

Lack of association between dual antiplatelet therapy use and stent thrombosis between 1 and 12 months following resolute zotarolimus-eluting stent implantation

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Aim	The optimal duration of dual antiplatelet therapy (DAPT) following the use of new generation drug-eluting stents is unknown.
Methods and results	The association between DAPT interruption and the rates of stent thrombosis (ST) and cardiac death/target-vessel myocardial infarction (CD/TVMI) in patients receiving a Resolute zotarolimus-eluting stent (R-ZES) was analysed in 4896 patients from the pooled RESOLUTE clinical programme. Daily acetylsalicylate (ASA) and a thienopyridine for 6–12 months were prescribed. A DAPT interruption was defined as any interruption of ASA and/or a thienopyridine of > 1 day; long interruptions were > 14 days. Three groups were analysed: no interruption, interruption during the first month, and > 1–12 months. There were 1069 (21.83%) patients with a DAPT interruption and 3827 patients with no interruption. Among the 166 patients in the 1-month interruption group, 6 definite/probable ST events occurred (3.61%; all long DAPT interruptions), and among the 903 patients in the > 1–12 months (60% occurred between 6 and 12 months) interruption group, 1 ST event occurred (0.11%; 2-day DAPT interruption). Among patients with no DAPT interruption, 32 ST events occurred (0.84%). Rates of CD/TVMI were 6.84% in the 1-month long interruption group, 1.41% in the > 1–12 months long interruption group, and 4.08% in patients on continuous DAPT.
Conclusion	In a pooled population of patients receiving an R-ZES, DAPT interruptions within 1 month are associated with a high risk of adverse outcomes. Dual antiplatelet therapy interruptions between 1 and 12 months were associated with low rates of ST and adverse cardiac outcomes. Randomized clinical trials are needed to determine whether early temporary or permanent interruption of DAPT is truly safe.
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Keywords	Resolute zotarolimus-eluting stent • Dual antiplatelet therapy • Stent thrombosis

Introduction

The introduction of drug-eluting stents (DES) for the treatment of coronary artery disease has significantly reduced revascularization rates following percutaneous coronary intervention. However, the early enthusiasm for the first generation DES was tempered by

reports of an increased risk of late (30 days to 1 year) and very late (beyond 1 year) stent thrombosis (ST) with these devices.^{1–6}

These concerns, based on retrospective observational data with first generation sirolimus-eluting and paclitaxel-eluting stents,^{2,4} led to multi-disciplinary society guideline recommendations for extended duration of dual antiplatelet therapy (DAPT) in Europe (6–12 months)

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and in the USA for at least 12 months DAPT following percutaneous coronary revascularization with a DES.^{7–13} These recommendations stemmed from historical observations that DAPT with a thienopyridine and acetylsalicylic acid (ASA) can effectively reduce ST.^{14–16} Furthermore, in several observational studies, early discontinuation of the thienopyridine, clopidogrel, was identified as a strong predictor for ST.^{17–19} However, the current clinical practice guidelines were limited by the lack of randomized controlled data comparing the efficacy and safety of 6 and 12 months of DAPT. More recently, three randomized studies regarding the duration of DAPT have been published but compare either 6 month vs. 1 or 2 year DAPT,^{20,21} or 1 year vs. 2 year DAPT.²² None showed superiority of the longer DAPT duration. There remains limited evidence addressing the risks and benefits of prolonged DAPT with newer generation DES that have demonstrated a superior safety profile and lower overall rate of ST when compared to with first generation DES.^{23–25} In fact, in light of recent safety data with newer generation DES platforms, some have questioned whether the risk of ST still represents a significant limitation to the use of DES.²⁶

Given the paucity of randomized trial data to define optimal duration of DAPT with new generation DES and the importance of minimizing risks for adverse events following percutaneous revascularization with DES, we undertook a detailed *post hoc* analysis to assess the impact of DAPT interruption on ST following implantation of the Resolute™ zotarolimus-eluting stent (R-ZES, Medtronic, Inc., Santa Rosa, CA, USA). Because ST is a rare event but is associated with serious clinical consequences,²⁷ the analysis also includes an assessment of cardiac death and target-vessel myocardial infarction (CD/TVMI) for patients with and without a DAPT interruption as well as additional details related to the DAPT interruption and ST.

Methods

Clinical data were pooled from four prospective multicenter clinical trials of the R-ZES; RESOLUTE-All Comers (R-AC, $n = 1140$), RESOLUTE-International (R-INT, $n = 2349$), RESOLUTE-Japan (R-J, $n = 100$), and RESOLUTE-US (R-US, $n = 1402$). The RESOLUTE First-in-Man (R-FIM) trial was not included because the required data on DAPT use were not collected in this trial. Across the entire RESOLUTE global clinical programme consistent methodology was employed to allow data from multiple trials to be pooled in order to provide more reliable estimates of the true risk of clinical safety events. Specifically, these clinical trials were conducted using similar data collection procedures, identical adjudication processes, and consistent endpoint definitions.^{28–31} Notably, the R-AC and R-INT trials included a large number of patients with complex clinical or lesion characteristics. All trials were 100% monitored with the exception of R-INT which was 25% monitored in the first year, and Clinical Event Committees were harmonized across the trials to ensure consistency in adjudication and comparability of the data from the different trials. All trials complied with the *Declaration of Helsinki*, were approved by the appropriate ethics committees for each site and informed consent was obtained from all patients.

All trials recommended ASA was to be given indefinitely and a thienopyridine (clopidogrel 75 mg daily or ticlopidine 250 mg twice daily) for a minimum of 6 months and optimally for 12 months. For the purposes of this analysis, patients must have had key DAPT data available including start and stop dates of the thienopyridine or ASA. Additionally, 34 patients who started DAPT more than a day after stent implantation were excluded from this analysis (including a single patient who had a ST event prior to the start of DAPT) (Figure 1).

A DAPT interruption was defined as either a temporary interruption of ASA and/or a thienopyridine (interruption of > 1 day), or a permanent discontinuation. Based on reports that the pharmacodynamics effects of thienopyridines on platelet aggregation can take up to 14 days to clear following DAPT interruption,³² patients with a DAPT interruption of longer than 14 days were also analysed. Reasons for DAPT interruptions were categorized as clinical, procedural, or patient non-adherence based on reasons checked on patient case report forms. The timing of the first interruption was used to classify patients into an interruption group; patients in whom a ST occurred while on DAPT were included in the non-interruption group even if there was a DAPT interruption after the event.

Stent thrombosis events were categorized according to the Academic Research Consortium (ARC) definitions.³³ The impact of DAPT interruption within the first year after stent implantation on 1 year definite and probable ST events was analysed by categorizing the timing of interruption into three groups: patients with no DAPT interruption, DAPT interruption during the first month (30 days), and DAPT interruption between 1 and 12 months (Figure 1). All the patients who had a DAPT interruption within 12 months of the PCI procedure were followed for a full year after the time of the DAPT interruption to fully assess risk for ST. The population utilized for DAPT interruption analyses was also used to assess the incidence of CD/TVMI based upon DAPT interruption status. Bleeding events, which were available for the subgroup of patients enrolled on the R-INT trial, were analysed in a similar fashion based upon DAPT interruption status.

Statistical methods

The three analysis groups were based on timing of DAPT interruption (no interruption, interruption in the first month, and interruption after 1 to 12 months following stent placement) and were pre-specified before the *post hoc* analysis was undertaken. Descriptive statistics for the baseline characteristics are provided. Categorical variables were reported as counts and percentages, and were assessed using Pearson's Chi-square test. Continuous variables were presented as means \pm SD and were compared using one-way analysis of variance. The Kaplan–Meier method was used to calculate the cumulative incidence of ST events, and the log-rank test was used to compare between-group differences. A two-sided P -value of < 0.05 was considered to indicate statistical significance. Data analysis was conducted independently by the Harvard Clinical Research Institute (Boston, MA, USA).

Results

There were 1069 (21.8%) patients who had a DAPT interruption and 3827 patients who continued DAPT with no interruption. Among patients with a DAPT interruption 166 (15.5%) interrupted in the first month, another 92 (8.6%) interrupted between 1 and 3 months, and 171 (16.0%) interrupted DAPT between 3 and 6 months (Figure 2). Among patients with a classifiable reason for DAPT interruption, temporary DAPT interruption was usually prior to a medical/dental/surgical procedure (42.2%) or for another clinical indication (12.8%), whereas permanently discontinued DAPT most often occurred because patients completed their prescribed course (46.0%) (Figure 3). Stent thrombosis events were evenly distributed across the different reasons for DAPT interruption.

Baseline patient and lesion characteristics of the 4896 patients included in the analysis are shown in Table 1. The incidence of diabetes ($\sim 30\%$) and acute coronary syndromes (overall $\sim 40\%$) was similar between the three groups; however, patients with a DAPT

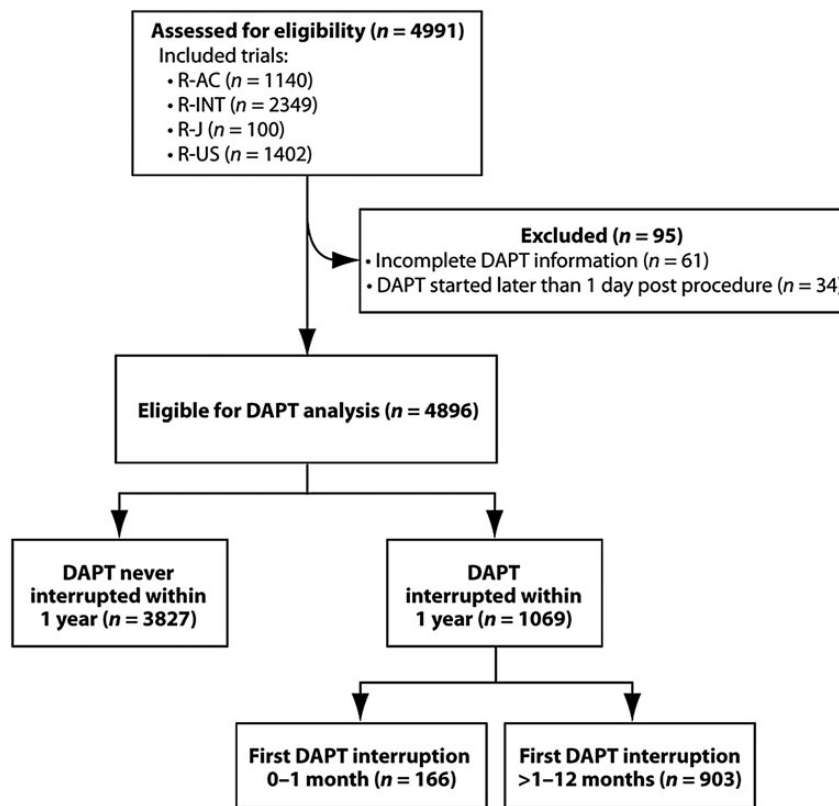


Figure 1 Patient disposition according to dual antiplatelet therapy interruption status. DAPT, dual antiplatelet therapy; R-AC, RESOLUTE-All comers; R-INT, RESOLUTE-International; R-J, RESOLUTE-Japan; R-US, RESOLUTE-US.

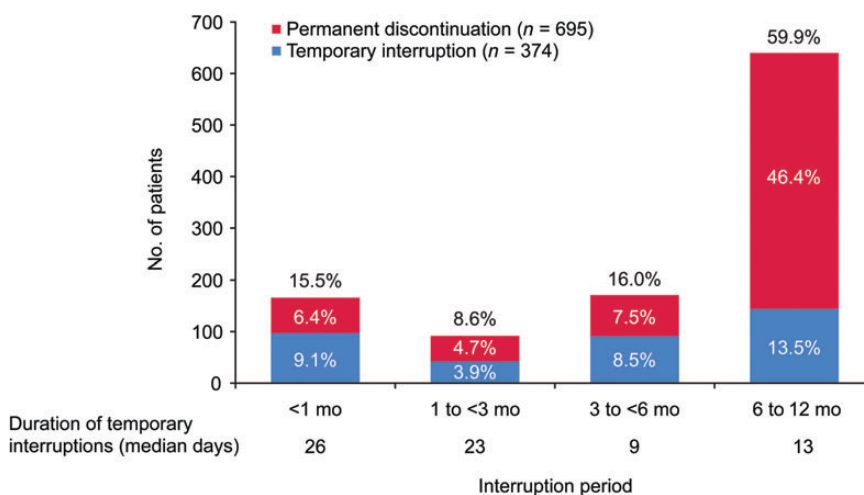


Figure 2 Distribution of patients according to time of first dual antiplatelet interruption.

interruption in the first month were older and had lower left ventricular ejection fractions. In addition, these patients had more B2/C class lesions and smaller reference vessel diameter, but shorter lesion lengths.

Timing of stent thrombosis

In total, 39 cases of ST occurred during the first year following R-ZES implantation. Overall, 32 (82.1%) cases of ST occurred when patients were on DAPT and 7 (17.9%) ST events occurred when patients were

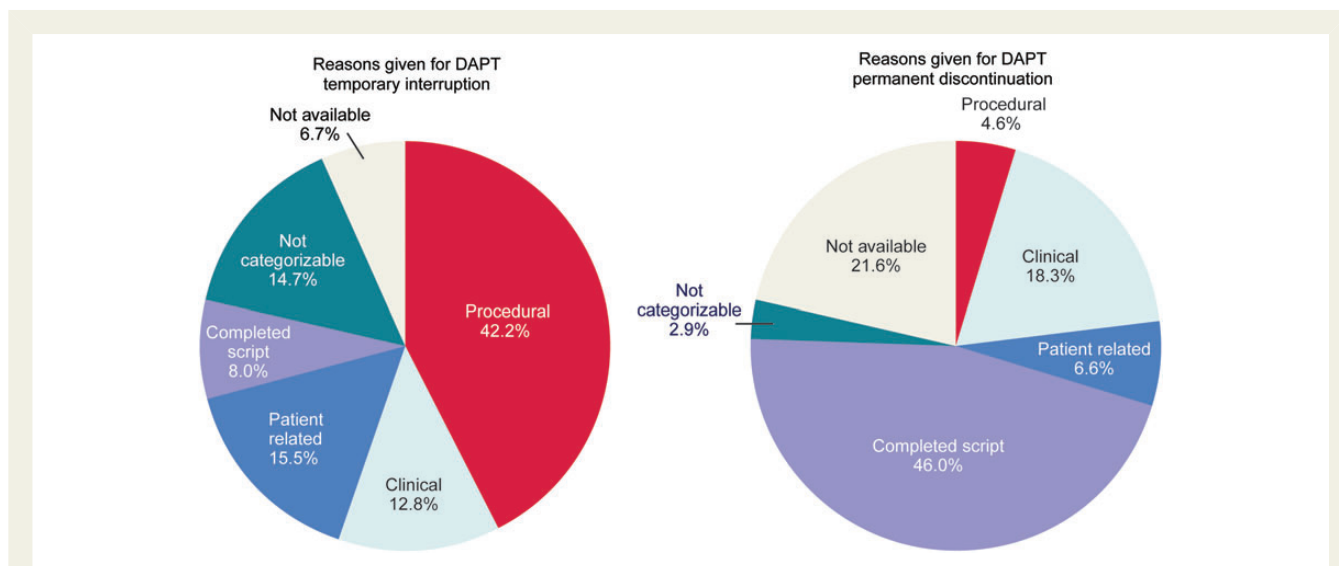


Figure 3 Reasons given for dual antiplatelet therapy interruptions.

Table 1 Baseline demographic and lesion characteristics

Baseline characteristics	Never interrupted, n = 3827 patients	Interrupted first month, n = 166 patients	Interrupted >1–12 months, n = 903 patients	P-value
Age (years)	63.4 ± 10.8 (3827)	66.6 ± 12.0 (166)	65.5 ± 11.3 (903)	<0.001
History of smoking	59.1% (2261/3827)	53.0% (88/166)	58.4% (527/903)	0.289
Prior percutaneous coronary revascularization	30.7% (1176/3827)	27.1% (45/166)	33.1% (299/903)	0.204
Diabetes mellitus	29.6% (1134/3827)	32.5% (54/166)	31.8% (287/903)	0.354
Insulin dependent	8.5% (327/3827)	10.8% (18/166)	10.2% (92/903)	0.201
Prior MI	25.6% (974/3800)	22.7% (37/163)	27.1% (242/893)	0.435
Left ventricular ejection fraction <30%	1.8% (48/2630)	5.7% (6/105)	2.1% (14/671)	0.020
Lesion class B2/C	65.9% (3271/4960)	72.7% (152/209)	68.5% (791/1154)	0.040
ACS	42.4% (1621/3827)	42.2% (70/166)	40.0% (361/903)	0.427
STEMI	8.5% (327/3827)	8.4% (14/166)	6.9% (62/903)	0.255
NSTEMI	7.8% (297/3827)	7.8% (13/166)	8.3% (75/903)	0.861
Unstable angina	26.1% (997/3827)	25.9% (43/166)	24.8% (224/846)	0.744
Pre-procedure RVD (mm)	2.79 ± 0.51 (4767)	2.70 ± 0.56 (198)	2.76 ± 0.53 (1092)	0.010
Lesion length (mm)	15.93 ± 9.66 (4744)	14.77 ± 8.33 (198)	15.09 ± 8.95 (1091)	0.010
Number of stents per patient	1.56 ± 0.94 (3827)	1.53 ± 1.10 (166)	1.52 ± 0.90 (903)	0.615
Total stent length per patient (mm)	29.38 ± 19.56 (3826)	27.84 ± 22.49 (166)	27.83 ± 18.84 (903)	0.071
Stent diameter (mm)	2.95 ± 0.45 (6367)	2.93 ± 0.46 (271)	2.94 ± 0.45 (1467)	0.476

Data are presented as means ± SD or % (n/N).

off DAPT at the time of ST (Figure 4). Among the 29 ST events occurring early (within 30 days), 25 of these events occurred on DAPT and 4 occurred off DAPT. Among the 10 cases of late ST, 7 occurred on DAPT and 3 occurred off DAPT.

Dual antiplatelet therapy interruption

Among the 3827 patients with no DAPT interruption, there were 32 ST events (0.84%). Among patients with DAPT interruption,

166 patients interrupted DAPT in the first month, with 6 ST events occurring in this group (3.61%). Among 903 patients with a DAPT interruption between 1 and 12 months, one ST event occurred (0.11%). Kaplan–Meier estimates of the cumulative incidence of ST events showed a significant difference between patients interrupted in the first month and patients with a DAPT interruption between 1 and 12 months (log-rank $P < 0.001$; Figure 5). In addition to the ST assessment at 12 months, when the 1069 patients with any DAPT

interruption were followed for one full year after the time of DAPT interruption, no additional ST events were identified beyond the seven events described here.

Dual antiplatelet therapy interruption longer than 14 days

Among the 874 patients with a DAPT interruption longer than 14 days, 122 interrupted in the first month. All of the six ST events that occurred in the first month were in these patients who had a prolonged DAPT interruption. Among the 752 patients with a longer than 14 day DAPT interruption between 1 and 12 months, there was no ST event.

Thienopyridine interruption

In patients with a DAPT interruption, the thienopyridine alone was interrupted in 662 (61.9%) patients; there were three total ST events in this group. Among patients interrupting thienopyridine only, 67 patients interrupted the thienopyridine within 1 month [with two ST events (3.0%)], and 595 patients interrupted the thienopyridine between 1 and 12 months [with one ST event (0.2%)].

Acetylsalicylate interruption

In patients with a DAPT interruption, the ASA alone was interrupted in 196 (18.3%) patients; there were four total ST events in this group. Among patients interrupting ASA only, 78 patients interrupted ASA within 1 month [with four ST events (5.1%)], and 118 patients interrupted ASA between 1 and 12 months (no ST events).

Simultaneous interruption

In patients with a DAPT interruption, simultaneous interruption of both the thienopyridine and ASA therapies occurred in 211 (19.7%) patients. Among these patients, 21 interrupted DAPT within the first month and 190 patients interrupted between 1 and 12 months. Notably, there were no ST events in either group.

Permanent discontinuation of dual antiplatelet therapy

Among patients with a DAPT interruption, there were 695 patients (65.0%) who stopped DAPT permanently; of these, 69 occurred within the first month. All four ST events among patients with permanent DAPT discontinuation occurred in patients who permanently discontinued DAPT within the first month.

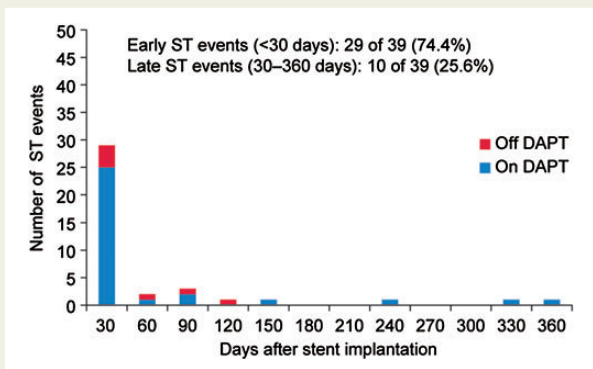
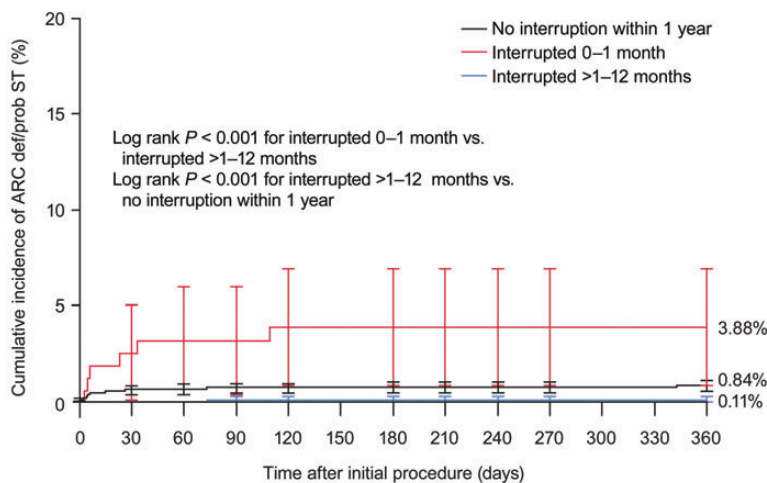


Figure 4 Timing of stent thrombosis regardless of time of dual antiplatelet therapy interruption. DAPT, dual antiplatelet therapy; ST, stent thrombosis.



	0	30	60	90	120	150	180	210	240	270	300	330	360
No interruption within 1 year	3827	3822	3795	3791	3788		3787	3784	3783	3780			3780
Interrupted 0–1 month	166	164	149	147	144		142	141	139	138			137
Interrupted >1–12 months	903	903	902	892	883		877	855	844	841			837

Figure 5 Cumulative incidence of definite or probable stent thrombosis through 1 year after stent implantation according to dual antiplatelet therapy interruption status. ST, stent thrombosis.

Table 2 Details of stent thrombosis events in patients with dual antiplatelet therapy interruption within 1 year of PCI procedure

Patient	Time of interruption	Duration of interruption	Interrupted medication	Time of ST event (duration of interruption until ST)	ARC classification of ST event
DAPT interruption 0–1 month					
1	Day 1	Permanent ^a	ASA	Day 108 (108)	Probable
2	Day 1	Permanent ^b	ASA	Day 2 (2)	Probable
3	Day 3	33 days	ASA	Day 22 (20)	Definite
4	Day 2	Permanent ^b	Clopidogrel	Day 4 (3)	Probable
5	Day 2	Permanent	ASA	Day 5 (4)	Probable
6	Day 2	30 days	Clopidogrel	Day 32 (31)	Definite
DAPT interruption 1–12 months					
7	Day 69	2	Clopidogrel	Day 71(3)	Definite

^aPatient was permanently off DAPT for 108 days before ST event and death.

^bPatients died after ST event within 2–3 days of DAPT interruption.

Details of stent thrombosis events in dual antiplatelet therapy interrupted patients

Of the seven ST events that occurred in DAPT interrupted patients within 1 year after the interruption, three were definite and four were probable (Table 2). Two definite ST and four probable ST events were in patients who had a DAPT interruption within the first month. The median number of days to interruption following the PCI for all six patients in this group was 2 days.

For the single case of ARC definite ST that occurred in the interrupted group between 1 and 12 months, the patient had a history of ST prior to the PCI procedure and had two total occlusions close to the previously implanted stents that were treated during the PCI procedure (Table 2). The median number of days to interruption for all patients was 211 days.

Cardiac death/target-vessel myocardial infarction by dual antiplatelet therapy interruption longer than 14 days

Overall there were 4071 patients who never interrupted DAPT > 14 days or were on DAPT at the time of the CD or TVMI. Among patients who never interrupted DAPT longer than 14 days, the rate of CD/TVMI was 4.08% (166/4071). The rate of CD/TVMI was 6.84% in patients with a longer than 14 day DAPT interruption within the first month; lower rates of CD/TVMI occurred in patients interrupted longer than 14 days between 1–3, 3–6 and 6–12 months (Figure 6).

Bleeding outcomes

Of the 2309 patients from R-INT with bleeding data ascertained, 1896 patients had no DAPT interruption prior to any bleeding event; there were 34 bleeding events in these patients (1.79%). No patient who had a DAPT interruption within the first month ($n = 56$) had a bleeding event, and two bleeding events occurred in the 357 patients (0.56%) with a DAPT interruption from 1 to 12 months.

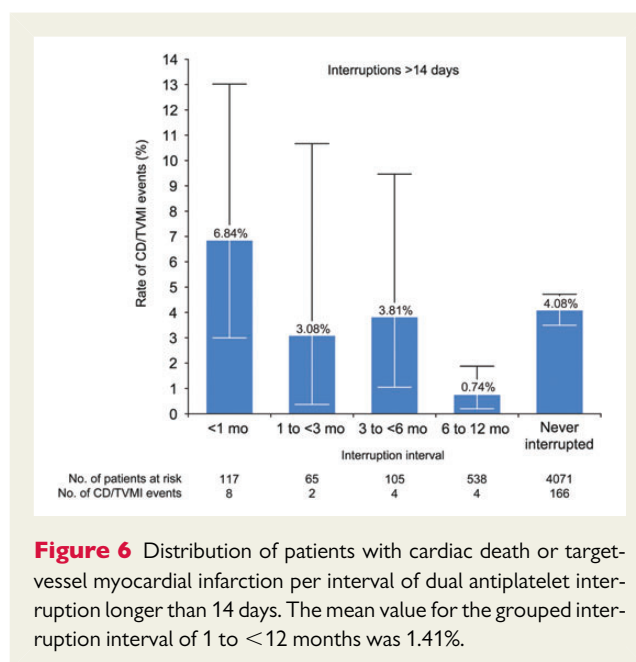


Figure 6 Distribution of patients with cardiac death or target-vessel myocardial infarction per interval of dual antiplatelet interruption longer than 14 days. The mean value for the grouped interruption interval of 1 to <12 months was 1.41%.

Discussion

In patients with stable coronary artery disease, current recommendations for DES call for a minimum of 6 months in the European^{7,8} and 12 months in the US guidelines.⁹ The recently revised American College of Cardiology Foundation/American Heart Association guidelines for management of ST-elevation myocardial infarction recommend 12 months DAPT duration and a strict minimum of 6 months following DES placement for these high-risk patients.¹⁰ In patients with acute coronary syndromes, both guidelines recommend DAPT for 12 months, irrespective of stent type.^{7–9,11–13} However, prolonged DAPT has been associated with higher bleeding rates,³⁴ and optimal DAPT duration with new generation DES is unknown. In this analysis, >4800 patients treated with the R-ZES,

we found that most ST events occurred within 30 days of the index procedure, irrespective of DAPT status. Moreover, DAPT interruptions beyond 30 days were associated with a low risk of ST and no increased risk of CD/TVMI.

Data from other newer generation stent platforms also show that the greatest risk of ST is within the first 30 days and that the risk of ST does not differ between patients on DAPT and off DAPT following this time point.³⁵ These data suggest that other factors such as procedural factors, implantation technique, and patient-related factors impacting the risk for ST are especially important during the first 30 days post-procedure.^{36–39} It is known that ~4–7% of patients undergoing PCI and stent placement will require non-cardiac surgery in each year after treatment and thus it is often unavoidable to interrupt DAPT before the 6–12 months post-procedure recommended.⁴⁰ For patients that interrupted DAPT in the current analysis, nearly all ST events (six of seven) occurred in patients who interrupted DAPT between 0 and 1 month and only one patient that interrupted DAPT after 1 and before 12 months had a ST.

While event numbers are small, interruption of DAPT after 1 month appeared to confer no additional risk for ST, compared with no interruption of DAPT. However, interruption of DAPT during the first month was associated with a greater risk of ST. The log-rank *P*-value for the difference in ST rates between patients interrupted between 1 and 12 months and patients interrupted within the first month is <0.0001, which would imply that the patients that interrupted between 1–12 months has a lower risk of ST than patients that interrupted within a month of R-ZES. These data do not address patients who may be at a higher risk for ST regardless of stent type but suggest that DAPT interruption after 1 month may not confer increased risk for ST, CD, or MI for many patients receiving a Resolute stent. While observational studies of the first generation DES consistently showed a correlation between early discontinuation of DAPT and higher rates of ST, it is not clear that the same observations apply to new generation DES such as the R-ZES, as evidenced by our observation that the rate of ST in patients with a DAPT interruption after 1 month is quite low.

It is also important to consider the role of duration of interruption. The thienopyridines, ticlopidine, and clopidogrel are pro-drugs metabolized in the liver to active metabolites that are non-competitive antagonists of the platelet adenosine diphosphate receptor, P2Y₁₂. Inhibition of platelet aggregation by these drugs is delayed until 24–48 h after administration, with maximal inhibition achieved after 3–5 days. Studies have shown that it takes up to 14 days for the platelet function to recover after DAPT withdrawal,³² which supports the relevance and importance of assessing ST status for subjects that interrupt for longer than 14 days given that a DAPT effect on platelet function could still be active during shorter interruption durations. Consistent with these data, the DAPT Study being conducted in over 20 000 subjects uses a duration of DAPT longer than 14 days to define compliance.⁴¹ In this analysis, no ST events occurred in patients with longer than 14 day interruption in the 1–12-month interruption group. All six ST events in patients with longer than 14 day interruption occurred in the 1-month interruption group.

When the reasons for DAPT interruption were investigated, we noted no difference in the incidence of ST according to reason for interruption although the small number of events precludes any

definitive conclusions. However a recently published observational study of over 5000 patients looking at cessation of DAPT and cardiac events after PCI observed a significantly greater risk for major adverse cardiac events when patients disrupted their therapy than when physicians chose to discontinue or interrupt DAPT.⁴²

Prolonged use of antiplatelet drugs is a known risk for bleeding events and there is evidence to suggest that for some patients, DAPT extension beyond 3 months confers no additional benefit in terms of reduction in ST events, but is associated with more major bleeding events.⁴³ Even mild-to-moderate bleeding events are associated with a poorer long-term prognosis compared with those patients without bleeding.⁴⁴ These results (1.79% bleeding with no DAPT interruption and 0.56% bleeding in DAPT interrupted patients) are consistent with observations that there is an increased risk for bleeding in the presence of DAPT.

In addition to the lack of safety benefit demonstrated with extended use of DAPT, there is increasing evidence to show comparable safety outcomes in terms of ST and cardiac death with a shorter DAPT duration than is currently recommended by guidelines. Analysis from multiple publications shows the greatest risk for ST and cardiac death is observed when DAPT interruption occurs within 30 days after stent implantation.^{17,45–48} These observations highlight the need for randomized controlled trials to evaluate the risk vs. benefit of very short (1 month) vs. longer durations of DAPT after DES implantation.

Cardiac death/target-vessel myocardial infarction

The clinical consequences of ST can be serious, with death and myocardial infarction being the most severe. A pooled analysis of multicentre coronary stent trials and registries has shown that ST is a rare but usually catastrophic event, frequently associated with a myocardial infarction or death. The use of DAPT for a period longer than 12 months in patients who had received DESs was not significantly more effective than aspirin monotherapy in reducing the rate of myocardial infarction or death from cardiac causes in a previously randomized study.²² Although not all cardiac deaths and myocardial infarctions are ST-related, we analysed the occurrence of CD/TVMI in patients with and without a longer than 14 day DAPT interruption to provide a more inclusive assessment of ST. Results support the conclusion that the antiplatelet therapy discontinuation was not necessarily followed by major cardiovascular events, at least in patients with a prolonged DAPT interruption later than 1 month after stenting.

There are several possible mechanisms explaining the relative safety of the R-ZES. Pre-clinical studies of the Biolinx™ polymer blend used on the R-ZES demonstrate that the hydrophilic surface of this polymer coating does not induce an inflammatory response and provides excellent biocompatibility.⁴⁹ This observation was confirmed in a porcine coronary artery model showing minimal inflammation following implantation of the R-ZES.⁵⁰ Clinical studies have also supported the safety of ZES. For example, some of these findings might be explained by better neointimal coverage in the early post-implant period compared with earlier generation DES.^{51,52} In optical coherence tomography studies, most of the stent struts were covered with neointima at 3 months after R-ZES implantation

and the rates of malapposition ($0.7 \pm 2.2\%$) and thrombus (1/18, 5.6%) were quite low,⁵² and exposure of stent struts and thrombi was observed less frequently in patients undergoing PCI with ZES than in those undergoing PCI with SES at 9-month follow-up.⁵¹

Although 1 year of clinical follow-up may not be sufficient to assess the very late outcomes, the data presented here are meaningful given that the majority of the ST events occurs within the first year following stent implantation. Moreover, the optimal duration of DAPT might be different according to DES types. These data suggest for R-ZES, DAPT use for the first month after stent placement is important but the necessity for continued DAPT beyond this time is unclear. DES that can offer both safety and efficacy are desirable, especially for those who may need to stop DAPT early after DES implantation.

Limitations

This is a *post hoc* analysis of pooled datasets that may not reflect the higher ST risk likely to occur in routine clinical practice. Specifically, the RESOLUTE-Japan and RESOLUTE-US trials enrolled subjects likely to be at a lower risk for clinical events; however, the majority (70%) of the patients included in this analysis was taken from the RESOLUTE-International Registry ($n = 2349$) and the RESOLUTE-All Comers trial ($n = 1140$) which enrolled a high proportion of high-risk 'real world' patients. These results should not be overinterpreted in this observational database given that physicians may have appropriately selected those patients who could safely interrupt DAPT and the small number of ST events that occurred after R-ZES implantation. Additionally, most of the DAPT interruptions (often temporary and brief) occurred after 6 months making it difficult to sort out the exact role of nature of the association between DAPT interruptions and adverse clinical events. The generalized application of these results to the entire population demands careful attention given that a larger sample size and a randomized trial might be required to provide a definite answer regarding low frequency events such as ST. The findings reported here apply only to R-ZES. Because safety and efficacy differ according to the DES type, additional analyses that determine the feasibility of short duration DAPT after implantation of other DES are needed.

Conclusion

In a large pooled population of patients treated with an R-ZES, DAPT interruptions between 1 and 12 months were associated with low rates of ST and adverse cardiac outcomes. It would be inappropriate to suggest any changes to the ESC or ACC/AHA/SCAI guidelines for PCI post-stent implantation; however, the current analysis may provide reassurance for clinicians and patients implanted with an R-ZES who may need to interrupt or discontinue the medications before the recommended duration for a variety of unplanned reasons. Randomized clinical trials are needed to determine whether early temporary or permanent interruption of DAPT is truly safe.

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