



DAPT Score to Stratify Ischemic and Bleeding Risk after Percutaneous Coronary Intervention: An Updated Systematic Review, Meta-Analysis, and Meta-Regression of 100,211 Patients

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A personalized approach to dual antiplatelet therapy (DAPT) duration after percutaneous coronary intervention (PCI) is recommended by international guidelines¹ and the DAPT score (DS) was developed as a decision-making tool accounting for both ischemic and bleeding risk to identify patients who can benefit from prolonged DAPT beyond 12 months after PCI (►Fig. 1).² Nonetheless, the DS showed a modest discrimination in individual, or pooled, validation studies but novel data are available and the impact of the run-in event-free DAPT period was not assessed.³

We searched electronic databases from 2016 up to March 2020 for studies that investigated the association of DS with the occurrence of ischemic and bleeding events. Results were reported according to the PRISMA⁴ guideline (►Supplementary Fig. S1 [available in the online version]). Our main analysis investigated the external validity of the DS by exploring the occurrence of an ischemic endpoint (composite of myocardial infarction [MI] and stent thrombosis [ST]) and of a bleeding endpoint (all events were included as reported by individual studies) according to DS stratum including all study types. We then performed two sets of sensitivity analysis: first, the outcomes of interest were analyzed in randomized clinical trials (RCTs) only or in registries only; second, we excluded the derivation cohort from our analysis as this may introduce bias. We also explored the same endpoints in patients treated with extended or standard DAPT according to DS stratum. Concordance statistics (*c*-stat) and observed:expected (O:E) ratios from individual studies were pooled to assess discrimination and calibration power of the DS.⁵ Finally, in a meta-regres-

sion we assessed the effect of a longer uneventful run-in DAPT period before DS calculation on the score's ability to predict ischemic and bleeding events. Treatment effect is reported as relative risk (RR) and 95% confidence interval (CI). Statistical analysis was performed using R environment.

Overall, nine studies were included in our random-effect meta-analysis.^{2,6–13} Their characteristics are summarized in ►Supplementary Table S1 (available in the online version). Of the 100,211 patients included (►Supplementary Table S2, available in the online version), 42.5% had a DS ≥ 2 and when compared with those with lower DS, they experienced a significantly higher hazard of MI and ST combined (RR: 1.72; 95% CI: 1.50–1.97; $p < 0.0001$) and a significantly lower hazard of bleeding (RR: 0.79; 95% CI: 0.70–0.89; $p = 0.0001$; ►Fig. 2). These findings were confirmed by our secondary analysis including only RCTs (RR: 1.86; 95% CI: 1.45–2.39; $p < 0.0001$ for ischemic events; RR: 0.68; 95% CI: 0.55–0.84; $p = 0.0004$ for bleedings; ►Supplementary Fig. S2A [available in the online version]) or only registries (RR: 1.57; 95% CI: 1.43–2.43; $p < 0.0001$ for ischemic events; RR: 0.85; 95% CI: 0.74–0.98; $p = 0.03$ for bleedings; ►Supplementary Fig. S2B [available in the online version]). These results were confirmed also by excluding the derivation cohort from the analysis (►Supplementary Fig. S2C [available in the online version]).

Only four studies separately reported outcomes of subjects according to DAPT duration and DS strata: in this secondary analysis of 27,462 patients, in the DS ≥ 2 stratum prolonged DAPT was associated with a significantly lower occurrence of MI and ST combined (RR: 0.54; 95% CI: 0.43–0.67; $p < 0.0001$) without a significant increase in bleeding (RR: 1.26; 95% CI:

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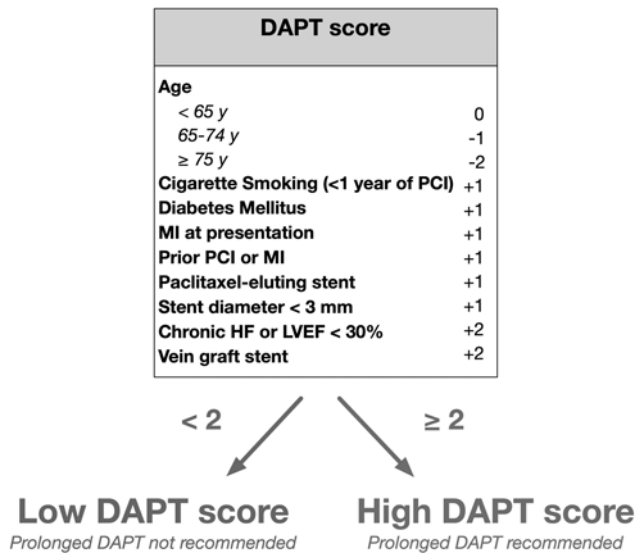


Fig. 1 Variables included in the DAPT score.² DAPT, dual antiplatelet therapy.

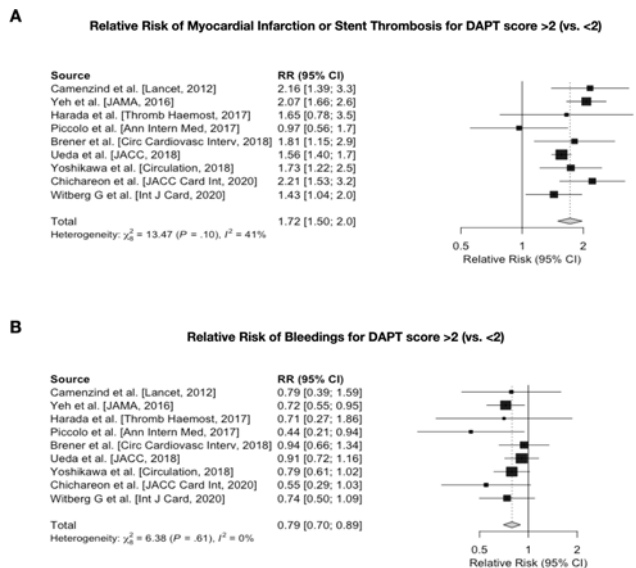


Fig. 2 (A,B) Forest plot of the main analysis. Random-effect relative risks (RRs) are shown.

0.89–1.76; $p = 0.19$) when compared with standard DAPT duration. (–**Supplementary Fig. S3** [available in the online version]) On the contrary, in the low DS stratum prolonged DAPT was associated with an increased occurrence of bleedings (RR: 2.00; 95% CI: 1.49–2.70; $p < 0.001$) and a neutral effect on ischemic events (RR: 1.03; 95% CI: 0.65–1.61; $p = 0.9$).

Our analysis revealed that the DS had only a modest discriminative power in predicting ischemic (pooled c -stat: 0.65; 95% CI: 0.62–0.69) and bleeding events (pooled c -stat: 0.66; 95% CI: 0.63–0.69; –**Supplementary Fig. S4A** and –**Supplementary Table S3** [available in the online version]). Calibration was suboptimal with a tendency toward underpredicting both ischemic (pooled O:E ratio: 0.48; 95% CI: 0.31–0.76) and bleeding events (pooled O:E ratio: 0.65, 95% CI: 0.36–1.14; –**Supplementary Fig. S4B** and –**Supplementary Table S3** [available in the online version]). Finally, in the framework of

a meta-regression analysis, we observed that a longer run-in period of DAPT before DS calculation significantly increased the RR of ischemic events ($p < 0.0001$) and significantly decreased the RR of bleedings ($p = 0.0003$) in the $DS \geq 2$ stratum (–**Supplementary Fig. S5** [available in the online version]) and was associated with a significant increase in the c -stat for both ischemic and bleeding events (both $p < 0.0001$; –**Supplementary Fig. S6** [available in the online version]).

The DS was validated in a RCT⁶ with disappointing results, while a recent meta-analysis showed modest clinical utility for bleeding and ischemic risk stratification.³ In the current analysis with a larger population of 100,211 subjects after PCI, a $DS \geq 2$ was confirmed to stratify well patients who are at increased risk of coronary ischemic events and relatively low risk of bleeding, despite only modest discriminative power and suboptimal calibration were observed. These results were confirmed in several sensitivity analyses.

Moreover, prolonged DAPT significantly reduced ischemic events without a payoff in terms of more bleedings in the $DS \geq 2$ strata, while only a detrimental effect of increased bleedings was observed with prolonged DAPT in $DS < 2$. These findings corroborate the rationale for prolonged DAPT beyond 1 year in such scenario.

Finally, our meta-regression was the first to analyze the effect of DS calculation at different event-free timeframes from the canonical 12 months and supports the use of the original cut-off at 12 months. In fact, a higher predictive ability both for ischemic and bleeding events was observed and this is probably explained by a longer event-free period after PCI which identifies a relatively low-risk population. Considering that the c -stat values for both ischemic and bleeding events showed a significant linear increase with a longer run-in period, 12 months might be considered an adequate time point to calculate the DS.

Limitations

First, we included data of the original derivation cohort,⁶ but we performed a sensitivity analysis that excluded this population and confirmed our results. Second, validation cohorts included different DAPT types and durations. Third, in the study by Chichareon et al, aspirin was compared with ticagrelor as single antiplatelet therapy. Finally, included studies had different follow-up periods.

In conclusion, the DS is a useful clinical tool able to stratify patients at high residual ischemic risk, relatively low bleeding risk, and who benefit from prolonged DAPT. The DS should be calculated at 12 months after PCI to maximize its discriminative power.

Conflict of Interest
None declared.

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