Watanabe, Hirotoshi; Domei, Takenori; Morimoto, Takeshi; Natsuaki, Masahiro; Shiomi, Hiroki; Toyota, Toshiaki; Ohya, Masanobu; ... Furukawa, Yutaka; Nakagawa, Yoshihisa; Kimura, Takeshi

1 **Details on the Effect of Very Short Dual Antiplatelet Therapy**

2 **after Drug-eluting Stent Implantation in Patients with High**

3 **Bleeding Risk;**

4 **Insight from the STOPDAPT-2 Trial**

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6 **Short title:** Detail of STOPDAPT-2 HBR subgroup analysis

7

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2    **Total Word Counts:** 5862 words

3    (Title 25; Abstract 245; Text and Acknowledgement 2969; and Reference, Legends, Tables

4    2623)

5

6    **Journal Subject Terms:** antiplatelet therapy; high bleeding risk; coronary artery disease;

7    percutaneous coronary intervention.

8

10

1 **Abstract**

2 Previously we briefly reported the effect of 1-month dual antiplatelet therapy (DAPT) for

3 patients with high bleeding risk (HBR) receiving percutaneous coronary intervention (PCI) in

4 the STOPDAPT-2 trial, but full analysis data has not been available. We conducted post-hoc

5 subgroup analysis regarding the effect of very short DAPT for HBR patients in

6 STOPDAPT-2 trial. The primary endpoint was a 1-year composite of cardiovascular

7 (cardiovascular death, myocardial infarction, definite stent thrombosis, or stroke) and

8 bleeding (TIMI major/minor bleeding) outcomes. Major secondary endpoints were 1-year

9 cardiovascular composite endpoint and bleeding endpoint. HBR was defined by the academic

10 research consortium (ARC) HBR criteria. Among the 3009 study patients, 1054 (35.0%) were

11 classified as HBR and 1955 (65.0%) were as non-HBR. There were no significant

12 interactions between HBR/non-HBR subgroups and the assigned DAPT group on the primary

13 endpoint (HBR; 3.48% vs. 5.98%, HR 0.57, 95%CI 0.32-1.03, and non-HBR; 1.81% vs.

14 2.36%, HR 0.78, 95%CI 0.42-1.45; P for interaction=0.48), the major secondary

15 cardiovascular endpoint (HBR; 3.07% vs. 4.03%, HR 0.77, 95%CI 0.40-1.48, and non-HBR;

16 1.41% vs. 1.61%, HR 0.89, 95%CI 0.43-1.84; P for interaction=0.77), and the major

17 secondary bleeding endpoint (HBR; 0.41% vs. 2.71%, HR 0.15, 95%CI 0.03-0.65, and

1    non-HBR; 0.40% vs. 0.85%, HR 0.48, 95%CI 0.14-1.58; P for interaction=0.22). In

2    conclusion, the effects of 1-month DAPT for the primary and major secondary endpoints

3    were consistent in HBR and non-HBR patients without any significant interactions. The

4    benefit of 1-month DAPT in reducing major bleeding was numerically greater in HBR

5    patients.

6    (245/250 words)

7

8    **Keywords:** antiplatelet therapy, coronary stent, bleeding, high bleeding risk, and percutaneous

9    coronary intervention.

10    **Clinical trial registration:** Short and Optimal duration of Dual Antiplatelet Therapy after

11    everolimus-eluting cobalt-chromium stent-2 [STOPDAPT-2]; NCT02619760

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1 **TEXT**

2        The current US and European guidelines recommend DAPT for at least 12 months in

3 acute coronary syndrome, and for at least 6 months in stable coronary artery disease, if not at

4 high bleeding risk (HBR)[1,2]. In HBR patients, the updated European guideline recommended

5 shorter DAPT for 6 months in acute coronary syndrome and for 1 month in stable coronary

6 artery disease[2]. There were 3 clinical trials comparing different devices with abbreviated

7 DAPT durations targeting HBR patients, such as LEADERS FREE (the Prospective

8 randomized comparison of the BioFreedom biolimus A9 drug-coated stent versus the gazelle

9 BMS in patients at high bleeding risk), ZEUS (The Zotarolimus- eluting Endeavor sprint

10 stent in Uncertain DES Candidates), and SENIOR (SYNERGY II Everolimus elutiNg stent

11 In patients Older than 75 years under-going coronary Revascularization associated with a

12 short dual antiplatelet therapy)[3-5]. However, no previous study has compared different DAPT

13 durations in HBR patients, and thus, the optimal DAPT duration after PCI using DES in HBR

14 patients has not been yet adequately defined. We previously reported the result of the

15 STOPDAPT-2 (Short and optimal duration of dual antiplatelet therapy after

16 everolimus-eluting cobalt-chromium stent) trial, and the result showed the benefit of 1-month

17 DAPT over 12-month DAPT with reduction of bleeding events without increase in

7

1    cardiovascular events in an all-comer population[6]. This strategy might be particularly

2    beneficial in HBR patients to reduce bleeding events. Therefore, we conducted a post-hoc

3    subgroup analysis of the STOPDAPT-2 trial based on the recently proposed ARC (academic

4    research consortium) HBR criteria[7]. Recently, we published a brief report of this

5    STOPDAPT-2 HBR substudy[8]. However, the important information, whole baseline

6    characteristics and outcomes or time-to-event curves were missing in the brief report, and

7    herein, we report the full analysis data and the additional analysis about the bleeding site and

8    provide further discussion.

9

10    **Methods**

11    **Study population**

12         STOPDAPT-2 is a prospective, multicenter, open-label, adjudicator blinded

13    randomized clinical trial conducted in Japan. The main objective of the STOPDAPT-2 study

14    was to test the non-inferiority of 1 month of DAPT followed by clopidogrel monotherapy

15    compared to 12 months of DAPT with aspirin and clopidogrel in terms of the primary

16    cardiovascular and bleeding composite endpoint in patients receiving PCI with exclusive use

17    of cobalt-chromium everolimus-eluting stent (CoCr-EES). The design, patient enrollment,

1    and main results at 1-year follow-up of the STOPDAPT-2 were previously reported in detail[6].

2    In brief, a total of 3045 patients with successful CoCr-EES implantation and without the plan

3    of staged procedure were enrolled and randomized in a 1-to-1 ratio either to the 1-month

4    DAPT group or 12-month DAPT group. During the initial 1-month (30- to 59-day), all the

5    patients were to receive DAPT with aspirin 81-200 mg/day and P2Y12 receptor blockers

6    (clopidogrel 75mg/day or prasugrel 3.75 mg/day at the discretion of the attending physicians).

7    In the 1-month DAPT group, antiplatelet therapy was switched to clopidogrel monotherapy at

8    1-month, while in the 12-month DAPT group, patients were to receive DAPT with aspirin and

9    clopidogrel up to 12-month. The study basically adopted an "all-comer" design with exclusion

10    criteria limited only to the use of oral anticoagulants, history of intracranial hemorrhage, or

11    known intolerance to clopidogrel. After exclusion of 36 participants who withdrew consent,

12    the final analysis set included 3009 patients comprising 1500 patients in the 1-month DAPT

13    group and 1509 patients in the 12-month DAPT group (Figure 1). Kyoto University Certified

14    Review Board approved the study protocol and written informed consents were obtained

15    from all patients.

16

**Application of ARC-HBR definition**

In the present analysis, patients were divided into HBR or non-HBR based on the

ARC-HBR definitions[7]. Patients were regarded as HBR if having at least one major criterion or

two minor criteria. We modified the ARC-HBR definitions, because some criteria of

ARC-HBR were not exactly captured in the STOPDAPT-2 trial; medication of oral

anticoagulants at discharge from the index hospitalization was regarded as major criterion of

long-term oral anticoagulation. The usage of oral anticoagulants was one of the exclusion

criteria, but some patients receiving anticoagulation were enrolled (protocol violation) and

included in analysis; all previous bleeding history was regarded as minor criterion, because we

did not have information on the timing, requirement of hospitalization or transfusion, and

recurrence for previous history of spontaneous bleeding; liver cirrhosis was considered as

major criterion regardless of the presence of portal hypertension; malignancy was excluded

from the criteria for HBR, because we did not have information whether it was active or not;

history of stroke was regarded as minor criterion, because we did not have information on its

timing; history of intracranial bleeding was regarded as major criteria regardless of its etiology,

although we did not have information whether it was traumatic or spontaneous; planned major

surgery was included as major criteria, regardless of whether the procedure was deferrable or

10

1    not. The information on bleeding diathesis, brain arterio-venous malformation, and recent

2    major trauma or surgery (major criteria), use of non-steroid anti-inflammatory drugs or steroids

3    (minor criteria) were not captured in this trial, and these criteria were regarded as absent. There

4    were missing values for serum creatinine in 10 patients, for platelet counts in 11 patients, and

5    for hemoglobin in 6 patients, and these patients were regarded as not having those HBR

6    criteria such as chronic kidney disease, thrombocytopenia, and anemia.

7         We also assessed thrombotic and bleeding risks of the individual patients by using

8    the Patterns of Non-Adherence to Anti-Platelet Regimen in Stented Patients (PARIS)

9    thrombotic/bleeding risk scores, and Coronary REvascularization Demonstrating Outcome

10   study in Kyoto (CREDO-Kyoto) thrombotic/bleeding risk scores[9,10]. Further, we also

11   evaluated the high-risk features of stent-driven recurrent ischemia derived from the 2017

12   European Society of Cardiology (ESC) focused update on DAPT[2].

13

14   **Outcome measures and definitions**

15        The primary endpoint of the STOPDAPT-2 was a composite of cardiovascular and

16   bleeding outcomes, that is a composite of death from cardiovascular cause, myocardial

17   infarction (MI), definite stent thrombosis, ischemic or hemorrhagic stroke, and bleeding

11

1    defined as Thrombolysis in Myocardial Infarction (TIMI) major or minor criteria[11]. The

2    major secondary cardiovascular endpoint was a composite of death from cardiovascular cause,

3    MI, definite stent thrombosis, and ischemic or hemorrhagic stroke, and the major secondary

4    bleeding endpoint was the bleeding defined as TIMI major or minor. Other secondary

5    endpoints were described in the supplemental appendix. Bleeding events were also

6    adjudicated and classified with the Bleeding Academic Research Consortium (BARC) criteria

7    or Global Utilization of Streptokinase and TPA For Occluded Arteries (GUSTO), and

8    classified by locations or causes (intracranial, gastrointestinal, related with surgery, or

9    others)[12,13]. The definitions of MI, and stent thrombosis were derived from ARC, and stroke

10   was adjudicated if the neurological dysfunction lasted longer than 24 hours[14]. The

11   independent clinical event committee adjudicated the clinical events with blinded fashion

12   about the assigned group. Persistent DAPT discontinuation was defined as discontinuation of

13   either aspirin or $P2Y_{12}$ receptor blockers according to the study protocol or discontinuation

14   lasting for >60 days in consistent with our previous studies[15,16].

15

16   **Statistical Analysis**

17          Categorical variables were presented as number and percentage and were compared

1    with $\chi^2$ test. Continuous variables were expressed as mean +/- standard deviation (SD) or

2    median with interquartile range (IQR) and were compared using the Student *t* test or Wilcoxon

3    rank-sum test depending on their distributions. The cumulative incidence was estimated with

4    the Kaplan-Meier method and compared with log-rank test. Absolute difference of incidence

5    rate was calculated as the event rate in the 1-month DAPT group minus the event rate in the

6    12-month DAPT group. The hazard ratios (HR) for the endpoint events were calculated by the

7    Cox's proportional hazard model with 95% confidential interval (CI) calculated from Wald's

8    statistics.

9        Because the present study was post-hoc subgroup analysis, we did not make any

10    power calculation for the primary and major secondary endpoints, and all reported P values

11    were 2 tailed. P values <0.05 were considered statistically significant. All analysis was

12    performed with JMP version 14.0 software (SAS Institute Inc., Cary, NC).

13

14    **Results**

15    **HBR definitions and classification**

16        Among the 3009 study patients, there were 1054 patients (35.0%) with HBR

17    (1-month DAPT group: N=496, and 12-month DAPT group: N=558), and 1955 patients

1    (65.0%) with non-HBR (1-month DAPT group: N=1004, and 12-month DAPT group:

2    N=951). Patients who met the ARC-HBR major criteria were not commonly found in this

3    randomized trial except for the small proportion patients with severe anemia (8.7%) and

4    end-stage CKD (5.5%), while the ARC-HBR minor criteria were much more prevalent

5    including age >=75 years old (31.5%), moderate CKD (29.4%), and moderate anemia

6    (21.6%) (Supplemental Table 1).

7    **Baseline characteristics, and medications**

8          When we compared HBR patients with non-HBR patients, patient characteristics

9    were totally different (Table 1). HBR patients were older, more often women, and less often

10   current smokers, and had lower body mass index than non-HBR patients. HBR patients more

11   often presented as stable coronary artery disease, and more often had prior PCI, and prior

12   first-generation DES implantation than non-HBR patients. Besides those included in the

13   ARC-HBR criteria, HBR patients more often had comorbidities such as hypertension,

14   diabetes, heart failure, peripheral artery disease, malignancy, left ventricular dysfunction, and

15   mitral regurgitation than non-HBR patients. HBR patients compared with non-HBR patients

16   more often had intermediate/high PARIS and CREDO-Kyoto thrombotic and bleeding risk

17   scores, as well as high-risk features of stent-driven recurrent ischemia derived from the 2017

1    ESC focused update on DAPT. Procedural characteristics were also different between HBR

2    and non-HBR patients, with higher prevalence of femoral approach, longer stenting, targets

3    of left main coronary artery and right coronary artery, and multivessel targets in HBR patients.

4    However, the SYNTAX (Synergy between percutaneous coronary intervention with taxus and

5    cardiac surgery) score evaluated in 20 % of randomly selected patients were comparable

6    between HBR and non-HBR patients[17]. Regarding medications at discharge, HBR patients

7    more often received clopidogrel as the P2Y12 receptor blocker within 1-month than

8    non-HBR patients. Statins were less often prescribed in HBR patients than in non-HBR

9    patients, while the prevalence of proton pump inhibitor use was high and not different

10   between HBR and non-HBR patients (Table 1).

11          Baseline characteristics and medications were well balanced between the 1-month

12   DAPT and 12-month DAPT groups regardless of HBR and non-HBR patients (Supplemental

13   Table 2).

14          In the entire study population, DAPT was actually stopped in 150 patients (10.0%)

15   during the first 30 days, in 752 patients (50.1%) during the first 37 days, in 1090 patients

16   (72.7%) during the first 44 days, in 1286 patients (85.7%) during the first 51 days, and in 1428

17   patients (95.2%) during the first 60 days in the 1-month DAPT group, while DAPT was

15

1    maintained in 1331 patients (88.2%) for 335 days, and in 848 patients (56.2%) for 365-day in

2    the 12-month DAPT group. The patterns of DAPT discontinuation were similar in HBR and

3    non-HBR patients (Supplemental Figure).

4    **Clinical outcomes**

5        In HBR patients, the primary endpoint occurred in 17 patients (3.48%) in the

6    1-month DAPT group and in 33 patients (5.98%) in the 12-month DAPT (absolute difference

7    -2.50%, 95%CI -5.06% to 0.06%, HR 0.57, 95%CI 0.32-1.03, P=0.06) (Figure 2a, 3, and

8    Table 2a). In non-HBR patients, the primary endpoint occurred in 18 patients (1.81%) in the

9    1-month DAPT group and in 22 patients (2.36%) in the 12-month DAPT group (absolute

10    difference -0.55%, 95%CI -1.83% to 0.73%, HR 0.78, 95%CI 0.42-1.45, P=0.43) (Figure 2a

11    and Table 2b). There was no significant interaction between HBR/non-HBR subgroups and

12    the effect of 1-month DAPT relative to 12-month DAPT on the primary endpoint (P for

13    interaction=0.48).

14        The major secondary cardiovascular endpoint occurred in 15 patients (3.07%) in

15    the 1-month DAPT group and in 22 patients (4.03%) in the 12-month DAPT group in HBR

16    patients (absolute difference -0.96%, 95%CI -3.21% to 1.29%, HR 0.77, 95%CI 0.40-1.48,

17    P=0.43) (Figure 2b and Table 2a). In non-HBR patients, the major secondary cardiovascular

16

1    endpoint occurred in 14 patients (1.41%) in 1-month DAPT group and in 15 patients (1.61%)

2    in the 12-month DAPT group (absolute difference -0.20%, 95%CI -1.28% to 0.88%, HR 0.89,

3    95%CI 0.43-1.84, P=0.75) (Figure 2b, 3, and Table 2b). There was no significant interaction

4    between HBR/non-HBR subgroups and the effect of 1-month DAPT relative to 12-month

5    DAPT on the major secondary cardiovascular endpoint (P for interaction=0.77).

6        The rate of the major secondary bleeding endpoint was significantly lower in the

7    1-month DAPT group (2 patients, 0.41%) than in the 12-month DAPT group (15 patients,

8    2.71%) in HBR patients (absolute difference -2.30%, 95%CI -3.77% to -0.83%, HR 0.15,

9    95%CI 0.03-0.65, P=0.01) (Figure 2c and Table 2a). In non-HBR patients, the major

10   secondary bleeding endpoint occurred in 4 patients (0.40%) in the 1-month DAPT group and

11   in 8 patients (0.85%) in the 12-month DAPT group (absolute difference -0.45%, 95%CI

12   -1.16% to 0.26%, HR 0.48, 95%CI 0.14-1.58, P=0.22) (Figure 2c and Table 2b). There was

13   no significant interaction between HBR/non-HBR subgroups and the effect of 1-month

14   DAPT relative to 12-month DAPT on the major secondary bleeding endpoint (P for

15   interaction=0.22). However, the benefit of 1-month DAPT over 12-month DAPT in reducing

16   major bleeding was numerically greater in HBR patients than in non-HBR patients.

17       In HBR patients, intracranial hemorrhage occurred in no patient (0%) in the

17

1    1-month DAPT group and in 3 patients (0.54%) in the 12-month DAPT group (Figure 3, and

2    Table 2).

3

4    **Discussion**

5           The main findings of the present post-hoc subgroup analysis of the STOPDAPT-2

6    trial based on the ARC-HBR criteria were the followings; 1) The effects of 1-month DAPT

7    relative to 12-month DAPT for the primary and major secondary endpoints were consistent in

8    HBR and non-HBR patients without any significant interactions; 2) The benefit of 1-month

9    DAPT over 12-month DAPT in reducing major bleeding was numerically greater in HBR

10   patients than in non-HBR patients.

11          Recently, there is an increasing attention on HBR patients who undergo PCI. HBR

12   patients were often excluded or underrepresented in the randomized trials, and therefore, the

13   optimal antithrombotic management after PCI in HBR patients has not been yet well

14   established. Furthermore, HBR patients had not been well defined, and the definitions of

15   HBR patients were different among the HBR trials[3-5]. The ARC-HBR has been proposed to

16   standardize the definition of HBR from the literature review and by the consensus of experts[7].

17   In the ARC-HBR initiative, HBR was arbitrarily defined as a BARC 3 or 5 bleeding >=4% at

1      1-year or a risk of an intracranial hemorrhage >=1% at 1-year. In the present analysis, the

2      prevalence of ARC-HBR patients were high (35%) even if we excluded those with very high

3      bleeding risk such as those with use of oral anticoagulants and/or history of intracranial

4      hemorrhage. The rate of major bleeding with 12-month DAPT was substantially higher in

5      HBR patients than in non-HBR patients. In HBR patients, 1-month DAPT compared with

6      12-month DAPT was associated with significantly lower risk for major bleeding, and the

7      benefit of 1-month DAPT over 12-month DAPT in reducing major bleeding was numerically

8      greater in HBR patients than in non-HBR patients. Therefore, 1-month DAPT is an attractive

9      DAPT regimen particularly in HBR patients. In the previous HBR trials, the 1-year rates of

10     major bleeding remained high even with the abbreviated DAPT regimen (LEADERS FREE:

11     7.2%, ZEUS: 3.5-5%, and SENIOR: 3-4%)[3-5], while the 1-year rate of major bleeding with

12     1-month DAPT in HBR patients was extremely low (0.41%) in the present study. In the

13     previous HBR trials, aspirin monotherapy was generally used after stopping DAPT. One of

14     the reasons for this very low rate of major bleeding in the present study might be related to

15     the use of clopidogrel monotherapy[18,19]. However, we did not test aspirin monotherapy after

16     stopping DAPT at 1-month. Further research would be important to define the optimal

17     antiplatelet monotherapy after stopping DAPT in HBR patients.

1          One of the most important issues related to the adoption of very short DAPT

2      duration in HBR patients would be whether it might result in an increase in the

3      cardiovascular events. It is well known that HBR patients also have higher risk for ischemic

4      cardiovascular events[10]. Indeed, more than 70% of HBR patients in this study also had

5      high-risk features of stent-driven recurrent ischemia defined in the ESC focused update of

6      DAPT guideline[2]. However, in the present study, 1-month DAPT in HBR patients was not

7      associated with an increase in cardiovascular event rates, but was associated with a numerical

8      decrease in cardiovascular event rates. Despite the positive results in the STOPDAPT-2 trial,

9      1-month DAPT has not been yet the generally accepted regimen after PCI using DES.

10     Nevertheless, 1-month DAPT followed by clopidogrel monotherapy would be an important

11     option in patients with very high bleeding risk, considering the substantial mortality impact

12     and iatrogenic nature of the bleeding events[20,21].

13          There are several important limitations in current analysis. First, the majority of

14     patients enrolled in the STOPDAPT-2 trial had low/intermediate ischemic risk. The benefit of

15     very short DAPT should be confirmed in other populations such as patients with acute

16     coronary syndrome or with complex coronary artery disease. Furthermore, the STOPDAPT-2

17     trial enrolled those patients who did not have procedural complications, leading to

1    underestimation of the rate of major bleeding at 1-year. Second, the present post-hoc

2    subgroup analysis related to HBR/non-HBR patients was totally underpowered and

3    exploratory. Therefore, the favorable results of 1-month DAPT in HBR patients should be

4    regarded as hypothesis generating. Third, there were some uncaptured data for ARC-HBR

5    criteria. Fourth, it is well known that Japanese patients with coronary artery disease had lower

6    ischemic risk as compared with US/European patients[22-24]. In addition, the vast majority of

7    patients in this study underwent PCI guided by intracoronary imaging devices, which were

8    rarely used in US and Europe. Therefore, we should be cautious about extrapolating the current

9    study results outside Japan.

10

11   **Conclusion**

12       In this post-hoc subgroup analysis of the STOPDAPT-2 trial based on the

13   ARC-HBR criteria, the effects of 1-month DAPT relative to 12-month DAPT for the primary

14   and major secondary endpoints were consistent in HBR and non-HBR patients without any

15   significant interactions. The benefit of 1-month DAPT over 12-month DAPT in reducing

16   major bleeding was numerically greater in HBR patients than in non-HBR patients.

17

1    **Acknowledgements**

10    **Conflict of interests**

11    Koichi Nakao has received a speaker honorarium from Sanofi and Daiichi-Sankyo. Kenji Ando

12    has received a speaker honorarium from Japan Lifeline, Medtronic Japan, Terumo, and

13    Biotronik Japan. Kengo Tanabe has received a speaker honorarium from Kaneka Medix. Yuji

14    Ikari received a research grant from Abbott Vascular Japan. Yoshihisa Nakagawa has received

15    a speaker honorarium from Daiichi-Sankyo, Bayer Yakuhin, and Bristol-Myers Squibb.

16    Takeshi Kimura serves as a advisory role to Abbott Vascular japan and received a research

1    grant from Daiichi-Sankyo. Others have no conflict of interest

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3

1    **Figure legends**

2    **Figure 1. Study flow**

3    HBR is defined by ARC-HBR definition.

4    ARC=Academic Research Consortium, DAPT=dual antiplatelet therapy, and HBR=high

5    bleeding risk.

6

7    **Figure 2. Clinical Outcomes at 1-year stratified by HBR and non-HBR: 1-momth**

8    **versus 12-month DAPT**

9    Time-to-event curves up to 1-year for (a) primary endpoint, (b) major secondary

10    cardiovascular endpoint, and (c) major secondary bleeding endpoint stratified by HBR and

11    non-HBR.

12    CI=confidence interval, HBR=high bleeding risk, HR=hazard ratio, MI=myocardial

13    infarction, PCI=percutaneous coronary intervention, and TIMI=Thrombolysis in Myocardial

14    Infarction.

15

16    **Figure 3. Bleeding sites in HBR patients and non-HBR patients**

17    Cumulative 1-year incidences of TIMI major or minor bleeding, and its breakdown classified

1    by the bleeding sites in HBR patients and non-HBR patients.

2    DAPT=dual antiplatelet therapy, GI=gastrointestinal, HBR=high bleeding risk,

3    ICH=intracranial hemorrhage, and TIMI=Thrombolysis in Myocardial Infarction.

**Tables**

## Table 1. Background differences between HBR patients and non-HBR patients

| | HBR | Non-HBR | P value |
|---|---|---|---|
| | N=1054 | N=1955 | |
| **Base background** | | | |
| Age, years | 75.8±8.6 | 64.8±9.7 | <0.001 |
| >=75 | 708 (67.2) | 239 (12.2) | <0.001 |
| Men | 736 (69.8) | 1601 (81.9) | <0.001 |
| BMI, kg/m$^2$ | 23.5±3.5 | 24.7±3.5 | <0.001 |
| <25 | 721 (68.4) | 1094 (56.0) | <0.001 |
| **Presentation** | | | |
| Acute coronary syndrome | 310 (29.4) | 838 (42.9) | <0.001 |
| STEMI | 139 (13.2) | 422 (21.6) | <0.001 |
| NSTEMI | 41 (3.9) | 139 (7.1) | <0.001 |
| Unstable angina | 130 (12.3) | 277 (14.2) | 0.16 |
| Stable coronary artery disease | 744 (70.6) | 1117 (57.1) | <0.001 |

**Past history**

| | | | |
|---|---|---|---|
| Prior PCI | 464 (44.0) | 568 (29.1) | <0.001 |
| Prior first-generation DES | 60 (5.7) | 52 (2.7) | <0.001 |
| Prior CABG | 35 (3.3) | 24 (1.2) | <0.001 |
| Prior myocardial infarction | 164 (15.6) | 242 (12.4) | 0.016 |
| Prior stroke | 149 (14.1) | 37 (1.9) | <0.001 |
| Prior ischemic stroke | | | |
| Prior hemorrhagic stroke | 8 (0.8) | 0 (0) | <0.001 |
| Prior bleeding | 42 (4.0) | 5 (0.3) | <0.001 |
| Congestive heart failure | 141 (13.4) | 81 (4.1) | <0.001 |
| Atrial fibrillation | 33 (3.1) | 24 (1.2) | <0.001 |
| Severe anemia | 263 (25.0) | 0 (0) | <0.001 |
| Thrombocytopenia | 31 (2.9) | 0 (0) | <0.001 |
| COPD | 41 (3.9) | 43 (2.2) | 0.009 |
| Liver cirrhosis | 10 (1.0) | 0 (0) | <0.001 |
| Malignancy | 147 (14.0) | 109 (5.6) | <0.001 |

| | | | |
|---|---|---|---|
| Peripheral artery disease | 134 (12.7) | 62 (3.2) | <0.001 |
| Moderate CKD | 595 (56.5) | 288 (14.7) | <0.001 |
| Severe CKD | 166 (15.8) | 0 (0) | <0.001 |
| eGFR<30 and not on dialysis | 64 (6.1) | 0 (0) | <0.001 |
| Dialysis | 102 (9.7) | 0 (0) | <0.001 |
| Hypertension | 855 (81.1) | 1366 (69.9) | <0.001 |
| Dyslipidemia | 765 (72.6) | 1479 (75.7) | 0.07 |
| Diabetes mellitus | 466 (44.2) | 693 (35.5) | <0.001 |
| Insulin-treated | 95 (9.0) | 107 (5.5) | <0.001 |
| Current smoking | 145 (13.8) | 565 (28.9) | <0.001 |
| Left ventricular ejection fraction | 58.7±10.9 | 60.3±10.0 | <0.001 |
| <40% | 55 (5.7) | 60 (3.3) | 0.004 |
| Mitral regurgitation with grade 3/4 | 43 (4.1) | 32 (1.6) | <0.001 |
| PARIS thrombotic risk score | 3.4±1.6 | 2.2±1.5 | <0.001 |
| Low | 328 (31.1) | 1159 (59.3) | <0.001 |
| Intermediate | 430 (40.8) | 666 (34.1) | |

| | | | |
|---|---|---|---|
| High | 296 (28.1) | 130 (6.7) | |
| PARIS bleeding risk score | 7.3±2.4 | 4.1±1.9 | <0.001 |
| Low | 83 (7.9) | 775 (39.6) | <0.001 |
| Intermediate | 468 (44.4) | 1090 (55.8) | |
| High | 503 (47.7) | 90 (4.6) | |
| CREDO-Kyoto thrombotic risk score | 2.4±1.7 | 0.6±0.8 | <0.001 |
| Low | 380 (36.1) | 1718 (87.9) | <0.001 |
| Intermediate | 447 (42.4) | 229 (11.7) | |
| High | 227 (21.5) | 8 (0.4) | |
| CREDO-Kyoto bleeding risk score | 1.2±1.5 | 0.3±0.7 | <0.001 |
| Low | 497 (47.2) | 1495 (76.5) | <0.001 |
| Intermediate | 381 (36.2) | 418 (21.4) | |
| High | 176 (16.7) | 42 (2.2) | |
| High-risk features of stent-driven recurrent ischemia † | 807 (76.6) | 486 (24.9) | <0.001 |

**Procedural background**

| | | | |
|---|---|---|---|
| Invasive FFR | 162 (15.4) | 253 (12.9) | 0.07 |
| Radial approach | 785 (74.5) | 1711 (87.5) | <0.001 |
| Brachial approach | 96 (9.1) | 64 (3.3) | <0.001 |
| Femoral approach | 179 (17.0) | 203 (10.4) | <0.001 |
| Number of lesions | 1.11±0.36 | 1.15±0.40 | 0.01 |
| SYNTAX scores* | 10.2±6.6 | 10.4±7.1 | 0.75 |
| Minimal stent diameter, mm | 2.96±0.47 | 2.98±0.49 | 0.23 |
| <3.0 | 445 (42.2) | 792 (40.5) | 0.36 |
| Total stent length, mm | 31.6±17.7 | 29.7±16.2 | 0.003 |
| >=28 | 574 (54.5) | 955 (48.9) | 0.003 |
| Target vessel | | | |
| LMCA | 44 (4.2) | 36 (1.8) | <0.001 |
| LAD | 546 (51.8) | 1136 (58.1) | 0.001 |
| CX | 195 (18.5) | 378 (19.3) | 0.58 |
| RCA | 342 (32.5) | 504 (25.8) | <0.001 |
| Graft | 5 (0.5) | 1 (0.1) | 0.01 |

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| | | | |
|---|---|---|---|
| Target of CTO | 38 (3.6) | 84 (4.3) | 0.35 |
| Target of bifurcation | 283 (26.9) | 486 (24.9) | 0.23 |
| Bifurcation with 2 stents | 7 (0.7) | 7 (0.4) | 0.25 |
| Target of 2 vessels or more | 98 (9.3) | 118 (6.0) | 0.001 |
| Target of 3 vessels | 5 (0.5) | 6 (0.3) | 0.48 |
| Use of intravascular ultrasound | 907 (86.1) | 1649 (84.4) | 0.21 |
| Use of optical coherence tomography | 141 (13.4) | 302 (15.5) | 0.12 |
| **Medication at discharge** | | | |
| Aspirin | 1051 (99.7) | 1955 (100) | 0.01 |
| P2Y12 receptor blockers | 1053 (99.9) | 1954 (99.95) | 0.66 |
| Clopidogrel | 713 (67.7) | 1139 (58.3) | <0.001 |
| Prasugrel | 337 (32.0) | 814 (41.6) | <0.001 |
| Ticlopidine | 3 (0.3) | 1 (0.1) | 0.1 |
| Cilostazol | 3 (0.3) | 3 (0.2) | 0.45 |
| Oral anticoagulants | 13 (1.2) | 0 (0) | <0.001 |
| Beta blockers | 464 (44.0) | 851 (43.5) | 0.79 |

| | | | |
|---|---|---|---|
| ACE inhibitors or ARB | 668 (63.4) | 1205 (61.6) | 0.35 |
| Statins | 853 (80.9) | 1782 (91.2) | <0.001 |
| Proton pump inhibitors | 818 (77.6) | 1565 (80.1) | 0.12 |

Values are means ± SD or number (%). ACE=angiotensin converting enzyme,

ARB=angiotensin 2 receptor blockers, BMI=body mass index, CABG=coronary artery

bypass grafting, CKD=chronic kidney disease, COPD=chronic obstructive pulmonary

disease, CREDO-Kyoto=Coronary REvascularization Demonstrating Outcome study in

Kyoto, CTO=chronic total occlusion, CX= left circumflex coronary artery, DAPT=dual

antiplatelet therapy, DES=drug eluting stents, eGFR=estimated glomerular filtration rate,

FFR=fractional flow reserve, HBR=high bleeding risk, LAD=left anterior descending

coronary artery, LMCA=left main coronary artery, NSTEMI=Non ST-segment elevation

myocardial infarction, PARIS=Patterns of Non- Adherence to Anti-Platelet Regimen in

Stented Patients, PCI=percutaneous coronary intervention, RCA=right coronary artery,

SD=standard deviation, STEMI=ST-segment elevation myocardial infarction, and

SYNTAX=Synergy Between Percutaneous Coronary Intervention With Taxus.

*SYNTAX scores were calculated at core laboratory of angiogram for randomly selected

571 patients.

† High-risk features of stent-driven recurrent ischemia were derived from 2017 ESC

focused update of on DAPT[2].

**Table 2. Clinical outcomes stratified by HBR and non-HBR**

**(a) HBR stratum**

| | No. (event %) | | Hazard ratio | P value |
|---|---|---|---|---|
| | 1M-DAPT | 12M-DAPT | (95% CI) | |
| | (N=496) | (N=558) | | |
| **Primary endpoint** | | | | |
| Cardiovascular death, MI, Definite ST, Stroke, or TIMI major or minor bleeding | 17 (3.48%) | 33 (5.98%) | 0.57 (0.32-1.03) | 0.06 |
| **Major secondary endpoints** | | | | |
| Cardiovascular death, MI, Definite ST, or Stroke | 15 (3.07%) | 22 (4.03%) | 0.77 (0.40-1.48) | 0.43 |
| TIMI major or minor bleeding | 2 (0.41%) | 15 (2.71%) | 0.15 (0.03-0.65) | 0.01 |
| **Other endpoints** | | | | |
| Death | 13 (2.67%) | 12 (2.16%) | 1.22 (0.56-2.67) | 0.62 |

| | | | | |
|---|---|---|---|---|
| Cardiac death | 5 (1.02%) | 6 (1.09%) | 0.94 (0.29-3.08) | 0.92 |
| Cardiovascular death | 5 (1.02%) | 8 (1.44%) | 0.70 (0.23-2.15) | 0.54 |
| Non-cardiovascular death | 8 (1.66%) | 4 (0.73%) | 2.25 (0.68-7.48) | 0.18 |
| MI | 6 (1.24%) | 3 (0.55%) | 2.25 (0.56-9.01) | 0.25 |
| Large MI (CKMB>=10*ULN) | 1 (0.21%) | 0 (0.00%) | - | - |
| Small MI (CKMB<10*ULN) | 5 (1.04%) | 2 (0.36%) | 2.82 (0.55-14.52) | 0.22 |
| MI without CKMB elevation | 0 (0.00%) | 1 (0.18%) | - | - |
| MI without measurement of CKMB | 0 (0.00%) | 0 (0.00%) | - | - |
| Definite ST | 0 (0.00%) | 0 (0.00%) | - | - |
| Definite or Probable ST | 1 (0.20%) | 0 (0.00%) | - | - |
| Stroke | 5 (1.03%) | 12 (2.24%) | 0.47 (0.16-1.33) | 0.15 |
| Ischemic | 5 (1.03%) | 11 (2.07%) | 0.51 (0.18-1.47) | 0.21 |
| Hemorrhagic | 0 (0.00%) | 1 (0.18%) | - | - |
| Bleeding | | | | |
| TIMI major | 0 (0.00%) | 10 (1.81%) | - | - |
| TIMI minor | 2 (0.41%) | 5 (0.91%) | 0.45 (0.09-2.31) | 0.34 |

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| | | | | |
|---|---|---|---|---|
| BARC 3 or 5 | 3 (0.61%) | 18 (3.26%) | 0.19 (0.05-0.63) | 0.007 |
| BARC 5 | 1 (0.20%) | 3 (0.54%) | 0.38 (0.04-3.61) | 0.4 |
| BARC 5b | 1 (0.20%) | 2 (0.36%) | 0.56 (0.05-6.21) | 0.64 |
| BARC 5a | 0 (0.00%) | 1 (0.18%) | - | - |
| BARC 3 | 2 (0.41%) | 15 (2.72%) | 0.15 (0.03-0.65) | 0.01 |
| BARC 3c | 0 (0.00%) | 2 (0.37%) | - | - |
| BARC 3b | 0 (0.00%) | 7 (1.27%) | - | - |
| BARC 3a | 2 (0.41%) | 7 (1.27%) | 0.32 (0.07-1.54) | 0.16 |
| GUSTO moderate/severe | 2 (0.41%) | 15 (2.72%) | 0.15 (0.03-0.65) | 0.01 |
| GUSTO severe | 1 (0.20%) | 7 (1.27%) | 0.16 (0.02-1.30) | 0.09 |
| GUSTO moderate | 1 (0.20%) | 8 (1.45%) | 0.14 (0.02-1.12) | 0.06 |
| Intracranial bleeding | 0 (0.00%) | 3 (0.54%) | - | - |
| Gastrointestinal bleeding | 3 (0.61%) | 13 (2.35%) | 0.26 (0.07-0.90) | 0.03 |
| Revascularization | 41 (8.58%) | 38 (7.10%) | 1.21 (0.78-1.89) | 0.39 |
| TLR | 15 (3.10%) | 10 (1.88%) | 1.70 (0.76-3.78) | 0.19 |
| CD-TLR | 10 (2.07%) | 7 (1.32%) | 1.61 (0.61-4.23) | 0.33 |

| | | | | |
|---|---|---|---|---|
| Non-TLR | 30 (6.31%) | 30 (5.59%) | 1.12 (0.68-1.86) | 0.65 |
| CABG | 2 (0.44%) | 2 (0.37%) | 1.13 (0.16-8.01) | 0.9 |
| Death or MI | 17 (3.48%) | 15 (2.70%) | 1.28 (0.64-2.56) | 0.49 |
| Cardiovascular death or MI | 10 (2.05%) | 11 (1.99%) | 1.02 (0.43-2.41) | 0.96 |
| MACE (Cardiac death, MI, or CD-TLR) | 15 (3.08%) | 14 (2.58%) | 1.21 (0.58-2.50) | 0.61 |

## (b) Non-HBR stratum

| Patients without HBR | 1M-DAPT (N=956) | 12M-DAPT (N=890) | Hazard ratio (95% CI) | P Value |
|---|---|---|---|---|
| **Primary endpoint** | | | | |
| Cardiovascular death, MI, Definite ST, Stroke, or TIMI major or minor bleeding | 18 (1.81%) | 22 (2.36%) | 0.78 (0.42-1.45) | 0.43 |
| **Major secondary endpoints** | | | | |
| Cardiovascular death, MI, | 14 (1.41%) | 15 (1.61%) | 0.89 (0.43-1.84) | 0.75 |

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Definite ST, or Stroke

| | | | | |
|---|---|---|---|---|
| TIMI major or minor bleeding | 4 (0.40%) | 8 (0.85%) | 0.48 (0.14-1.58) | 0.22 |

**Other endpoints**

| | | | | |
|---|---|---|---|---|
| Death | 8 (0.81%) | 6 (0.64%) | 1.27 (0.44-3.66) | 0.66 |
| Cardiac death | 3 (0.30%) | 2 (0.22%) | 1.43 (0.24-8.54) | 0.7 |
| Cardiovascular death | 4 (0.40%) | 3 (0.32%) | 1.27 (0.28-5.67) | 0.75 |
| Non-cardiovascular death | 4 (0.40%) | 3 (0.32%) | 1.27 (0.28-5.68) | 0.75 |
| MI | 7 (0.71%) | 8 (0.87%) | 0.83 (0.30-2.30) | 0.72 |
| Large MI (CKMB>=10*ULN) | 4 (0.41%) | 2 (0.21%) | 1.90 (0.35-10.39) | 0.46 |
| Small MI (CKMB<10*ULN) | 2 (0.20%) | 3 (0.33%) | 0.63 (0.11-3.80) | 0.62 |
| MI without CKMB elevation | 1 (0.10%) | 1 (0.11%) | 0.96 (0.06-15.28) | 0.97 |
| MI without measurement of CKMB | 0 (0.00%) | 2 (0.21%) | - | - |
| Definite ST | 2 (0.20%) | 1 (0.11%) | 1.90 (0.17-20.97) | 0.6 |
| Definite or Probable ST | 3 (0.30%) | 1 (0.11%) | 2.85 (0.30-27.39) | 0.36 |
| Stroke | 3 (0.30%) | 4 (0.42%) | 0.71 (0.16-3.18) | 0.66 |

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| | | | | |
|---|---|---|---|---|
| Ischemic | 3 (0.30%) | 4 (0.42%) | 0.71 (0.16-3.18) | 0.66 |
| Hemorrhagic | 0 (0.00%) | 0 (0.00%) | - | - |
| Bleeding | | | | |
| TIMI major | 3 (0.30%) | 6 (0.64%) | 0.48 (0.12-1.90) | 0.29 |
| TIMI minor | 1 (0.10%) | 2 (0.21%) | 0.48 (0.04-5.24) | 0.54 |
| BARC 3 or 5 | 5 (0.50%) | 9 (0.96%) | 0.53 (0.18-1.57) | 0.25 |
| BARC 5 | 0 (0.00%) | 0 (0.00%) | - | - |
| BARC 5b | 0 (0.00%) | 0 (0.00%) | - | - |
| BARC 5a | 0 (0.00%) | 0 (0.00%) | - | - |
| BARC 3 | 5 (0.50%) | 9 (0.96%) | 0.53 (0.18-1.57) | 0.25 |
| BARC 3c | 2 (0.20%) | 2 (0.21%) | 0.95 (0.13-6.76) | 0.96 |
| BARC 3b | 1 (0.10%) | 4 (0.42%) | 0.24 (0.03-2.12) | 0.2 |
| BARC 3a | 2 (0.20%) | 3 (0.32%) | 0.63 (0.11-3.79) | 0.62 |
| GUSTO moderate/severe | 4 (0.40%) | 8 (0.85%) | 0.48 (0.14-1.58) | 0.22 |
| GUSTO severe | 3 (0.30%) | 4 (0.43%) | 0.71 (0.16-3.19) | 0.66 |
| GUSTO moderate | 1 (0.10%) | 4 (0.42%) | 0.24 (0.03-2.12) | 0.2 |

| | | | | |
|---|---|---|---|---|
| Intracranial bleeding | 2 (0.20%) | 2 (0.21%) | 0.95 (0.13-6.76) | 0.96 |
| Gastrointestinal bleeding | 3 (0.30%) | 6 (0.64%) | 0.47 (0.12-1.90) | 0.29 |
| Revascularization | 57 (5.87%) | 38 (4.18%) | 1.45 (0.96-2.18) | 0.08 |
| TLR | 20 (2.03%) | 13 (1.43%) | 1.48 (0.73-2.97) | 0.27 |
| CD-TLR | 16 (1.62%) | 12 (1.32%) | 1.28 (0.60-2.70) | 0.52 |
| Non-TLR | 41 (4.24%) | 30 (3.28%) | 1.31 (0.82-2.10) | 0.26 |
| CABG | 4 (0.41%) | 3 (0.32%) | 1.27 (0.28-5.68) | 0.75 |
| Death or MI | 15 (1.51%) | 14 (1.51%) | 1.02 (0.49-2.11) | 0.96 |
| Cardiovascular death or MI | 11 (1.11%) | 11 (1.19%) | 0.95 (0.41-2.20) | 0.91 |
| MACE (Cardiac death, MI, or CD-TLR) | 23 (2.32%) | 18 (1.97%) | 1.22 (0.66-2.27) | 0.52 |

BARC=the Bleeding Academic Research Consortium, CABG=Coronary Artery Bypass Grafting, CD-TLR=Clinically-driven Target Lesion Revascularization, CKMB=Creatine Kinase-MB, DAPT=Dual Antiplatelet Therapy, GUSTO=Global Utilization of Streptokinase and TPA For Occluded Arteries, HBR= High bleeding risk, MACE=Major Adverse Cardiac Event, MI=Myocardial Infarction, ST=Stent thrombosis, TIMI=Thrombolysis in Myocardial

Infarction, TLR=Target Lesion Revascularization, and ULN=Upper limit of Normal.
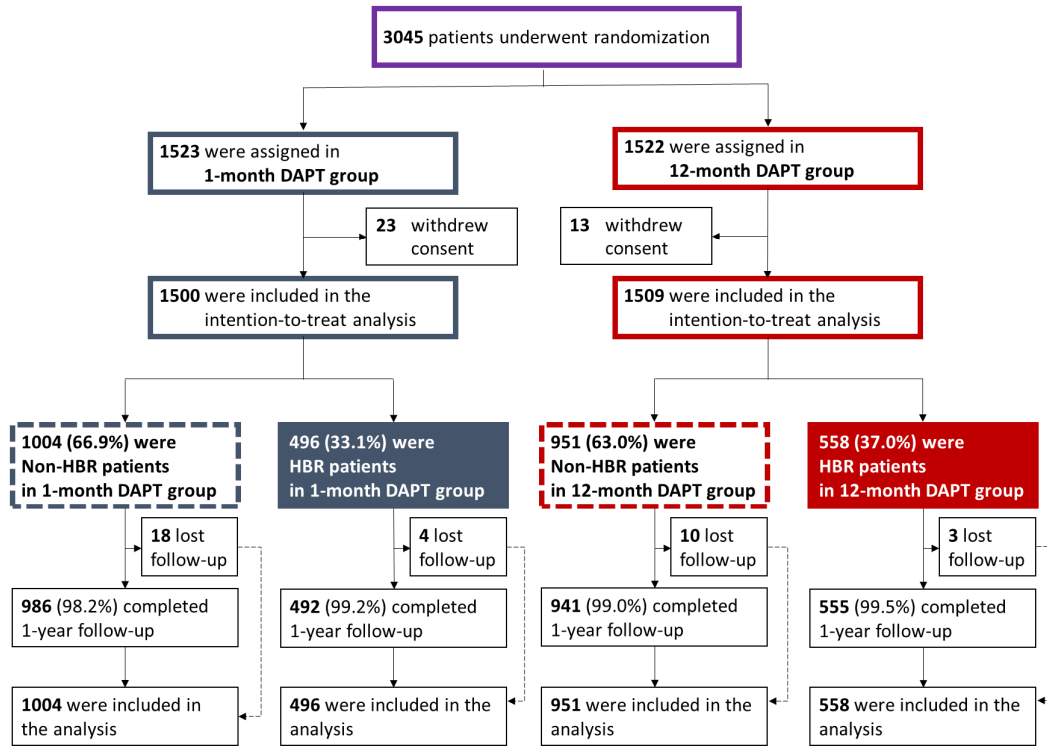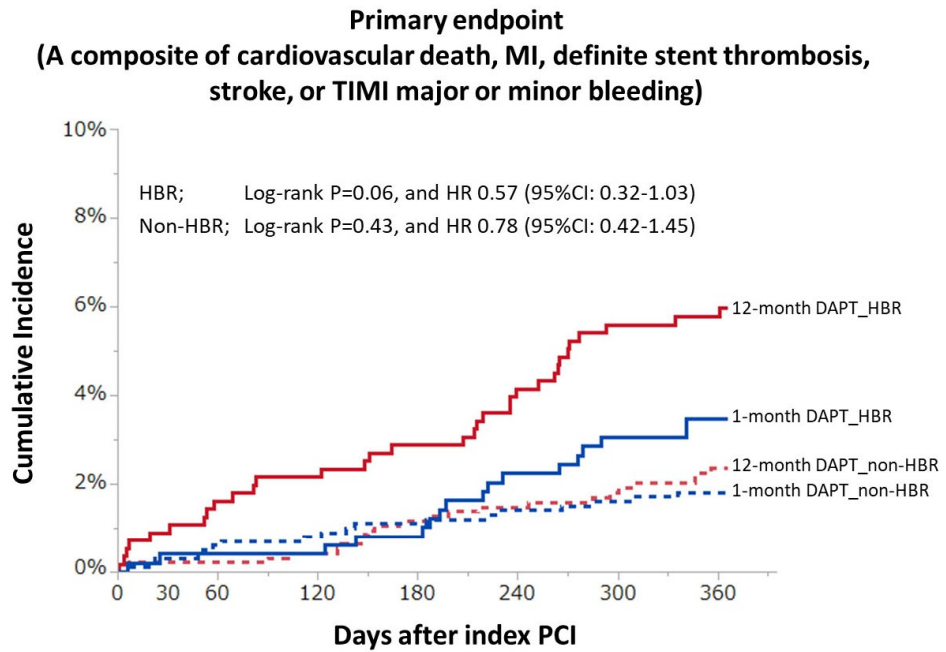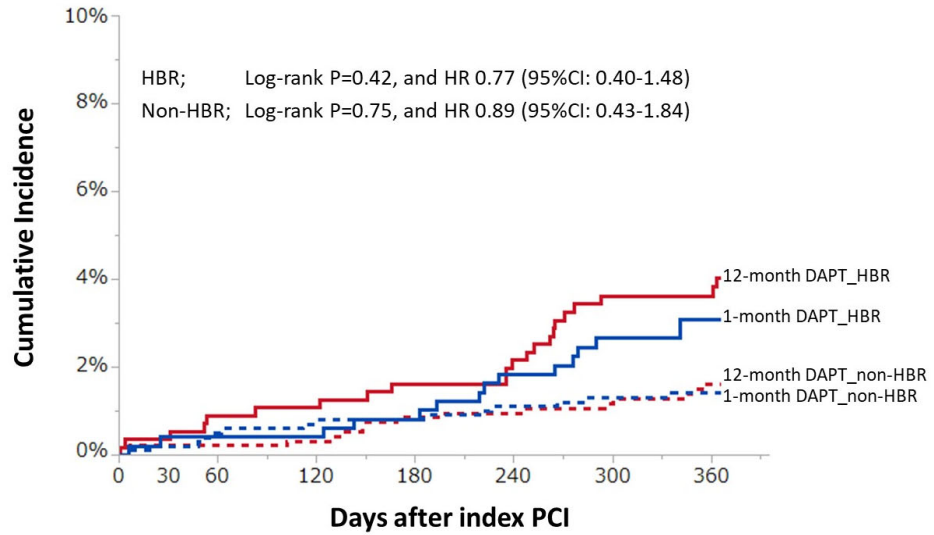
**Figures.**

**Figure 1.**

**Figure 2.**

**(a)**

### Primary endpoint
### (A composite of cardiovascular death, MI, definite stent thrombosis, stroke, or TIMI major or minor bleeding)

HBR;  Log-rank P=0.06, and HR 0.57 (95%CI: 0.32-1.03)
Non-HBR;  Log-rank P=0.43, and HR 0.78 (95%CI: 0.42-1.45)

12-month DAPT_HBR
1-month DAPT_HBR
12-month DAPT_non-HBR
1-month DAPT_non-HBR

Cumulative Incidence

Days after index PCI

**HBR patients**

| 12-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
|---|---|---|---|---|---|---|---|---|
| Number of patients with event | | 5 | 9 | 12 | 16 | 23 | 31 | 33 |
| Number of patients at risk | 558 | 553 | 546 | 543 | 538 | 530 | 521 | 424 |
| Cumulative incidence (%) | | 0.9 | 1.6 | 2.2 | 2.9 | 4.1 | 5.6 | 6.0 |
| 1-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
| Number of patients with event | | 2 | 2 | 2 | 4 | 11 | 15 | 17 |
| Number of patients at risk | 496 | 493 | 490 | 488 | 486 | 478 | 471 | 385 |
| Cumulative incidence (%) | | 0.4 | 0.4 | 0.4 | 0.8 | 2.2 | 3.1 | 3.5 |

**Non-HBR patients**

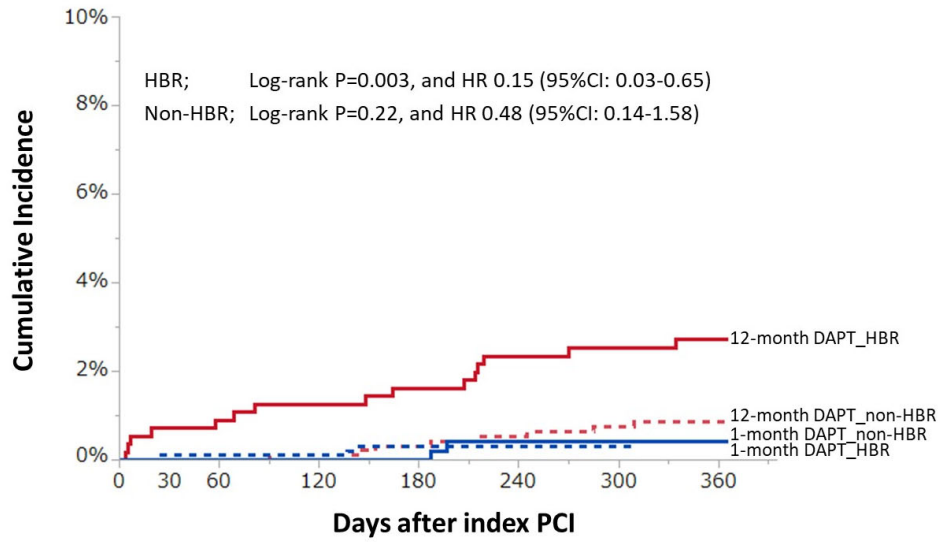| 12-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
|---|---|---|---|---|---|---|---|---|
| Number of patients with event | | 2 | 2 | 4 | 11 | 14 | 18 | 22 |
| Number of patients at risk | 951 | 948 | 940 | 938 | 931 | 928 | 921 | 735 |
| Cumulative incidence (%) | | 0.2 | 0.2 | 0.4 | 1.2 | 1.5 | 1.9 | 2.4 |
| 1-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
| Number of patients with event | | 3 | 6 | 8 | 11 | 14 | 16 | 18 |
| Number of patients at risk | 1004 | 1001 | 989 | 987 | 982 | 975 | 970 | 766 |
| Cumulative incidence (%) | | 0.3 | 0.6 | 0.8 | 1.1 | 1.4 | 1.6 | 1.8 |

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**(b)**

**Major Secondary Cardiovascular Endpoint
(A composite of cardiovascular death, MI,
definite stent thrombosis, or stroke)**

HBR;        Log-rank P=0.42, and HR 0.77 (95%CI: 0.40-1.48)
Non-HBR;  Log-rank P=0.75, and HR 0.89 (95%CI: 0.43-1.84)



**HBR patients**

| 12-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
|---|---|---|---|---|---|---|---|---|
| Number of patients with event | | 2 | 5 | 6 | 9 | 12 | 20 | 22 |
| Number of patients at risk | 558 | 556 | 550 | 549 | 545 | 540 | 531 | 431 |
| Cumulative incidence (%) | | 0.4 | 0.9 | 1.1 | 1.6 | 2.2 | 3.6 | 4.0 |
| 1-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
| Number of patients with event | | 2 | 2 | 2 | 4 | 9 | 13 | 15 |
| Number of patients at risk | 496 | 493 | 490 | 488 | 486 | 480 | 473 | 387 |
| Cumulative incidence (%) | | 0.4 | 0.4 | 0.4 | 0.8 | 1.8 | 2.7 | 3.1 |

**Non-HBR patients**

| 12-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
|---|---|---|---|---|---|---|---|---|
| Number of patients with event | | 2 | 2 | 3 | 8 | 9 | 12 | 15 |
| Number of patients at risk | 951 | 948 | 940 | 939 | 934 | 933 | 927 | 741 |
| Cumulative incidence (%) | | 0.2 | 0.2 | 0.3 | 0.9 | 1.0 | 1.3 | 1.6 |
| 1-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
| Number of patients with event | | 2 | 5 | 7 | 8 | 11 | 13 | 14 |
| Number of patients at risk | 1004 | 1002 | 990 | 988 | 985 | 978 | 973 | 770 |
| Cumulative incidence (%) | | 0.2 | 0.5 | 0.7 | 0.8 | 1.1 | 1.3 | 1.4 |

**(c)**

## Major Secondary Bleeding Endpoint
### (TIMI major or minor bleeding)



HBR;        Log-rank P=0.003, and HR 0.15 (95%CI: 0.03-0.65)
Non-HBR;  Log-rank P=0.22, and HR 0.48 (95%CI: 0.14-1.58)

**HBR patients**

| 12-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
|---|---|---|---|---|---|---|---|---|
| Number of patients with event | | 4 | 5 | 7 | 9 | 13 | 14 | 15 |
| Number of patients at risk | 558 | 554 | 549 | 546 | 542 | 536 | 532 | 436 |
| Cumulative incidence (%) | | 0.7 | 0.9 | 1.3 | 1.6 | 2.4 | 2.5 | 2.7 |
| 1-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
| Number of patients with event | | 0 | 0 | 0 | 0 | 2 | 2 | 2 |
| Number of patients at risk | 496 | 494 | 491 | 489 | 489 | 483 | 479 | 393 |
| Cumulative incidence (%) | | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 | 0.4 | 0.4 |

**Non-HBR patients**

| 12-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
|---|---|---|---|---|---|---|---|---|
| Number of patients with event | | 0 | 0 | 1 | 3 | 5 | 7 | 8 |
| Number of patients at risk | 951 | 950 | 942 | 941 | 938 | 935 | 930 | 744 |
| Cumulative incidence (%) | | 0.0 | 0.0 | 0.1 | 0.3 | 0.5 | 0.7 | 0.9 |
| 1-month DAPT | 0 | 30 | 60 | 120 | 180 | 240 | 300 | 365 |
| Number of patients with event | | 1 | 1 | 1 | 3 | 3 | 3 | 4 |
| Number of patients at risk | 1004 | 1001 | 992 | 992 | 988 | 984 | 978 | 773 |
| Cumulative incidence (%) | | 0.1 | 0.1 | 0.1 | 0.3 | 0.3 | 0.3 | 0.4 |

**Figure 3.**