ANTITHROMBOTIC THERAPY AROUND PCI

THREE TARGETS — WHAT EACH DRUG BLOCKS

- **COX-1 Aspirin** — irreversible acetylation; no thromboxane A_2 for the platelet's life
- **P2Y12 (ADP) Clopidogrel, prasugrel** — prodrugs, **irreversible. Ticagrelor** — direct-acting, **reversible,** oral. **Cangrelor** — direct, reversible, **IV;** function back within **1 h**
- **GP IIb/IIIa** The final common pathway — **eptifibatide, tirofiban** (reversible)
- **Thrombin UFH** (antithrombin-dependent, IIa + Xa) · **enoxaparin** (mainly Xa) · **fondaparinux** (Xa only) · **bivalirudin** (direct thrombin inhibitor, reversible; t½ 25 min)

- **Pearl** *Clopidogrel is activated principally by **CYP2C19** — poor metabolizers make little active drug (boxed warning). Prasugrel and ticagrelor do not depend on it*
- **Pearl** *Irreversible drugs wear off only as new platelets are made — the labels say **5 days** off clopidogrel or ticagrelor and **≥7 days** off prasugrel before surgery*

PRETREATMENT AND THE CLOCK

- **NSTE-ACS** Angiography expected **>24 h:** upstream clopidogrel or ticagrelor **may be considered** — COR 2b (2025)
- **ACCOAST** Prasugrel before angiography: no ischemic benefit (HR 1.02) and **TIMI major bleeding to day 7 HR 1.90**
- **STEMI** Prehospital ticagrelor (**ATLANTIC):** co-primary endpoints neutral; definite stent thrombosis 0.2% vs 1.2% at 30 d
- **Opioids** IV morphine or fentanyl **delay the effect of oral P2Y12 inhibitors** (2025 slide set)
- **After a lytic** PCI within 24 h: **clopidogrel 300 mg** load (COR 1, 2021) · ticagrelor a reasonable alternative if <75 y (2b)
- **Anticoagulant** Continue parenteral anticoagulation **until revascularization** (COR 1, 2025). Lytic without an invasive plan: for the hospital stay, **up to 8 days**
- **Early surgery** Stop clopidogrel or ticagrelor **5 d,** prasugrel **7 d** before CABG (labels). **Cangrelor** can bridge when a P2Y12 gap is unsafe (2025 slide set)

WHICH P2Y12 INHIBITOR?

- **ACS + PCI Prasugrel or ticagrelor** in preference to clopidogrel — **COR 1** (ACC/AHA 2025; it was 2a in 2021)
- **TRITON** Prasugrel vs clopidogrel: CV death/MI/stroke **9.9% vs 12.1%,** HR 0.81; stent thrombosis 1.1% vs 2.4% — but **TIMI major bleeding HR 1.32, fatal 0.4% vs 0.1%**
- **PLATO** Ticagrelor vs clopidogrel: **9.8% vs 11.7%,** HR 0.84; all-cause death 4.5% vs 5.9%
- **Head to head ISAR-REACT 5** (open label): death/MI/stroke 9.3% ticagrelor vs **6.9% prasugrel,** HR 1.36. **SWITCH SWEDEHEART** (2026, regional default policy, n=17,095): ischemic OR 0.90 (0.77–1.06), major bleeding OR **0.80** (0.64–0.99) with prasugrel
- **NSTE-ACS, no cath Ticagrelor** — COR 1 (2025)
- **Clopidogrel** When prasugrel/ticagrelor are unavailable, not tolerated or contraindicated (COR 1) · with **fibrinolysis** (COR 1) · **elective PCI for chronic disease** (load: COR 1, 2021)
- **Prasugrel limits** **Prior stroke or TIA = COR 3: Harm** · age **≥75** generally not recommended (label) unless diabetes or prior MI · **5 mg** if <60 kg

IN THE LAB — ANTICOAGULANT AND IV AGENTS

- **UFH Default** — COR 1 for ACS PCI (2025). **70–100 U/kg** bolus to **ACT 250–300 s** (2021 dosing table)
- **Bivalirudin STEMI: COR 1** "to reduce mortality and bleeding" (2025; was 2b for any PCI in 2021). NSTE-ACS: 2b
- **BRIGHT-4** Bivalirudin + **high-dose infusion 2–4 h after PCI** vs UFH, 93% radial: death/BARC 3–5 **3.06% vs 4.39%,** HR 0.69; stent thrombosis 0.37% vs 1.10%
- **The earlier fight** HORIZONS-AMI (vs UFH + GPI) favoured bivalirudin but **acute stent thrombosis rose** (EUROMAX 1.1% vs 0.2%); HEAT-PPCI favoured heparin; VALIDATE-SWEDEHEART neutral (HR 0.96)
- **Enoxaparin** IV enoxaparin at PCI may be considered (2b, 2025). **ATOLL** primary endpoint neutral (RR 0.83, P=0.06). **SC dose within 12 h → do NOT add UFH (COR 3: Harm, 2021)**
- **Fondaparinux** **Never alone for PCI — COR 3: Harm (2025):** catheter thrombus 0.9% vs 0.4% (OASIS-5 PCI); give **standard-dose UFH** at PCI (FUTURA/OASIS-8)
- **GP IIb/IIIa** Bailout for **large thrombus, no-reflow or slow flow** — 2a (2025, IV or intracoronary). **Routine use = COR 3: Harm (2025)**
- **Cangrelor** P2Y12-naive ACS PCI — 2b. **CHAMPION PHOENIX:** OR 0.78; stent thrombosis OR 0.62
- **HIT** Replace UFH with **bivalirudin or argatroban** — COR 1 (2021)

ORAL ANTIPLATELETS — DOSE, DANGER, DURATION OFF

Agent	Mechanism · onset · offset	Load → maintenance (FDA label)	Forbidden in	Before surgery	Monitoring · signature toxicity · trial
COX-1					
Aspirin	Irreversible COX-1 acetylation	**162–325 mg** chewed (2021 slide set) → **81 mg** daily (75–100 mg; COR 1, LOE A, CCD 2023)	**With ticagrelor: more than 100 mg/day** (boxed warning — blunts ticagrelor)	—	GI bleeding · **ADAPTABLE**: 81 = 325 mg (HR 1.02)
P2Y12 INHIBITORS					
Clopidogrel	Prodrug (CYP2C19) · **irreversible** · effect 2 h after a dose · recovery ~5 d	**300 mg → 75 mg** daily (ACS label); 300 mg within 24 h of a lytic	Active pathological bleeding	**5 days**	**Boxed: poor CYP2C19 metabolizers** · avoid omeprazole/esomeprazole · TTP · **CURE**, **CREDO**
Prasugrel	Prodrug · **irreversible** · ≥50% inhibition by 1 h in ~90% · recovery 5–9 d	**60 mg → 10 mg** daily · **5 mg if <60 kg**	**Prior stroke or TIA** · active bleeding · ≥75 y generally not (except diabetes or prior MI)	**≥7 days**	**Boxed: significant, sometimes fatal bleeding** · TTP · **TRITON-TIMI 38**
Ticagrelor	Direct-acting · **reversible** · peak ~2 h · near placebo by day 5	**180 mg → 90 mg bid** × 1 y → **60 mg bid**	**History of ICH** · active bleeding · severe hepatic impairment (avoid) · strong CYP3A inhibitors/inducers	**5 days**	**Dyspnea 14–21%** · ventricular pauses · aspirin ≤100 mg · **PLATO**

IV ANTIPLATELETS AND PROCEDURAL ANTICOAGULANTS

Agent	Mechanism · offset	PCI dose (label or guideline table)	Kidneys	Forbidden in	Watch for · trial
IV ANTIPLATELETS					
Cangrelor	IV P2Y12, reversible · t½ 3–6 min · normal within 1 h	**30 µg/kg** bolus → **4 µg/kg/min** for ≥2 h or the PCI, whichever is longer	No adjustment	Significant active bleeding	**Switch: ticagrelor 180 mg during or after; prasugrel 60 or clopidogrel 600 mg only AFTER the infusion stops** · **CHAMPION PHOENIX**
Eptifibatide	GP IIb/IIIa, reversible · t½ ~2.5 h	**180 µg/kg** bolus → **2 µg/kg/min** + second 180 µg/kg bolus at 10 min	CrCl <50: **1 µg/kg/min**	**Dialysis dependence** · bleeding or stroke within 30 d · any hemorrhagic stroke	Thrombocytopenia → stop it and heparin
Tirofiban	GP IIb/IIIa, reversible · near baseline 4–8 h after stopping	**25 µg/kg** over ≤5 min → **0.15 µg/kg/min** up to 18 h	CrCl ≤60: **0.075 µg/kg/min**	Prior tirofiban thrombocytopenia · active bleeding · major surgery or trauma <1 mo	Bleeding · thrombocytopenia
ANTICOAGULANTS					
UFH	Antithrombin-dependent IIa + Xa	**70–100 U/kg → ACT 250–300 s**; already anticoagulated: add 2,000–5,000 U as needed (2021 Table 11)	No adjustment	**HIT** · SC enoxaparin within 12 h (Harm)	**ACT** · HIT
Enoxaparin	Mainly anti-Xa · protamine reverses ~60%	1 mg/kg SC q12h · **≥75 y: 0.75 mg/kg, no bolus** · last SC dose >8 h before PCI → **0.3 mg/kg IV**	CrCl <30: **1 mg/kg once daily**	**HIT within 100 d** · UFH on top of an SC dose given <12 h ago	**Boxed: spinal/epidural hematoma** · **ATOLL**
Bivalirudin	Direct thrombin inhibitor, reversible · t½ 25 min	**0.75 mg/kg → 1.75 mg/kg/h**; ACT at 5 min, extra 0.3 mg/kg if needed	CrCl <30: **1 mg/kg/h** · dialysis 0.25	Active major bleeding	**Acute stent thrombosis in STEMI PPCI** (label) · **BRIGHT-4** ran a high-dose infusion 2–4 h after PCI
Fondaparinux	Indirect, Xa only · t½ 17–21 h	**Not for PCI on its own** — ACS use rests on OASIS-5/6; ACS is not a US label indication	**CrCl <30: contraindicated**	**Sole anticoagulant for PCI (COR 3: Harm)**	Catheter thrombus → add standard-dose UFH (**FUTURA/OASIS-8**)

Educational quick-reference for cardiology fellows — ACC/AHA 2025 ACS guideline (Class from the AHA slide set), 2021 revascularization, 2023 CCD and 2023 AF guidelines; FDA labels. ESC grades not reproduced.

ANTITHROMBOTIC THERAPY AROUND PCI

ARC-HBR: ≥1 MAJOR OR ≥2 MINOR CRITERIA

Major (any one = HBR)	Minor (two = HBR)
HBR = BARC 3/5 BLEEDING ≥4% OR ICH ≥1% AT 1 YEAR	
Long-term **oral anticoagulation**	Age **≥75 y**
eGFR **<30** mL/min	eGFR **30–59**
Hemoglobin **<11** g/dL	Hb 11–12.9 (men), 11–11.9 (women)
Spontaneous bleed needing hospital or transfusion in **6 mo**, or ever if recurrent	First such bleed **6–12 mo** before PCI
Platelets **<100** × 10⁹/L before PCI	Long-term oral **NSAID or steroid** (≥4 d/wk)
Chronic bleeding diathesis	Any ischemic stroke not meeting the major criterion
Cirrhosis with portal hypertension	
Active cancer (≤12 mo or on treatment)	
Any prior spontaneous ICH; traumatic ICH ≤12 mo; brain AVM	
Moderate/severe ischemic stroke ≤6 mo (NIHSS ≥5)	
Non-deferrable major surgery on DAPT · major surgery or trauma ≤30 d before PCI	

NO ASPIRIN FROM DAY ONE — NOT YET

- **STOPDAPT-3** Prasugrel 3.75 mg alone from PCI (ACS or HBR): bleeding **not reduced** (HR 0.95) and **subacute stent thrombosis HR 3.40**
- **NEO-MINDSET** Potent P2Y12 alone within 4 d of ACS: ischemic events 7.0% vs 5.5% — **non-inferiority NOT met;** bleeding 2.0% vs 4.9%; stent thrombosis 12 vs 4 patients
- **PREMIUM** 2026 · STEMI, low-dose prasugrel without aspirin from primary PCI: death/stroke/MI **11.0% vs 8.5%,** HR 1.34 (1.02–1.75) — **NOT non-inferior;** BARC 3/5 HR 0.66 (descriptive only)
- **LEGACY** Immediate aspirin omission after NSTE-ACS PCI (n≈3,090): design published 2023; **no results found** as of Oct 2026 — do not cite an outcome
- **Pearl** *Every trial that worked kept aspirin for **weeks to months** first (T-PASS median 16 d; TARGET-FIRST and STOPDAPT-2 1 mo; TWILIGHT and TICO 3 mo)*

SHORTER DAPT — WHAT THE TRIALS SHOWED

- **Pattern** Drop **aspirin,** keep the **P2Y12 inhibitor:** bleeding falls, ischemic events do not rise — **in the patients studied**
- **TWILIGHT** Ticagrelor alone after 3 mo, high-risk PCI: BARC 2/3/5 **4.0% vs 7.1%** , HR 0.56; death/MI/stroke 3.9% both
- **TICO** Ticagrelor alone after 3 mo, ACS: NACE 3.9% vs 5.9%, HR 0.66
- **T-PASS** Ticagrelor alone after <1 mo (median 16 d), ACS: NACE 2.8% vs 5.2%, HR 0.54
- **ULTIMATE-DAPT** Placebo-controlled, months 1–12, ACS: BARC 2/3/5 **2.1% vs 4.6%,** HR 0.45; MACCE 3.6% vs 3.7%
- **TARGET-FIRST** P2Y12 alone after 1 mo, low-risk AMI fully revascularized: NACE 2.1% vs 2.2% (non-inferior); BARC 2/3/5 HR 0.46
- **STOPDAPT-2** 1 mo DAPT → clopidogrel: net benefit in PCI (HR 0.64) — but **in ACS non-inferiority was NOT met** (HR 1.14; CV events HR 1.50)
- **HBR MASTER DAPT:** stop DAPT at 1 mo — NACE 7.5% vs 7.7% (non-inferior); clinically relevant bleeding 6.5% vs 9.4%
- **De-escalate** Potent → clopidogrel: **TOPIC** (unguided, single centre) HR 0.48 · **TROPICAL-ACS** (platelet-function) non-inferior · **POPular Genetics** (CYP2C19) non-inferior, less bleeding · **TAILOR-PCI:** genotype-guided P=0.06, **not significant**
- **Pearl** *Clopidogrel alone after 1 mo failed in ACS (STOPDAPT-2 ACS); the ACS successes kept a **potent** drug as the monotherapy*

BEYOND 12 MONTHS — LONGER, OR WHICH ONE?

- **DAPT study** Thienopyridine months 12–30: stent thrombosis **0.4% vs 1.4%,** MACCE HR 0.71 — **bleeding 2.5% vs 1.6%; death HR 1.36**
- **PEGASUS** Ticagrelor 60 or 90 bid, 1–3 y after MI: HR 0.84 / 0.85; TIMI major bleeding ~2.5% vs 1.1%
- **DAPT-MVD** 2026 · multivessel DES, event-free at 12 mo (China, ≤75 y): 12 more months of clopidogrel + aspirin vs aspirin — CV death/MI/stroke **5.8% vs 6.8%,** HR 0.82; BARC ≥2 HR 0.89 (NS)
- **A-CLOSE** 2026 · high ischemic risk, 12 mo after DES (Korea): clopidogrel alone vs DAPT — NACE 5.0% vs 5.1% (non-inferior) but **ischemic events 3.7% vs 1.6%, HR 2.33;** bleeding HR 0.43
- **CCD rule** Prior MI, low bleeding risk: DAPT up to **3 years** — 2b (CCD 2023)

- **Which single drug? Clopidogrel over aspirin: HOST-EXAM** HR 0.73 at 2 y and **0.86 at 10 y** (2026) · **SMART-CHOICE 3** HR 0.71 · 7-trial patient-level meta-analysis MACCE HR 0.86, bleeding not increased
- **Pearl** *Mostly East Asian trials — guidelines still name aspirin 81 mg as the default single agent (COR 1, CCD 2023)*

AFTER PCI — WHICH REGIMEN, FOR HOW LONG

indication → bleeding risk → the clock · Class from ACC/AHA 2025 (ACS) and 2023 (CCD, AF)

1 · ACS, NOT HIGH BLEEDING RISK — the default

ACS + PCI
default strategy

→ **DAPT ≥12 MONTHS — COR 1**
Aspirin 81 mg + ticagrelor or prasugrel
Clopidogrel only if they cannot be used

→ **THEN ONE AGENT, LONG TERM**
Aspirin 81 mg is the guideline default
Clopidogrel beat aspirin: HOST-EXAM, SMART-CHOICE 3

OR LONGER DAPT — SELECTED
Prior MI, low bleeding risk: up to 3 y (2b, CCD)
DAPT, PEGASUS, DAPT-MVD (2026)

2 · ACS, BLEEDING TO BE REDUCED — keep the P2Y12 inhibitor, drop or soften the rest

ACS + PCI
choose one option

→ **TICAGRELOR ALONE — COR 1**
Stop aspirin at 1–3 months, keep ticagrelor
TWILIGHT · TICO · T-PASS · ULTIMATE-DAPT

DE-ESCALATE — 2b
Switch to clopidogrel >1 month after PCI
TOPIC · TROPICAL-ACS · POPular Genetics

HIGH BLEEDING RISK — 2b
Stop aspirin OR the P2Y12 >1 month after PCI
ARC-HBR ≥1 major or ≥2 minor · MASTER DAPT

3 · CHRONIC CORONARY DISEASE, ELECTIVE PCI

CCD + PCI
stable, no OAC

→ **DAPT 6 MONTHS — COR 1 (A)**
Aspirin + clopidogrel, then one agent
Aspirin 81 mg long term (COR 1, A)

OR SHORTER — 2a (A)
1–3 months of DAPT, then a P2Y12 inhibitor alone for ≥12 months

DO NOT
Add clopidogrel to aspirin without a PCI or ACS reason (3: No Benefit)
Prasugrel or vorapaxar after stroke, TIA or ICH (3: Harm)

4 · ALSO NEEDS AN ORAL ANTICOAGULANT — AF, VTE

OAC + PCI
DOAC over VKA (COR 1)

→ **TRIPLE: 1–4 WEEKS ONLY**
DOAC + clopidogrel + aspirin, then stop aspirin
Up to 30 d if stent-thrombosis risk is high (AF 2023 text)

→ **DOAC + CLOPIDOGREL**
ACS: to 12 months (COR 1) · CCD: 6 months (COR 1)
AUGUSTUS: aspirin HR 1.89 for bleeding

→ **THEN THE DOAC ALONE**
AF + CCD >1 y after PCI: OAC alone (COR 1, B-R)
AFIRE · EPIC-CAD · AQUATIC

THE RULE UNDER EVERY LANE

Shorten by dropping aspirin, not the P2Y12 inhibitor — and not on day one: aspirin-free from PCI failed in STOPDAPT-3, NEO-MINDSET and PREMIUM
With a DOAC the P2Y12 partner is clopidogrel: a potent P2Y12 + DOAC (EPIDAURUS, 2026) brought more bleeding and no ischemic benefit

Educational quick-reference for cardiology fellows — ACC/AHA 2025 ACS guideline (Class from the AHA slide set), 2021 revascularization, 2023 CCD and 2023 AF guidelines; FDA labels. ESC grades not reproduced.

ANTITHROMBOTIC THERAPY AROUND PCI

ON AN ORAL ANTICOAGULANT — THE TRIALS

- **WOEST** VKA + clopidogrel vs + aspirin too: any bleeding **19.4% vs 44.4%**
- **PIONEER AF-PCI** Rivaroxaban 15 mg + P2Y12: clinically significant bleeding 16.8% vs 26.7% (VKA triple), HR 0.59
- **RE-DUAL PCI** Dabigatran 110 / 150 bid + P2Y12: HR 0.52 / 0.72 for bleeding; thrombotic composite non-inferior
- **AUGUSTUS** 2×2: apixaban vs VKA HR 0.69 for bleeding; **aspirin vs placebo HR 1.89 — aspirin adds bleeding**
- **ENTRUST-AF PCI** Edoxaban + P2Y12: non-inferior (HR 0.83), not superior
- **Meta-analysis** Dual therapy: more stent thrombosis (OR 1.67) — NNT 42 to prevent one major bleed vs NNH 223 for stent thrombosis (AF 2023 text)
- **EPIDAURUS** 2026 · AF + ACS: DOAC + prasugrel/ticagrelor vs DOAC + clopidogrel — **stopped early: more bleeding, deaths and strokes, no ischemic benefit**

- **After 1 year AFIRE:** rivaroxaban alone vs + antiplatelet — non-inferior, less bleeding, **combination arm had higher mortality** · **EPIC-CAD** (edoxaban alone) NACE HR 0.44 · **AQUATIC** (2025): **aspirin on top of OAC raised ischemic events, deaths and major bleeding**

SPECIAL SITUATIONS

- **GI risk PPI** — COR 1 (ACS 2025) · 2a on DAPT (CCD 2023). **COGENT:** omeprazole GI events HR 0.34, CV events HR 0.99 — but the clopidogrel label still says avoid omeprazole/esomeprazole
- **CABG** Clopidogrel/ticagrelor off **5 d,** prasugrel **7 d** (labels); DAPT after CABG may reduce vein-graft occlusion (2b, CCD 2023)
- **Kidneys** Eptifibatide off in dialysis; tirofiban, enoxaparin and bivalirudin are dose-reduced; **fondaparinux contraindicated at CrCl <30**
- **Elderly / small** Prasugrel ≥75 y generally not recommended; **5 mg** if <60 kg · enoxaparin ≥75 y: 0.75 mg/kg, no IV bolus
- **Genotype Boxed warning** for CYP2C19 poor metabolizers; routine genotype-guided clopidogrel did not reach significance (**TAILOR-PCI)**
- **Extra drugs** Low-dose **rivaroxaban 2.5 mg bid + aspirin:** 2a in high ischemic, low-moderate bleeding risk CCD · **vorapaxar** 2b after MI, **3: Harm with prior stroke, TIA or ICH** · **chronic NSAIDs = 3: Harm** (CCD 2023)
- **Factor XI LIBREXIA-ACS** (2026, milvexian + antiplatelets, n=14,194): HR 1.05 — **stopped for futility**

WHAT IS NOT HERE — AND WHAT IS COMING

- ⚠ **Grades ACC/AHA 2025 ACS rows show the Class only:** they come from the AHA's slide set, which prints no Level of Evidence. 2021, CCD 2023 and AF 2023 rows show both
- ⚠ **ESC ESC 2023 ACS and 2024 CCS grades are not printed** — their recommendation tables could not be opened for this build
- ⚠ **Statement 2026 ACC Scientific Statement** on antiplatelet therapy (JACC 2026;88:1284) — consensus, not a COR/LOE guideline; its full text was not read
- ⚠ **Not found** UFH dose **with** a GP IIb/IIIa inhibitor is not printed — no readable source gave it
- **Watch LEGACY** results · **HD-PCI** (heparin dose for PCI, TCT 2026) · ACC guidance on patients with **multiple antithrombotic indications** (expected late 2026)

TRAPS — THE ERRORS THAT COST LIVES

- **Trap *Prasugrel after a stroke or TIA*** — *net harm (COR 3)*
- **Trap *Fondaparinux as the only anticoagulant in the lab*** — *catheter thrombus; add standard-dose UFH*
- **Trap *UFH on top of an SC enoxaparin dose given <12 h ago*** — *more bleeding (3: Harm)*
- **Trap *Loading prasugrel or clopidogrel DURING a cangrelor infusion*** — *give them after it stops (ticagrelor can go during)*
- **Trap *Aspirin 325 mg with ticagrelor*** — *>100 mg/day blunts ticagrelor (boxed warning)*
- **Trap *Routine GP IIb/IIIa in ACS*** — *3: Harm (2025); reserve for thrombus, no-reflow, slow flow*
- **Trap *Triple therapy beyond the first weeks,*** *or a potent P2Y12 with a DOAC (EPIDAURUS) — use* ***clopidogrel***
- **Trap *Interrupting the P2Y12 inhibitor soon after PCI with no plan*** — *cangrelor can bridge when a gap is unsafe (2025 slide set)*
- **Trap *Forgetting that bivalirudin raised acute stent thrombosis in STEMI*** *(HORIZONS-AMI, EUROMAX) — BRIGHT-4 ran a high-dose infusion 2–4 h after PCI*

ACC/AHA RECOMMENDATIONS — ANTITHROMBOTIC THERAPY AND PCI

ACUTE CORONARY SYNDROME — IN HOSPITAL (2025: Class from the AHA slide set; Level not shown there)			
1		ACS: oral aspirin load, then daily low-dose aspirin, to reduce death and MACE.	ACC/AHA 2025
1		ACS: an oral P2Y12 inhibitor in addition to aspirin. NSTE-ACS or STEMI undergoing PCI: prasugrel or ticagrelor (to reduce MACE and stent thrombosis); clopidogrel when they are unavailable, not tolerated or contraindicated.	ACC/AHA 2025
1		NSTE-ACS managed without planned invasive evaluation: ticagrelor. STEMI treated with fibrinolysis: clopidogrel concurrently.	ACC/AHA 2025
2b		NSTE-ACS with angiography expected >24 h: upstream clopidogrel or ticagrelor may be considered.	ACC/AHA 2025
3: Harm		History of stroke or TIA: prasugrel should NOT be given (worse net clinical outcomes).	ACC/AHA 2025
2b		ACS PCI in a patient who has not received a P2Y12 inhibitor: IV cangrelor may be reasonable.	ACC/AHA 2025
2a		ACS PCI with large thrombus, no-reflow or slow flow: adjunctive IV or intracoronary GP IIb/IIIa inhibitor is reasonable.	ACC/AHA 2025
3: Harm		ACS: GP IIb/IIIa inhibitors should NOT be given routinely (no ischemic benefit, more bleeding).	ACC/AHA 2025
1		ACS undergoing PCI: IV UFH. STEMI undergoing PCI: bivalirudin is useful as an alternative to UFH to reduce mortality and bleeding.	ACC/AHA 2025
2b		NSTE-ACS PCI: bivalirudin may be reasonable instead of UFH to reduce bleeding. ACS: IV enoxaparin may be considered instead of UFH at PCI.	ACC/AHA 2025
3: Harm		ACS: fondaparinux should NOT be used to support PCI (catheter thrombosis).	ACC/AHA 2025
ACUTE CORONARY SYNDROME — AFTER DISCHARGE (2025 slide set)			
1		Default: DAPT ≥12 months (ticagrelor or prasugrel preferred after PCI). After DAPT with ticagrelor, stop aspirin at 1–3 months and continue ticagrelor alone.	ACC/AHA 2025
2b		De-escalate the P2Y12 inhibitor to clopidogrel >1 month after PCI. High bleeding risk: stop aspirin or the P2Y12 inhibitor >1 month after PCI and continue a single agent.	ACC/AHA 2025
1		Needs oral anticoagulation: stop aspirin 1–4 weeks after PCI; continue OAC + P2Y12 inhibitor (preferably clopidogrel) for 12 months.	ACC/AHA 2025
ANY PCI — PROCEDURAL (2021; Class and Level from the AHA slide set)			
1	B-R	Aspirin loading dose, then daily, for anyone undergoing PCI.	ACC/AHA/SCAI 2021
1	C-LD	Stable ischemic heart disease undergoing PCI: clopidogrel load, then daily. Within 24 h after a fibrinolytic: clopidogrel 300 mg load.	ACC/AHA/SCAI 2021
3: No Benefit	B-R	Stable ischemic heart disease undergoing PCI: routine IV GP IIb/IIIa inhibitor is not recommended.	ACC/AHA/SCAI 2021
3: Harm	B-R	Therapeutic SC enoxaparin with the last dose <12 h before PCI: UFH should not be used.	ACC/AHA/SCAI 2021
1	C-LD	Heparin-induced thrombocytopenia undergoing PCI: bivalirudin or argatroban instead of UFH.	ACC/AHA/SCAI 2021
2a	A	Selected patients: DAPT for 1–3 months, then P2Y12 inhibitor monotherapy, to reduce bleeding.	ACC/AHA/SCAI 2021
CHRONIC CORONARY DISEASE (2023; slide set)			
1	A	PCI: DAPT with aspirin and clopidogrel for 6 months, then single antiplatelet therapy. No OAC indication: aspirin 81 mg (75–100 mg) long term.	AHA/ACC CCD 2023
2a	A	Selected DES patients who completed 1–3 months of DAPT: P2Y12 inhibitor monotherapy for ≥12 months.	AHA/ACC CCD 2023
2b	A	Prior MI, low bleeding risk: DAPT beyond 12 months, up to 3 years.	AHA/ACC CCD 2023
1	B-R	Elective PCI and needs OAC: DAPT 1–4 weeks, then clopidogrel alone for 6 months, in addition to a DOAC.	AHA/ACC CCD 2023
3: Harm	B-R	Prior stroke, TIA or ICH: prasugrel should not be used. Chronic NSAIDs should not be used.	AHA/ACC CCD 2023
ATRIAL FIBRILLATION AND PCI (2023 AF guideline, full text)			
1	A	AF with stroke risk undergoing PCI: DOACs preferred over VKAs with antiplatelet therapy. Most patients: stop aspirin at 1–4 weeks and continue OAC + P2Y12 inhibitor rather than triple therapy.	ACC/AHA AF 2023
1	B-R	AF with chronic coronary disease (>1 year after revascularization, no stent thrombosis): OAC alone rather than OAC + a single antiplatelet.	ACC/AHA AF 2023

1 *is recommended* 2a *is reasonable* 2b *may be considered* 3: No Benefit *is not recommended* 3: Harm *is potentially harmful*

Educational quick-reference for cardiology fellows — ACC/AHA 2025 ACS guideline (Class from the AHA slide set), 2021 revascularization, 2023 CCD and 2023 AF guidelines; FDA labels. ESC grades not reproduced.