

## Key issues regarding Dual Therapy (Clopidogrel + Aspirin) use in clinical practice

### Primary Prevention:

No benefit for Clopidogrel and increased risk of mortality for dual therapy (CHARISMA Study 5.4% vs 3.8%)

### Stable Coronary Artery Disease:

**Monotherapy:** In the Clopidogrel versus Aspirin in Patients at Risk of Ischemic Events (CAPRIE) trial a 9% was shown in the primary composite end point (n=19,185) with a recent history of stroke, myocardial infarction (MI), or symptomatic peripheral artery disease.

However, because of the small effect size and the marginal statistical significance ( $P = 0.045$ ) achieved in a large sample, the FDA **did not** grant a superiority claim over aspirin.

The overall safety and tolerability profile of clopidogrel was as good as that of medium-dose aspirin; **without** any bleeding risk benefits

### Percutaneous Coronary Intervention (PCI)

*With Stenting:* Dual Therapy: Up to 1 month with bare metal stents, longer treatment (>18 mo and perhaps longer) with drug-eluting stents in patients with PCI.

*(Aspirin 325 mg po daily and Clopidogrel 75 mg daily for 4-6 months, then 81-325 mg Aspirin and Clopidogrel 75 mg for minimum of 12-18 months or longer.)*

### Acute coronary Syndrome (ACS)

At least up to 9-12 months in high-risk patients with UA/NSTEMI who are at **low-risk** for bleeding.  
At least 1 month with fibrinolytic treatment in patients with STEMI;

### Cerebrovascular Accidents or TIA

Not recommended as first-line therapy for patients with cerebrovascular accidents unless a clear indication, such as acute coronary syndromes or stent placement, also are present.

### Pretreatment for Elective Coronary Artery Bypass Grafting

**No definite** benefit but increased bleeding risk is associated with coronary artery bypass grafting.  
Timing of elective coronary artery bypass grafting and other surgical procedures  
Stop therapy at least 5 days, preferably 7 days, before surgery.

