**Title: MASTER DAPT at 15M: Abbreviated vs Standard Antiplatelet Therapy After PCI With BP-SES**

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**Dr Marco Valgimigli**

"- Hello, my name is Marco Valgimigli. I am a professor of cardiology at the University of the Italian, Switzerland, and deputy chief of Cardiocentro Ticino Institute in Lugano, Switzerland.

Importance of MASTER-DAPT

Well, I think MASTER-DAPT is a very important study because if anything, it is the only properly powered randomised controlled study focusing on HBR patients who have not been selected based on the ischemic risk, namely based on the presentation, or the complexity of the intervention they undertook.

Data at 15 Months

So in MASTER-DAPT, we compared a short DAPT regimen versus a more prolonged, let's say standard DAPT duration. We presented the first time, the primary results last year at the ESC, and we showed non-inferiority for NACE and MAACE, and superiority for bleeding, with respect to lower DAPT being better than prolonged DAPT. Now, this year, we are presenting the final 15 months data which is in a way showing the confirmatory results of what we showed before. MAACE and NACE do not differ, and the difference in major bleeding is even slightly greater in favour of an abbreviated DAPT regimen. There is also another piece of the results which is potentially even more interesting than the main results per se. Namely, after 12 months we allowed so-called routine care. Basically patients in respect of prior location were allowed to be treated according to the choice and the decision of the treating physician. That is what we call routine care. And when we designed that last phase, we were anticipating all DAPT being discontinued in both treatment groups. Surprisingly enough, that was not the case, with a very surprisingly high proportion of patients, especially in the standard DAPT group, still taking DAPT well beyond one year, which is completely against the guidelines. We ran multivariable modelling to understand why was the case, and in fact, we realised that prior allocation of standard treatment was a major and independent predictor of prolonging DAPT, which is what we called in the presentation carryover effects, whereby clinicians in practice tend to simply confirm previous treatment despite this treatment may not be indicated or may be even harmful.

Recommendations for Clinical Practice

I think the clinical implication of what we are reporting here at ESC is twofold. From one side, you need to go short, and you need to make that provision very clear when you discharge the patient, because if you don't make that provision very clear nobody would dare to stop the medication. Secondly, we also look into the decision making with respect to prolonging or not prolonging DAPT, and realise that clinicians are still basing 100% of decision making on ischemic risk markers. They don't look into the bleeding risk markers which do impact, as the study does show.

Future Directions in Antiplatelet Therapy for PCI Pts

I think the future direction is to try to provide simplified algorithm to clearly tell the patient when should DAPT be stopped depending on the intersection between ischemic and bleeding risk. On the other hand, since we have been shortening DAPT to a very short extent now, one month or even lower in patients with oral anticoagulation, I think the next logical question is whether we do need DAPT at all. I think that would be the next sect of studies that will come up.

Unanswered Questions in HBR and DAPT

So I think a critical step nowadays when we speak about HBR is to come up with a universally accepted definition of HBR. We have based that definition on consensus definition which was developed by the Academic Research Consortium which I was very glad to be part of, but that was a consensus that was basically expressing our opinions. That framework has been, in a way, validated multiple times, and we know that it does work, but it's not perfect. On the other side of the spectrum, we have risk score which are integrating the coverage in a continuous manner, which may be more precise in telling us the risk. I think the future direction is to try to come up with the algorithm which is merging both strengths of these two new systems to have a universally accepted way of defining HBR.