | 0.21 | 0.11 | 0.71 | 13.37 ± 10.37 | 9.52 ± 5.31 | 0.12 |
| STS-PROM, % | 6.36 ± 7.61 | 0.73 | 0.67 | 0.23 | 7.22 ± 5.18 | 4.08 ± 2.53 | 0.014 |
| HAS-BLED | 2.75 ± 1.30 | 0.63 | 0.87 | 0.34 | 2.69 ± 0.90 | 2.40 ± 0.81 | 0.25 |
| CHA ₂ DS ₂ -VASC | 4.00 ± 1.41 | 0.15 | 0.11 | 0.39 | 4.70 ± 1.36 | 4.38 ± 1.41 | 0.43 |

Values are mean ± SD or n (%). *p values of comparison between registry group and randomized group. †p values of comparison between registry group and clopidogrel + aspirin group. ‡p values of comparison between registry group and ticagrelor + aspirin group. §p values of comparison between both randomized groups.

BMI = body mass index; CABG = coronary artery bypass graft; CKD = chronic kidney disease; COPD = chronic obstructive pulmonary disease; LVEF = left ventricular ejection fraction; NT-proBNP = N-terminal pro-B-type natriuretic peptide; NYHA = New York Heart Association functional class; PAP = pulmonary arterial pressure; PCI = percutaneous coronary intervention; PVD = peripheral vascular disease; STS = Society of Thoracic Surgeons; TIA = transient ischemic attack.

in the overall population during the entire study. There were no statistically significant differences in the incidence of major bleeding or cardiovascular death among the study groups at 4 months follow-up,

as well as other adjudicated adverse events according VARC-2 definitions (Table 3). Only 1 patient had an in-hospital major bleeding related to vascular access while on a PRU value of 70 at 6 h after TAVR.

TABLE 2 Procedural Characteristics and In-Hospital Outcome

| | Normal Platelet Reactivity Registry (n = 20) | *p Value Registry vs. Randomized | †p Value Registry vs. Clopidogrel + Aspirin | ‡p Value Registry vs. Ticagrelor + Aspirin | High On-Treatment Platelet Reactivity | | §p Value |
|--|--|----------------------------------|---|--|---------------------------------------|-------------------------------|----------|
| | | | | | Clopidogrel + Aspirin (n = 24) | Ticagrelor + Aspirin (n = 24) | |
| Procedural data | | | | | | | |
| Local anesthesia only | 3 (15.0) | 0.003 | 0.10 | <0.001 | 3 (12.5) | 1 (4.2) | 0.07 |
| Conscious sedation | 5 (25.0) | | | | 14 (58.3) | 21 (87.5) | |
| General anesthesia | 12 (60.0) | | | | 7 (29.2) | 2 (8.3) | |
| Transfemoral access | 20 (100.0) | 1.00 | 1.00 | 1.00 | 24 (100) | 24 (100.0) | 1.00 |
| Balloon pre-dilation | 4 (20.0) | 1.00 | 1.00 | 1.00 | 5 (20.8) | 5 (20.8) | 1.00 |
| Balloon size, mm | 23.3 ± 1.5 | 0.01 | 0.17 | 0.008 | 20.7 ± 2.3 | 19.8 ± 1.1 | 0.48 |
| Valve type, size, and post-dilation | | | | | | | |
| Balloon-expandable valve | 6 (30.0) | | | | 9 (37.5) | 14 (58.3) | |
| Self-expandable valve | 9 (45.0) | | | | 11 (45.8) | 9 (37.5) | |
| Other type of valve | 5 (25.0) | 0.37 | 0.86 | 0.11 | 4 (16.7) | 1 (4.2) | 0.21 |
| ≤23-mm valve | 0 (0.0) | 0.10 | 0.10 | 0.11 | 7 (29.2) | 7 (29.2) | 0.83 |
| 25- to 29-mm valve | 18 (90.0) | | | | 15 (62.5) | 16 (66.7) | |
| >29-mm valve | 2 (10.0) | | | | 2 (8.3) | 1 (4.1) | |
| Balloon post-dilation | 5 (25.0) | 0.70 | 1.00 | 0.64 | 6 (25.0) | 3 (12.5) | 0.46 |
| Balloon size, mm | 24.3 ± 0.96 | 0.38 | 0.38 | 0.49 | 22.7 ± 2.3 | 23.3 ± 2.3 | 0.76 |
| Vascular closure | | | | | | | |
| 2 ProGlides | 13 (65.0) | 0.66 | 0.63 | 0.71 | 19 (79.2) | 16 (66.7) | 0.58 |
| Prostar | 5 (25.0) | | | | 3 (12.5) | 4 (16.7) | |
| Surgical closure | 2 (10.0) | | | | 2 (8.3) | 4 (16.7) | |
| Procedural outcome | | | | | | | |
| Procedural success | 18 (90.0) | 1.00 | NA | 1.00 | 23 (96) | 23 (87.5) | 1.00 |
| Final maximum gradient, mm Hg | 17.9 ± 15.8 | 0.37 | 0.26 | 0.29 | 7.0 ± 4.6 | 11.4 ± 8.1 | 0.17 |
| Final mean gradient, mm Hg | 8.7 ± 8.1 | 0.75 | 0.35 | 0.78 | 4.8 ± 3.7 | 9.8 ± 5.5 | 0.11 |
| Final AR ≥moderate | 2 (10.0) | 0.13 | 0.08 | 0.35 | 1 (4.1) | 3 (12.5) | 0.35 |
| Total dose of UFH, UI | 5,090 ± 2,634 | 0.02 | 0.06 | 0.03 | 6,904 ± 2,462 | 7,000 ± 2,161 | 0.89 |
| Need of valve recapture and reposition | 2 (10.0) | 0.59 | 0.60 | 0.60 | 2 (8.3) | 2 (8.3) | 1.00 |
| Need for a second valve | 0 (0.0) | NA | NA | NA | 0 (0) | 0 (0.0) | NA |
| Conversion to open-heart surgery | 0 (0.0) | NA | NA | NA | 0 (0) | 0 (0.0) | NA |
| Need of permanent pacemaker implantation | 3 (15.0) | 0.71 | 1.00 | 1.00 | 5 (20.8) | 5 (20.8) | 1.00 |
| Hospital stay, days | 7.9 ± 3.6 | 0.86 | 0.88 | 0.85 | 7.7 ± 4.0 | 7.6 ± 5.6 | 0.93 |

Values are n (%), or mean ± SD. *p values of comparison between the registry group and the randomized group. †p values of comparison between the registry group and the clopidogrel + aspirin group. ‡p values of comparison between the registry group and the ticagrelor + aspirin group. §p values of comparison between both randomized groups. Other type of valve includes Lotus valve and Direct Flow valve.

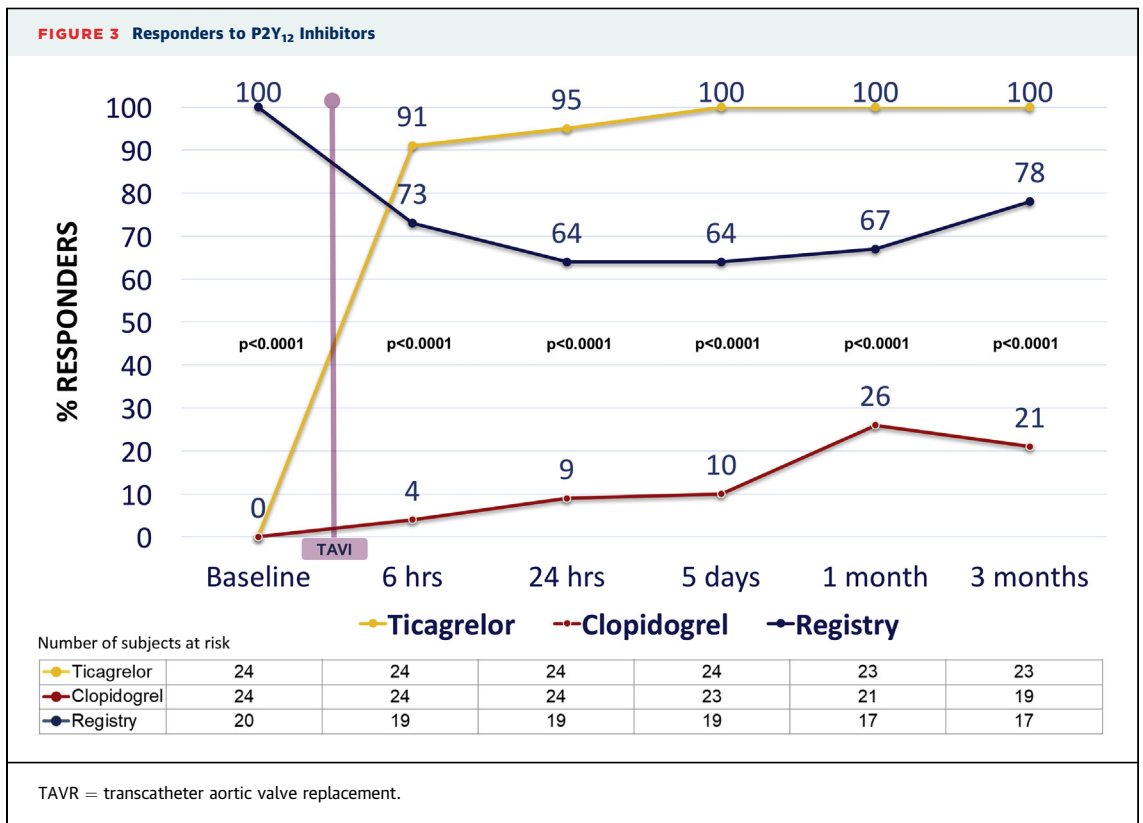
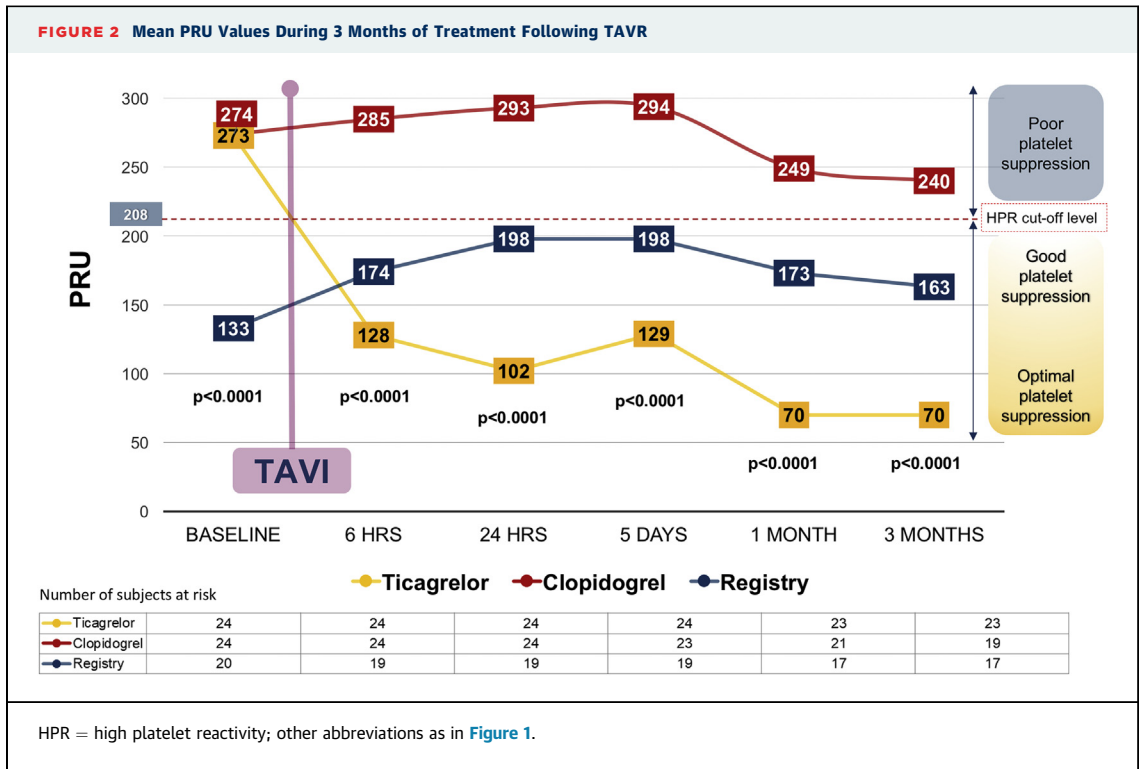
AR = aortic regurgitation; UFH = unfractionated heparin.

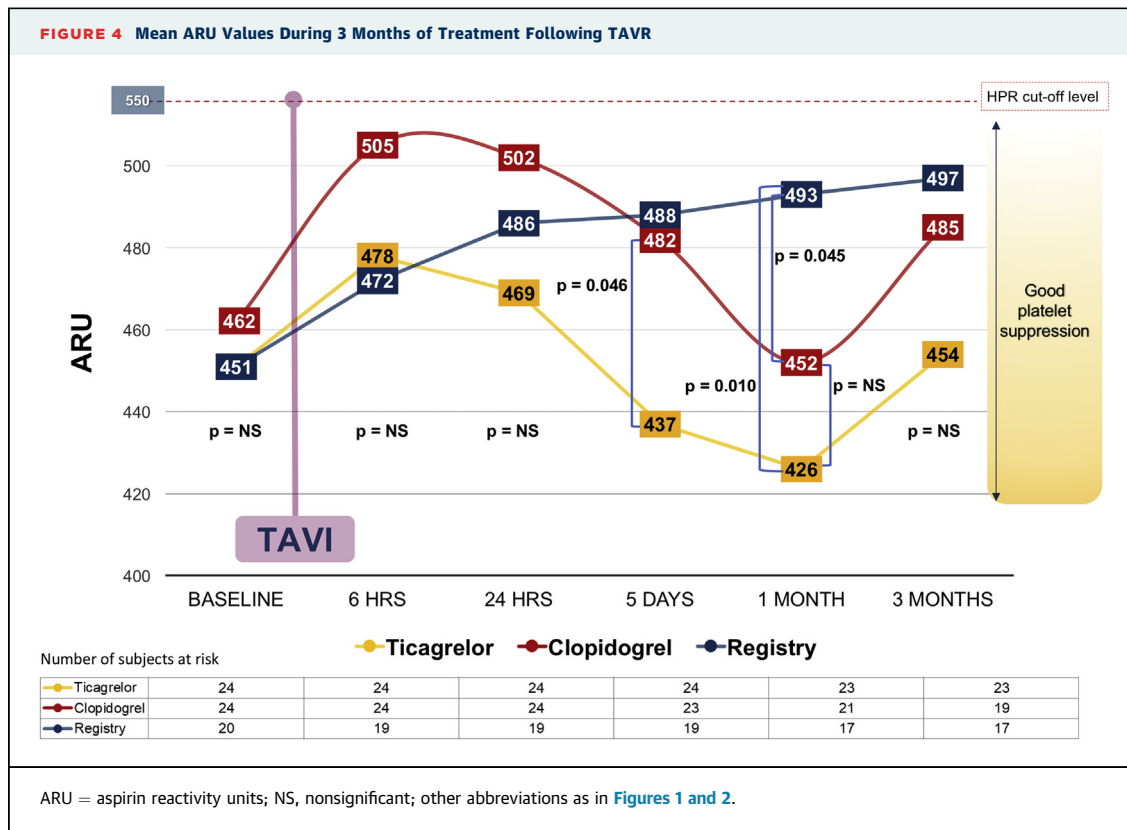
DISCUSSION

To date, there are limited studies evaluating profiles of platelet reactivity in patients with severe AS undergoing TAVR (19–21). The present study is the first to our knowledge to prospectively evaluate profiles of platelet reactivity of patients with AS undergoing TAVR treated with aspirin plus clopidogrel therapy and to evaluate the effects of ticagrelor among patients with HPR. The main results of our study are as follows: 1) HPR to clopidogrel is present in more than two-thirds of patients with AS undergoing TAVR; 2) more than one-third of patients who were identified to be responders to clopidogrel developed HPR status during the first month after TAVR; and 3) ticagrelor is

highly effective for the suppression of HPR to clopidogrel after TAVR with reduced rates of HPR observed already a few hours after valve implantation and with consistent effects throughout the treatment period.

Previous studies have demonstrated that platelet reactivity is abnormally increased in patients with valvular heart disease, generating deposition of platelets and formation of thrombi on the surface of altered or diseased, natural heart valves (22). This may act as a nidus for microthrombi formation in vivo. Increased platelet activation and the thrombogenic environment in patients with severe AS undergoing aortic bioprosthesis implantation might be related to: 1) high transvalvular gradient leading to





increased shear stress and endothelial injury, thereby promoting platelet adhesion and activation; 2) altered aortic blood flow and activation of various prothrombotic factors (23-26) (von Willebrand factor, factor VIII); 3) exposure of subendothelial thrombus-producing materials and release of activated thrombotic factors, such as tissue factor and thrombin, from degenerated native aortic valve leaflets (27) into the circulation generating microthromboemboli (28); and 4) poor antiplatelet effects leading to accumulation of fibrin in the stent valve and microthrombi formation on the nonendothelialized surface of the bovine pericardial tissue leaflets, due to microfissures (potentially produced during crimping) prone to platelet adhesion (Figure 5).

Also, abnormal functional characteristics of platelets in patients with valvular heart disease have been documented, compared with normal subjects, consisting of morphological alterations and with subendothelial components, such as collagen fibers, exposed to the circulating blood with platelet aggregates adhering to collagen fibers. Moreover, abnormally increased thromboplastic activity and decreased fibrinolytic capacity in histopathology analysis of rheumatic mitral valves have been described (29). These features may explain the

hyperactive platelet response found in these patients sustaining a thrombogenic environment.

Platelets are well known to play a major role in coronary stent thrombosis and adequate antiplatelet therapy protects against this phenomenon (17,18,30-34). However, the role of platelets and thus that of antiplatelet therapy in the development of clinical (transient ischemic attack, stroke, valve thrombosis) or subclinical (hypoattenuated leaflet thickening and reduced leaflet motion) thrombotic events after a percutaneous or surgical implant of an aortic bioprosthesis (35-37) is less established. Theoretically, poor antiplatelet response (i.e., presence of HPR) after bioprosthesis implantation could promote fibrin deposition and platelet aggregation, favoring the thickening of valvular leaflets and bioprosthetic structures, a phenomenon that would end with the formation of thrombotic material. Symptomatic increased pressure gradients with thickened leaflet tips, leaflet adhesion, and impairing proper opening but with no evidence of thrombi have been described after early discontinuation of DAPT, with complete resolution after DAPT resume (38). Also, acute cerebral occlusion by a fresh thrombus consisting mainly of accumulations of fibrin and platelets during TAVR, have been reported (39). Ongoing clinical trials are

TABLE 3 Clinical Events at 4-Month Follow-Up

| | Normal Platelet Reactivity Registry (n = 20) | *p Value Registry vs. Randomized | †p Value Registry vs. Clopidogrel + Aspirin | ‡p Value Registry vs. Ticagrelor + Aspirin | High On-Treatment Platelet Reactivity | | |
|---|--|----------------------------------|---|--|---------------------------------------|-------------------------------|----------|
| | | | | | Clopidogrel + Aspirin (n = 24) | Ticagrelor + Aspirin (n = 24) | §p Value |
| Death | 2 (10.0) | 1.00 | 0.67 | 0.20 | 4 (16.7) | 0 (0.0) | 0.10 |
| Stroke | 1 (5.0) | 0.50 | 1.00 | 0.45 | 1 (4.2) | 0 (0.0) | 1.00 |
| Myocardial infarction | 1 (5.0) | 0.29 | 0.45 | 0.45 | 0 (0.0) | 0 (0.0) | NA |
| Major bleeding | 1 (5.0) | 0.15 | 0.54 | 0.61 | 7 (29.2) | 3 (12.5) | 0.28 |
| MACE | 3 (15.0) | 0.68 | 0.71 | 0.08 | 5 (20.8) | 0 (0.0) | 0.05 |
| NACE | 4 (20.0) | 0.43 | 0.07 | 0.68 | 11 (45.8) | 3 (12.5) | 0.01 |
| All bleeding events | 1 (5.0) | 0.09 | 0.05 | 0.35 | 7 (29.2) | 4 (16.7) | 0.49 |
| Acute renal failure | 0 (0.0) | 1.00 | NA | 1.00 | 0 (0.0) | 1 (4.2) | 1.00 |
| Vascular complication | 0 (0.0) | 0.55 | 0.49 | 1.00 | 2 (8.3) | 1 (4.2) | 1.00 |
| Vascular closure device failure | 0 (0.0) | 0.55 | 1.00 | 0.49 | 1 (4.2) | 2 (8.3) | 1.00 |
| Arrhythmias and conduction disturbances | 2 (10.0) | 0.19 | 0.15 | 0.25 | 7 (29.2) | 6 (25.0) | 1.00 |

Values are n (%). *p values of comparison between the registry group and the randomized group. †p values of comparison between the registry group and the clopidogrel + aspirin group. ‡p values of comparison between the registry group and the ticagrelor + aspirin group. §p values of comparison between both randomized groups. All events are according Valve Academic Research Consortium-2 criteria. MACE includes death, stroke, and myocardial infarction. NACE includes death, stroke, myocardial infarction, and major bleeding.

MACE = major adverse cardiovascular event(s); NACE = net adverse clinical event(s).

evaluating oral anticoagulation and DAPT in TAVR patients without atrial fibrillation and will help to define the role of platelets and thrombin on thrombotic events after TAVR (Global Study Comparing a rivAroxaban-based Antithrombotic Strategy to an antiPlatelet-based Strategy After Transcatheter aortic valve replacement to Optimize Clinical Outcomes [GALILEO], [NCT02556203](#); Dual Antiplatelet Therapy Versus Oral Anticoagulation for a Short Time to Prevent Cerebral Embolism After TAVI [AUREA], [NCT01642134](#)).

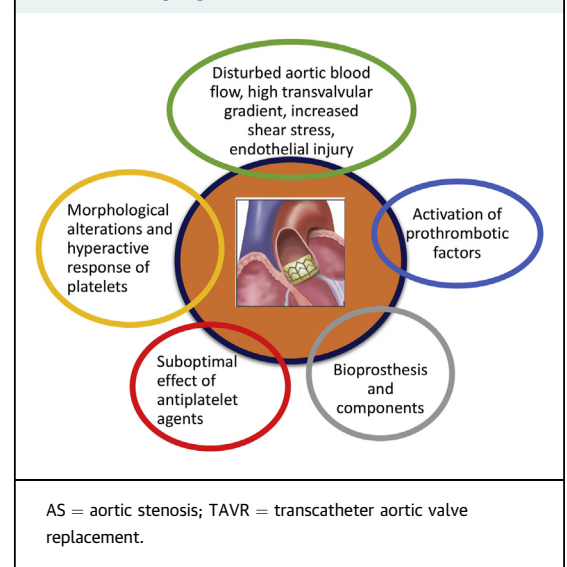
The TAVR population is continuously increasing and poses unique challenges on implementing the optimal antithrombotic regimen. Overall, our results confirm the superior potency of ticagrelor over clopidogrel to achieve prompt and potent platelet inhibitory effects in a new challenging scenario, comparable to what has been described in prior investigations conducted in other clinical settings (40,41). Notably, by the 6-h time point after TAVR, <10% of ticagrelor-treated patients still had HPR. The suppression of HPR with ticagrelor was reached in 100% at 5 days post-TAVR, remaining unchanged during follow-up in all patients. Furthermore, the fact that over 30% of patients initially responding to clopidogrel became nonresponders during the first month after valve implantation, highlights the significant increase in platelet reactivity induced by the bioprosthetic valve implantation procedures and its components at an early stage (use of large-bore catheters and stiff guidewire in the left ventricle, pre-/post-dilation with disruption of native aortic valve leaflets, and calcifications of the aortic valve annulus and aortic arch), as

well as the poor efficacy of clopidogrel to maintain adequate platelet inhibition during the following 3 months after TAVR.

Therefore, ticagrelor represent an attractive alternative to clopidogrel, not only to treat HPR, but also to prevent this from occurring in patients who may present with optimal response to clopidogrel before TAVR.

Platelet reactivity seems to be a dynamic phenomenon, giving relevance to the effect of the timing of measurement on the level of reactivity. Also, interindividual variability in the platelet inhibitory response

FIGURE 5 Potential Factors Leading to Increased Platelet Activation and Prothrombotic Environment in Patients With AS Undergoing TAVR



to clopidogrel has been demonstrated in patients undergoing elective coronary stenting. Gurbel et al. (42), found that the maximum inhibitory response to a 300-mg loading dose of clopidogrel occurs within 24 h. In GRAVITAS (Gauging Responsiveness With A VerifyNow Assay-Impact On Thrombosis And Safety) trial (43), HPR measured 12 to 24 h after percutaneous coronary intervention resolved at the 30-day follow-up in 38% of the patients randomly assigned to standard-dose clopidogrel. In our study, 79% of patients were on long-term (>30 days) use of clopidogrel, and the remaining 29% clopidogrel-naive patients received a 300-mg loading dose, with evaluation of platelet reactivity 24 h after the loading dose. This heterogeneity to timing of baseline platelet function assessment with relationship to timing of clopidogrel intake may explain why 21% of patients initially identified to be nonresponders became responders after TAVR. Furthermore, the Hawthorne effect could also have a role in this change. Hence, the clinical, procedural, and genetic predictors of the early resolution of HPR after TAVR deserve further evaluation.

STUDY LIMITATIONS. The HPR cutoff point used in our study was the cutoff recommended for the evaluation of thrombotic events in patients with coronary artery disease. But, the HPR cutoff for assessing thrombotic events in the TAVR population is still unclear. Given the pharmacodynamic design of the study, it was underpowered for clinical endpoints warranted by adequately powered studies for this purpose.

CONCLUSIONS

Our data suggest that patients undergoing TAVR for severe AS and treated with clopidogrel have high

rates of residual platelet reactivity during the periprocedural period, with a significant increase in platelet reactivity during the first month after TAVR and that may last for up to 3 months thereafter, casting doubts of its efficacy in this setting. Ticagrelor achieves a better and faster effect, providing sustained benefit to these patients over the course of the treatment period without safety concerns. Larger studies are urgently needed to define its clinical benefit in this setting.

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PERSPECTIVES

WHAT IS KNOWN? Lack of compelling evidence exists on the efficacy of aspirin + clopidogrel as antithrombotic treatment in patients with severe AS undergoing TAVR.

WHAT IS NEW? HPR to clopidogrel is present in a considerable number of patients with AS undergoing TAVR and more than one third of patients initially responders to clopidogrel become nonresponder during the treatment period. Ticagrelor achieves a better and faster effect providing sustained suppression of HPR to these patients.

WHAT IS NEXT? Larger clinical trials are needed to assess the clinical implications of these findings.

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KEY WORDS antithrombotic therapy, aortic stenosis, high platelet reactivity, transcatheter aortic valve replacement, VerifyNow

APPENDIX For supplemental methods and a list of the trial investigators, coordinators, committees, and study sites, please see the online version of this paper.