Akut Koroner Sendromda ve PKG yapılan AF'lu hastalarda antikoagülan ve antitrombositer tedavi yaklaşımları

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Antitrombotik tedavi
AF ve PKG/AKS

Antikoagülan tx

Antikoagülasyon
> antiplatelet tx

Antiplatelet tx

Dual antiplatelet tx
> ASA

İKİSİ BİRLİKTE

Antikoagülan ve
dual antiplatelet tx
= **üçlü tedavi**

Yüksek kanama Riski

Üçlü tedavi - kanama

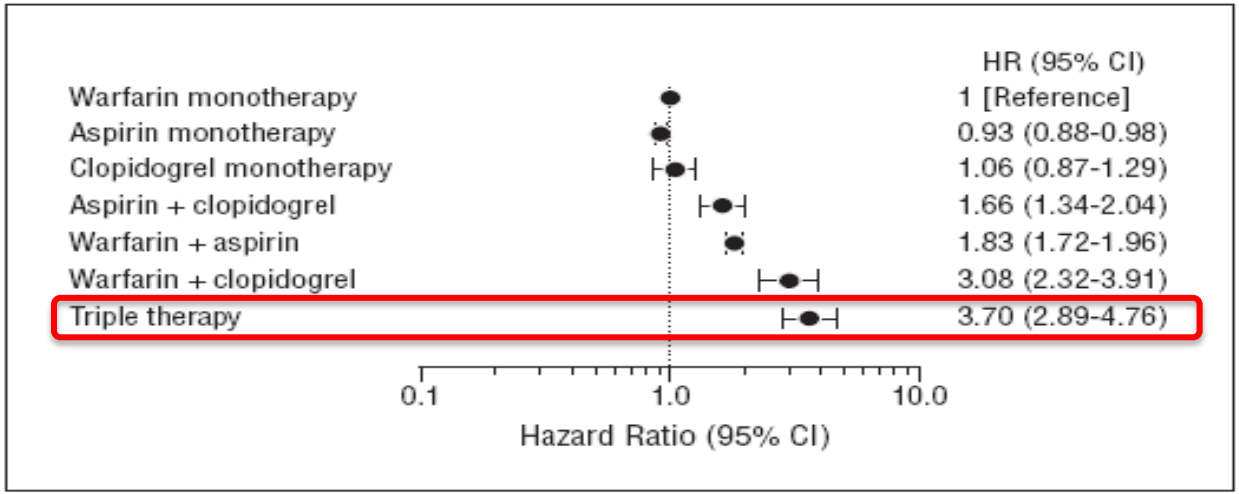
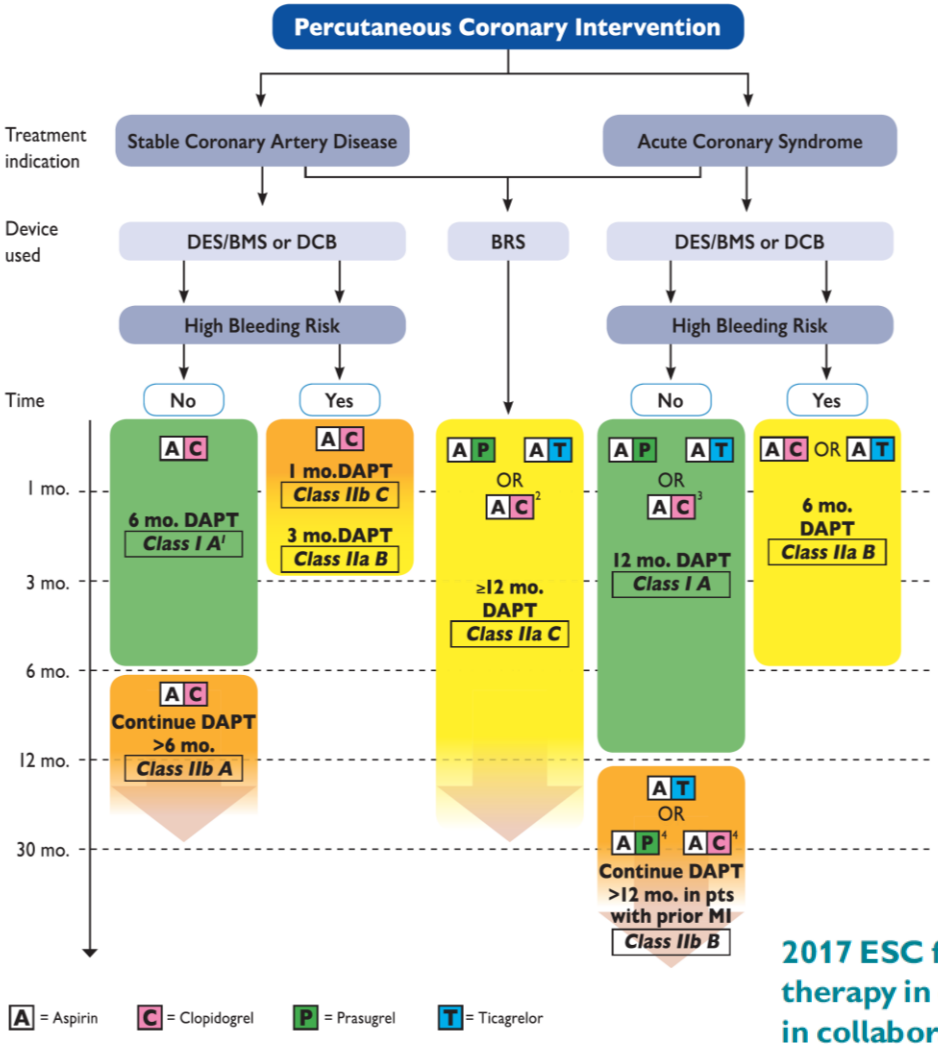


Figure 3. Hazard ratios (HRs) for the risk of nonfatal (n=12 191) and fatal (n=1381) bleeding associated with the use of warfarin, aspirin, clopidogrel, and combinations of these drugs. CI indicates confidence interval.

- AF ile yatan ve taburculukta farklı antitrombotik reçete edilen olgular

Hansen ML. Arch Intern Med 2010;170:1433



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Stabil koroner arter hastalığı

- > 1 sene post PKG
- > 1 sene post AKS

- Stabil KAH + AF
  - Sadece OAK yeterli – genel kabul

Periprosedürel dönem stabil KAH

WARFARİN

- Strateji 1
  - Warfarin (INR>2.5 ise) altında
    - Radyal yol
    - Periprosedürel Heparin/DMAH yok
- Strateji 2
  - Warfarini kes
  - INR < 1.5-2 olunca PKG
    - Femoral/radyal
    - Periprosedürel Heparin/DMAH gerekli
    - Köprülemeye gerek yok
  - Hemostaz sağlanınca yeniden warfarin başla (eski dozdan, heparin örtüşmesi gerekli değil)

NOAK

- NOAK antikoagülasyonu altında PKG yapma !
- NOAK kesilir
  - 24-48 saat sonra PKG
  - Femoral/radyal
  - Periprosedürel Heparin/DMAH gerekli
  - Köprülemeye gerek yok
  - Hemostaz sağlanınca NOAK tekrar başla

Periprosedürel dönem
AKS

AF + ST elevasyonlu AKS

- Primer PKG tercih edilmeli
- Fibrinolitik tedavi kontrendike değil

6.5.1 Patients taking oral anticoagulation

Many patients presenting with STEMI are previously on oral anticoagulation or require long-term anticoagulation afterwards. The addition of DAPT to oral anticoagulation increases the risk of bleeding complications two- to three-fold compared to anticoagulation alone.[266–269]

Management during STEMI: Given that oral anticoagulation is a relative contraindication for fibrinolysis, when these patients present with a STEMI, they should be triaged for primary PCI strategy regardless of the anticipated time to PCI-mediated reperfusion. Patients should receive additional parenteral anticoagulation, regardless of the timing of the last dose of oral anticoagulant. GP IIb/IIIa inhibitors

2017 ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation

Fibrinolitik tedavi

- Varfarin alan olgu
  - Mutlak kontrendike değil
  - INR < 1.8 ise fibrinolitik verilebilir
  - Kanama riski fazla olabilir
- YOAK alan olgu
  - aPTT (dabigatran için) veya PT (rivaroksaban, edoksaban ve apiksaban için) normalin üst sınırını geçmiyorsa, fibrinolitik tedavi düşünülebilir
  - YOAK etkisi geçene dek ilave PE antikoagülan verilmemelidir

Acil girişimsel yaklaşım
STEMI/NSTEMI/UA

2015 ESC guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

- Hastayı lab'a almadan OAK ihtiyacını tartın
  - Sağlam OAK endikasyonu var mı ?
    - CHADSVASc skoru ≥ 2
      - Erkekte 2 ve üzeri
      - Kadında 3 ve üzeri
    - yakın zamanda VTE
    - LV trombüs
    - mekanik protez kapak
- Bu sayede kullanacağınız P_2Y_{12}i konusunda seçim yapma şansınız olabilir

Öneriler	Sınıf	KD
Sağlam OAK endikasyonu (AF + CHADSVASc skoru ≥ 2, yakın zamanda VTE, LV trombüs, mekanik protez kapak) olan hastalarda, antiplatelet tedaviye ilaveten OAK önerilir	I	C

Öneriler	Sınıf	KD
AF ve NSTE AKS için koroner stentleme sonrası dönemde, CHADSVASc skoru kadınlarda ≤ 2 erkeklerde ≤ 1 ise, üçlü tedaviye alternatif olarak sadece ikili antiplatelet tedavi (yeni P2Y12 inhibitörleri de dahil) düşünülmelidir	IIa	C

2015 ESC guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS

Oral anticoagulation therapy to prevent thromboembolism is recommended for all male AF patients with a CHA_2DS_2-VASc score of 2 or more.	I
Oral anticoagulation therapy to prevent thromboembolism is recommended in all female AF patients with a CHA_2DS_2-VASc score of 3 or more.	I
Oral anticoagulation therapy to prevent thromboembolism should be considered in male AF patients with a CHA_2DS_2-VASc score of 1, considering individual characteristics and patient preferences.	IIa
Oral anticoagulation therapy to prevent thromboembolism should be considered in female AF patients with a CHA_2DS_2-VASc score of 2, considering individual characteristics and patient preferences.	IIa

Üçlü tedavi

- Klopidogrel
- Mide korunmalı
- VKA – INR = 2-2.5
- YOAK – düşük doz

Öneriler	Sınıf	KD
Üçlü tedavinin bir bileşeni olarak tikagrelor veya prasugrel önerilmez	III	C

2015 ESC guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

Öneriler	Sınıf	KD
KAG öncesi, OAK'a ilaveten inisiyal ikili antiplatelet tedavi (ASA + bir P2Y12i) önerilmez	III	C

Öneriler	Sınıf	KD
Periprosedürel dönemde, VKA veya YOAK'larla kesintisiz terapötik antikoagülasyon düşünülmelidir	IIa	C

2015 ESC guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

Öneriler	Sınıf	KD
PKG sırasında, VKA alanlarda INR < 2.5 ise veya YOAK alanlarda (son dozun alınma zamanına bakılmaksızın) ilave PE antikoagülasyon önerilir	I	C

UFH – 60 U/kg
Enoksaparin 0.5 mg/kg

2015 ESC guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

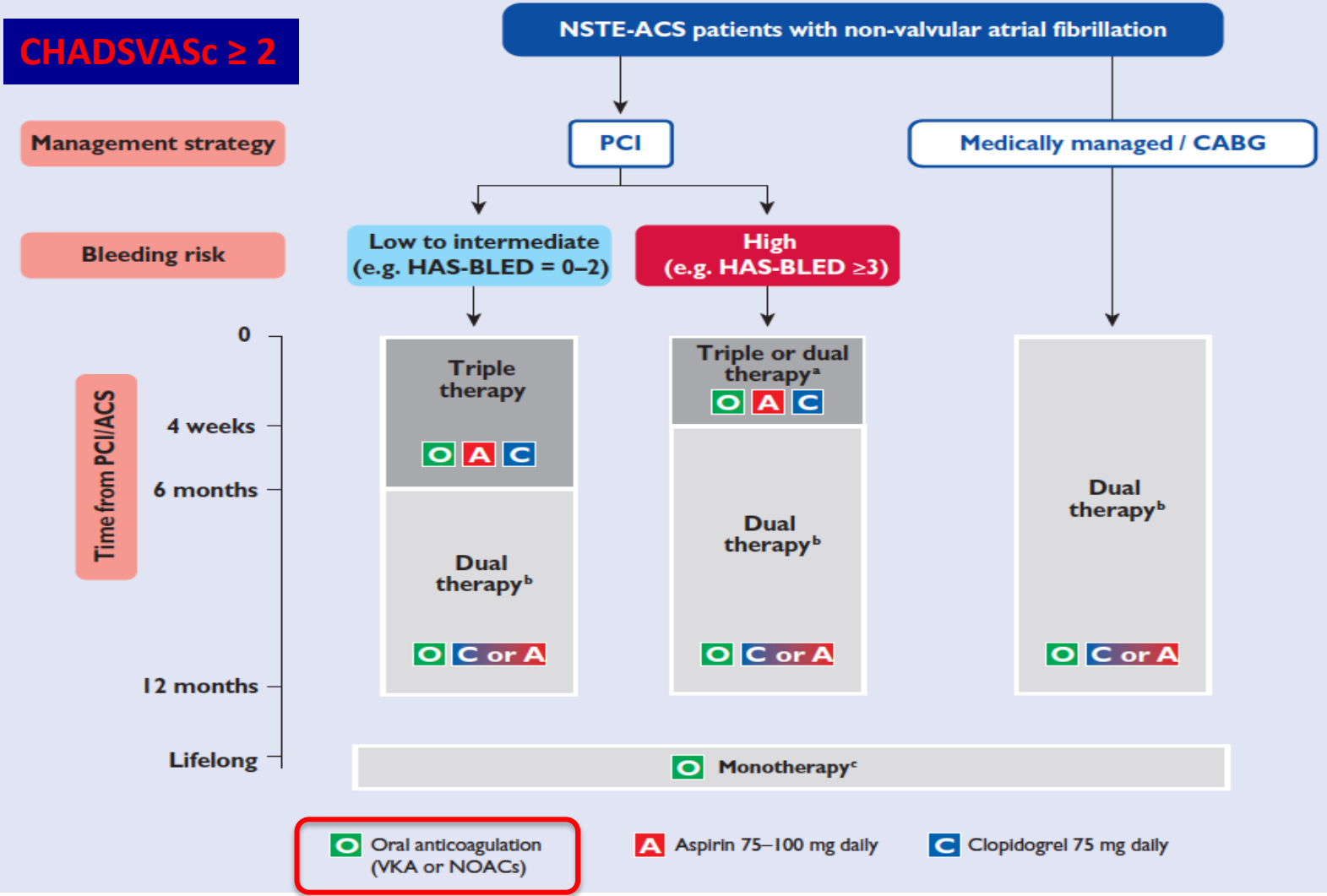
Öneriler	Sınıf	KD
Femoral yerine radyal girişim tercih edilmelidir	I	A

Öneriler	Sınıf	KD
OAK gereksinimi olan olgularda, BMS yerine yeni jenerasyon DES kullanımı düşünülmelidir	IIa	B

2015 ESC guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

Table 12 Suggested strategies to reduce bleeding risk related to PCI

- Anticoagulant doses adjusted to bodyweight and renal function, especially in women and elderly patients.
- Radial approach preferred.
- Proton pump inhibitors in patients on DAPT at higher than average risk of gastrointestinal bleeds (i.e. history of gastrointestinal ulcer/haemorrhage, anticoagulant therapy, chronic NSAIDs/corticosteroid use, or two or more among age ≥65 years, dyspepsia, gastrooesophageal reflux disease, *Helicobacter pylori* infection, and chronic alcohol use).
- In patients on OAC
  - PCI performed without interruption of VKAs or NOACs.
  - In patients on VKAs, do not administer UFH if INR value >2.5.
  - In patients on NOACs, regardless of the timing of the last administration of NOACs, add additional low-dose parenteral anticoagulation (e.g. enoxaparin 0.5 mg/kg i.v. or UFH 60 IU/kg).
  - Aspirin indicated but avoid pretreatment with $P2Y_{12}$ inhibitors.
  - GPIIb/IIIa inhibitors only for bailout of periprocedural complications.


CHADSVASc ≥ 2
NSTE-ACS patients with non-valvular atrial fibrillation
Management strategy
PCI
Medically managed / CABG
Bleeding risk
Low to intermediate (e.g. HAS-BLED = 0–2)
High (e.g. HAS-BLED ≥3)
Time from PCI/ACS
0
4 weeks
6 months
12 months
Lifelong
Triple therapy
O A C
Dual therapy[b]
O C or A
Triple or dual therapy[a]
O A C
Dual therapy[b]
O C or A
Dual therapy[b]
O C or A
O Monotherapy[c]
O Oral anticoagulation (VKA or NOACs)
A Aspirin 75–100 mg daily
C Clopidogrel 75 mg daily

Öneriler	Sınıf	KD
Seçilmiş bazı olgularda (HASBLED skoru > 2 ve stent trombozu riski düşük olan), üçlü tedaviye alternatif olarak OAK + klopidogrel 75 mg düşünülebilir	IIb	B

Medikal izlenen olgular

Öneriler	Sınıf	KD
12 aya kadar, OAK'a ilaveten 1 antiplatelet kullanımı düşünülmelidir	IIa	C

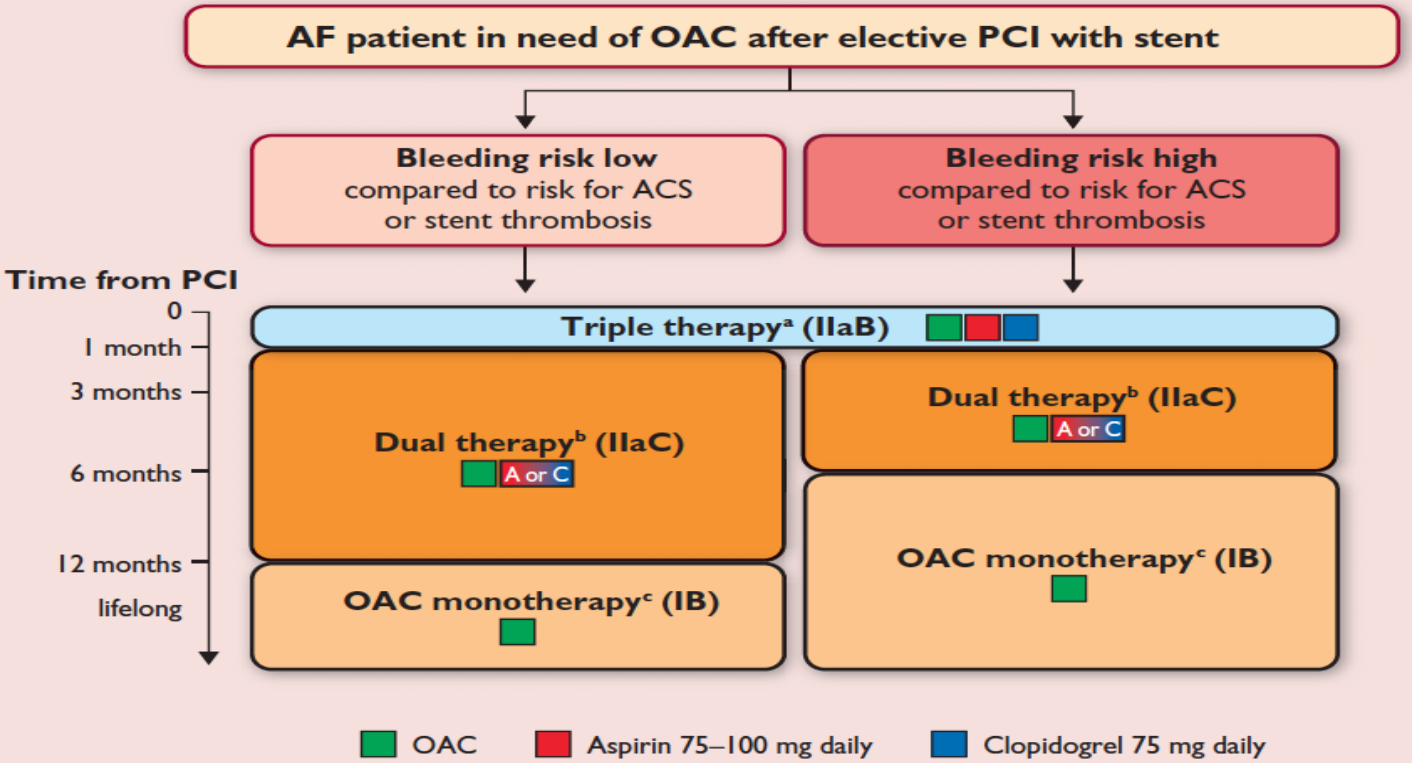
Dip notlar

- Koroner olay ihtimali çok yüksek değerlendirilen olgularda
  - üçlü tedavinin 12 aya kadar uzatılması,
  - 12 aydan sonra OAK tedaviye ilaveten bir antiplatelet (ASA veya klopidogrel) verilmesi düşünülebilir

2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS

Recommendations for combination therapy with oral anticoagulants and antiplatelets

Recommendations	Class[a]	Level[b]
After elective coronary stenting for stable coronary artery disease in AF patients at risk of stroke, combination triple therapy with aspirin, clopidogrel and an oral anticoagulant should be considered for 1 month to prevent recurrent coronary and cerebral ischaemic events.	IIa	B
After an ACS with stent implantation in AF patients at risk of stroke, combination triple therapy with aspirin, clopidogrel and an oral anticoagulant should be considered for 1–6 months to prevent recurrent coronary and cerebral ischaemic events.	IIa	C
After an ACS without stent implantation in AF patients at risk of stroke, dual treatment with an oral anticoagulant and aspirin or clopidogrel should be considered for up to 12 months to prevent recurrent coronary and cerebral ischaemic events.	IIa	C
The duration of combination antithrombotic therapy, especially triple therapy, should be kept to a limited period, balancing the estimated risk of recurrent coronary events and bleeding.	IIa	B
Dual therapy with any oral anticoagulant plus clopidogrel 75 mg/day may be considered as an alternative to initial triple therapy in selected patients.	IIb	C

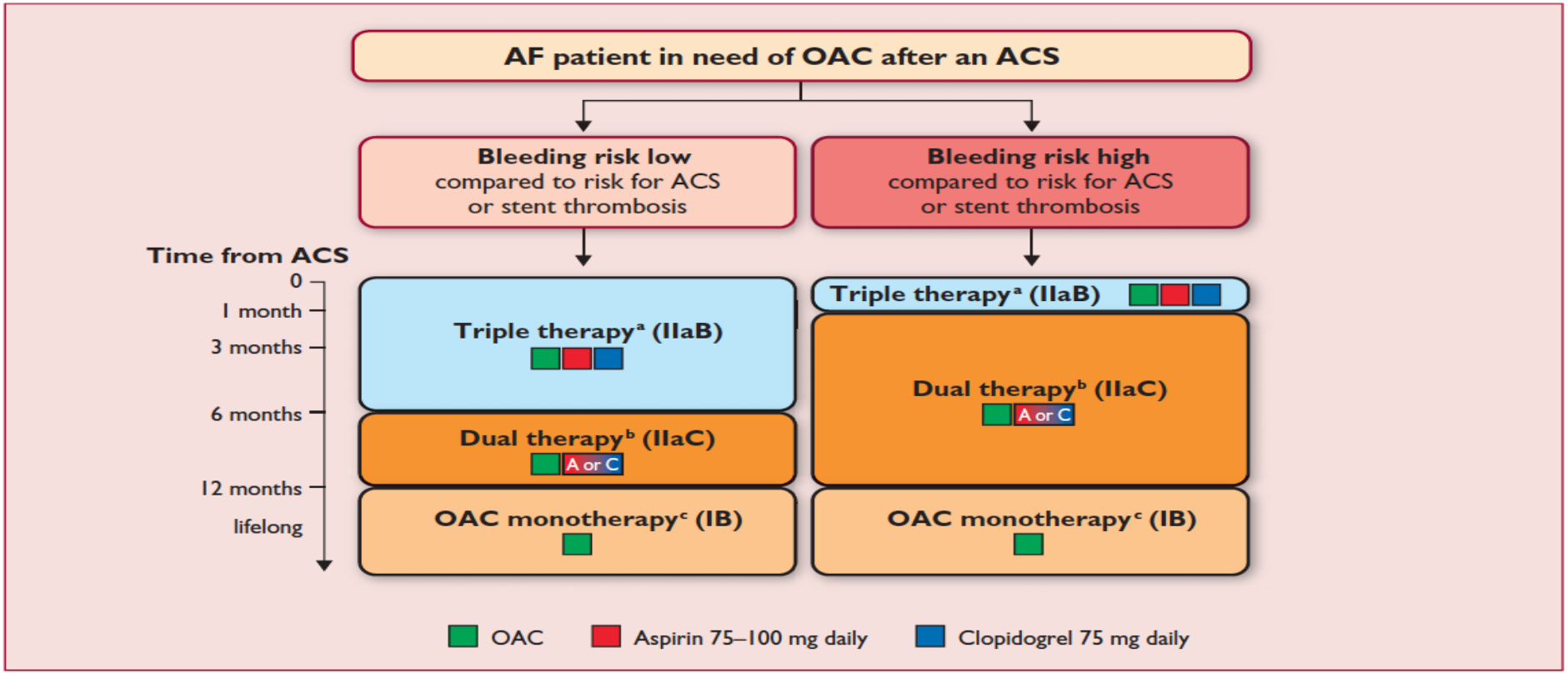


ACS = acute coronary syndrome; AF = atrial fibrillation; OAC = oral anticoagulation (using vitamin K antagonists or non-vitamin K antagonist oral anticoagulants); PCI = percutaneous coronary intervention.

[a]Dual therapy with OAC and aspirin or clopidogrel may be considered in selected patients.

[b]OAC plus single antiplatelet.

[c]Dual therapy with OAC and an antiplatelet agent (aspirin or clopidogrel) may be considered in patients at high risk of coronary events.



ACS = acute coronary syndrome; AF = atrial fibrillation; OAC = oral anticoagulation (using vitamin K antagonists or non-vitamin K antagonist oral anticoagulants); PCI = percutaneous coronary intervention.

[a]Dual therapy with OAC and aspirin or clopidogrel may be considered in selected patients, especially those not receiving a stent or patients at a longer time from the index event.

[b]OAC plus single antiplatelet.

[c]Dual therapy with OAC and an antiplatelet agent (aspirin or clopidogrel) may be considered in patients at high risk of coronary events.

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Table 5 High-risk features of stent-driven recurrent ischaemic events

• Prior stent thrombosis on adequate antiplatelet therapy
• Stenting of the last remaining patent coronary artery
• Diffuse multivessel disease especially in diabetic patients
• Chronic kidney disease (i.e. creatinine clearance <60 mL/min)
• At least three stents implanted
• At least three lesions treated
• Bifurcation with two stents implanted
• Total stent length >60 mm
• Treatment of a chronic total occlusion

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In patients treated with coronary stent implantation, triple therapy with aspirin, clopidogrel, and OAC should be considered for 1 month, irrespective of the type of stent used.[195]	IIa	B

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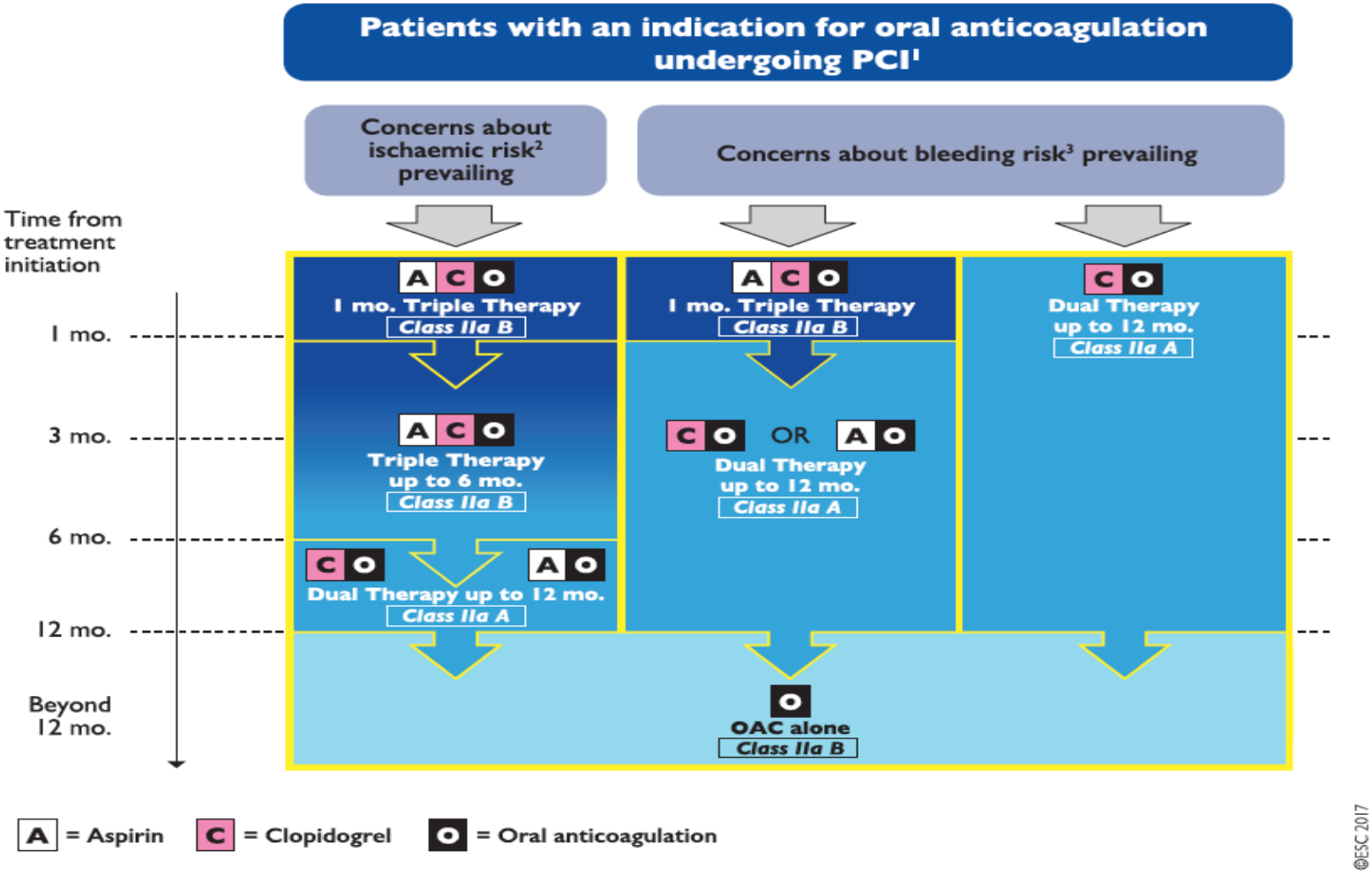
Triple therapy with aspirin, clopidogrel, and OAC for longer than 1 month and up to 6 months should be considered in patients with high ischaemic risk due to ACS or other anatomical/procedural characteristics that outweigh the bleeding risk.[195]	IIa	B

bleeding.[198] Dual therapy with OAC and one antiplatelet agent (aspirin or clopidogrel) may be considered beyond 1 year in patients at very high risk of coronary events as defined in *Table 5*[34] and in patients with mechanical prosthesis and atherosclerotic disease.


Patients with an indication for oral anticoagulation undergoing PCI[1]
Concerns about ischaemic risk[2] prevailing
Concerns about bleeding risk[3] prevailing
Time from treatment initiation
1 mo.
3 mo.
6 mo.
12 mo.
Beyond 12 mo.
A C O
1 mo. Triple Therapy
Class IIa B
A C O
1 mo. Triple Therapy
Class IIa B
C O
Dual Therapy up to 12 mo.
Class IIa A
A C O
Triple Therapy up to 6 mo.
Class IIa B
C O OR A O
Dual Therapy up to 12 mo.
Class IIa A
C O
A O
Dual Therapy up to 12 mo.
Class IIa A
O
OAC alone
Class IIa B
A = Aspirin
C = Clopidogrel
O = Oral anticoagulation
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Prevention of Bleeding in Patients with Atrial Fibrillation Undergoing PCI

C. Michael Gibson, M.D., Roxana Mehran, M.D., Christoph Bode, M.D., Jonathan Halperin, M.D., Freek W. Verheugt, M.D., Peter Wildgoose, Ph.D., Mary Birmingham, Pharm.D., Juliana Ianus, Ph.D., Paul Burton, M.D., Ph.D., Martin van Eickels, M.D., Serge Korjian, M.D., Yazan Daaboul, M.D., Gregory Y.H. Lip, M.D., Marc Cohen, M.D., Steen Husted, M.D., Eric D. Peterson, M.D., M.P.H., and Keith A. Fox, M.B., Ch.B.

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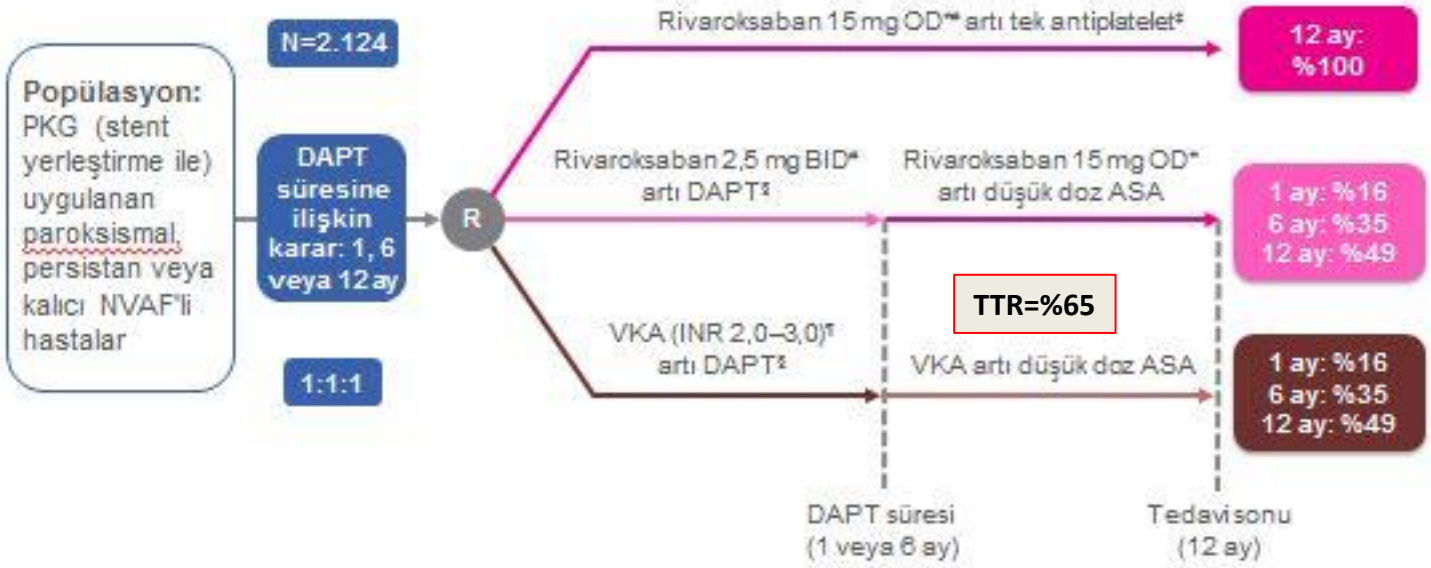
Popülasyon:
PKG (stent yerleştirme ile) uygulanan paroksismal, persistan veya kalıcı NVAF'li hastalar
N=2.124
DAPT süresine ilişkin karar: 1, 6 veya 12 ay
1:1:1
R
Rivaroksaban 15 mg OD** artı tek antiplatelet*
12 ay: %100
Rivaroksaban 2,5 mg BID* artı DAPT*
Rivaroksaban 15 mg OD* artı düşük doz ASA
1 ay: %16
6 ay: %35
12 ay: %49
TTR=%65
VKA (INR 2,0–3,0)† artı DAPT*
VKA artı düşük doz ASA
1 ay: %16
6 ay: %35
12 ay: %49
DAPT süresi (1 veya 6 ay)
Tedavi sonu (12 ay)

Tablo 1. Birincil güvenlik sonlanım noktası

	Grup 1 (n=696)	Grup 2 (n=706)	Grup 3 (n=697)	Grup 1 vs Grup 3		Grup 2 vs Grup 3	
				HR (%95 GA)	*p*	HR (%95 GA)	*p*
Klinik önemi olan kanama	109 (16.8)	117 (18)	167 (26.7)	0.59 (0.47–0.76)	<0.001	0.63 (0.50–0.80)	<0.001
Majör kanama	14 (2.1)	12 (1.9)	20 (3.3)	0.66 (0.33–1.31)	0.23	0.57 (0.28–1.16)	0.11
Minör kanama	7 (1.1)	7 (1.1)	13 (2.2)	0.51 (0.20–1.28)	0.14	0.50 (0.20–1.26)	0.13
Tıbbi bakım gerektiren kanama	93 (14.6)	102 (15.8)	139 (22.6)	0.61 (0.47–0.80)	<0.001	0.67 (0.52–0.86)	0.002

Tablo 2. Sekonder sonlanım noktaları

	Grup 1 (n=694)	Grup 2 (n=704)	Grup 3 (n=695)	Grup 1 vs Grup 3		Grup 2 vs Grup 3	
				HR (%95 GA)	*p*	HR (%95 GA)	*p*
Majör istenmeyen KV olay	41 (6.5)	36 (5.6)	36 (6.0)	1.08 (0.69–1.68)	0.75	0.93 (0.59–1.48)	0.76
KV ölüm	15 (2.4)	14 (2.2)	11 (1.9)	1.29 (0.59–2.80)	0.52	1.19 (0.54–2.62)	0.66
Miyokard infarktüsü	19 (3.0)	17 (2.7)	21 (3.5)	0.86 (0.46–1.59)	0.62	0.75 (0.40–1.42)	0.37
İnme	8 (1.3)	10 (1.5)	7 (1.2)	1.07 (0.39–2.96)	0.89	1.36 (0.52–3.58)	0.53
Stent trombozu	5 (0.8)	6 (0.9)	4 (0.7)	1.20 (0.32–4.45)	0.79	1.44 (0.40–5.09)	0.57

KV: Kardiyovasküler; HR: Zarar oranı; GA: Güven aralığı.

CONCLUSIONS

In participants with atrial fibrillation undergoing PCI with placement of stents, the administration of either low-dose rivaroxaban plus a $P2Y_{12}$ inhibitor for 12 months or very-low-dose rivaroxaban plus DAPT for 1, 6, or 12 months was associated with a lower rate of clinically significant bleeding than was standard therapy with a vitamin K antagonist plus DAPT for 1, 6, or 12 months. The three groups had similar efficacy rates, although the observed broad confidence intervals diminish the surety of any conclusions regarding efficacy. (Funded by Janssen Scientific Affairs and Bayer Pharmaceuticals; PIONEER AF-PCI ClinicalTrials.gov number, NCT01830543.)

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Dual Antithrombotic Therapy with Dabigatran after PCI in Atrial Fibrillation

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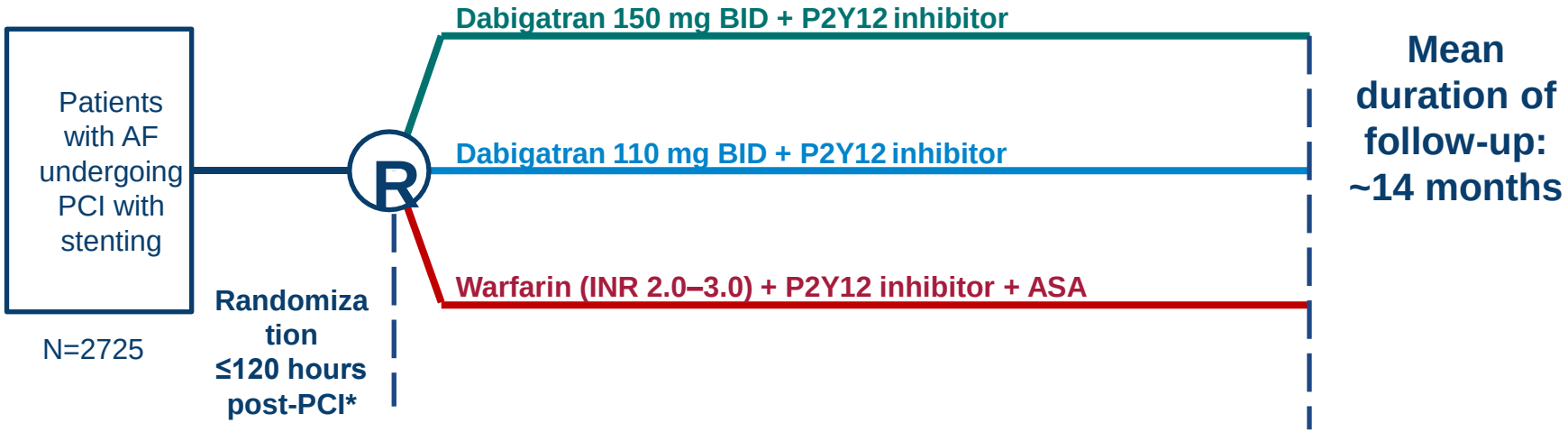
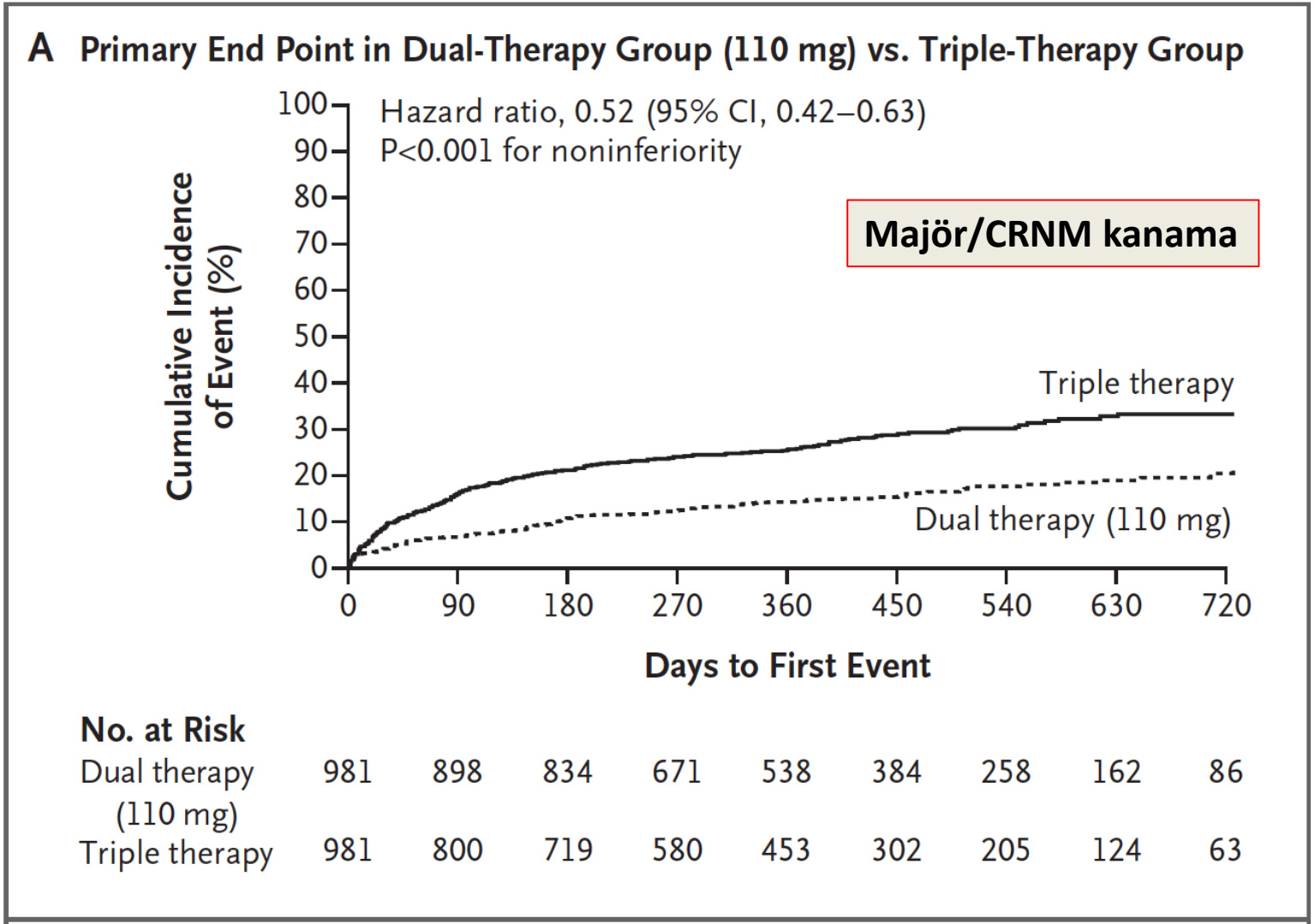
Study Design: Multicenter, randomized, open-label trial following a PROBE design



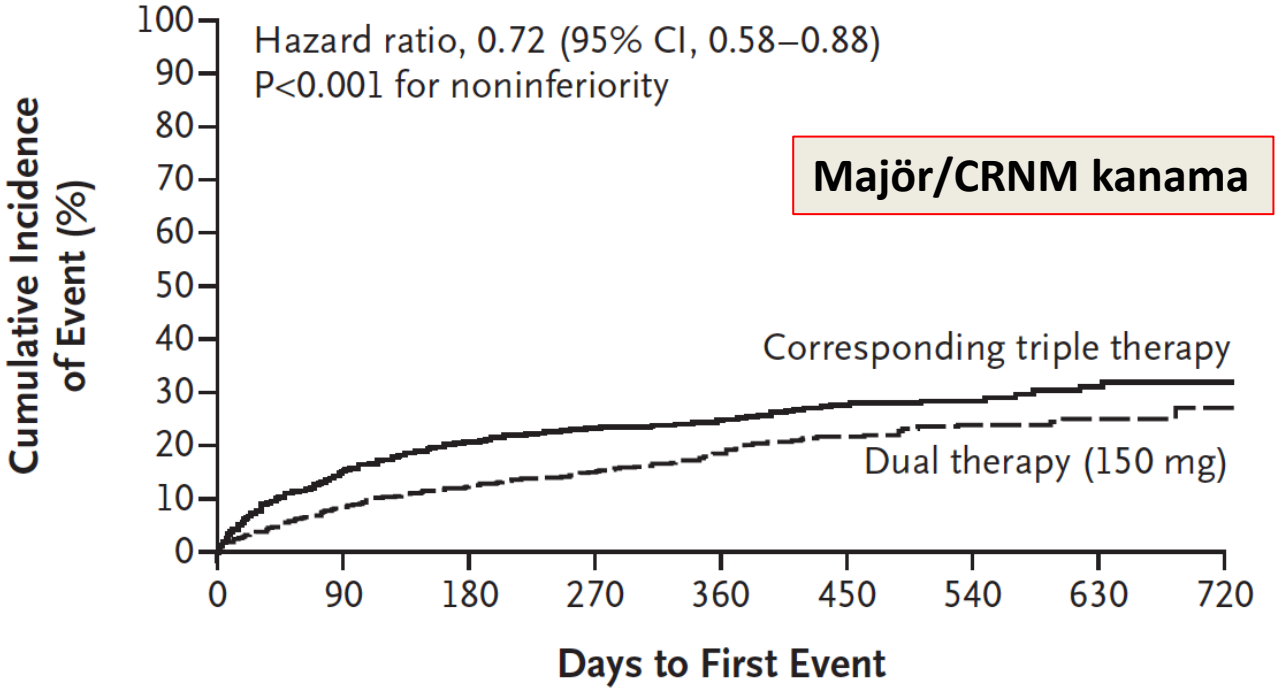
Sonlanım noktaları

- Primer güvenlik
  - Majör veya majör olmayan klinik anlamlı kanama
- Sekonder – etkinlik (bileşke)
  - MI, inme, sistemik emboli
  - Planlanmamış revaskülarizasyon
  - ölüm

- % 12 tika, gerisi klop
- TTR % 64 (INR 2-3)
- % 50.5 AKS için stentleme
- BMS için 1 ay, DES için 3 ay ASA, daha sonra ASA kesiliyor

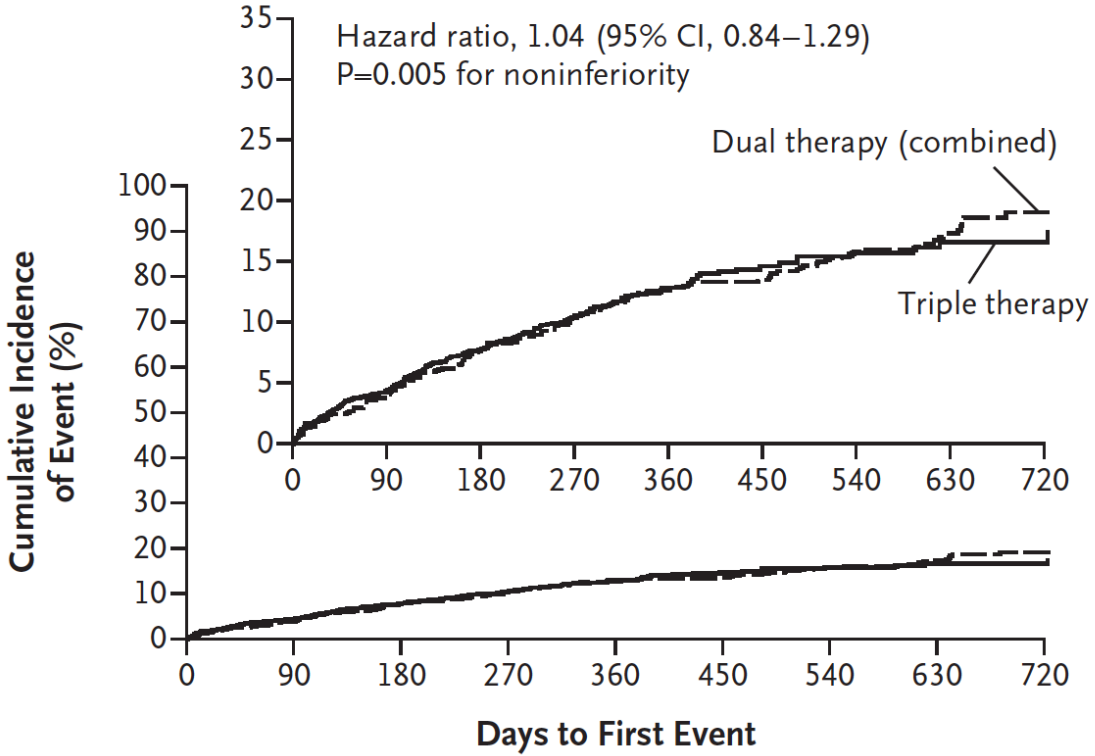

A Primary End Point in Dual-Therapy Group (110 mg) vs. Triple-Therapy Group
Hazard ratio, 0.52 (95% CI, 0.42–0.63)
P<0.001 for noninferiority
Majör/CRNM kanama
Cumulative Incidence of Event (%)
100
90
80
70
60
50
40
30
20
10
0
Triple therapy
Dual therapy (110 mg)
0
90
180
270
360
450
540
630
720
Days to First Event
No. at Risk
Dual therapy (110 mg) 981 898 834 671 538 384 258 162 86
Triple therapy 981 800 719 580 453 302 205 124 63

B **Primary End Point in Dual-Therapy Group (150 mg) vs. Triple-Therapy Group**



No. at Risk									
Dual therapy (150 mg)	763	694	640	514	404	278	182	113	65
Corresponding triple therapy	764	630	562	446	349	222	152	88	47

C **Secondary Efficacy End Point in Dual-Therapy Groups (Combined) vs. Triple-Therapy Group**



No. at Risk

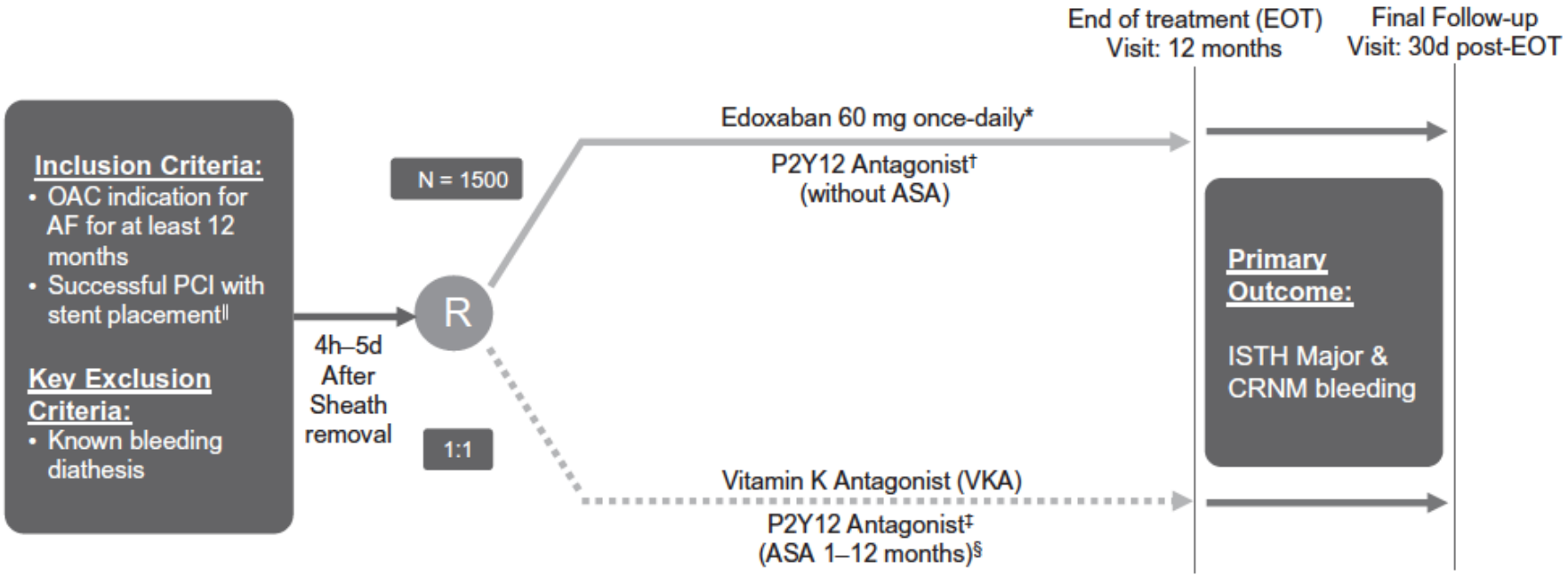
Dual therapy (combined)	1744	1660	1561	1257	1003	720	481	295	161
Triple therapy	981	921	854	700	548	383	259	161	81

Evaluation of the safety and efficacy of an edoxaban-based antithrombotic regimen in patients with atrial fibrillation following successful percutaneous coronary intervention (PCI) with stent placement: Rationale and design of the ENTRUST-AF PCI trial

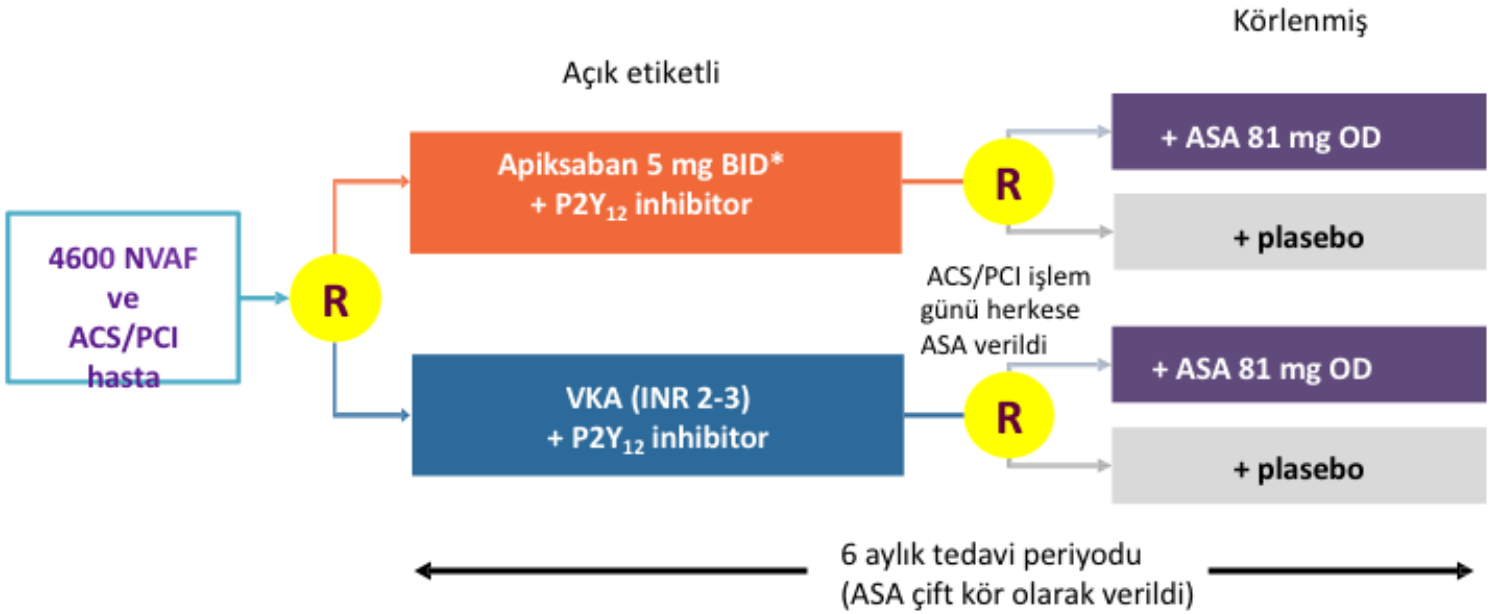
Pascal Vranckx [a] Thorsten Lewalter [b] Marco Valgimigli [c] Jan G. Tijssen [d] Paul-Egbert Reimitz [e] Lars Eckardt [f] Hans-Joachim Lanz [e] Wolfgang Zierhut [e] Rüdiger Smolnik [e] and Andreas Goette [g] *Hasselt, Belgium; Munich, Muenster, Magdeburg, Germany; Bern, Switzerland and Amsterdam, the Netherlands*

(Am Heart J 2018;196:105-112.)

Figure


End of treatment (EOT)
Visit: 12 months
Final Follow-up
Visit: 30d post-EOT
Inclusion Criteria:
• OAC indication for AF for at least 12 months
• Successful PCI with stent placement‖
Key Exclusion Criteria:
• Known bleeding diathesis
4h–5d After Sheath removal
N = 1500
R
1:1
Edoxaban 60 mg once-daily*
P2Y12 Antagonist†
(without ASA)
Vitamin K Antagonist (VKA)
P2Y12 Antagonist‡
(ASA 1–12 months)§
Primary Outcome:
ISTH Major & CRNM bleeding

Akut Koroner Sendromlu veya Perkutanoz Koroner Girişim Planlanan NVAF Hastaları



*Seçilmiş hastalarda Apiksaban 2.5 mg BID

*Patients with ≥2 of the following: age ≥80 years, weight ≤60 kg, serum creatinine ≥1.5 mg/dL (133 µmol/L).

BMS. A study of apixaban in patients with atrial fibrillation, not caused by a heart valve problem, who are at risk for thrombosis (blood clots) due to having had a recent coronary event, such as a heart attack or a procedure to open the vessels of the heart. Available from: https://clinicaltrials.gov/ct2/show/NCT02415400.
NLM Identifier: NCT02415400. Accessed on February 09, 2017.

ACS, acute coronary syndrome;
ISTH, International Society on Thrombosis and Haemostatsis; MI, myocardial infarction;
NVAF, non-valvular atrial fibrillation;
PCI, percutaneous coronary intervention;
R, randomization; VKA, vitamin k antagonist.

Use of clopidogrel with or without aspirin in patients taking oral anticoagulant therapy and undergoing percutaneous coronary intervention: an open-label, randomised, controlled trial

Lancet 2013; 381: 1107–15

Willem J M Dewilde, Tom Oirbans, Freek W A Verheugt, Johannes C Kelder, Bart J G L De Smet, Jean-Paul Herrman, Tom Adriaenssens, Mathias Vrolix, Antonius A C M Heestermans, Marije M Vis, Jan G P Tijsen, Arnoud W van 't Hof, Jurriën M ten Berg, for the WOEST study investigators

- OAK kullanan ve PKG yapılan 573 olgu
- Randomize
  - OAK + klop + ASA
  - OAK + klop
- 1 yıl içinde herhangi kanama

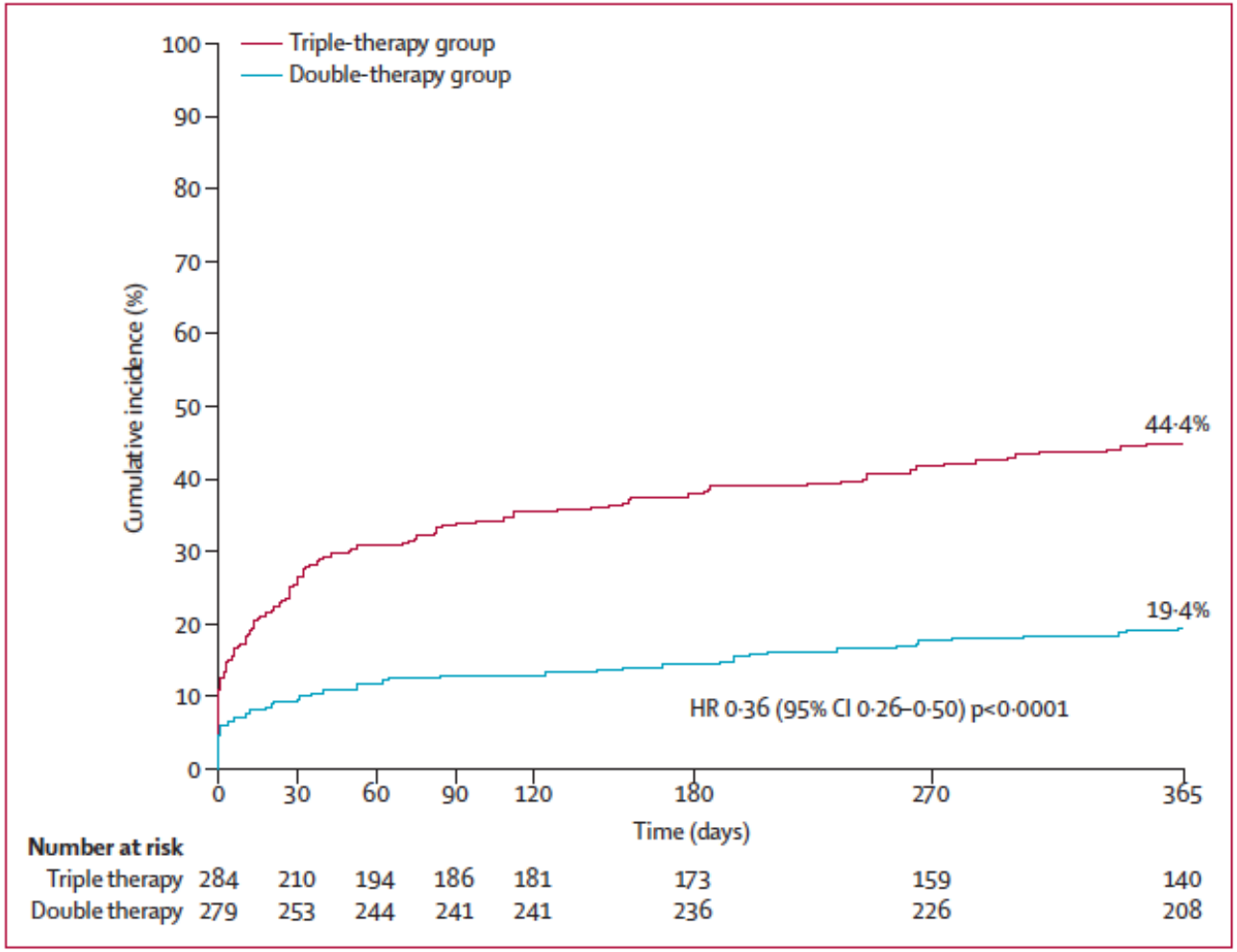


Figure 2: **Incidence of the primary endpoint (any bleeding)**
HR=hazard ratio.

Lancet 2013; 381: 1107–15

	Double therapy (n=297)	Triple therapy (n=284)	Hazard ratio (95% CI)	p value
Combined secondary endpoint	31 (11·1%)	50 (17·6%)	0·60 (0·38–0·94)	0·025
Death				
All-cause	7 (2·5%)	18 (6·3%)	0·39 (0·16–0·93)	0·027
Cardiac	3 (1·1%)	7 (2·5%)	0·43 (0·11–1·66)	0·207
Non-cardiac	4 (1·4%)	11 (3·9%)	0·36 (0·11–1·13)	0·069
Myocardial infarction				
Any	9 (3·2%)	13 (4·6%)	0·69 (0·29–1·60)	0·382
STEMI	1 (0·4%)	3 (1·1%)	0·34 (0·04–3·25)	0·325
Non-STEMI	8 (2·9%)	10 (3·5%)	0·79 (0·31–2·01)	0·625
Target-vessel revascularisation				
PCI or CABG	20 (7·2%)	19 (6·7%)	1·05 (0·56–1·97)	0·876
PCI	17 (6·1%)	16 (5·6%)	1·06 (0·54–2·10)	0·869
CABG	3 (1·1%)	3 (1·1%)	1·00 (0·20–4·90)	0·998
Stroke				
Any	3 (1·1%)	8 (2·8%)	0·37 (0·10–1·40)	0·128
Ischaemic	2 (0·7%)	8 (2·8%)	0·25 (0·05–1·17)	0·056
Haemorrhagic	1 (0·4%)	0	NA	0·321
Disabling	2 (0·7%)	2 (0·7%)	0·99 (0·14–6·99)	0·988
Non-disabling	1 (0·4%)	7 (2·5%)	0·14 (0·02–1·16)	0·034
Stent thrombosis				
Any	4 (1·4%)	9 (3·2%)	0·44 (0·14–1·44)	0·165
Definite	1 (0·4%)	3 (1·1%)	0·33 (0·03–3·22)	0·319
Probable	0	2 (0·7%)	NA	0·161
Possible	3 (1·1%)	4 (1·4%)	0·75 (0·17–3·30)	0·708

Percentages are calculated from the Kaplan-Meier curve. STEMI=ST-elevation myocardial infarction. PCI=percutaneous coronary intervention. CABG=coronary artery bypass graft. NA=not applicable.

Table 5: **Secondary and safety endpoints at 1 year**

Lancet 2013; 381: 1107–15

Eve gidecek mesajlar

- Bireysel yaklaşım şart
  - Antiplatelet tedavi gereksinimi ortaya çıktığında OAK endikasyonunu yeniden tartın
  - Koroner riski değerlendirin
- Üçlü tedavi kanatır
  - Endikasyon iyi sorgulanmalı
    - Sağlam endikason olmalı
  - Mümkün olduğunca kısa tutulmalı
  - Belki de terk edilmeli
    - WOEST
    - PIONEER-AF PCI
    - reDUAL PCI