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Letter to the Editor: How Should We Treat High-risk Patients in the Chronic Phase Following PCI: Clopidogrel or Prolonged DAPT?

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▸ See the article "Long-term Outcomes of Clopidogrel Monotherapy versus Prolonged Dual Antiplatelet Therapy beyond 12 Months after Percutaneous Coronary Intervention in High-risk Patients" in volume 36, number 16, e106.

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Dear Editor,

We read with interest the paper by Kim et al.[1] which reported that compared with prolonged dual antiplatelet therapy (DAPT), clopidogrel monotherapy showed similar long-term outcomes in patients at high-risk after second-generation drug-eluting stents (DES) implantation. In this study, 637 patients without adverse events were included and divided into two groups, the clopidogrel monotherapy group and the prolonged DAPT group. Interestingly, no mention was made of the exclusion of aspirin monotherapy. Would you tell us whether aspirin monotherapy group was excluded? Theoretically, there should be three groups: clopidogrel monotherapy, aspirin monotherapy, and DAPT groups. However, 266 patients received clopidogrel and 377 received DAPT, what was the number of people in the aspirin monotherapy group?

Additionally, in the part of method, you mentioned that "Patients were categorized into two groups according to anti-platelet treatment status at 24 months after index PCI: the clopidogrel group (aspirin discontinued within 24 months) and the prolonged DAPT group (prolonged DAPT more than 24 months)." Would you tell us why the patients were not categorized into two groups according to antiplatelet treatment status at 12 months after index PCI, but for 24 months?

In **Table 3**, the median duration of DAPT was 14.7 and 36.0 months in clopidogrel monotherapy group and extended DAPT groups, respectively. Would you tell us what criteria were used to divide the clopidogrel monotherapy group and the extended DAPT group? The DAPT duration seems to discordant to the treatment group.

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The Author's Response: Long-term Outcomes of Clopidogrel Monotherapy versus Prolonged Dual Antiplatelet Therapy beyond 12 Months after Percutaneous Coronary Intervention in High-risk Patients

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We thank Dr Wang and his colleagues for their interest in our findings on clopidogrel monotherapy and prolonged dual antiplatelet therapy (DAPT) after percutaneous coronary intervention (PCI) for patients at high risk for ischemic events.[1]

Dr Wang and his colleagues asked why we compared the clopidogrel group and the DAPT group, without an aspirin group. Prior to the present study, our group had reported the comparison of clinical outcome of aspirin versus clopidogrel monotherapy.[2] In the observational study, clopidogrel monotherapy was associated with lower rate of ischemic events, without increased bleeding risk, compared to aspirin monotherapy, after 12 months DAPT following drug-eluting stent implantation. Having this result in the previous study, we wanted to compare clopidogrel monotherapy with prolonged DAPT for high-risk patients, who might have benefit from prolonged DAPT in our present study. Therefore, we excluded patients receiving aspirin monotherapy in the present analysis.

Another point they raised was why the status of DAPT at 24 months categorized the study groups, not the status of DAPT at 12 months. Current guidelines recommend prolonged DAPT more than 12 months only for patient with high ischemic risk and without high risk for bleeding event.[3] This was an observational study and the duration of DAPT was decided by clinician's discretion, and the timing of shift from DAPT to clopidogrel was not controlled. We planned to compare clopidogrel monotherapy with prolonged DAPT more than 12 months after the index PCI. Therefore, the prolonged DAPT group had to have significantly longer duration of DAPT

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than the clopidogrel group in the present study. When the two groups were divided by the status of DAPT at 24 months, duration of DAPT between the clopidogrel group and the DAPT group were significantly different (**Table 3**),[1] that best served the purpose of our study. The criteria of the two treatment groups were as detailed in Method.[1]

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