Supplementary Appendix

This appendix has been provided by the authors to give readers additional information about their work.

Supplement to: Valgimigli M, Frigoli E, Heg D, et al. Dual antiplatelet therapy after PCI in patients at high bleeding risk. N Engl J Med 2021;385:1643-55. DOI: 10.1056/NEJMoa2108749

Dual Antiplatelet Therapy after PCI in Patients at High Bleeding Risk

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MASTER DAPT TRIAL: COMMITTEES AND INVESTIGATORS

Executive Committee

Coprincipal Investigator	M. Valgimigli
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Sponsor Representative	G.A. Van Es until June 1, 2018
Sponsor Representative	From June, 1 2018, G.B.W.E. Vos
Sponsor Representative	From October 16, 2020, E. Spitzer
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Bern University Hospital Representative	A. Frenk
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National Lead Investigators

Bangladesh, India	M.S. Ajit
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Belgium	J. Bartunek
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Italy	A. Colombo
United Kingdom	D. Hildick-Smith
Portugal, Spain	A. Iñiguez
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Singapore, South Korea, Vietnam	P.J. Ong
Japan	Y. Ozaki
Argentina	A.E. Rodriguez
Switzerland	M. Roffi
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Macedonia, Serbia	G. Stankovic
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Top Enrollers

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North Estonia Medical Center, Tallinn, Estonia	Peep Laanmets
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Biostatistician	S. Pocock
Cardiologist	P. Urban

Clinical Events Committee

Chair	S. Leonardi
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Neurologist	R. O. Roine

Safety reporting group (Cardialysis, Rotterdam, The Netherlands)
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CEC management group (Cardialysis, Rotterdam, The Netherlands)
Ingrid de Zwart (Data Manager), Liliane Elshout (Data Manager), Judith Jonk (Data Manager), Tessa Rademaker-Havinga (Statistician).

Project Management
Ria van Vliet (Project Manager, ECRI, Rotterdam, The Netherlands). Marie-Claude Morice (Medical Director, CERC, France), Phani Krishna Kondamudi (Clinical Project Leader, CERC, France), Laure Morsiani (Clinical Operations Manager, CERC, France), Ute Windhövel (Regulatory Affairs Manager, CERC, France). Anita van der Wal (Project Manager, Cardialysis, Rotterdam, the Netherlands), Chantal Bakker (Project Manager, Cardialysis, Rotterdam, The Netherlands). Kazuhiro Minagawa (Project Manager, CVQuest, Tokyo, Japan).

COUNTRIES, INVESTIGATORS, AND NUMBERS OF PATIENTS ENROLLED

Country	Site Name	Principal Investigator	Patients Randomized (N=4579)	Patients Consented but Not Randomized (N=625)
Argentina			16	1
	Buenos Aires, Otamendi Hospital	Dr. Juan Mieres	8	
	Buenos Aires, Institutio Cardiovascular de Buenos Aires	Dr. Fernando Cura	5	1
	Buenos Aires, Clinica IMA	Dr. Carlos Fernandez-Pereira	3	
Australia			142	19
	Perth, Royal Perth Hospital-Cardiology Research	Prof. Carl Schultz	66	7
	Wollongong, Wollongon Hospital	Dr. Astin Lee	55	6
	Sydney, Prince of Wales Hospital	Dr. Nigel Jepson	8	2
	Fitzroy, St Vincent Hospital	Prof. Robert Whitbourn	7	
	Chermside, The Prince Charles Hospital	Dr. Owen Christopher Raffel	6	4
Austria			44	11
	Vienna, Wilhelminenspital	Prof. Kurt Huber	29	9
	Vienna, Rudolfstiftung Hospital	Prof. Franz Weidinger	15	2
Bangladesh	Dhaka, National Heart Foundation Hospital & Research Institute	Prof. Fazila-Tun-Nesa Malik	39	1
Belgium			302	51
	Hasselt, Jessa Ziekenhuis	Prof. Pascal Vranckx	91	14
	Bonheiden, Imelda Ziekenhuis	Dr. Willem Dewilde	90	14
	Charleroi, CHU de Charleroi – Hopital Civil Marie Curie	Dr. Adel Aminian	48	3
	Aalst, OLV Ziekenhuis	Prof. Emanuele Barbato----from 6th Sep 2018 Dr. Jozef Bartunek	47	7
	Liege, CHR La Citadelle	Dr. Suzanne Pourbaix	24	11
	Brussels, CHU St. Pierre UMC St. Pieter	Dr. Panagiotis Xaplanteris	2	2
Bulgaria			183	11
	Sofia, UMHAT St. Anna	Dr. Vasil Velchev	91	
	Plovdiv, MHAT "Sveta Karidad" Plovdiv	Dr. Dimitar Karageorgiev	60	10
	Sofia, National Heart Hospital	Dr. Hristo Mateev	23	1
	Sofia, Tokuda Hospital	Prof. Valeri Gelev	9	

Country	Site Name	Principal Investigator	Patients Randomized (N=4579)	Patients Consented but Not Randomized (N=625)
Czech Republic			134	17
	Brno, University Hospital Brno	Prof. Petr Kala	120	17
	Praha, Na Homolce Hospital	Dr. Martin Mates	14	
Denmark	Roskilde, Roskilde Hospital Kogevej	Dr. Henning Kelbæk	13	
Estonia	Tallinn, North-Estonia Medical Centre Foundation	Dr. Peep Laanmets	259	12
France			578	67
	Massy, Hopital Prive Jacques Cartier	Dr. Thomas Hovasse	129	19
	Montauban, Clinique du Pont de Chaume	Dr. Laurent Delorme	124	7
	Marseille, CHU La Timone	Prof. Thomas Cuisset	41	
	Annecy, Centre Hospitalier Annecy Genvois	Dr. Loïc Belle	37	
	Caen, Centre hospitalier regional universitaire de Caen	Prof. Farzin Beygui	33	9
	Nantes, Hopital Prive le Confluent	Dr. Ashok Tirouvanziam	31	
	Montpellier, Clinique du Millenaire	Prof. Christophe Piot	30	4
	Caen, Hopital Prive Saint Martin	Dr. Jean François Morelle	27	4
	Rouen, Clinique Saint-Hilaire	Dr. Rene Koning	27	7
	Metz, Hopital de Mercy	Dr. Mathieu Valla	24	3
	Dijon, GCIDB – Hopital Prive Dijon Bourgogne	Dr. Philippe Brunel	23	5
	Nimes, CHU Caremeau	Dr. Guillaume Cayla	18	4
	Creteil, Centre Hospitalier Universitaire Henri-Mondor	Prof. Emmanuel Teiger	12	2
	Paris, Hopital Universitaire Pitie-Salpetriere	Prof. Gilles Montalescot	10	2
	Paris, Hopital Europeen Georges-Pompidou	Prof. Christian Spaulding	9	1
	Saint-Denis, Centre Cardiologique du Nord	Dr. Phillipe Guyon	3	
Germany			24	6
	Homburg, Saarland University	Prof. Felix Mahfoud	20	6
	Landshut, Landshut-Archdorf Krankenhaus	Dr. Pyxaras, Stylianos	4	
Hungary			68	5

Country	Site Name	Principal Investigator	Patients Randomized (N=4579)	Patients Consented but Not Randomized (N=625)
	Budapest, Semmelweis University Heart and Vascular Center	Prof. Béla Merkely	46	5
	Szeged, Invasive Cardiology Unit University of Szeged	Dr. Imre Ungi	22	
India			147	11
	Coimbatore, G Kuppuswamy Naidu Memorial Hospital	Dr. Rajpal K Abhaichand	94	10
	Surat, Shri BD Mehta Mahavir Heart Institute	Dr. Atul Damodar Abhyankar	33	
	Chennai, Apollo Hospitals, Chennai	Dr. Sengottuvelu. G	13	1
	Chennai, Madras Medical Mission	Dr. Ajit Mullasari .S	7	
Israel			100	33
	Safed, Ziv Medical Center, Cardiology Department	Dr. Halabi Majdi	37	9
	Petach Tikva, Rabin MC	Prof. Ran Kornowski	34	11
	Haifa, Rambam Medical Center	Prof. Ariel Roguin----from 14th Oct 2018 Dr. Yair Feld	16	6
	Jerusalem, Hadassah Ein Karem Medical Center	Prof. Chaim Lotan	13	7
Italy			276	37
	Rome, Policlinico Casilino	Dr. Michael Donahue	99	6
	Vimercate, Ospedale di Vimercate	Dr. Stefano Garducci	48	3
	Rozzano, Humanitas Research Hospital	Dr. Bernhard Reimers	30	2
	Rome, Policlinico Umberto I	Dr. Gennaro Sardella	20	2
	Milan, San Raffaele Hospital	Dr. Antonio Colombo---from 20th June 2019 Dr. Alaide Chieffo	12	1
	Catania, Ferrarotto Hospital	Prof. Corrado Tamburino	9	2
	Messina, AOU Policlinico Martino	Dr. Giuseppe Andò	8	4
	Milan, Policlinico San Donato	Dr. Luca Testa	8	4
	Milan, Sacco Hospital	Dr. Maurizio Di Biasi	8	6
	Rome, Ospedale Sandro Pertini	Dr. Alessandro Sciahbasi	8	3
	Caserta, Azienda Ospedaliera di Caserta Sant Anna e San Sebastiano	Dr. Paolo Calabro	6	1

Country	Site Name	Principal Investigator	Patients Randomized (N=4579)	Patients Consented but Not Randomized (N=625)
	Andria, Ospedale Lorenzo Bonomo	Dr. Gianluigi Minervini	5	
	Cagliari, Azienda Ospedaliera Brotzu	Dr. Bruno Loi	5	
	Milan, Centro Cardiologico Monzino IRCCS	Dr. Franco Fabbiocchi	5	
	Milan, ASST Grande Ospedale Metropolitano Niguarda	Dr. Jacopo Oreglia	4	3
	Treviglio, ASST Bergamo Ovest	Dr. Paolo Sganzerla	1	
Japan			188	17
	Toyoake, Fujita Health University Hospital	Prof. Yukio Ozaki	60	2
	Kokura, Fukuoka Kokura Memorial Hospital	Dr. Kenji Ando	43	2
	Osaka, Osaka Police Hospital	Dr. Yoshiharu Higuchi	22	4
	Tokyo, Sakakibara Heart Institute	Dr. Mamoru Nanasato	13	1
	Kanagawa, St. Marianna University School of Medicine	Dr. Yuki Ishibashi	11	1
	Gifu, Gifu Heart Center	Dr. Hitoshi Matsuo	10	
	Nagoya, Japanese Red Cross Nagoya Daini Hospital	Dr. Ruka Yoshida	8	2
	Ichinomiya, Ichinomiya municipal hospital	Dr. Kiyokazu Shimizu	6	2
	Nagoya, Japanese Red Cross Nagoya	Dr. Haruo Kamiya	4	2
	634 – Japan, Tokyo, St. Lukes International Hospital	Dr. Nobuyuki Komiyama	4	1
	Nagakuteshi, Aichi Medical University Hospital	Dr. Tetsuya Amano	3	
	Nagoya, Nagoya University Hospital	Dr. Toyoaki Murohara	2	
	Sapporo, Sapporo Higashi Tokushukai Hospital	Dr. Seiji Yamazaki	2	
Kingdom of Bahrain	Riffa, Bahrain Defence Force Hospital	Dr. Husam Noor	7	1
Macedonia	Skopje, University Clinic of Cardiology	Dr. Sasko Kedev	120	3
Poland			177	7
	Krakow, Institute Of Cardiology Jagiellonian University	Dr. Jakub Podolec	69	4
	Poznan, Szpital Kliniczny Przemienienia Panskiego	Prof. Maciej Lesiak	50	1
	Wroclaw, 4 Wojskowy Szpital Kliniczny	Dr. Krzysztof Reczuch	33	1

Country	Site Name	Principal Investigator	Patients Randomized (N=4579)	Patients Consented but Not Randomized (N=625)
	Lubin, Miedziowe Centrum Zdrowia SA	Dr. Adrian Wlodarczak	18	1
	Krakow, University Hospital Krakow Poland	Prof. Dariusz Dudek	7	
Portugal	Lisbon, Hospital de Santa Maria	Dr. Pedro Canas da Silva	1	
Saudi Arabia	King Fahd Armed Forces Hospital	Dr. Mirvat Alasnag	16	1
Serbia			138	11
	Belgrade, Institute for Cardiovascular Disease Dedinje	Dr. Ljupco Mangovski − from 17 April 2019 Dr. Dragan Topic	67	4
	Belgrade, Clinical Center of Serbia	Prof. Goran Stankovic	61	7
	Sremska Kamenica, Institute of Cardiovascular Diseases	Dr. Dragan Debeljacki	10	
Singapore			46	10
	Singapore, Tan Tock Seng Hospital	Prof. Paul Ong Jau Lueng	38	10
	Singapore, KhooTeck Puat Hospital	Dr. Syed Saqib Imran	8	
South Korea	Seoul, Asan Medical Center	Dr. Park Seung-Jung	15	
Spain			196	10
	Huelva, Juan Ramon Jimenez Hospital	Dr. José Francisco Diaz Fernandez	47	1
	Vigo, Alvaro Cunqueiro	Prof. Andrés Iniguez	40	2
	Barcelona, Hospital Vall Hebron	Dr. Bruno Garcia del Blanco	27	
	Alicante, Hospital General Universitario de Alicante	Dr. Vicente Mainar	19	2
	Madrid, Hospital 12 de Octubre	Dr. Ivan Gomez Blazquez	17	
	El Palmar, Universitario Virgen de la Arrixaca	Dr. Eduardo Pinar	15	1
	Madrid, Hospital Clinico San Carlos	Prof. Javier Escaned Barbosa	11	2
	Barcelona, Bellvitge University Hospital	Dr. Joan Antoni Gomez Hospital	10	2
	Santander, Hospital Universitario Valdecilla	Dr. Fermin Sainz	9	
	Majadahonda, Hospital Universitario Puerta de Hierro	Dr. Javier Goicolea	1	
Sweden			8	
	Orebro, Orebro University Hospital	Dr. Ole Fröbert	6	

Country	Site Name	Principal Investigator	Patients Randomized (N=4579)	Patients Consented but Not Randomized (N=625)
	Gavle, Gavle Hospital	Dr. Robert Kastberg	2	
Switzerland			499	111
	Bern, Inselspital	Dr. Aris Moschovitis---from 20th Oct 2020 Prof. Stephan Windecker	308	61
	Liestal, Kantonsspital Baselland	Dr. Gregor Leibundgut	68	14
	Lugano, Cardiocentro Ticino	Dr. Giovanni Pedrazzini	31	9
	Geneva, University Hospital	Prof. Marco Roffi	29	13
	Bern, Lindenhofspital	Dr. Ali Garachemani	28	3
	Zurich, University Hospital Zurich	Dr. Patrick Siegrist	18	7
	Fribourg, HFR Hopital cantonal	Prof. Stéphane Cook	17	4
Netherlands			539	122
	Rotterdam, Maasstad Ziekenhuis	Dr. Peter Smits	233	79
	Terneuzen, Zorgsaam	Dr. Al Mafragi	87	5
	Emmen, Treant Zorggroep	PI Dr. Jessurun---from 1st July 2020 Dr. Ruifrok	67	9
	Eindhoven, Catharina Ziekenhuis	Dr. Pim Tonino	54	10
	Arnhem, Rijnstate Ziekenhuis	Dr. Peter Danse	29	8
	Hertogenbosch, Jeroen Bosch Ziekenhuis	Dr. J. Polad	21	3
	Dordrecht, Albert Schweitzer Ziekenhuis	Dr. Floris Kauer	20	6
	Enschede, Medisch Spectrum Twente	Dr. Clemens von Birgelen	19	
	Nieuwegein, Antonius Ziekenhuis Nieuwegein	Dr. Jurrien ten Berg	5	1
	Breda, Amphia Ziekenhuis	Dr. Sander Ijsselmuiden	3	
	Den Haag, Hagahospital	Dr. Samer Somi	1	1
United Kingdom			279	48
	Bristol, Bristol Heart Institute	Dr. Tom Johnson	55	13
	Worcester, Worcestershire Royal Hospital	Dr. Helen Routledge	43	8
	Brighton, Brighton & Sussex University Hospitals Trust	Dr. David Hildick-Smith	40	3
	Bournemouth, Royal Bournemouth Hospital	Dr. Jehangir Din	34	7

Country	Site Name	Principal Investigator	Patients Randomized (N=4579)	Patients Consented but Not Randomized (N=625)
	Wolverhampton, Heart and Lung Centre – New Cross Hospital	Dr. Shahzad Munir	22	6
	Blackburn, Royal Blackburn Hospital	Dr. John McDonald	20	1
	Stevenage, Lee Haynes Research Institute, Lister Hospital	Dr. Neville Kukreja	20	1
	Stoke on Trent, Royal Stoke University Hospital	Prof. Mamas Mamas	20	5
	Newcastle upon Tyne, Freeman Hospital	Dr. Rajiv Das	13	1
	Manchester, Wythenshawe Hospital	Dr. Hussain Contractor	8	3
	Derry, Altnagelvin Hospital	Dr. Aaron Peace	2	
	London, St. George's Hospitals	Dr. Rupert Williams	2	
Vietnam	Vietnam National Heart Institute – Bach Mai Hospital Hanoi	Prof. Nguyen Ngoc Quang	25	2

FUNDING

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MANUSCRIPT RESPONSIBILITY

Marco Valgimigli, M.D., Ph.D., wrote the first draft of the manuscript, which was critically revised and checked for consistency by the executive committee members and the members of the statistical committee. All remaining authors critically revised the manuscript. Dr. Valgimigli submitted the manuscript for publication on behalf of the authors. Under the agreement between ECRI and the funding manufacturer, the manuscript was to be provided to the manufacturer for review in advance of publication. However, they did not have the right of refusal.

ADDITIONAL INFORMATION ON THE METHODS[1]

1. Criteria for High Bleeding Risk

Post-percutaneous coronary intervention (PCI), patients are at high bleeding risk if at least one of the following criteria applies:

1. Clinical indication for treatment with oral anticoagulant (OAC) for at least 12 months.
2. Recent (<12 months) nonaccess site bleeding episode(s) that required medical attention (i.e. actionable bleeding).
3. Previous bleeding episode(s) that required hospitalization if the underlying cause had not been definitively treated (i.e. surgical removal of the bleeding source).
4. Age ≥75 years.
5. Systemic conditions associated with an increased bleeding risk (e.g. hematological disorders, including a history of current thrombocytopenia defined as a platelet count <100.00/ mm^3 (<100 × 10^9/L) or any known coagulation disorder associated with increased bleeding risk.
6. Documented anemia, defined as repeated hemoglobin levels <11 g/dL or transfusion during the 4 weeks before inclusion.
7. Need for chronic treatment with steroids or nonsteroidal anti-inflammatory drugs.
8. Diagnosed malignancy (other than skin) considered at high bleeding risk including gastrointestinal, genitourethral/renal and pulmonary.
9. Stroke at any time or transient ischemic attack in the previous 6 months.
10. PRECISE-DAPT score ≥25.

2. Inclusion and Exclusion Criteria

Inclusion Criteria

Inclusion criteria after index PCI

1. Age ≥18 years
2. At least one high bleeding risk criterion (listed above)
3. All coronary lesions successfully treated with Ultimaster stent
4. Free of any flow-limiting angiographic complications that required prolonged dual antiplatelet therapy (DAPT) duration based on operator's decision
5. All stages of PCI were complete and no further PCI was planned

Inclusion criteria at 1-month randomization visit (30−44 days after qualifying index PCI)

1. At least one high bleeding risk criterion (listed above) or on the basis of post-PCI actionable nonaccess-site related bleeding episode
2. Uneventful 30-day clinical course (i.e. freedom from any new episode of acute coronary syndrome, symptomatic restenosis, stent thrombosis, stroke, any revascularization requiring prolonged DAPT)
3. If not on OAC:
   a) Patient was on DAPT regimen of aspirin and a $P2Y_{12}$ inhibitor;
   b) Patient with one type of $P2Y_{12}$ inhibitor for at least 7 days
4. If on OAC:
   a) Patient was on the same type of OAC for at least 7 days;
   b) Patient was on clopidogrel for at least 7 days

Exclusion Criteria

Patients were not eligible if any of the following applied:

1. Treated with stent other than Ultimaster stent within 6 months prior to index PCI
2. Treated for in-stent restenosis or stent thrombosis at index PCI or within 6 months before
3. Treated with a bioresorbable scaffold at any time prior to index procedure
4. Incapable of providing written informed consent
5. Under judicial protection, tutorship or curatorship

6. Unable to understand and follow study-related instructions or unable to comply with study protocol
7. Active bleeding requiring medical attention (Bleeding Academic Research Consortium [BARC] ≥2) on randomization visit
8. Life expectancy less than 1 year
9. Known hypersensitivity or allergy to aspirin, clopidogrel, ticagrelor, prasugrel, cobalt chromium or sirolimus
10. Any planned and anticipated PCI
11. Participation in another trial
12. Pregnant or breastfeeding women

3. Treatment Regimen

Patients were treated according to the randomized regimen from the day of randomization until 11 months after randomization (12 months after the index procedure). After 11 months post randomization, antiplatelet therapy was at the discretion of treating physician.

3.1. Abbreviated DAPT regimen

In patients not on OAC: DAPT was discontinued, and a single antiplatelet agent (SAPT) was continued until at least 11 months post randomization (i.e. 12 months after index PCI).

In patients on OAC: DAPT was discontinued. Either aspirin or clopidogrel was continued until 5 months post randomization (i.e. 6 months after index PCI). OAC was continued until at least 11 months post randomization (i.e. 12 months after index PCI).

3.2. Standard DAPT regimen

In patients not on OAC: Aspirin was continued until at least 11 months post randomization (i.e. 12 months after index PCI). The P2Y12 inhibitor being taken at the time of randomization was continued for at least 5 months and up to 11 months post randomization (i.e. 12 months after index PCI).

In patients on OAC: Aspirin and clopidogrel were continued for at least 2 months (i.e. 3 months after index PCI) and up to 11 months post randomization (i.e. 12 months after index PCI). Thereafter, either aspirin or clopidogrel was continued up to 11 months post randomization (i.e. 12 months after index PCI). OAC was continued until at least 11 months post randomization (i.e. 12 months after index PCI).

The rationale for mandating clopidogrel as the only acceptable P2Y12 inhibitor in the OAC population in both study arms came from the absence of safety and efficacy data regarding the combination of ticagrelor or prasugrel with aspirin and OAC (as patients requiring OAC were excluded from approval RCT) and a recommendation of Class III (i.e. not indicated) in the European guidelines.

3.3. Implementation of randomized study regimens

Study regimens were implemented by regular drug prescription as described above. The investigators provided the necessary prescription to the study participants. The following are recommended according to the current guidelines and local practice.

- Aspirin is prescribed at the standard dose of at least 75 mg/day and up to 162 mg/day.
- Clopidogrel is prescribed in standard dose of 75 mg once daily.
- Prasugrel is prescribed at the standard dose of 10 mg/day or 5 mg/day in patients weighing less than 60 kg or who are over 75 years old. In regions where other standard dose exists (i.e. Japan), prasugrel dosage is adjusted according to the locally approved dose.
- Ticagrelor is prescribed at the standard dose of 180 mg/day (90 mg b.i.d.).
- Vitamin K antagonist is dosed to keep the international normalized ratio within the guideline range.

- Nonvitamin K oral antagonist oral anticoagulants (NOAC; rivaroxaban, edoxaban, dabigatran and apixaban) are given in locally approved doses.
- Switching from a vitamin K antagonist to NOAC or vice-versa is not allowed unless there are clinical and well documented reasons for doing so. Similarly, switching from a NOAC to a VKA during the course of the study is not allowed, unless dictated by a clinical and documented reason (e.g. change in renal function during the course of the investigation), which will be captured in the eCRF.

Prescribed units of aspirin, clopidogrel, prasugrel, ticagrelor and OAC were recorded in the eCRF. Patients are queried on general drug adherence.

4. Outcome Definitions

4.1. Death

All deaths were categorized as cardiovascular, noncardiovascular, or undetermined based on the definitions below.

4.1.1. Cardiovascular death

Cardiovascular death was defined as death resulting from an acute myocardial infarction, sudden cardiac death, death due to heart failure, death due to stroke, death due to cardiovascular procedures, death due to cardiovascular hemorrhage, and death due to other cardiovascular causes.

4.1.2. Death due to acute myocardial infarction

Death due to acute myocardial infarction was death by any mechanism (arrhythmia, heart failure, low output) within 30 days after a myocardial infarction related to the immediate consequences of the myocardial infarction, such as progressive congestive heart failure (CHF), inadequate cardiac output, or refractory arrhythmia. If these events occurred after a “break” (e.g. a CHF- and arrhythmia-free period of at least a week), they were designated by the immediate cause, even though the myocardial infarction may have increased the risk of that event (e.g. late arrhythmic death becomes more likely after an acute myocardial infarction). The acute myocardial infarction was verified to the extent possible by the diagnostic criteria outlined for acute myocardial infarction or by autopsy findings showing recent myocardial infarction or recent coronary thrombus. Sudden cardiac death, if accompanied by symptoms suggestive of myocardial ischemia, new ST elevation, new left bundle branch block (LBBB), or evidence of fresh thrombus by coronary angiography and/or at autopsy should be considered death resulting from an acute myocardial infarction, even if death occurs before blood samples or 12-lead electrocardiogram (ECG) could be obtained, or at a time before the appearance of cardiac biomarkers in the blood. Death resulting from a procedure to treat a myocardial infarction (i.e. PCI, coronary artery bypass graft surgery [CABG]), or to treat a complication resulting from myocardial infarction, should also be considered death due to acute myocardial infarction. Death resulting from an elective coronary procedure to treat myocardial ischemia (i.e. chronic stable angina) or death due to a myocardial infarction that occurred as a direct consequence of a cardiovascular investigation/procedure/operation should be considered as a death due to a cardiovascular procedure.

4.1.3. Sudden cardiac death

Sudden cardiac death was death that occurred unexpectedly, not following an acute myocardial infarction, and included the following:

- Death witnessed and occurring without new or worsening symptoms.
- Death witnessed within 60 min of the onset of new or worsening cardiac symptoms, unless documented (i.e. by ECG or other objective) to be due to acute myocardial infarction.
- Death witnessed and attributed to an identified arrhythmia (e.g. captured on an ECG recording, witnessed on a monitor, or unwitnessed but found on implantable cardioverter-defibrillator review).

- Death after unsuccessful resuscitation from cardiac arrest. Death after successful resuscitation from cardiac arrest and without identification of a noncardiac etiology.
- Unwitnessed death without other cause of death (information regarding the patient's clinical status preceding death should be provided, if available).

4.1.3.1. GENERAL CONSIDERATIONS

A subject seen alive and clinically stable 24 h prior to being found dead without any evidence or information of a specific cause of death was classified as "sudden cardiac death." Typical scenarios included:

- Subject well the previous day but found dead in bed the next day
- Subject found dead at home on the couch with the television on
- Deaths for which there was no information beyond "Patient found dead at home" may be classified as "death due to other cardiovascular causes".

4.1.4. Death due to heart failure or cardiogenic shock

Death due to congestive heart failure referred to a death in association with clinically worsening symptoms and/or signs of heart failure not following an acute myocardial infarction. Deaths due to heart failure could have various etiologies, including single or recurrent myocardial infarctions, ischemic or nonischemic cardiomyopathy, hypertension, or valvular disease. Cardiogenic shock not occurring in the context of an acute myocardial infarction or as the consequence of an arrhythmia occurring in the absence of worsening heart failure was defined as systolic blood pressure (SBP) <90 mm Hg for greater than 1 hour, not responsive to fluid resuscitation and/or heart rate correction, and felt to be secondary to cardiac dysfunction and associated with at least one of the following signs of hypoperfusion:

- Cool, clammy skin or
- Oliguria (urine output <30 mL/h) or
- Altered sensorium or
- Cardiac index <2.2 L/min/m²
- Cardiogenic shock could also be defined if SBP <90 mm Hg and increased to ≥90 mm Hg in less than 1 hour with positive inotropic or vasopressor agents alone and/or with mechanical support.

4.1.5. Death due to stroke

Death due to stroke referred to death after a stroke that was either a direct consequence of the stroke or a complication of the stroke. Acute stroke was verified to the extent possible by the diagnostic criteria outlined for stroke.

4.1.6. Death due to cardiovascular procedures

Death due to cardiovascular procedures referred to death caused by the immediate complications of a cardiac procedure and excluded death resulting from procedures to treat an acute myocardial infarction or the complications resulting from an acute myocardial infarction.

4.1.7. Death due to cardiovascular hemorrhage

Death due to cardiovascular hemorrhage referred to death related to hemorrhage such as a nonstroke intracranial hemorrhage, nonprocedural or nontraumatic vascular rupture (e.g. aortic aneurysm), or hemorrhage causing cardiac tamponade.

4.1.8. Death due to other cardiovascular causes

Death due to other cardiovascular causes referred to a cardiovascular death not included in the above categories (e.g. pulmonary embolism or peripheral artery disease).

4.1.9. Noncardiovascular death

Noncardiovascular death was defined as any death that was not thought to be due to a cardiovascular cause. The following categories may be collected.

4.1.9.1. NONMALIGNANT CAUSES

- Pulmonary
- Renal
- Gastrointestinal
- Hepatobiliary
- Pancreatic
- Infection (includes sepsis)
- Noninfectious (e.g. systemic inflammatory response syndrome)
- Hemorrhage*, excluding hemorrhagic strokes and bleeding in the setting of coronary revascularization
- Noncardiovascular procedure or surgery
- Accidental (e.g. physical accidents or drug overdose) or trauma
- Suicide
- Prescription drug error (e.g. prescribed drug overdose, use of inappropriate drug, or drug-drug interaction)
- Neurological process that was not a stroke or hemorrhage
- Other noncardiovascular, specify: _____

**Examples: Death due to gastrointestinal bleeding was not considered a cardiovascular death. Death due to retroperitoneal hematoma following PCI was considered cardiovascular death. Death due to intracerebral hemorrhage was considered cardiovascular death.*

4.1.9.2. MALIGNANT CAUSES

Death from a malignant cause was that resulting directly from the cancer, or death resulting from a complication of the cancer (e.g. infection, complication of surgery / chemotherapy / radiotherapy), or death resulting from withdrawal of other therapies because of concerns relating to the poor prognosis associated with the cancer.

Cancer deaths that arose from cancers that were present prior to randomization or which developed subsequently were further classified (worsening prior malignancy; new malignancy).

4.1.10. Undetermined cause of death

Undetermined cause of death referred to a death not attributable to one of the above categories of cardiovascular death or to a noncardiovascular cause, due to absence of any information (e.g. the only available information is “patient died”). The use of this category of death was discouraged and should have only applied to a minimal number of cases when no information at all on the circumstances of death were available (i.e. found on obituary of local newspaper). In all circumstances the reviewer used all available information to attribute to one of the categories based on best clinical judgment.

For each death event an assessment was made as to whether the event was caused (on the basis of the totality of the evidence) by a bleeding (i.e. a fatal bleeding occurred) or not.

4.2. Myocardial Infarction

For the primary analysis, the myocardial infarction outcome was defined based on the Third Universal Definition of myocardial infarction with the exception of periprocedural myocardial infarction after PCI, which was defined according to the Society for Cardiovascular Angiography and Intervention (SCAI) definition. For secondary analyses, PCI-related myocardial infarction according to the Third Universal Definition (type 4a) was also adjudicated.

4.2.1. Spontaneous myocardial infarction (>48 h after intervention, myocardial infarction type 1)

Symptoms suggestive of ischemia/infarction in association with ECG, cardiac biomarker, or pathologic evidence of infarction were as follows:

- Detection of a rise and/or fall of cardiac biomarker values (preferably cardiac troponin T or I) with at least one value above the 99th percentile upper reference limit (URL) and with at least one of the following:
    - Symptoms of ischemia
    - New or presumed new significant ST segment-T wave (ST-T) changes or new LBBB
    - Development of new Q waves in the ECG
    - Evidence of new loss of viable myocardium or new regional wall motion abnormality
    - Identification of an intracoronary thrombus by angiography or autopsy

Spontaneous myocardial infarction typically occurs after the periprocedural period and may be secondary to late stent complications or progression of native disease (e.g. nonculprit lesion plaque rupture). Performance of ECG and angiography supports adjudication to either a target or nontarget vessel or lesion in most cases.

4.2.2. Type 2 myocardial infarction

In instances of myocardial injury with necrosis where a condition other than coronary artery disease (CAD) contributes to an imbalance between myocardial oxygen supply and/or demand, e.g. coronary endothelial dysfunction, coronary artery spasm, coronary embolism, tachy/bradyarrhythmias, anemia, respiratory failure, hypotension, and hypertension with or without left ventricular hypertrophy.

4.2.3. Type 3 myocardial infarction

Cardiac death with symptoms suggestive of myocardial ischemia and presumed new ischemic ECG changes or new LBBB, but death occurred before cardiac biomarkers were obtained, or before cardiac biomarker values would be increased.

4.2.4. Type 4a myocardial infarction (not used for primary analysis, see section 4.8 for primary definition of periprocedural myocardial infarction)

Type 4a myocardial infarction was defined by elevation of cardiac troponin (cTn) values (>5 × URL) occurring within 48 h of the procedure in patients with normal baseline values (≤URL) or a rise of cTn values >20% if the baseline values are elevated and are stable or falling. In addition, at least one of the following was required:

- Symptoms suggestive of myocardial ischemia
- New ischemic ECG changes
- Angiographic findings consistent with a procedural complication
- Imaging demonstration of new loss of viable myocardium or new regional wall motion abnormality.

4.2.5. Type 4b myocardial infarction

Type 4b myocardial infarction was defined as stent thrombosis associated with myocardial infarction when detected by coronary angiography or autopsy in the setting of evidence of myocardial ischemia and with a rise and/or fall of cardiac biomarker values with at least one value above the URL.

4.2.6. Type 4c myocardial infarction

Type 4c myocardial infarction was defined as spontaneous myocardial infarction where a restenosis was the only angiographic explanation.

4.2.7. Type 5 myocardial infarction

4.2.7.1. CORONARY ARTERY BYPASS GRAFTING-RELATED MYOCARDIAL INFARCTION

Coronary artery bypass grafting (CABG) related myocardial infarction was defined by elevation of troponin values (>10 × URL) occurring within 48 h of the procedure in patients with normal baseline cTn values (≤URL). In addition, at least one of the following was required:

- New pathological Q waves or new LBBB
- Angiographic documented new graft or new native coronary artery occlusion
- Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

4.2.8. Periprocedural myocardial infarction after PCI (within 48 h of PCI)

Periprocedural myocardial infarction was defined based on the SCAI definitions as follows:

1) In patients with normal baseline creatine kinase-MB (CK-MB): The peak CK-MB measured within 48 h of the procedure rises to ≥10 × the local laboratory ULN, or to ≥5 × ULN with new pathologic Q-waves in ≥2 contiguous leads or new persistent LBBB, OR in the absence of CK-MB measurements and a normal baseline cTn, a cTn (I or T) level measured within 48 h of the PCI rises to ≥70 × the local laboratory ULN, or ≥35 × ULN with new pathologic Q-waves in ≥2 contiguous leads or new persistent LBBB.
2) In patients with elevated baseline CK-MB (or cTn) in whom the biomarker levels are stable or falling: The CK-MB (or cTn) rises by an absolute increment equal to those levels recommended above from the most recent preprocedure level.
3) In patients with elevated CK-MB (or cTn) in whom the biomarker levels have not been shown to be stable or falling: The CK-MB (or cTn) rises by an absolute increment equal to those levels recommended above plus new ST-segment elevation or depression plus signs consistent with a clinically relevant myocardial infarction, such as new onset or worsening heart failure or sustained hypotension.

4.2.9. Target-vessel vs. nontarget-vessel myocardial infarction

Any myocardial infarction not clearly attributable to a nontarget vessel was considered as target-vessel myocardial infarction.

4.3. Stent Thrombosis

Stent thrombosis was defined by the Academic Research Consortium as follows:

4.3.1. Definite stent thrombosis

Definite stent thrombosis was considered to have occurred by either angiographic or pathological confirmation:

a. *Angiographic confirmation of stent thrombosis (the incidental angiographic documentation of stent occlusion in the absence of clinical signs or symptoms was not considered a confirmed stent thrombosis ([silent occlusion])*
The presence of an intracoronary thrombus that originates in the stent or in the segment 5 mm proximal or distal to the stent and presence of at least 1 of the following criteria within a 48-h time window:

- Acute onset of ischemic symptoms at rest
- New ischemic ECG changes that suggest acute ischemia

- Typical rise and fall in cardiac biomarkers (refer to definition of spontaneous myocardial infarction: Troponin or CK-MB >99th percentile of URL)
- Nonocclusive thrombus. Intracoronary thrombus was defined as a (spheric, ovoid, or irregular) noncalcified filling defect or lucency surrounded by contrast material (on 3 sides or within a coronary stenosis) seen in multiple projections, or persistence of contrast material within the lumen, or a visible embolisation of intraluminal material downstream
- Occlusive thrombus Thrombolysis In Myocardial Infarction (TIMI) 0 or TIMI 1 intrastent or proximal to a stent up to the most adjacent proximal side branch or main branch (if originates from the side branch)

b. Pathological confirmation of stent thrombosis

- Evidence of recent thrombus within the stent determined at autopsy or via examination of tissue retrieved following thrombectomy

4.3.2. Probable stent thrombosis

Clinical definition of probable stent thrombosis was considered to have occurred after intracoronary stenting in the following cases:

- Any unexplained death within the first 30 days.
- Irrespective of the time after the index procedure, any myocardial infarction related to documented acute ischemia in the territory of the implanted stent without angiographic confirmation of stent thrombosis and in the absence of any other obvious cause.

4.3.3. Possible stent thrombosis

Clinical definition of possible stent thrombosis was considered to have occurred with any unexplained death from 30 days following intracoronary stenting until end of trial follow-up.

4.4. Stroke

Stroke was defined as an acute episode of focal or global neurological dysfunction caused by central nervous system (CNS) vascular injury as a result of hemorrhage or infarction. CNS included brain, spinal cord and retina. Stroke was defined as follows.

4.4.1. Ischemic stroke

Ischemic stroke was defined as an acute episode of focal cerebral, spinal, or retinal dysfunction caused by CNS infarction. Evidence of infarction was defined as “Pathological, imaging, or other objective evidence of acute cerebral, spinal cord, or retinal focal ischemic injury in a defined vascular distribution; or in the absence of the above (i.e. imaging or autopsy unavailable), clinical evidence of cerebral, spinal cord, or retinal focal ischemic injury was based on symptoms persisting for ≥24 h or until death, and other etiologies excluded. Hemorrhagic infarction, defined as a parenchymal hemorrhage after CNS infarction, was considered an ischemic stroke

4.4.2. Cerebral hemorrhage

Hemorrhages in the CNS were classified as stroke if they were nontraumatic, caused by a vascular event, and resulted in injury to the CNS. In contrast, traumatic hemorrhages were not characterized as stroke. Subdural hematoma was not classified as a stroke. The diagnoses included in this section were intracerebral hemorrhage (intraparenchymal and intraventricular) and subarachnoid hemorrhage (both aneurysmal and nonaneurysmal).

4.4.3. Stroke caused by intracerebral hemorrhage

Rapidly developing clinical signs of neurological dysfunction (focal or global) attributable to a focal collection of blood within the brain parenchyma or ventricular system that was not caused by trauma.

4.4.4. Stroke caused by subarachnoid hemorrhage

Rapidly developing signs of neurological dysfunction (focal or global) and/or headache because of bleeding into the subarachnoid space (the space between the arachnoid membrane and the pia mater of the brain or spinal cord), which was not caused by trauma. Hemorrhages could be further classified according to location (example, supratentorial, subtentorial, etc.)

4.4.5. Stroke not otherwise specified

An episode of acute neurological dysfunction presumed to be caused by ischemia or hemorrhage, persisting ≥24 h or until death, but without sufficient evidence to be classified as one of the above.

4.5. Bleeding

All potential bleeding events were primarily adjudicated according to Bleeding Academic Research Consortium (BARC) classification.

Type 0	No bleeding
Type 1	Bleeding that is not actionable and does not cause the patient to seek unscheduled performance of studies, hospitalization, or treatment by a health care professional. May include episodes leading to self-discontinuation of medical therapy by the patient, without consulting a health care professional.
Type 2	Any overt, actionable sign of hemorrhage (e.g. more bleeding than would be expected for a clinical circumstance; including bleeding found by imaging alone) that does not fit the criteria for Types 3, 4, or 5 but does meet at least one of the following criteria: Requiring nonsurgical, medical intervention by a health care professional Leading to hospitalization of increased level of care Prompting evaluation
Type 3a	Overt bleeding plus hemoglobin drop of 3 to <5* g/dL (provided hemoglobin drop is related to bleed) Any transfusion with overt bleeding
Type 3b	Overt bleeding plus hemoglobin drop ≥5* g/dL (provided hemoglobin drop is related to bleed) Cardiac tamponade Bleeding requiring surgical intervention for control (excluding dental / nasal / skin / hemorrhoid) Bleeding requiring intravenous vasoactive agents
Type 3c	Intracranial hemorrhage (does not include microbleeds or hemorrhagic transformation; does include intraspinal) Subcategories: confirmed by autopsy or imaging or lumbar puncture Intra-ocular bleed compromising vision
Type 4	CABG-related bleeding Perioperative intracranial bleeding within 48 h Reoperation following closure of sternotomy for the purpose of controlling bleeding Transfusion of ≥5 units of whole blood or packed red blood cells within 48 hour period† Chest tube output ≥2 L within a 24 hour period
Type 5a	Probable fatal bleeding; no autopsy or imaging confirmation, but clinically suspicious
Type 5b	Definite fatal bleeding: overt bleeding or autopsy or imaging confirmation

Platelet transfusions were recorded and reported, and were not included in these definitions until further information was obtained about the relationship to outcomes.
*Corrected for transfusion (1 unit packed red blood cells or 1 unit whole blood=1g/dL hemoglobin).
†Cell saver products were not counted.

ADDITIONAL DETAILS ON STATISTICAL ANALYSES

The trial was designed to test the following three hypotheses (in hierarchical order):

Coprimary Hypothesis 1. The abbreviated dual antiplatelet regimen is noninferior to the standard dual antiplatelet regimen with respect to the time to first occurrence of any component of the first coprimary end point of net adverse clinical events (the composite of all-cause death, myocardial infarction, stroke, and major or clinically relevant nonmajor bleeding) between randomization and 335 days thereafter, in a time-to-event analysis performed in the per-protocol population.

Coprimary Hypothesis 2. The abbreviated dual antiplatelet regimen is noninferior to the standard dual antiplatelet regimen with respect to the time to first occurrence of any component of the second coprimary end point of major adverse cardiac and cerebral events (the composite of all-cause death, myocardial infarction, and stroke) between randomization and 335 days thereafter, in a time-to-event analysis performed in the per-protocol population.

Coprimary Hypothesis 3. The abbreviated dual antiplatelet regimen is superior to the standard dual antiplatelet regimen with respect to the time to first occurrence of any component of the third coprimary end point of major or clinically relevant nonmajor bleeding between randomization and 335 days thereafter, in a time-to-event analysis performed in the intention-to-treat population.

The intention-to-treat population consisted of all randomized patients. Patients who underwent randomization but did not fulfill enrollment criteria and patients in whom protocol mandated dual or single antiplatelet regimen within 14 days of randomization was not implemented were excluded from the per-protocol population. Statistical testing of the primary hypotheses was performed in a closed hierarchical testing procedure to preserve the overall alpha level at 0.025 (one-sided), corresponding to 0.05 (two-sided). For patients with a primary outcome, time-to-event was calculated as the difference between the date of occurrence of the outcome event and the date of randomization plus 1. For patients with an outcome event and complete follow-up until the end of day 335, time to censoring was calculated as 335 days. For patients with incomplete clinical follow-up, time to censoring was defined as the difference between the dates of last known clinical status and randomization plus 1. For the third coprimary end point, the occurrence of death was defined as a competing risk event, and follow-up was censored at the time of the occurrence of death. Kaplan−Meier curves were created for the first two (time-to-event) coprimary outcomes, and cause-specific Kaplan−Meier curves for the third coprimary end point (with censoring at the time of the competing risk event of unrelated death). Kaplan−Meier calculations included all (first) adjudicated outcome events that occurred between randomization and 335 days thereafter according to the randomized treatment assignment, irrespective of the dual antiplatelet regimen received at the time of the outcome event. Cause-specific hazard ratios and 95% confidence intervals were generated for primary and secondary end points with the use of Cox proportional hazards regression analysis with censoring at end of study and at the time of the competing risk event of unrelated death as defined above.

Cumulative incidences of primary outcome events were calculated as Kaplan−Meier estimates at 335 days. The 95% confidence interval for the difference in cumulative incidence (cumulative incidence under the abbreviated dual antiplatelet regimen minus that under the standard dual antiplatelet regimen) was calculated according to the method of Com-Nougue,[2] with the use of the Kaplan−Meier estimates and Greenwood estimators of the standard error.

To show *noninferiority for the first coprimary outcome* of net adverse clinical events, the upper limit of the 95% confidence interval for the difference in cumulative incidence had to fall below a prespecified margin of 3.6%, which is equivalent to noninferiority testing at a one-sided alpha level of 2.5%. The one-sided P value for noninferiority was calculated with the use of the Com-Nougue approach to estimate the z statistic for the difference in Kaplan–Meier 335-day cumulative incidences and a non-inferiority margin of 3.6%, with standard errors estimated by means of Greenwood's formula.

To show *noninferiority for adverse major adverse cardiac and cerebrovascular events*, the upper limit of the 95% confidence interval for the difference in cumulative incidence had to fall below a prespecified margin of 2.4%, which is equivalent to noninferiority testing at a one-sided alpha level of 2.5%. The one-sided P value for noninferiority was calculated as defined above but with a noninferiority margin of 2.4%.

To show *superiority for major or clinically relevant nonmajor bleeding*, the upper limit of the 95% confidence interval for the difference in cumulative incidence had to fall below the conventional 0%, which is equivalent to superiority testing at a two-sided alpha level of 5%. The two-sided P value for superiority was calculated with the use of the Com-Nougue approach to estimate the z statistic for the difference in Kaplan–Meier 335-day cumulative incidences, with standard errors estimated by means of Greenwood's formula.

For sample size and power calculations, we estimated that the standard dual antiplatelet regimen would be associated with 335-day cumulative incidences of 12.0%, 8.0%, and 6.5% for the three coprimary outcomes respectively. These estimations were primarily based on outcome data from the zotarolimus-eluting stent in uncertain DES candidates in the ZEUS trial[3] and the LEADERS FREE trial.[4] The Kaplan Meier curves for the latter's primary safety end point (cardiac death, MI or stent thrombosis) showed that one-third of the events occurred within 30 days and the remaining two-thirds between 30 days and one year after percutaneous coronary intervention. Major or clinically relevant nonmajor bleeding (BARC 2, 3 or 5) was observed in 14.5% of patients despite 1 month of treatment with dual antiplatelet therapy only. Based on data from the ZEUS trial, we expected that 50% of the bleeding events would have occurred within the first 30 days after percutaneous intervention. Henceforth, the LEADERS FREE indirectly (for net adverse clinical events and major adverse cardiac and cerebral events) or directly (for major or clinically relevant nonmajor bleeding) corroborated the expected event rates in this trial in patients at high bleeding risk.

We hypothesized that the abbreviated antiplatelet regimen would be associated with equal cumulative incidences for the coprimary end points of net adverse clinical events and of major adverse cardiac and cerebral events in non-inferiority analyses. We further hypothesized that the abbreviated antiplatelet regimen would show a reduction in the incidence of the third coprimary outcome of major or clinically relevant nonmajor bleeding from 6.5% to 4.2%, equivalent to a proportional reduction of 35% in a superiority analysis. Sample size and power calculations were performed for each of the three primary hypotheses using PASS 14 with the modules suited for noninferiority or superiority testing of proportion type outcomes.

First, we calculated that a total sample size of 4100 patients would provide 90% power to show noninferiority for *net adverse clinical outcomes* under an assumed cumulative incidence of 12.0%.

Second, we calculated that a total sample size of 4100 patients would provide 80% power to show noninferiority for major adverse cardiac and cerebral events under an assumed cumulative incidence of 8.0%.

Third, we calculated that a total sample size of 4100 patients would provide 90% power to show superiority for major or clinically relevant bleeding under an assumed reduction of the cumulative incidence from 6.5% to 4.2%.

As indicated above, we expected an incidence of net adverse clinical events of 12.0%, and major adverse cardiac and cerebral events of 8.0%. Non-inferiority margins of 3.6% for net adverse clinical events and 2.4% for major adverse cardiac and cerebral events represented 30% of these expected percentages. This approach of defining noninferiority margins is consistent with those in other trials that have evaluated pharmacologic and device based interventions within a noninferiority framework.[4-6]

As prespecified in the statistical analysis plan, we performed exploratory sensitivity analyses for the three coprimary outcomes. The primary analysis for the first coprimary outcome of net

adverse clinical events was done in the intention-to-treat population, as was the primary analysis for the second coprimary outcome of major adverse cardiac and cerebral events. The primary analysis for the third coprimary outcome of major or clinically relevant nonmajor bleeding was done in the per-protocol population. Except for the choice of the analysis population, all other statistical methods in these sensitivity analyses were identical to those of the corresponding primary analyses.

The proportional hazards assumption was violated for the major or clinically relevant nonmajor bleeding outcome. However, we used the Com-Nougue method on the cumulative incidence difference estimate with a confidence interval of this difference on day 335 since randomization for the primary outcome analyses (not a test on the hazard ratio scale).

As prespecified in the protocol, we performed subgroup analyses for the three coprimary outcomes in subgroups of patients defined by the presence of a clinical indication for treatment with oral anticoagulants, a history of myocardial infarction in the 12 months before the index percutaneous intervention, indication for percutaneous coronary intervention by acute coronary syndrome or stable coronary artery disease, DAPT score <2 or ≥2, PRECISE score <25 or ≥25, female or male sex, creatinine clearance < 60 or ≥ 60 ml/min, age ≥75 or <75 years, and presence of diabetes mellitus.

All statistical analyses were performed within subgroups of patients with the same statistical methodology that was used in the primary analyses. The 95% confidence intervals were not adjusted for multiplicity and should not be used to infer definitive treatment effects. All analyses were performed in Stata Release 16.1.

Table S1. Screening Log of Patients Not Consented for the MASTER DAPT Trial

Eligibility	N=2738
Not eligible	
Patient did not fulfill inclusion or exclusion criteria for the participation in the trial	2228 (81.4)
Patient refused to participate	111 (4.1)
Eligible	399 (14.6)
Investigator did not want to enroll the patient because the patient had very high bleeding risk	12 (0.4)
Investigator did not want to enroll the patient because the patient had very high ischemic risk	42 (1.5)
Investigator did not want to enroll the patient for any other clinical reason	27 (1.0)
Investigator forgot to ask patient to participate in the trial	20 (0.7)
The cardiologist responsible for the patient's health was not involved in the trial	90 (3.3)
Other	176 (6.4)
Not documented	32 (1.2)

Data are number (%).
Sixty-five sites participated in the screening log for a median duration of 14 days (interquartile range 14 to 14) whereby all consecutive patients undergoing percutaneous coronary intervention were screened for participation in the trial. A total of 510 (18.6%) patients were potentially eligible. Overall, 111 (4.1%) patients refused to participate, 399 (14.6%) patients were not included for the reasons listed above. During the Screening log, 109 patients were consented and participated in the MASTER DAPT trial (including 88 patients eventually randomized and 21 patients eventually not randomized).

Table S2. Baseline Characteristics of Randomized Versus Nonrandomized Patients and Eligible and Ineligible Patients.*

Characteristic	Consented Patients (N=5204)	Randomized Patients (N=4579)	Nonrandomized Patients (N=625)	Eligible But Not Randomized Patients (N=289)	Ineligible and Not Randomized Patients (Including Dead) (N=336)
Age — years	76.26±8.66	76.04±8.74	n=625 77.90±7.88	78.85±7.49	n=336 77.07±8.13
Male sex	3588 (68.9)	3171 (69.3)	n=625 417 (66.7)	182 (63.0)	n=336 235 (69.9)
Body mass index†	n=5200 27.30±4.77	27.35±4.71	n=621 26.96±5.13	n=288 26.73±4.61	n=333 27.16±5.54
Family history of coronary artery disease	n=5198 1250 (24.0)	1109 (24.2)	n=619 141 (22.8)	n=285 52 (18.2)	n=334 89 (26.6)
Arterial hypertension	n=5202 4035 (77.6)	3553 (77.6)	n=623 482 (77.4)	n=287 217 (75.6)	n=336 265 (78.9)
Uncontrolled hypertension	n=5202 264 (5.1)	236 (5.2)	n=623 28 (4.5)	n=287 17 (5.9)	n=336 11 (3.3)
Diabetes mellitus	n=5203 1734 (33.3)	1538 (33.6)	n=624 196 (31.4)	n=288 75 (26.0)	n=336 121 (36.0)
Hyperlipidemia	n=5203 3497 (67.2)	3097 (67.6)	n=624 400 (64.1)	n=288 183 (63.5)	n=336 217 (64.6)
Smoker	n=5169	n=4566	n=603	n=273	n=330
Never smoked	2719 (52.6)	2424 (53.1)	295 (48.9)	149 (54.6)	146 (44.2)
Previous smoker	1972 (38.2)	1728 (37.8)	244 (40.5)	95 (34.8)	149 (45.2)
Current smoker	478 (9.2)	414 (9.1)	64 (10.6)	29 (10.6)	35 (10.6)
Peripheral vascular disease‡	n=5203 570 (11.0)	485 (10.6)	n=624 85 (13.6)	n=288 35 (12.2)	n=336 50 (14.9)
Carotid artery disease	n=5203 304 (5.8)	264 (5.8)	n=624 40 (6.4)	n=288 19 (6.6)	n=336 21 (6.3)
Heart failure	n=5202 986 (19.0)	867 (18.9)	n=623 119 (19.1)	n=287 51 (17.8)	n=336 68 (20.2)
Left ventricular ejection fraction — %	n=4858 53.00±11.72	n=4297 53.22±11.61	n=561 51.34±12.40	n=249 51.92±12.26	n=312 50.88±12.52
Prior myocardial infarction	n=5203 989 (19.0)	864 (18.9)	n=624 125 (20.0)	n=288 53 (18.4)	n=336 72 (21.4)
Prior PCI	n=5203	1188 (25.9)	n=624	n=288	n=336

Characteristic	Consented Patients (N=5204)	Randomized Patients (N=4579)	Nonrandomized Patients (N=625)	Eligible But Not Randomized Patients (N=289)	Ineligible and Not Randomized Patients (Including Dead) (N=336)
	1363 (26.2)		175 (28.0)	83 (28.8)	92 (27.4)
Prior cerebrovascular event	n=5203 664 (12.8)	570 (12.4)	n=624 94 (15.1)	n=288 35 (12.2)	n=336 59 (17.6)
Stroke	n=5203 470 (9.0)	410 (9.0)	n=624 60 (9.6)	n=288 24 (8.3)	n=336 36 (10.7)
Transient ischemic attack	n=5203 203 (3.9)	170 (3.7)	n=624 33 (5.3)	n=288 11 (3.8)	n=336 22 (6.5)
Undetermined	n=5203 40 (0.8)	29 (0.6)	n=624 11 (1.8)	n=288 3 (1.0)	n=336 8 (2.4)
Arterial thromboembolism	n=5203 71 (1.4)	55 (1.2)	n=624 16 (2.6)	n=288 7 (2.4)	n=336 9 (2.7)
History of venous thromboembolism	n=5203 272 (5.2)	239 (5.2)	n=624 33 (5.3)	n=288 16 (5.6)	n=336 17 (5.1)
Prior coronary artery bypass graft	n=5203 407 (7.8)	341 (7.4)	n=624 66 (10.6)	n=288 30 (10.4)	n=336 36 (10.7)
Prior prosthetic mechanical heart valve	n=5203 121 (2.3)	101 (2.2)	n=624 20 (3.2)	n=288 9 (3.1)	n=336 11 (3.3)
Aortic valve stenosis	n=4673 239 (5.1)	n=4120 195 (4.7)	n=553 44 (8.0)	n=265 20 (7.5)	n=288 24 (8.3)
Prior bleeding before/after qualifying PCI	n=5203 454 (8.7)	359 (7.8)	n=624 95 (15.2)	n=288 33 (11.5)	n=336 62 (18.5)
Chronic pulmonary disease	n=5203 637 (12.2)	538 (11.7)	n=624 99 (15.9)	n=288 40 (13.9)	n=336 59 (17.6)
Chronic kidney disease§	n=5203 1041 (20.0)	876 (19.1)	n=624 165 (26.4)	n=288 71 (24.7)	n=336 94 (28.0)
Liver disease	n=5203 79 (1.5)	61 (1.3)	n=624 18 (2.9)	n=288 7 (2.4)	n=336 11 (3.3)
Atrial fibrillation	n=5203 1758 (33.8)	1490 (32.5)	n=624 268 (42.9)	n=288 99 (34.4)	n=336 169 (50.3)
History of cancer	n=5203 802 (15.4)	699 (15.3)	n=624 103 (16.5)	n=288 56 (19.4)	n=336 47 (14.0)
Active cancer	n=5203 275 (5.3)	236 (5.2)	n=624 39 (6.3)	n=288 18 (6.3)	n=336 21 (6.3)
Hematological or coagulation disorders	n=5203 693 (13.3)	578 (12.6)	n=624 115 (18.4)	n=288 51 (17.7)	n=336 64 (19.0)
Chronic treatment with steroids or nonsteroidal anti-inflammatory drug	n=5203 490 (9.4)	441 (9.6)	n=624 49 (7.9)	n=288 19 (6.6)	n=336 30 (8.9)

Characteristic	Consented Patients (N=5204)	Randomized Patients (N=4579)	Nonrandomized Patients (N=625)	Eligible But Not Randomized Patients (N=289)	Ineligible and Not Randomized Patients (Including Dead) (N=336)
Prior vitamin K antagonist	n=5203 730 (14.0)	626 (13.7)	n=624 104 (16.7)	n=288 37 (12.8)	n=336 67 (19.9)
Current treatment with oral anticoagulant	n=5203 1964 (37.7)	1669 (36.4)	n=624 295 (47.3)	n=288 111 (38.5)	n=336 184 (54.8)
Clinical indication for 12 months oral anticoagulant	1962 (37.7)	1666 (36.4)	n=625 296 (47.4)	111 (38.4)	n=336 185 (55.1)
Oral anticoagulant treatment at randomization¶	n=1962 1942 (99.0)	n=1666 1656 (99.4)	n=296 286 (96.6)	n=111 108 (97.3)	n=185 178 (96.2)
PRECISE DAPT score§	27.08±11.17	26.76±10.98	n=625 29.39±12.19	30.03±12.76	n=336 28.84±11.67
Prior bleeding	371 (7.1)	320 (7.0)	n=625 51 (8.2)	27 (9.3)	n=336 24 (7.1)
Hemoglobin — g/L	13.19±1.80	13.22±1.79	n=625 12.97±1.90	12.94±1.82	n=336 12.99±1.97
White blood cell count§ — $\times 10^9$/L	n=5203 8.19±8.06	n=4578 8.17±8.45	n=625 8.34±4.23	8.51±5.06	n=336 8.20±3.36
Creatinine clearance¦¦ — mL/min/1.73 m²	70.52±24.24	70.86±24.04	n=625 68.06±25.54	67.97±24.81	n=336 68.14±26.19

* Number (%). Plus–minus values are means±SD.
† The body-mass index is the weight in kilograms divided by the square of the height in meters.
‡ Defined as intermittent claudication, peripheral artery bypass for insufficiency, gangrene, acute arterial insufficiency, untreated aneurysm (≥6 cm), ankle brachial index ≤0.90, and aortic plaque.
§ Defined as kidney damage (pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests or imaging studies) or glomerular filtration rate <60 mL/min/1.73 m² for ≥3 months.
¶ Vitamin K-antagonist or nonvitamin K antagonist oral anticoagulant.
§ Calculated at screening visit; n=1 PRECISE score calculated without risk due to white blood cell count.
¦¦ Modification of Diet in Renal Disease.

Table S3. Procedural Characteristics of Randomized Versus Nonrandomized Patients.*

Characteristic	Consented Patients (N=5204)	Randomized Patients (N=4579)	Nonrandomized Patients (N=625)	Ineligible and Not Randomized Patients (Including Dead Patients) (N=336)	Eligible But Not Randomized Patients (N=289)
Clinical presentation† — no. (%)					
Stable angina	2063 (39.6)	1849 (40.4)	214 (34.2)	123 (36.6)	91 (31.5)
Silent ischemia	586 (11.3)	519 (11.3)	67 (10.7)	38 (11.3)	29 (10.0)
NSTEMI	1362 (26.2)	1153 (25.2)	209 (33.4)	109 (32.4)	100 (34.6)
STEMI	611 (11.7)	538 (11.7)	73 (11.7)	29 (8.6)	44 (15.2)
Unstable angina	582 (11.2)	520 (11.4)	62 (9.9)	37 (11.0)	25 (8.7)
Killip II, III or IV	569 (10.9)	506 (11.1)	n=625 63 (10.1)	n=336 31 (9.2)	32 (11.1)
Cardiac arrest	62 (1.2)	58 (1.3)	n=625 4 (0.6)	n=336 1 (0.3)	3 (1.0)
Heart rate — beats/min	n=5198 73.78±16.72	n=4574 73.65±16.48	n=624 74.66±18.36	n=336 75.36±19.49	n=288 73.85±16.95
Systolic blood pressure — mmHg	n=5189 137.04±25.60	n=4567 137.14±25.49	n=622 136.26±26.37	n=335 134.71±25.93	n=287 138.07±26.81
Procedural characteristics† — no. (%)					
Arterial access site	n=5204,	n=4579,	n=625,	n=336,	n=289,
Femoral	758 (14.6)	653 (14.3)	105 (16.8)	58 (17.3)	47 (16.3)
Radial	4434 (85.2)	3914 (85.5)	520 (83.2)	278 (82.7)	242 (83.7)
Brachial	12 (0.2)	12 (0.3)	0 (0.0)	0 (0.0)	0 (0.0)
Intra-aortic balloon pump	61 (1.2)	54 (1.2)	n=625 7 (1.1)	n=336 4 (1.2)	3 (1.0)
Left ventricular assist device	9 (0.2)	8 (0.2)	n=625 1 (0.2)	n=336 1 (0.3)	0 (0.0)
Total amount of contrast — cc	n=5152 167.82±79.70	n=4537 167.49±79.91	n=615 170.23±78.12	n=330 161.93±73.24	n=285 179.83±82.52

Characteristic	Consented Patients (N=5204)	Randomized Patients (N=4579)	Nonrandomized Patients (N=625)	Ineligible and Not Randomized Patients (Including Dead Patients) (N=336)	Eligible But Not Randomized Patients (N=289)
Medications† — no. (%)					
Unfractionated heparin	n=5202 4950 (95.2)	n=4578 4356 (95.2)	n=624 594 (95.2)	n=336 319 (94.9)	n=288 275 (95.5)
Bivalirudin	n=5202 7 (0.1)	n=4578 7 (0.2)	n=624 0 (0.0)	n=336 0 (0.0)	n=288 0 (0.0)
Low-molecular-weight heparin	n=5202 152 (2.9)	n=4578 127 (2.8)	n=624 25 (4.0)	n=336 13 (3.9)	n=288 12 (4.2)
Cangrelor	n=5202 14 (0.3)	n=4578 11 (0.2)	n=624 3 (0.5)	n=336 2 (0.6)	n=288 1 (0.3)
Glycoprotein II/IIIa inhibitor	n=5202 184 (3.5)	n=4578 162 (3.5)	n=624 22 (3.5)	n=336 9 (2.7)	n=288 13 (4.5)
Number of percutaneous coronary interventions‡	n=5204	n=4579	n=625	n=336	n=289
1	4726 (90.8)	4159 (90.8)	567 (90.7)	311 (92.6)	256 (88.6)
2	461 (8.9)	405 (8.8)	56 (9.0)	23 (6.8)	33 (11.4)
3	17 (0.3)	15 (0.3)	2 (0.3)	2 (0.6)	0 (0.0)
Number of vessels treated per patient§ — no. (%)	n=5204	n=4579	n=625	n=336	n=289
1	3840 (73.8)	3365 (73.5)	475 (76.0)	263 (78.3)	212 (73.4)
2	1148 (22.1)	1024 (22.4)	124 (19.8)	58 (17.3)	66 (22.8)
3	216 (4.2)	190 (4.1)	26 (4.2)	15 (4.5)	11 (3.8)
Treated vessel(s) per patient					
Left main	298 (5.7)	260 (5.7)	n=625 38 (6.1)	n=336 19 (5.7)	19 (6.6)
Left arterial descending artery	2839 (54.6)	2511 (54.8)	n=625 328 (52.5)	n=336 169 (50.3)	159 (55.0)
Left circumflex artery	1530 (29.4)	1341 (29.3)	n=625 189 (30.2)	n=336 98 (29.2)	91 (31.5)
Right coronary artery	1866 (35.9)	1660 (36.3)	n=625	n=336	92 (31.8)

Characteristic	Consented Patients (N=5204)	Randomized Patients (N=4579)	Nonrandomized Patients (N=625)	Ineligible and Not Randomized Patients (Including Dead Patients) (N=336)	Eligible But Not Randomized Patients (N=289)
			206 (33.0)	114 (33.9)	
Bypass graft	95 (1.8)	76 (1.7)	n=625 19 (3.0)	n=336 14 (4.2)	5 (1.7)
Total number of treated lesions per patient	n=5204	n=4579	n=625	n=336	n=289
1	3541 (68.0)	3115 (68.0)	426 (68.2)	231 (68.8)	195 (67.5)
2	1169 (22.5)	1025 (22.4)	144 (23.0)	73 (21.7)	71 (24.6)
3 or more	494 (9.5)	439 (9.6)	55 (8.8)	32 (9.5)	23 (8.0)
Total stented lesions per patient	n=5204	n=4579	n=625	n=336	n=289
1	3614 (69.4)	3176 (69.4)	438 (70.1)	236 (70.2)	202 (69.9)
2	1132 (21.8)	993 (21.7)	139 (22.2)	71 (21.1)	68 (23.5)
3 or more	458 (8.8)	410 (9.0)	48 (7.7)	29 (8.6)	19 (6.6)
At least one complex lesion B2 or C	3564 (68.5)	3141 (68.6)	n=625 423 (67.7)	n=336 213 (63.4)	210 (72.7)
Number of stents per patient	1.75±1.13	1.75±1.12	n=625 1.79±1.19	n=336 1.77±1.16	1.81±1.22
Total stent length per patient	39.51±29.03	39.51±28.82	n=625 39.52±30.55	n=336 38.14±29.09	41.11±32.15
Any overlapping stenting	1063 (20.4)	938 (20.5)	n=625 125 (20.0)	n=336 69 (20.5)	56 (19.4)
Any bifurcation or trifurcation stenting¶	206 (4.0)	184 (4.0)	n=625 22 (3.5)	n=336 8 (2.4)	14 (4.8)

* Number (%). Plus–minus values are means±SD.

† Data from first percutaneous coronary intervention only.

‡ One percutaneous coronary intervention and up to two staged percutaneous coronary interventions. The last percutaneous coronary intervention was the qualifying intervention 1 month before the randomization.

§ Left main counted as two vessels; left internal mammary artery/right internal mammary artery/radial/ saphenous vein grafts counted as one vessel.

¶ Stenting into both main and side branch(es).

Table S4. Protocol Deviations and Definition of Per-Protocol Population.

	Patients (%)
Standard dual antiplatelet therapy	**N=2284**
No protocol violation	2230 (97.6)
Not high bleeding risk*	1 (0.04)
Not on dual antiplatelet therapy at randomization	6 (0.3)
Not on dual antiplatelet therapy at randomization and not on protocol-mandated treatment within 14 days	5 (0.2)
Not on protocol-mandated treatment within 14 days	3 (0.1)
Received other stents (bare-metal stent or drug-eluting stent)	7 (0.3)
Treated in-stent restenosis or stent thrombosis	28 (1.2)
Treated in-stent restenosis or stent thrombosis and not on dual antiplatelet therapy at randomization	1 (0.04)
Treated in-stent restenosis or stent thrombosis and not treated with study stent and received other stents (bare-metal stent and drug-eluting stent)	1 (0.04)
Treated in-stent restenosis or stent thrombosis and received other stents (bare-metal stent or drug-eluting stent)	2 (0.09)
Abbreviated dual antiplatelet therapy	**N=2295**
No protocol violation	2204 (96.0)
Not high bleeding risk*	3 (0.13)
Not on dual antiplatelet therapy at randomization	14 (0.6)
Not on protocol-mandated treatment within 14 days	43 (1.9)
Not treated with study stent and received other stents (bare-metal stent or drug-eluting stent)	1 (0.04)
Received other stents (bare-metal stent or drug-eluting stent)	6 (0.3)
Treated in-stent restenosis or stent thrombosis	24 (1.1)

*One patient had two access-site bleedings between percutaneous coronary intervention and the 1-month visit. One patient stopped steroids between screening and the 1-month visit. One patient had high-bleeding risk cancer (not confirmed). One patient was not on oral anticoagulant and the indication was not confirmed.

Table S5. Criteria for High Bleeding Risk.

Criteria	Abbreviated Treatment Group (N=2295)		Standard Treatment Group (N=2284)	
	One or More Criteria*	Single Criterion†	One or More Criteria*	Single Criterion†
	n (%)			
Clinical indication for treatment with oral anticoagulant for ≥12 months	848 (36.9)	264 (11.5)	818 (35.8)	248 (10.9)
Recent (<12 months) nonaccess site bleeding episode(s) that required medical attention	99 (4.3)	0 (0.0)	102 (4.5)	0 (0.0)
Previous bleeding episode(s) that required hospitalization if the underlying cause had not been definitively treated	94 (4.1)	0 (0.0)	89 (3.9)	0 (0.0)
Age ≥75 years	1582 (68.9)	390 (17.0)	1572 (68.8)	391 (17.1)
Systemic conditions associated with an increased bleeding risk‡	41 (1.8)	4 (0.2)	46 (2.0)	2 (0.1)
Documented anemia§	261 (11.4)	4 (0.2)	257 (11.3)	3 (0.1)
Need for chronic treatment with steroids or nonsteroidal anti-inflammatory drugs	202 (8.8)	17 (0.7)	240 (10.5)	30 (1.3)
Diagnosed malignancy (other than skin) considered at high bleeding risk	146 (6.4)	31 (1.4)	147 (6.4)	20 (0.9)
Stroke at any time or transient ischemic attack in the previous 6 months	220 (9.6)	36 (1.6)	258 (11.3)	50 (2.2)
PRECISE-DAPT score ≥25	1251 (54.5)	66 (2.9)	1213 (53.1)	53 (2.3)

* All patients fulfilling the criteria are listed.
† Only patients fulfilling the criterion in isolation are listed.
‡ For example, hematological disorders, including a history of current thrombocytopenia defined as platelet count <100.00/mm^3 (<100×10^9/L) or any known coagulation disorder associated with increased bleeding risk.
§ Defined as repeated hemoglobin levels <11 g/dL or transfusion in the 4 weeks before inclusion.

Table S6. Procedural Characteristics.*

Characteristic	Abbreviated Dual Antiplatelet Therapy (N=2295)	Standard Dual Antiplatelet Therapy (N=2284)
Procedural characteristics — no. (%)		
Arterial access site		
Femoral	360 (15.7)	293 (12.8)
Radial	1930 (84.1)	1984 (86.9)
Brachial	5 (0.2)	7 (0.3)
Number of vessels treated per patient† — no. (%)		
One	1716 (74.8)	1649 (72.2)
Two	483 (21.0)	541 (23.7)
Three	96 (4.2)	94 (4.1)
Treated vessel(s) per patient — no. (%)		
Left main	126 (5.5)	134 (5.9)
Left arterial descending artery	1240 (54.0)	1271 (55.6)
Left circumflex artery	652 (28.4)	689 (30.2)
Right coronary artery	854 (37.2)	806 (35.3)
Bypass graft	38 (1.7)	38 (1.7)
Total number of treated lesions per patient		
One	1579 (68.8)	1536 (67.3)
Two	503 (21.9)	522 (22.9)
Three or more	213 (9.3)	226 (9.9)
Total stented lesions per patient		
One	1611 (70.2)	1565 (68.5)
Two	486 (21.2)	507 (22.2)
Three or more	198 (8.6)	212 (9.3)
At least one complex lesion B2 or C — no. (%)	1562 (68.1)	1579 (69.1)
Number of stents per patient	1.74±1.13	1.76±1.11
Total stent length per patient	39.3±29.2	39.7±28.4
Any overlapping stenting — no. (%)	488 (21.3)	450 (19.7)
Any bifurcation or trifurcation stenting‡ — no. (%)	83 (3.6)	101 (4.4)

* Plus–minus values are means±SD.
† Data from first percutaneous coronary intervention only.
‡ Left main counted as two vessels.

Table S7. Characteristics of Treated Lesions.*

Characteristic	Abbreviated Treatment Group (N=2295)	Standard Treatment Group (N=2284)
Number of treated lesions	3294	3340
Lesion location		
Left main	128 (3.9)	135 (4.0)
Left arterial descending artery	1394 (42.3)	1432 (42.9)
Left circumflex artery	727 (22.1)	768 (23.0)
Right coronary artery	1005 (30.5)	962 (28.8)
Bypass graft		
Saphenous vein	34 (1.0)	38 (1.1)
Left internal mammary artery/right internal mammary artery/radial graft	9 (0.3)	6 (0.2)
Bifurcation or trifurcation disease per lesion	535 (16.2)	521 (15.6)
Rotablator used per lesion	78 (2.4)	73 (2.2)
Final residual lesion stenosis confirmed <20% per lesion	3250 (98.7)	3300 (98.8)
TIMI flow before PCI per lesion	n=3261	n=3313
0 or 1	424 (13.0)	468 (14.1)
2	361 (11.1)	342 (10.3)
3	2476 (75.9)	2503 (75.6)
TIMI flow after PCI per lesion	n=3293	n=3338
0 or 1	11 (0.3)	3 (0.1)
2	18 (0.5)	30 (0.9)
3	3264 (99.1)	3305 (99.0)
Lesion treatment		
Ballooning or thrombus aspiration only	56 (1.7)	58 (1.7)
Stenting	3238 (98.3)	3282 (98.3)
Number of stented lesions	3238	3282
Stent(s) used per lesion†		
Study stent	3231 (99.8)	3275 (99.8)
Other drug-eluting stent	9 (0.3)	9 (0.3)
Bare-metal stent	0 (0.0)	1 (0.0)
Number of stents used per lesion	n=3213 1.24±0.55	n=3267 1.23±0.54
Overlapping stenting per lesion	n=3213 525 (16.3)	n=3267 482 (14.8)
Total stent length per lesion — mm	27.85±16.68	27.65±16.08
Average stent diameter per lesion — mm	3.00±0.47	2.99±0.48
Direct stenting per lesion	976 (30.1)	1043 (31.8)
Post-dilatation per lesion	2031 (62.7)	1998 (60.9)

* Number (%). Plus–minus values are means±SD.
† In 5 lesions in 5 different patients, both study stent and other drug-eluting stents were used; in 14 lesions in 12 different patients, only bare-metal or only another nonstudy drug-eluting stent was used.
TIMI = Thrombolysis In Myocardial Infarction.

Table S8. Medications Before and After Randomization.*

Medication	Abbreviated Treatment Group (N=2295)	Standard Treatment Group (N=2284)
At 1-month visit (before randomization)	*n (%)*	
Dual antiplatelet therapy	2281 (99.4)	2272 (99.5)
Single antiplatelet therapy	14 (0.6)	12 (0.5)
No antiplatelet therapy	0 (0.0)	0 (0.0)
Acetylsalicylic acid	2284 (99.5)	2273 (99.5)
$P2Y_{12}$ inhibitor	2292 (99.9)	2283 (100.0)
Clopidogrel	1828 (79.7)	1804 (79.0)
Prasugrel	59 (2.6)	56 (2.5)
Ticagrelor	405 (17.6)	423 (18.5)
Oral anticoagulant	843 (36.7)	813 (35.6)
Vitamin K antagonist	290 (12.6)	273 (12.0)
Warfarin	92 (4.0)	77 (3.4)
Acenocoumarol	138 (6.0)	134 (5.9)
Phenprocoumon	28 (1.2)	38 (1.7)
Fluindione	32 (1.4)	24 (1.1)
Nonvitamin K antagonist oral anticoagulant	553 (24.1)	540 (23.6)
Dabigatran	112 (4.9)	99 (4.3)
Apixaban	224 (9.8)	203 (8.9)
Rivaroxaban	179 (7.8)	206 (9.0)
Edoxaban	38 (1.7)	32 (1.4)
Calcium-channel blocker	688 (30.0)	661 (28.9)
Proton pump inhibitor	1607 (70.0)	1641 (71.8)
Beta-blocker	1681 (73.2)	1658 (72.6)
Angiotensin-converting enzyme inhibitor	1086 (47.3)	1080 (47.3)
Angiotensin II receptor blocker	636 (27.7)	636 (27.8)
Histamine H2-receptor blocker	42 (1.8)	49 (2.1)
Insulin	241 (10.5)	199 (8.7)
Oral hypoglycemic drug	567 (24.7)	588 (25.7)
Statin	1974 (86.0)	1986 (87.0)
Other lipid-lowering drug	188 (8.2)	189 (8.3)
Proprotein convertase subtilisin-kexin type 9 inhibitor	5 (0.2)	4 (0.2)
Sacubitril + valsartan	26 (1.1)	36 (1.6)
Amiodarone	138 (6.0)	116 (5.1)
Ivabradine	17 (0.7)	31 (1.4)
Nitrate	358 (15.6)	337 (14.8)

Diuretic	887 (38.6)	886 (38.8)
Spironolactone or eplerenone	261 (11.4)	264 (11.6)
Steroid	191 (8.3)	214 (9.4)
Nonsteroidal anti-inflammatory drug	52 (2.3)	55 (2.4)
At 1-month visit (after randomization)		
Dual antiplatelet therapy	52 (2.3)	2272 (99.5)
Single antiplatelet therapy	2234 (97.3)	9 (0.4)
No antiplatelet therapy	9 (0.4)	3 (0.1)
Acetylsalicylic acid	712 (31.0)	2273 (99.5)
$P2Y_{12}$ inhibitor	1626 (70.8)	2280 (99.8)
Clopidogrel	1275 (55.6)	1806 (79.1)
Prasugrel	28 (1.2)	55 (2.4)
Ticagrelor	323 (14.1)	419 (18.3)
Oral anticoagulant	836 (36.4)	810 (35.5)
Vitamin K antagonist	289 (12.6)	272 (11.9)
Warfarin	91 (4.0)	76 (3.3)
Acenocoumarol	138 (6.0)	134 (5.9)
Phenprocoumon	28 (1.2)	38 (1.7)
Fluindione	32 (1.4)	24 (1.1)
Nonvitamin K antagonist oral anticoagulant	547 (23.8)	538 (23.6)
Dabigatran	112 (4.9)	97 (4.2)
Apixaban	220 (9.6)	203 (8.9)
Rivaroxaban	177 (7.7)	206 (9.0)
Edoxaban	38 (1.7)	32 (1.4)
At 3-month visit		
Dual antiplatelet therapy	n=2262 71 (3.1)	n=2254 1937 (85.9)
Single antiplatelet therapy	n=2262 2180 (96.4)	n=2254 310 (13.8)
No antiplatelet therapy	n=2262 11 (0.5)	n=2254 7 (0.3)
Acetylsalicylic acid	n=2262 716 (31.7)	n=2254 2025 (89.8)
$P2Y_{12}$ inhibitor	n=2262 1606 (71.0)	n=2254 2159 (95.8)
Clopidogrel	n=2262 1274 (56.3)	n=2254 1707 (75.7)
Prasugrel	n=2262 26 (1.1)	n=2254 56 (2.5)
Ticagrelor	n=2262 307 (13.6)	n=2254 396 (17.6)
Oral anticoagulant	n=2262 846 (37.4)	n=2254 807 (35.8)
Vitamin K antagonist	n=2262 286 (12.6)	n=2254 264 (11.7)

Warfarin	91 (4.0)	74 (3.3)
Acenocoumarol	138 (6.1)	133 (5.9)
Phenprocoumon	27 (1.2)	34 (1.5)
Fluindione	30 (1.3)	23 (1.0)
Nonvitamin K antagonist oral anticoagulant	n=2262 560 (24.8)	n=2254 543 (24.1)
Dabigatran	n=2262 111 (4.9)	n=2254 98 (4.3)
Apixaban	n=2262 226 (10.0)	n=2254 210 (9.3)
Rivaroxaban	n=2262 187 (8.3)	n=2254 202 (9.0)
Edoxaban	n=2262 36 (1.6)	n=2254 33 (1.5)
Calcium-channel blocker	n=2261 670 (29.6)	n=2254 661 (29.3)
Proton pump inhibitor	n=2261 1524 (67.4)	n=2254 1602 (71.1)
Beta-blocker	n=2261 1649 (72.9)	n=2254 1611 (71.5)
Angiotensin-converting enzyme inhibitor	n=2261 1041 (46.0)	n=2254 1039 (46.1)
Angiotensin II receptor blocker	n=2261 630 (27.9)	n=2254 638 (28.3)
Histamine H2-receptor blocker	n=2261 40 (1.8)	n=2254 37 (1.6)
Insulin	n=2261 222 (9.8)	n=2254 185 (8.2)
Oral hypoglycemic drug	n=2261 552 (24.4)	n=2254 567 (25.2)
Statin	n=2261 1955 (86.5)	n=2254 1947 (86.4)
Other lipid-lowering drug	n=2261 205 (9.1)	n=2254 197 (8.7)
Proprotein convertase subtilisin-kexin type 9 inhibitor	n=2261 8 (0.4)	n=2254 2 (0.1)
Sacubitril + valsartan	n=2261 25 (1.1)	n=2254 35 (1.6)
Amiodarone	n=2261 138 (6.1)	n=2254 122 (5.4)
Ivabradine	n=2261 19 (0.8)	n=2254 27 (1.2)
Nitrate	n=2261 336 (14.9)	n=2254 315 (14.0)
Diuretic	n=2261 870 (38.5)	n=2254 874 (38.8)
Spironolactone or eplerenone	n=2261 233 (10.3)	n=2254 253 (11.2)
Steroid	n=2261 179 (7.9)	n=2254 215 (9.5)
Nonsteroidal anti-inflammatory drug	n=2261 45 (2.0)	n=2254 44 (2.0)
At 6-month visit		

Dual antiplatelet therapy	n=2230 70 (3.1)	n=2220 1372 (61.8)
Single antiplatelet therapy	n=2230 1973 (88.5)	n=2220 826 (37.2)
No antiplatelet therapy	n=2230 187 (8.4)	n=2220 22 (1.0)
Acetylsalicylic acid	n=2230 678 (30.4)	n=2220 1693 (76.3)
$P2Y_{12}$ inhibitor	n=2230 1435 (64.3)	n=2220 1877 (84.5)
Clopidogrel	n=2230 1117 (50.1)	n=2220 1466 (66.0)
Prasugrel	n=2230 27 (1.2)	n=2220 53 (2.4)
Ticagrelor	n=2230 292 (13.1)	n=2220 358 (16.1)
Oral anticoagulant	n=2230 847 (38.0)	n=2220 793 (35.7)
Vitamin K antagonist	n=2230 278 (12.5)	n=2220 252 (11.4)
Warfarin	91 (4.1)	72 (3.2)
Acenocoumarol	135 (6.1)	128 (5.8)
Phenprocoumon	26 (1.2)	31 (1.4)
Fluindione	26 (1.2)	21 (0.9)
Nonvitamin K antagonist oral anticoagulant	n=2230 569 (25.5)	n=2220 541 (24.4)
Dabigatran	n=2230 113 (5.1)	n=2220 101 (4.5)
Apixaban	n=2230 232 (10.4)	n=2220 212 (9.5)
Rivaroxaban	n=2230 186 (8.3)	n=2220 195 (8.8)
Edoxaban	n=2230 38 (1.7)	n=2220 33 (1.5)
Calcium-channel blocker	n=2229 672 (30.1)	n=2220 670 (30.2)
Proton pump inhibitor	n=2229 1467 (65.8)	n=2220 1548 (69.7)
Beta-blocker	n=2229 1621 (72.7)	n=2220 1566 (70.5)
Angiotensin-converting enzyme inhibitor	n=2229 1009 (45.3)	n=2220 992 (44.7)
Angiotensin II receptor blocker	n=2229 628 (28.2)	n=2220 635 (28.6)
Histamine H2-receptor blocker	n=2229 32 (1.4)	n=2220 43 (1.9)
Insulin	n=2229 213 (9.6)	n=2220 185 (8.3)
Oral hypoglycemic drug	n=2229 552 (24.8)	n=2220 558 (25.1)
Statin	n=2229 1917 (86.0)	n=2220 1913 (86.2)
Other lipid-lowering drug	n=2229	n=2220

	214 (9.6)	210 (9.5)
Proprotein convertase subtilisin-kexin type 9 inhibitor	n=2229 11 (0.5)	n=2220 1 (0.0)
Sacubitril + valsartan	n=2229 31 (1.4)	n=2220 35 (1.6)
Amiodarone	n=2229 135 (6.1)	n=2220 126 (5.7)
Ivabradine	n=2229 19 (0.9)	n=2220 27 (1.2)
Nitrate	n=2229 311 (14.0)	n=2220 297 (13.4)
Diuretic	n=2229 873 (39.2)	n=2220 872 (39.3)
Spironolactone or eplerenone	n=2229 245 (11.0)	n=2220 246 (11.1)
Steroid	n=2229 178 (8.0)	n=2220 197 (8.9)
Nonsteroidal anti-inflammatory drug	n=2229 46 (2.1)	n=2220 46 (2.1)
At 12-month visit		
Dual antiplatelet therapy	n=2185 101 (4.6)	n=2167 770 (35.5)
Single antiplatelet therapy	n=2185 1372 (62.8)	n=2167 1185 (54.7)
No antiplatelet therapy	n=2185 712 (32.6)	n=2167 212 (9.8)
Acetylsalicylic acid	n=2185 712 (32.6)	n=2167 1546 (71.3)
$P2Y_{12}$ inhibitor	n=2185 862 (39.5)	n=2167 1179 (54.4)
Clopidogrel	n=2185 622 (28.5)	n=2167 942 (43.5)
Prasugrel	n=2185 27 (1.2)	n=2167 22 (1.0)
Ticagrelor	n=2185 213 (9.7)	n=2167 215 (9.9)
Oral anticoagulant	n=2185 836 (38.3)	n=2167 790 (36.5)
Vitamin K antagonist	n=2185 264 (12.1)	n=2167 239 (11.0)
Warfarin	88 (4.0)	73 (3.4)
Acenocoumarol	127 (5.8)	117 (5.4)
Phenprocoumon	23 (1.1)	28 (1.3)
Fluindione	26 (1.2)	21 (1.0)
Nonvitamin K antagonist oral anticoagulant	n=2185 572 (26.2)	n=2167 551 (25.4)
Dabigatran	n=2185 108 (4.9)	n=2167 98 (4.5)
Apixaban	n=2185 230 (10.5)	n=2167 218 (10.1)
Rivaroxaban	n=2185 192 (8.8)	n=2167 200 (9.2)

Edoxaban	n=2185 42 (1.9)	n=2167 35 (1.6)
Calcium-channel blocker	n=2184 656 (30.0)	n=2167 652 (30.1)
Proton pump inhibitor	n=2184 1406 (64.4)	n=2166 1460 (67.4)
Beta-blocker	n=2184 1553 (71.1)	n=2167 1508 (69.6)
Angiotensin-converting enzyme inhibitor	n=2183 942 (43.2)	n=2167 954 (44.0)
Angiotensin II receptor blocker	n=2184 631 (28.9)	n=2167 610 (28.1)
Histamine H2-receptor blocker	n=2184 31 (1.4)	n=2167 35 (1.6)
Insulin	n=2184 210 (9.6)	n=2167 175 (8.1)
Oral hypoglycemic drug	n=2184 539 (24.7)	n=2167 553 (25.5)
Statin	n=2184 1869 (85.6)	n=2167 1871 (86.3)
Other lipid-lowering drug	n=2184 248 (11.4)	n=2167 249 (11.5)
Proprotein convertase subtilisin-kexin type 9 inhibitor	n=2184 6 (0.3)	n=2167 5 (0.2)
Sacubitril + valsartan	n=2184 39 (1.8)	n=2167 35 (1.6)
Amiodarone	n=2184 125 (5.7)	n=2167 120 (5.5)
Ivabradine	n=2184 17 (0.8)	n=2167 24 (1.1)
Nitrate	n=2184 327 (15.0)	n=2167 307 (14.2)
Diuretic	n=2184 843 (38.6)	n=2167 853 (39.4)
Spironolactone or eplerenone	n=2184 255 (11.7)	n=2167 253 (11.7)
Steroid	n=2183 169 (7.7)	n=2167 193 (8.9)
Nonsteroidal anti-inflammatory drug	n=2184 43 (2.0)	n=2167 52 (2.4)

* Number (%) in patients in whom medications were assessed. Patients were switched to routine care around the 12-month visit post-qualifying intervention, and switching was allowed within a 14-day window.

Table S9. Additional Information on Type of Antiplatelet Therapy Before and After Randomization.*

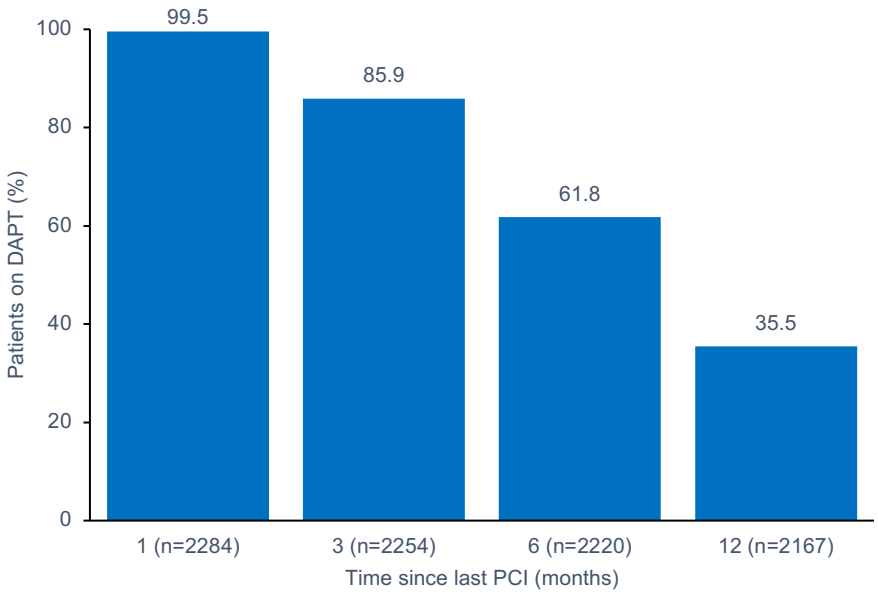
Medication	Abbreviated Treatment Group (N=2295)	Standard Treatment Group (N=2284)
At 1-month visit (before randomization)		
Dual antiplatelet therapy	2281 (99.4)	2272 (99.5)
Clopidogrel	1817 (79.2)	1793 (78.5)
Prasugrel	59 (2.6)	56 (2.5)
Ticagrelor	405 (17.6)	423 (18.5)
Single antiplatelet therapy	14 (0.6)	12 (0.5)
Acetylsalicylic acid	3 (0.1)	1 (0.0)
Clopidogrel	11 (0.5)	11 (0.5)
Prasugrel	0 (0.0)	0 (0.0)
Ticagrelor	0 (0.0)	0 (0.0)
At 1-month visit (after randomization)		
Dual antiplatelet therapy	52 (2.3)	2272 (99.5)
Clopidogrel	39 (1.7)	1798 (78.7)
Prasugrel	1 (0.0)	55 (2.4)
Ticagrelor	12 (0.5)	419 (18.3)
Single antiplatelet therapy	2234 (97.3)	9 (0.4)
Acetylsalicylic acid	660 (28.8)	1 (0.0)
Clopidogrel	1236 (53.9)	8 (0.4)
Prasugrel	27 (1.2)	0 (0.0)
Ticagrelor	311 (13.6)	0 (0.0)
At 3-month visit	n=2262	n=2254
Dual antiplatelet therapy	71 (3.1)	1937 (85.9)
Clopidogrel	56 (2.5)	1487 (66.0)
Prasugrel	1 (0.0)	56 (2.5)
Ticagrelor	14 (0.6)	394 (17.5)
Single antiplatelet therapy	2180 (96.4)	310 (13.8)
Acetylsalicylic acid	645 (28.5)	88 (3.9)
Clopidogrel	1218 (53.8)	220 (9.8)
Prasugrel	25 (1.1)	0 (0.0)
Ticagrelor	293 (13.0)	2 (0.1)
At 6-month visit	n=2230	n=2220
Dual antiplatelet therapy	70 (3.1)	1372 (61.8)
Clopidogrel	58 (2.6)	967 (43.6)
Prasugrel	0 (0.0)	53 (2.4)
Ticagrelor	12 (0.5)	352 (15.9)
Single antiplatelet therapy	1973 (88.5)	826 (37.2)

Medication	Abbreviated Treatment Group (N=2295)	Standard Treatment Group (N=2284)
Acetylsalicylic acid	608 (27.3)	321 (14.5)
Clopidogrel	1059 (47.5)	499 (22.5)
Prasugrel	27 (1.2)	0 (0.0)
Ticagrelor	280 (12.6)	6 (0.3)
At 12-month visit	n=2185	n=2167
Dual antiplatelet therapy	101 (4.6)	770 (35.5)
Clopidogrel	79 (3.6)	538 (24.8)
Prasugrel	1 (0.0)	22 (1.0)
Ticagrelor	21 (1.0)	210 (9.7)
Single antiplatelet therapy	1372 (62.8)	1185 (54.7)
Acetylsalicylic acid	611 (28.0)	776 (35.8)
Clopidogrel	543 (24.9)	404 (18.6)
Prasugrel	26 (1.2)	0 (0.0)
Ticagrelor	192 (8.8)	5 (0.2)

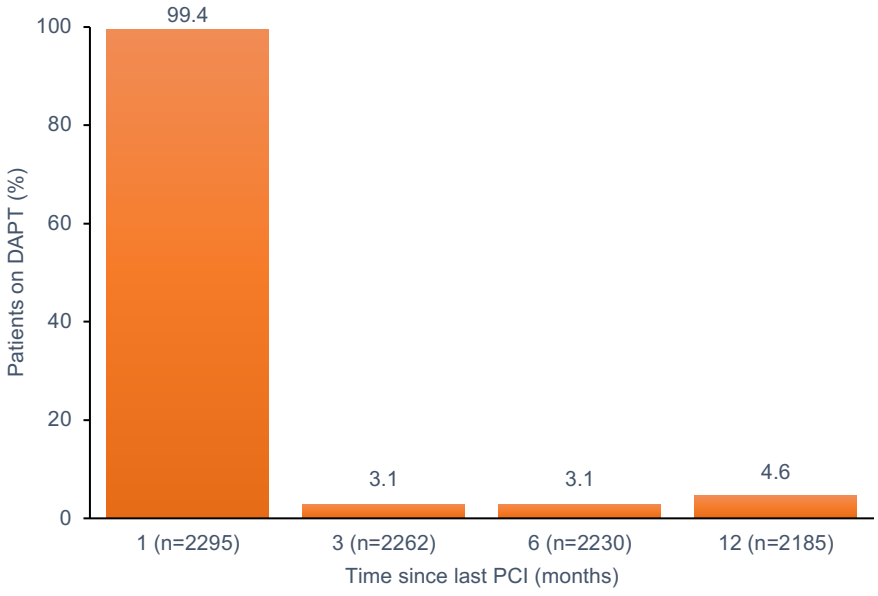
* Number (%) in patients in whom medications were assessed. Patients were switched to routine care around the 12-month visit post-qualifying intervention, and switching was allowed within a 14-day window.

Figure S1. Proportion of Patients on Dual Antiplatelet Therapy Over Time in (A) Standard and (B) Abbreviated Dual Antiplatelet Therapy Groups

A

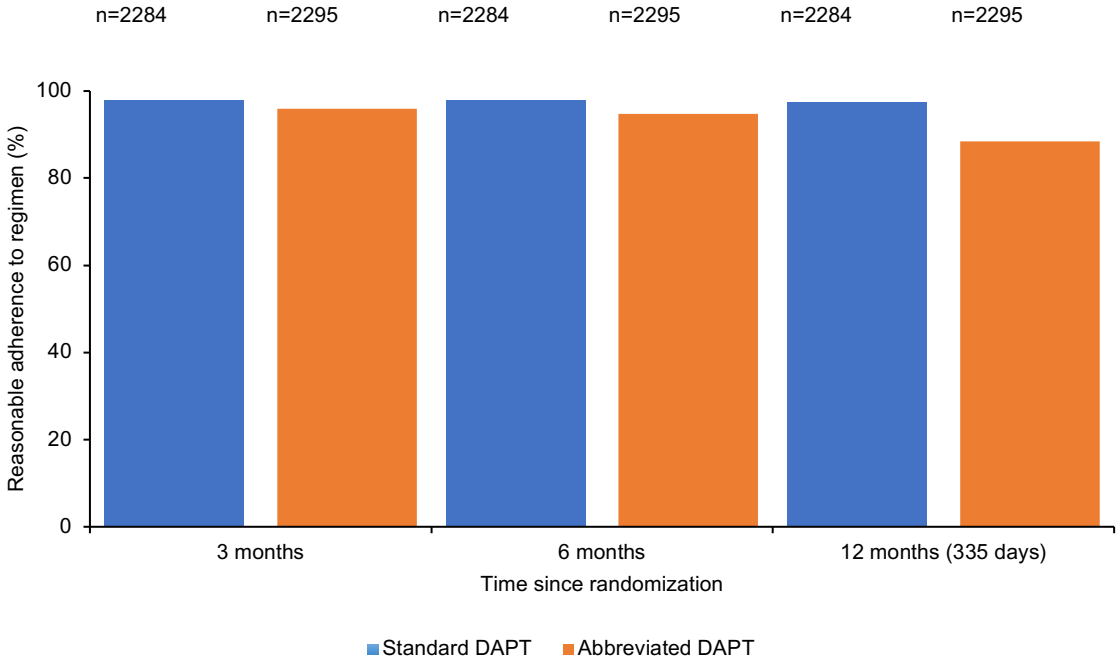


B



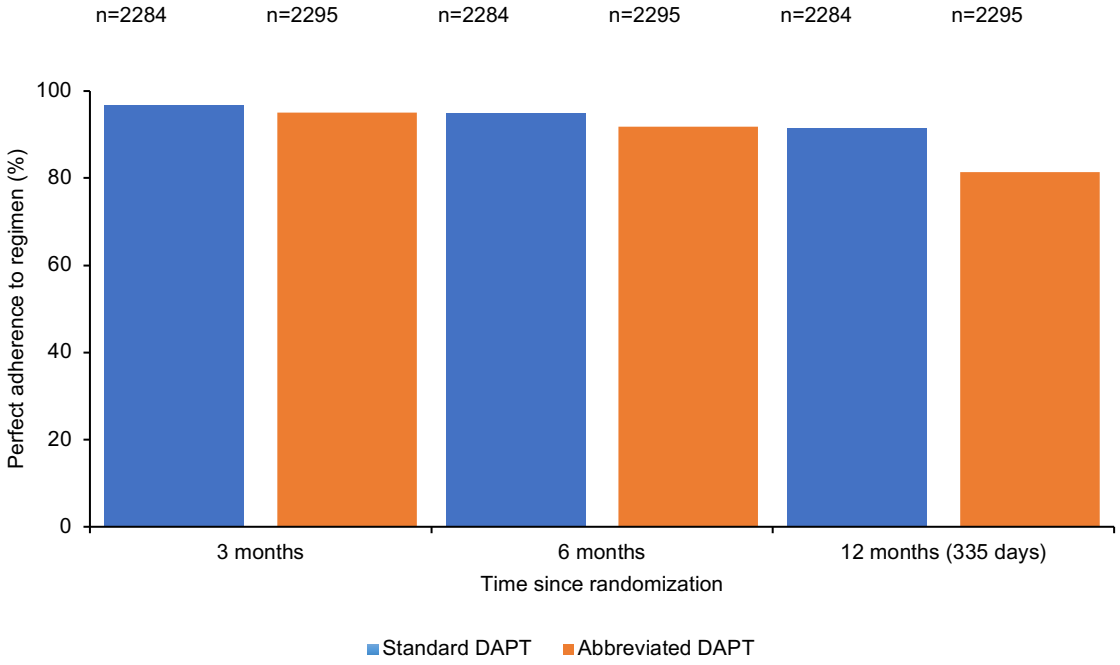
DAPT, dual antiplatelet therapy.

Figure S2. Rates of Reasonable Adherence* to Study Medication(s).



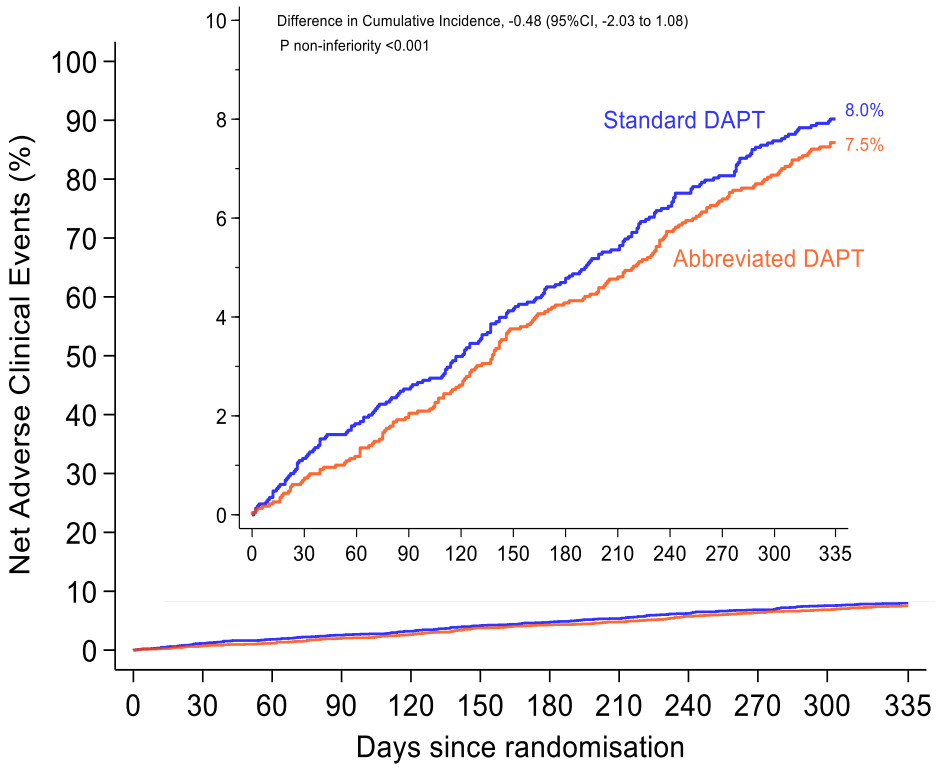
* Adherent ≥80% of the time (day 0 to *t* days since randomization).

Figure S3. Rates of Perfect Adherence to Study Medication(s)



* Adherent 100% or if <100% with a maximum of 2 consecutive days nonadherence (day 0 to *t* days since randomization).

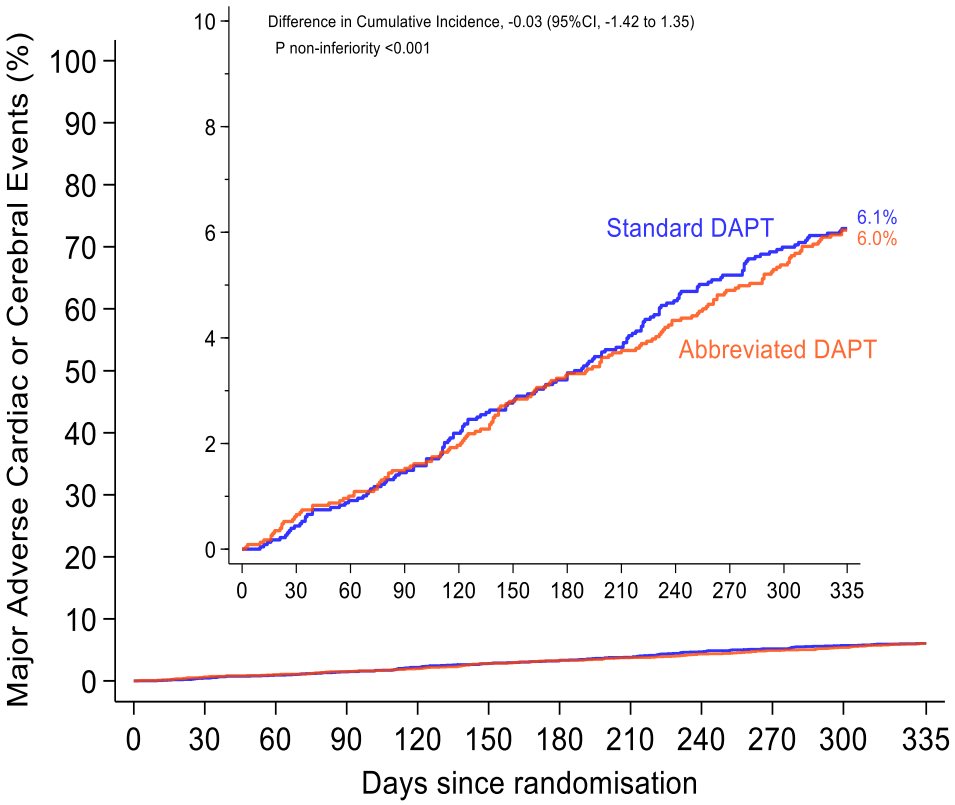
Figure S4. All-Cause Mortality, Myocardial Infarction, Stroke, or Major or Clinically Relevant Nonmajor Bleeding (Net Adverse Clinical Events) at 335 Days in Patients Randomized to Abbreviated versus Standard Dual Antiplatelet Therapy in the Intention-To-Treat Population.



No. at Risk

Standard DAPT	2284	2255	2238	2219	2204	2183	2164	2148	2126	2111	2095	2084
Abbreviated DAPT	2295	2273	2262	2241	2226	2199	2186	2175	2152	2138	2126	2108

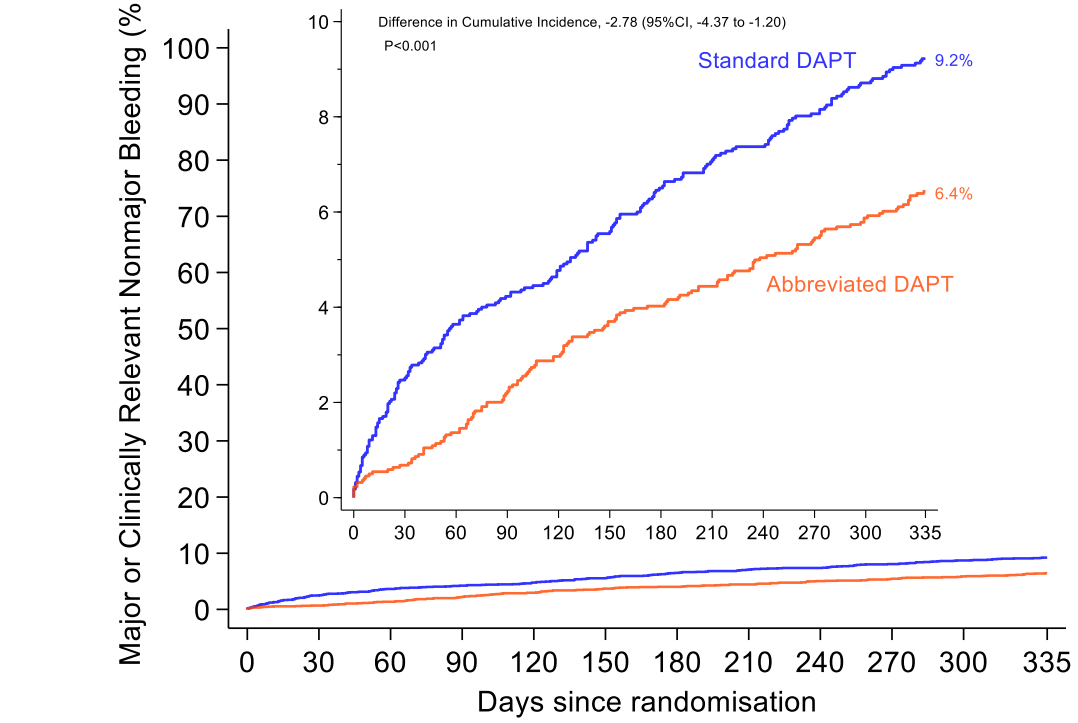
Figure S5. All-Cause Mortality, Myocardial Infarction or Stroke (Major Adverse Cardiac or Cerebral Events) at 335 Days in Patients Randomized to Abbreviated versus Standard Dual Antiplatelet Therapy in the Intention-To-Treat Population.



No. at Risk

Standard DAPT	2284	2271	2259	2244	2227	2214	2198	2183	2161	2149	2137	2128
Abbreviated DAPT	2295	2275	2266	2252	2241	2221	2209	2199	2184	2171	2160	2141

Figure S6. Major or Clinically Relevant Nonmajor Bleeding at 335 Days in Patients Randomized to Abbreviated versus Standard Dual Antiplatelet Therapy in The Per-Protocol Population.

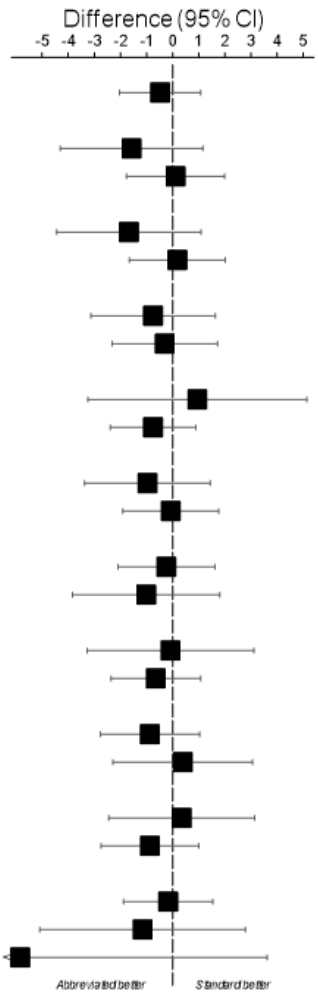


No. at Risk

Standard DAPT	2230	2169	2137	2117	2098	2075	2047	2030	2014	1990	1971	1955
Abbreviated DAPT	2204	2180	2163	2138	2117	2090	2079	2068	2050	2037	2022	2000

Figure S7. Subgroup Analysis for Net Adverse Clinical Events at 335 days.

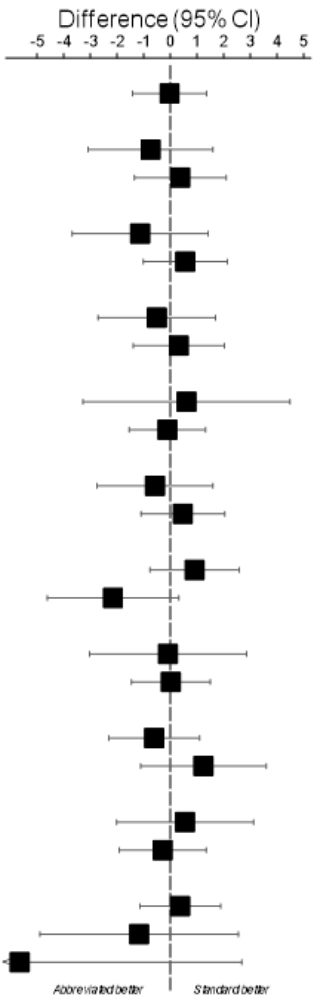
Subgroups	Abbreviated DAPT: Nr of events/Nr of patients N = 2295	Standard DAPT: Nr of events/Nr of patients N = 2284	Difference [Abbreviated/Standard] (95% CI)
All patients	172/2295	182/2284	-0.48 [-2.03 to 1.08]
Clinical indication for 12 months OAC			
Yes	68/848	78/818	-1.57 [-4.31 to 1.16]
No	104/1447	104/1466	0.11 [-1.76 to 1.99]
History of acute MI within 12 months*			
Yes	81/914	91/866	-1.67 [-4.44 to 1.09]
No	91/1381	91/1418	0.18 [-1.65 to 2.01]
Indication for PCI			
ACS	96/1128	100/1083	-0.75 [-3.13 to 1.63]
Stable CAD	76/1167	82/1201	-0.30 [-2.32 to 1.72]
DAPT score†			
High (≥2)	53/438	52/468	0.95 [-3.25 to 5.14]
Low (<2)	119/1857	130/1816	-0.75 [-2.38 to 0.89]
PRECISE DAPT score‡			
≥25	122/1251	130/1213	-0.96 [-3.37 to 1.44]
0-24	50/1044	52/1071	-0.07 [-1.91 to 1.77]
Sex			
Male	120/1590	123/1581	-0.24 [-2.10 to 1.62]
Female	52/705	59/703	-1.01 [-3.84 to 1.81]
Creatinine clearance			
<60 ml/min	79/733	80/734	-0.08 [-3.27 to 3.11]
≥60 ml/min	93/1562	102/1550	-0.64 [-2.35 to 1.07]
Age			
≥75 years	120/1582	133/1572	-0.87 [-2.77 to 1.04]
<75 years	52/713	49/712	0.39 [-2.29 to 3.06]
Diabetes mellitus			
Yes	65/754	65/784	0.35 [-2.45 to 3.14]
No	107/1541	117/1500	-0.87 [-2.73 to 1.00]
Geographical area			
Europe	150/1927	152/1911	-0.17 [-1.88 to 1.54]
Asia	16/286	20/297	-1.15 [-5.08 to 2.78]
Other	6/82	10/76	-5.84 [-15.30 to 3.62]



* Before index percutaneous coronary intervention.
† The DAPT score, whose components are age, diabetes, prior myocardial infarction or percutaneous coronary intervention, myocardial infarction at presentation, implanted stent diameter <3 mm, stent implantation in a vein graft, history of congestive heart failure or left ventricular ejection fraction <30%, smoking habit and paclitaxel-eluting stent implantation, ranges from −2 to 10 and identifies patients with net benefit from prolonged (>1 year) DAPT duration if ≥2.
‡ The PRECISE DAPT score, whose components are age, prior bleeding, hemoglobin, white blood cell count and creatinine clearance, ranges from 0 to 100 and identifies patients at high risk for bleeding if ≥25.
ACS, acute coronary syndrome; CAD, coronary artery disease; CI, confidence interval; DAPT, dual antiplatelet therapy; MI, myocardial infarction; Nr, number; OAC, oral anticoagulant.
The widths of two-sided 95% CIs were not adjusted for multiple comparisons and should not therefore be used for inference about treatment effects. Other in the geographical area includes Australia and Argentina.

Figure S8. Subgroup Analysis for Major Adverse Cardiac and Cerebrovascular Events at 335 days.

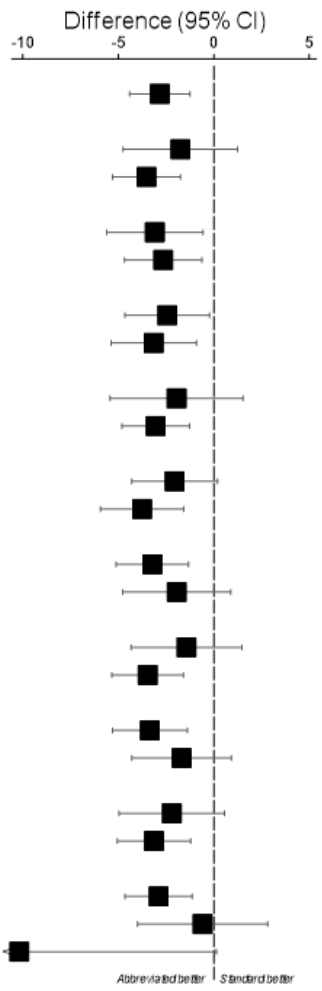
Subgroups	Abbreviated DAPT: Nr of events/Nr of patients N = 2295	Standard DAPT: Nr of events/Nr of patients N = 2284	Difference [Abbreviated/Standard] (95% CI)
All patients	138/2295	138/2284	-0.03 [-1.42 to 1.35]
Clinical indication for 12 months OAC			
Yes	50/848	54/818	-0.74 [-3.09 to 1.60]
No	88/1447	84/1466	0.37 [-1.35 to 2.09]
History of acute MI within 12 months*			
Yes	69/914	75/866	-1.13 [-3.68 to 1.42]
No	69/1381	63/1418	0.56 [-1.02 to 2.14]
Indication for PCI			
ACS	82/1128	84/1083	-0.51 [-2.72 to 1.70]
Stable CAD	56/1167	54/1201	0.31 [-1.39 to 2.02]
DAPT score†			
High (≥2)	44/438	44/468	0.61 [-3.27 to 4.49]
Low (<2)	94/1857	94/1816	-0.11 [-1.54 to 1.32]
PRECISE DAPT score‡			
≥25	99/1251	103/1213	-0.58 [-2.75 to 1.60]
0-24	39/1044	35/1071	0.47 [-1.11 to 2.04]
Sex			
Male	104/1590	89/1581	0.91 [-0.76 to 2.58]
Female	34/705	49/703	-2.15 [-4.62 to 0.32]
Creatinine clearance			
<60 ml/min	66/733	67/734	-0.09 [-3.04 to 2.86]
≥60 ml/min	72/1562	71/1550	0.02 [-1.46 to 1.50]
Age			
≥75 years	95/1582	104/1572	-0.61 [-2.31 to 1.10]
<75 years	43/713	34/712	1.24 [-1.11 to 3.60]
Diabetes mellitus			
Yes	55/754	53/784	0.55 [-2.02 to 3.12]
No	83/1541	85/1500	-0.29 [-1.92 to 1.34]
Geographical area			
Europe	120/1927	112/1911	0.37 [-1.15 to 1.88]
Asia	14/286	18/297	-1.17 [-4.89 to 2.55]
Other	4/82	8/76	-5.65 [-13.98 to 2.68]



* Before index percutaneous coronary intervention.
† The DAPT score, whose components are age, diabetes, prior myocardial infarction or percutaneous coronary intervention, myocardial infarction at presentation, implanted stent diameter <3 mm, stent implantation in a vein graft, history of congestive heart failure or left ventricular ejection fraction <30%, smoking habit and paclitaxel-eluting stent implantation, ranges from −2 to 10 and identifies patients with net benefit from prolonged (>1 year) DAPT duration if ≥2.
‡ The PRECISE DAPT score, whose components are age, prior bleeding, hemoglobin, white blood cell count and creatinine clearance, ranges from 0 to 100 and identifies patients at high risk for bleeding if ≥25.
ACS, acute coronary syndrome; CAD, coronary artery disease; CI, confidence interval; DAPT, dual antiplatelet therapy; MI, myocardial infarction; Nr, number; OAC, oral anticoagulant. Other in the geographical area includes Australia and Argentina.
The widths of two-sided 95% CIs were not adjusted for multiple comparisons and should not therefore be used for inference about treatment effects.

Figure S9. Subgroup Analysis for Major or Nonmajor Clinically Relevant Bleeding at 335 days.

Subgroups	Abbreviated DAPT Nr of events/Nr of patients N = 2295	Standard DAPT Nr of events/Nr of patients N = 2284	Difference [Abbreviated/Standard] (95% CI)
All patients	148/2295	211/2284	-2.82 [-4.40 to -1.24]
Clinical indication for 12 months OAC			
Yes	83/848	94/818	-1.75 [-4.75 to 1.25]
No	65/1447	117/1466	-3.52 [-5.29 to -1.74]
History of acute MI within 12 months*			
Yes	56/914	79/866	-3.08 [-5.60 to -0.57]
No	92/1381	132/1418	-2.64 [-4.67 to -0.62]
Indication for PCI			
ACS	69/1128	92/1083	-2.44 [-4.65 to -0.23]
Stable CAD	79/1167	119/1201	-3.14 [-5.38 to -0.90]
DAPT score†			
High (≥2)	28/438	39/468	-1.95 [-5.42 to 1.53]
Low (<2)	120/1857	172/1816	-3.04 [-4.81 to -1.27]
PRECISE DAPT score‡			
≥25	95/1251	117/1213	-2.05 [-4.30 to 0.20]
0-24	53/1044	94/1071	-3.76 [-5.93 to -1.58]
Sex			
Male	100/1590	150/1581	-3.21 [-5.11 to -1.31]
Female	48/705	61/703	-1.94 [-4.77 to 0.89]
Creatinine clearance			
<60 ml/min	57/733	68/734	-1.43 [-4.33 to 1.47]
≥60 ml/min	91/1562	143/1550	-3.46 [-5.33 to -1.59]
Age			
≥75 years	107/1582	158/1572	-3.34 [-5.30 to -1.38]
<75 years	41/713	53/712	-1.68 [-4.29 to 0.93]
Diabetes mellitus			
Yes	53/754	72/784	-2.19 [-4.96 to 0.57]
No	95/1541	139/1500	-3.13 [-5.04 to -1.21]
Geographical area			
Europe	130/1927	184/1911	-2.89 [-4.65 to -1.14]
Asia	12/286	14/297	-0.59 [-3.99 to 2.82]
Other	6/82	13/76	-10.18 [-20.50 to 0.14]



* Before index percutaneous coronary intervention.

† The DAPT score, whose components are age, diabetes, prior myocardial infarction or percutaneous coronary intervention, myocardial infarction at presentation, implanted stent diameter <3 mm, stent implantation in a vein graft, history of congestive heart failure or left ventricular ejection fraction <30%, smoking habit and paclitaxel-eluting stent implantation, ranges from −2 to 10 and identifies patients with net benefit from prolonged (>1 year) DAPT duration if ≥2.

‡ The PRECISE DAPT score, whose components are age, prior bleeding, hemoglobin, white blood cell count and creatinine clearance, ranges from 0 to 100 and identifies patients at high risk for bleeding if ≥25.

ACS, acute coronary syndrome; CAD, coronary artery disease; CI, confidence interval; DAPT, dual antiplatelet therapy; MI, myocardial infarction; Nr, number; OAC, oral anticoagulant. Other in the geographical area includes Australia and Argentina.

The widths of two-sided 95% CIs were not adjusted for multiple comparisons and should not therefore be used for inference about treatment effects.

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