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Efficacy and Safety of Clopidogrel, Prasugrel and Ticagrelor in ACS Patients Treated with PCI: A Propensity Score Analysis of the RENAMI and BleeMACS Registries

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1 **“Real world data of Prasugrel vs Ticagrelor in acute myocardial infarction: results**
2 **from the RENAMI registry”**

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31 **Key words:** Acute coronary syndromes, PCI; double antiplatelet therapy

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1 **ABSTRACT.**

2 Limited data are available concerning differences in clinical outcomes of real-life patients
3 treated with Ticagrelor and Prasugrel after PCI.

4 **Objective:** To determine and compare efficacy and safety of Ticagrelor and Prasugrel in a
5 real-world population.

6 **Design:** RENAMI is a retrospective, observational registry. Data and outcomes of patients
7 with acute coronary syndrome who underwent PCI and discharged with DAPT between
8 January 2012 and January 2016 were included. The mean follow-up period was of 17 ± 9
9 months.

10 **Setting:** 11 university hospitals from 6 European countries participated.

11 **Participants:** Consecutive patients with ACS discharged with DAPT after primary PCI
12 were enrolled. After propensity-score matching there were no substantial differences in the
13 baseline clinical and interventional features.

14 **Exposures:** All patients were treated with acetylsalicylic acid plus prasugrel (10 mg o.d.)
15 or plus ticagrelor (90 mg b.d.). Mean duration of DAPT was 12.04 ± 3.4 for patients treated
16 with prasugrel and 11.90 ± 4.1 months for ticagrelor (p 0.47).

17 **Main outcomes and measures:** Long-term NACE was the primary end-point, while
18 MACEs the secondary ones, along with their single components. Subgroup analysis for
19 freedom from NACE and MACE were performed according to length of DAPT and to
20 clinical presentation (STEMI-ACS) vs (NSTEMI-ACS).

21 **Results:** 4244 patients (1699 in ticagrelor and 2275 in prasugrel group) were enrolled.
22 After propensity-score matching 1290 patients of each cohort were included in the
23 analysis. At 12 months, the incidence of NACE was lower in prasugrel patients (5.3% vs.
24 8.5%, p 0.0001), as that of MACE (6.05% vs. 8.1%, p 0.001), mainly driven by a reduction

1 in recurrent MI (2.4% vs. 4.0%, p 0.029) and a lower rate of BARC 3-5 bleeding (1.5% vs.
2 2.9%, p 0.011). The benefit of prasugrel was confirmed for NSTEMI patients and for those
3 discharged with a DAPT regimen of 12 months or less. Only a trend in reduction for of
4 NACE and MACE was noted for STEMI or for those treated with longer DAPT.

5 **Conclusions and relevance:** The comparison between the drugs suggests better efficacy
6 and safety of prasugrel versus ticagrelor used in combination with aspirin after NSTEMI,
7 while not in STEMI patients. No differences were found for events occurring after 12
8 months. **Due to the non-randomized design of the present research, further studies**
9 **are warranted to support these findings.**

10

11 **KEY MESSAGES**

- 12 - **Dual antiplatelet therapy is a cornerstone of the treatment of acute coronary**
13 **syndromes but evidences comparing ticagrelor vs prasugrel in the real life**
14 **setting are missing**
- 15 - **According to the results of this observational study, prasugrel is safer and**
16 **more effective than ticagrelor in NSTEMI patients with a reduction of re-**
17 **infarction and major bleeding after a follow up of 12 months.**
- 18 - **In STEMI patients and in the subgroup of patients treated with a long DAPT**
19 **regimen (>12 months) benefit of prasugrel as compared to ticagrelor was not**
20 **significant.**

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1. Introduction

Acute Coronary Syndromes (ACS) represent the most common clinical presentation for patients with CAD (Coronary Artery Disease) leading to a high risk of mortality and morbidity (1-4).

From an interventional point of view, PCI (Percutaneous Coronary Intervention) improved the prognosis of these patients, thanks to technological improvement also in high risk anatomic settings (5-7). Regarding Dual AntiPlatelet Therapy (DAPT), the most debated questions are related to its length (8-11) and to the choice of the new antiplatelet agents (prasugrel and ticagrelor) which in randomized controlled trials (RCTs) offered a reduction of recurrent ischemic events despite a higher risk of bleeding (12,13).

Both ticagrelor and prasugrel were found to be superior to clopidogrel for the treatment of ACS after PCI, showing some differences in their effect that may be related to the study design, but potentially also to the different drug formulation (14). Actually, from a pharmacodynamic point of view, level of antiaggregation did not differ in most of the reported studies (15). From a clinical point of view, randomized controlled trial on this topic did not show any difference, although underpowered especially due to low rate of events in a selected population (16). In most of the observational reports, prasugrel and ticagrelor have been compared to clopidogrel, showing a better efficacy and safety profile, while direct comparisons are limited by 30 days follow up or mostly focused on economic point of views (17,18). Another RCT designed to directly compare the two drugs in terms of clinical outcome is ongoing, but partial results have not been anticipated (19).

1 Consequently we performed the RENAMI, (REgistry of New Antiplatelets in patients
2 with Myocardial Infarction) to allow a real life comparison between these such diffused
3 new antiplatelet medicaments.

4

5 **2. Methods**

6 **2.1 Study population.**

7 RENAMI (REgistry of New Antiplatelet therapy in patients with acute Myocardial Infarction)
8 is a retrospective, observational, multicenter, and international registry, in which 11 centers
9 from 6 European countries (Spain, Italy, Switzerland, Greece, Serbia, United Kingdom)
10 have voluntarily participated. RENAMI is an unfunded registry whose aim was to expand
11 the knowledge about the long-term ischemic and hemorrhagic outcomes of patients
12 discharged with DAPT with prasugrel or ticagrelor. All participating centers were university
13 hospitals that had 24-hour catheterization laboratory, with internal clinical databases for
14 ACS patients. Patients with ACS who underwent PCI and were discharged with DAPT with
15 acetylsalicylic acid plus prasugrel (10 mg o.d.) or plus ticagrelor (90 mg b.d.) between
16 January 2012 and January 2016 were consecutively included in the registry by the
17 different participating centers.

18 ACS were classified as acute myocardial infarction (AMI) with persistent ST-segment
19 elevation (STEMI), AMI without persistent ST segment elevation (NSTEMI) and unstable
20 angina, based on the definitions from clinical practice guidelines (20-21). The diagnoses of
21 AMI were based on the universal definition of AMI (22). The diagnosis of unstable angina
22 was established in the presence of suggestive symptoms or objective evidence of
23 myocardial ischemia in the stress test, together with the detection of a significant stenosis

1 in the coronary angiography ($\geq 70\%$, except for left main coronary artery, where the cut-off
2 is $\geq 50\%$).

3 Given the retrospective nature of the RENAMI registry, the diagnostic and therapeutic
4 procedures were performed according to the protocols and preferences of each center and
5 each physician.

6 For the purpose of RENAMI, a database was specifically designed and sent to each of the
7 11 participating centers. This database included information about clinical, analytical,
8 echocardiographic, and angiographic variables, as well as follow-up data in terms of
9 mortality, ischemic events and hemorrhagic events. The completed databases from each
10 center were sent in an encrypted way to the coordination centers, University Hospital from
11 Turin and University Hospital Álvaro Cunqueiro from Vigo, where they were merged into a
12 single registry. The analysis of this registry for this study was carried out by 3 investigators
13 from University Hospital from Turin. All of these steps were performed in accordance with
14 the rules of Helsinki Declaration. The registry was approved by the local ethics committees
15 of each center.

16 **2.2 End points.**

17 Long term NACE (Net Adverse Clinical Events, a composite end point of all cause
18 death, mi and barc 3-5 bleedings) was the primary end point, while MACE (Major Adverse
19 Clinical Events, a composite end point of all cause death, MI and ST) the secondary ones,
20 along with their single components, and all cause bleeding. Subgroup analysis for freedom
21 from NACE and MACE were performed according to length of DAPT and to clinical
22 presentation (STEMI-ACS) vs. (NSTEMI-ACS). All events were right censored at 12

1 months, while a sub group analysis was performed for events occurring after 12 months
2 only for patients with prolonged DAPT.

3 **2.3 Statistical analysis.**

4 Continuous variables are presented as means \pm standard deviation or median with the
5 interquartile range (IQR) and categorical variable are presented as frequency (%).
6 Categorical variables were compared with the Fisher's exact test. Parametric distribution
7 of continuous variables was tested graphically and with Kolmogorov Smirnov, and the
8 appropriate analyses were used in accordance with the results. For propensity score, first
9 logistic regression analysis was done for all baseline features that differed between aspirin
10 and DAT and matching was computed after division into quintiles and methods of nearest
11 neighbor on the estimated propensity score (23). Calibration was tested with Hosmer-
12 Lermeshow, and accuracy was assessed with Area Under the Curve. Standardized
13 differences were evaluated before and after matching to evaluate performance of the
14 model. The cumulative incidences of NACE and MACE were calculated using the Kaplan-
15 Meier method using length of DAPT as median follow up analysis and differences among
16 groups were analyzed using a stratified log-rank test. **Cox multivariate analysis on data**
17 **before propensity score were performed with NACE and MACE as dependent**
18 **variables.** All statistical analyses were performed with SPSS 21 and differences were
19 considered significant at $\alpha=0.05$.

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3. Results

3.1 Baseline features and outcomes before propensity score with matching

A total of 1699 patients were enrolled in the Prasugrel group and 2725 in the Ticagrelor group (see **Figure number 1**). The two populations significantly differed for the prevalence of some cardiovascular risk factors since patients in the Ticagrelor group were more frequently smokers (31% vs 19.3%, $p<0.001$), more often had arterial hypertension (56.4% vs 50.3%, $p<0.001$), diabetes (31.6% vs 27.2%, $p=0.002$) and dyslipidaemia (55.3% vs 51.4%, $p=0.012$) compared with Prasugrel group. Moreover a higher number of female (24.1% vs 15.7%, $p<0.0001$), patients older than 75 years old (17.8% vs 5.7%, $p<0.0001$) and with an impaired LVEF (10.9% vs 7.8%, $p=0.007$) could be notice in the Ticagrelor group. Clinical presentation was slightly different with a lower prevalence of STEMI (72.9% vs 48.8%, $p<0.0001$) in patients committed to Ticagrelor, although this group had more frequently a multivessel disease (47.1% vs 41.7, $p=0.002$) and a known history of CAD (25.4% vs 17.4%, $p<0.0001$, see **Appendix, web only, Tables S1 and S2**). A complete revascularization was achieved in 82.9% of patients in the ticagrelor group, whereas in the prasugrel group in the 76.8% of the cases ($p<0.0001$). DES were significantly more used in the ticagrelor group (68.9% vs 60.6%, $p<0.0001$) compared with the prasugrel group. However, patients enrolled in the latest, received more frequently a pre-treatment with GP IIB-IIIa inhibitors (28.6% vs 16.2%, $p>0.0001$) and thrombus aspiration (38.1% vs 20.3% $p<0.0001$). At discharge, length of DAPT was slightly longer in prasugrel (12.89 ± 3.6 for patients treated with prasugrel and 11.33 ± 3.5 , $p<0.001$).

1 A comparison between standardized difference for baseline and interventional features of
2 patients before and after propensity score with matching is provided in table S1a and S2a
3 respectively (see appendix, web only).

4 A lower incidence of in-hospital adverse events was recorded among patients enrolled in
5 Prasugrel group. In particular rates of IH-Re-AMI (0.8% vs 1.7%, $p=0.012$), IH-Stroke (0%
6 vs 0.6%, $p=0.002$) and IH bleeding (2.3% vs 3.7%, $p=0.008$) were significantly inferior,
7 although this had no impact on MACEs (4.8% vs 4.4%, $p=0.47$) or all-cause death (2.6%
8 vs 2.1%, $p=0.32$, **see Appendix, web only Table S3**). Indeed, after a mean follow up of
9 17 ± 9 months, no difference of statistical meaning was observed in the frequency of the
10 main outcomes investigated between the two enrolled populations.

11 **3.2** *Baseline features and outcomes after propensity score with matching*

12 After propensity score with matching 1290 patients of each cohort were included in
13 the analysis (**see Figure n 1**). There were no substantial differences in the baseline
14 clinical and interventional features, most of patients being men, with a relevant burden of
15 CV risk factors and presenting most frequently with STEMI (**see Tables 1 and 2**). Length
16 of DAPT was 12.04 ± 3.4 for patients treated with prasugrel and 11.90 ± 4.1 months for
17 ticagrelor ($p=0.47$). After propensity score with matching (**see Table 3a**) at 12 months,
18 incidence of NACE was lower in prasugrel patients (5.3% vs. 8.5%, $p=0.0001$), as that of
19 MACE (6.05% vs. 8.1%, $p=0.001$), mainly driven by recurrent MI (2.4% vs. 4.0%, $p=0.029$)
20 and BARC 3-5 bleedings (1.5% vs. 2.9%, $p=0.011$, **see figure n 2**). No differences were found
21 for events occurring after 12 months for patients with prolonged DAPT (**see Table 3b and**
22 **Figure 3**). Kaplan-Meier analysis was performed for NACE and MACE (**see figure 4**),
23 confirming the overall trend in favor of prasugrel.

1 Benefit of prasugrel for NACE and MACE was confirmed for patients treated with a
2 DAPT of 12 months or less (median 12, 11-13 I and III IQR), while only a trend was noted
3 for those treated with longer DAPT (median 16, 13-18 I and III IQR) **(see figure 5)**.
4 Regarding clinical presentation, STEMI patients did not show significant difference at
5 survival analysis, while those presenting with NSTEMI derived more benefit from prasugrel
6 **(see figure 6). The same results were confirmed at multivariate analysis for NACE**
7 **and MACE as dependent variable (see appendix, web only tables 1 and 2).**

8 **4. Discussion.**

9 The present observational study provides a real-world head-to-head comparison of
10 the efficacy and safety of ticagrelor versus prasugrel in a contemporary European cohort
11 of patients with ACS undergoing PCI. After propensity score matching, we have found that
12 DAPT with prasugrel was associated with significantly less incidence of ischemic and
13 bleeding events, during a follow-up period of 17 ± 9 months. Interestingly, this reported
14 benefit was concentrated in NSTEMI patients, without differences in ischemic or bleeding
15 outcomes in STEMI patients.

16 **Although the present study was not a randomized trial, the importance of its**
17 **results lies in the limited scientific evidence currently available that directly**
18 **compares DAPT with ticagrelor and prasugrel.** Physicians are increasingly being
19 confronted with the need to select a P2Y12 antagonist as part of the daily care of ACS
20 patients. ESC guidelines recommended DAPT with ticagrelor or prasugrel instead of DAPT
21 with clopidogrel, in absence of contraindications (9). DAPT with clopidogrel has been
22 relegated to those ACS patients who cannot receive ticagrelor or prasugrel, including
23 those with prior intracranial bleeding or indication for OAC. In their pivotal clinical trials
24 (PLATO and TRITON-TIMI 38), both ticagrelor and prasugrel have been shown to reduce

1 ischemic events against clopidogrel, with consequent increased hemorrhagic risk (12,13)
2 These data, together with the recommendations of clinical practice guidelines (9,22), could
3 suggest that ticagrelor and prasugrel could be interchangeable. Even with the more
4 marked bleeding risk reported with prasugrel in TRITON-TIMI 38, specially in high risk
5 patients (prior stroke, <60 kg,> 75 years) (12), the routine clinical practice could tend to
6 favor the use of ticagrelor. However, very few studies have directly compared the efficacy
7 and safety of ticagrelor versus prasugrel in patients with ACS (16, 18, 25-27). Our study
8 provides more evidence in this issue, and our results must be faced with data from the few
9 studies published to date about this topic.

10 There is only one randomized clinical trial that compared prasugrel and ticagrelor in ACS
11 patients, which is the PRAGUE-18 trial, that has not found significant differences in
12 adverse outcomes between DAPT with ticagrelor and DAPT with prasugrel (16). This is a
13 randomized, multicenter study designed to compare the efficacy and safety of prasugrel
14 and ticagrelor in patients with AMI treated with primary or immediate PCI. The PRAGUE-
15 18 trial included 1,230 STEMI and very-high risk NSTEMI patients (634 with prasugrel, 596
16 with ticagrelor). At 30 days, there was no difference in all-cause mortality, non-fatal AMI,
17 stroke and stent thrombosis. There were also no differences in bleeding rates based on
18 the TIMI definition or on the BARC definition. **Despite the potential limitations regarding**
19 **the non-randomized design of the present analysis,** our results are **somewhat** in line
20 with those of the PRAGUE-18 clinical trial, since we have not found differences in adverse
21 events for patients with STEMI, and in PRAGUE-18 trial, most of patients (90%) had
22 STEMI. The benefit of DAPT with prasugrel versus DAPT with ticagrelor that we found was
23 focused on patients with NSTEMI, who were only 5% in the PRAGUE-18 trial and were not
24 specifically analyzed for low-size samples ($n < 100$). A possible explanation of this finding

1 could also lie in the different physiopathology of the two different ACS syndromes. STEMI,
2 from an epidemiological point of view, is in fact more often a monovessel disease whereas
3 NSTEMI patients frequently report a multivessel pathology (28). This could have resulted
4 in a low number of vessels treated and stent implanted in STEMI patients, probably not
5 enough to bring out differences of statistical meaning.

6 In addition to the PRAGUE-18 trial data, there is also a retrospective observational study
7 that performed a "real-world" comparison of prasugrel and ticagrelor in ACS patients. This
8 is the study of Larmore et al. (18), that has shown net benefit at 3 months of DAPT with
9 prasugrel versus DAPT with ticagrelor. It is an observational study, using a payer database
10 from United States, with 16,098 ACS patients (<40% STEMI) undergone PCI (13,134 with
11 prasugrel, 2,964 with ticagrelor). After propensity score matching, 90-days net adverse
12 clinical events (NACE) was 22% lower in prasugrel-treated than in ticagrelor-treated
13 patients (RR 0.78; 95% CI, 0.64–0.94), with less mortality, myocardial infarction and
14 severe bleeding (defined as ≥ 3 or 4 transfusions, intracranial bleeding or bleeding leading
15 to death within 72 hours). Therefore, in a population in which NSTEMI predominates, the
16 results of a lower rate of NACE with DAPT with prasugrel versus DAPT with ticagrelor are
17 consistent with those of our study. Moreover, using another US-database (ProMetis-Lx)
18 with approximately 60% of NSTEMI, Simeone JC et al. (25) have found a higher 1-year
19 healthcare resource utilization (HRU) with ticagrelor than with prasugrel, primarily driven
20 by cardiovascular causes (all over congestive heart failure), although with no significant
21 difference in bleeding HRU.

22 Considering the presented studies and our data, it seems reasonable to hypothesize that
23 DAPT with prasugrel may be superior in terms of safety and efficacy to DAPT with
24 ticagrelor in patients with NSTEMI, with no differences between the two drugs in patients

1 with STEMI. It is difficult to give an explanation to these unexpected findings, although
2 consistent with current scientific evidence. With the current approved maintenance dosing
3 for both drugs, adequate levels of platelet inhibition are achieved in over 90% of patients
4 (29-31). However, the finding of significantly lower rates of ischemic events associated
5 with prasugrel in NSTEMI patients, common with the results of Larmore et al. (18), is also
6 directionally in line with two meta-analyses (26-27). In them, using PLATO and TRITON-
7 TIMI 38 data, making indirect comparisons between ticagrelor and prasugrel, it was shown
8 a greater ischemic protection with DAPT with prasugrel versus DAPT with ticagrelor,
9 especially in the reduction of stent thrombosis, with no difference in non-CABG bleeding
10 rates (26-27). The more extended explanation is based on the ticagrelor-induced non-
11 platelet side effects, in particular the onset of dyspnea, and of a twice-daily dosing regimen
12 on medication adherence and discontinuation, factors that may confer an increased risk for
13 subsequent cardiac events, especially given the more rapid offset of the antiplatelet effect
14 of ticagrelor (14). However, the finding of lower bleeding rates in NSTEMI patients treated
15 with Prasugrel results more difficult to explain. Larmore at al. (18), who in their study found
16 the same data, suggested that the different dosages of ASA used in the different countries,
17 not recorded in their database, could have contributed to the final outcome. Higher doses
18 could have obviously conferred an higher bleeding risk on one hand, but, on the other,
19 PLATO study demonstrated reduced efficacy of ticagrelor with high-dose aspirin thus
20 increasing the thrombotic risk as well. Finally it can not be excluded that differences in
21 prescribability of the two drugs could have influenced the results obtained, since both
22 Prasugrel and Ticagrelor are contraindicated in patients with active bleeding, but the
23 former is to be avoided in patients with previous TIA or stroke, thus probably contributing
24 to select a population with a lower hemorrhagic and thrombotic risk.

4.1 Limitations

While an important strength of this study is the use of a multicentric database that capture patients from 6 European countries, several limitations need to be considered when interpreting the data. First, those that are inherent to retrospective studies. Second, **this is not a RCT**; although propensity-score matching was used to adjust baseline differences, residual confounding may remain due to the potential imbalance of unknown and unmeasured known confounders (e.g., socioeconomic status, access to care, provider characteristics, therapy adherence...) between treatments groups, **consequently results have to be interpreted with caution. Despite all the patients enrolled were managed according the most recent available ESC guidelines for clinical practice, we acknowledge the lack of a specific analysis aimed to investigate differences in diagnostic and therapeutic approaches among participating centers. Finally, missing about baseline and procedural features were less than 5%, while less than 10% for outcomes, supporting our results.** In the context of these limitations, our finding should be considered as hypothesis-generating, and should encourage to conduct further head-to-head randomized trials.

5. Conclusions

Results of the present retrospective, observational, propensity-adjusted study suggest a better efficacy and safety profile of prasugrel as compared to ticagrelor in real-life ACS patients treated with primary PCI and DAPT. At subgroup analysis according the clinical presentation and DAPT duration, the benefit of prasugrel was confirmed in NSTEMI patients and in those treated with a 12 months or shorter DAPT, but not in STEMI patients or in those treated with long DAPT regimen. Further RCT are warranted to support these results.

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13 **this manuscript.**

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20 **Figures caption and legends**

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22 Figure 1 caption: design of the study.

23 Figure 2 caption: 12 months outcomes after propensity score with matching.

24 Legend: BARC = Bleeding Academic Research Consortium; MACE = Major adverse
25 cardiovascular events; MI= Myocardial infarction; NACE = net adverse clinical events; ST=
26 stent thrombosis

27 Figure 3 caption: Outcomes after 12 months (median 19:13-22) for patients with DAPT
28 longer than 12 months after propensity score with matching.

1 Legend: BARC = Bleeding Academic Research Consortium; MACE = Major adverse
2 cardiovascular events; MI= Myocardial infarction; NACE = net adverse clinical events;;
3 ST= stent thrombosis

4 Figure 4 caption: Kaplan Meier for survival from NACE (above) and MACE (below)

5 Figure 5 caption: Kaplan Meier for survival from NACE (right) and MACE (left) for patients
6 with with DAPT of 12 months (above) and longer (below).

7 Figure 6 caption: Kaplan Meier for survival from NACE (right) and MACE (left) for STEMI
8 (above) and NSTEMI-ACS (below).

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