

# Clopidogrel is Adequate in Most Patients With ACS

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The PEGASUS-TIMI 54<sup>1</sup> and DAPT<sup>2</sup> trials have both shown that intensified platelet inhibition with dual antiplatelet therapy (P2Y<sub>12</sub> antagonist plus aspirin) after 1 year effectively reduces the risk of ischemic events in patients with high-risk coronary artery disease at the expense of clinically serious bleeding. Therefore, a personalized antiplatelet strategy that is based on a risk-profile analysis including a therapeutic-window concept for platelet reactivity may improve the balance between efficacy and safety during long-term dual antiplatelet therapy.<sup>3</sup>

East Asians have less thrombophilia and a greater bleeding tendency than do Western populations during antiplatelet therapy.<sup>4,5</sup> Furthermore, active metabolite concentrations of prasugrel and ticagrelor are up to 50% greater among East Asians than among white patients, findings that translate into more potent platelet inhibition among East Asians.<sup>5</sup> In PEGASUS-TIMI 54, the net clinical benefit of the addition of long-term ticagrelor among Asian patients (East Asians: about three-quarters of Asian cohort) appears to be less favorable than among white patients (Fig. 1). A more judicious approach in adapting the strategy outlined in the PEGASUS-TIMI 54 trial for Asians without further dedicated studies in the Asian population will be an essential challenge, given these observations.

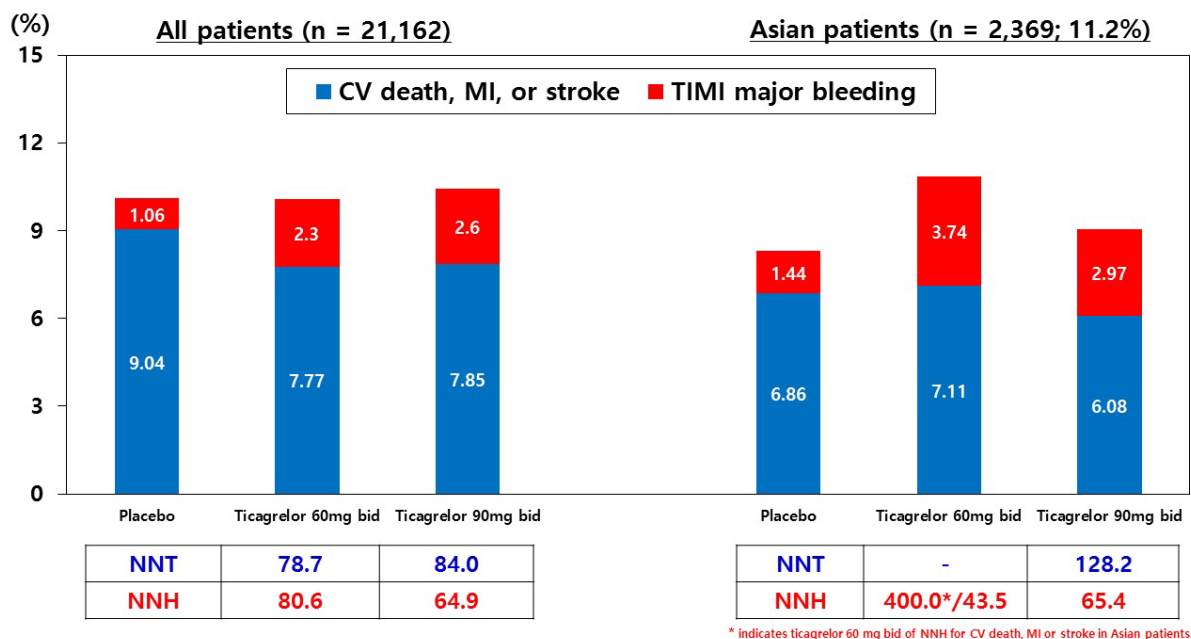


Figure 1. Net Clinical Benefit for Asian Patients, as Compared with All Patients, in the PEGASUS-TIMI 54 Trial.

Shown are the percentages of Asian patients, as compared with all patients, who had a composite cardiovascular event (death from cardiovascular [CV] death, causes or nonfatal myocardial infarction [MI], or stroke through 3 years) or who had a major bleeding episode (as defined by the Thrombolysis in Myocardial Infarction [TIMI] criteria through 3 years), according to the dose of ticagrelor or placebo. The values below the graph show the number of patients who would have need to be treated (NNT) to prevent one cardiovascular event and the number of patients who would need to be harmed (NNH) to cause one cardiovascular or bleeding event.

## REFERENCES

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