

Expert Opinion Review on the Shift from Dual Antiplatelet Therapy to Single Antiplatelet Therapy in Indian Clinical Practice



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ABSTRACT

Background: The management of antiplatelet therapy post-percutaneous coronary intervention (PCI) has evolved, balancing ischemic protection with bleeding risk mitigation. Dual Antiplatelet Therapy (DAPT) remains the standard, but emerging evidence supports early de-escalation to Single Antiplatelet Therapy (SAPT), particularly in high bleeding risk (HBR) patients. However, real-world adoption varies, and data on prescribing trends in India are limited.

Aim: The objective of this expert opinion was to understand prevailing clinical practices among Indian cardiologists related to DAPT duration, SAPT transition, and maintenance therapy in post-PCI management of ACS and CCS patients.

Materials and methods: A structured questionnaire was developed by an expert panel and disseminated among 162 cardiologists across multiple centers in India. The questionnaire covered key topics such as bleeding risk stratification, the shift from DAPT to SAPT, and preference for clopidogrel versus aspirin in real-world practice. Data were collected and analyzed using descriptive statistics, with responses compared against contemporary guidelines such as the 2023 ESC Guidelines for ACS and the ACC/AHA updates on DAPT duration, as well as key clinical trials including STOPDAPT-2, SMART-CHOICE, HOST-EXAM, HOST-EXAM Extended, OPT-BIRISK trial, and POPular AGE trial.

Results: Among respondents, 71.4% routinely screen for HBR patients, primarily using clinical parameters (66.7%), with 51.2% preferring a 3-month DAPT duration in HBR patients, favoring Clopidogrel plus Statin Fixed-Dose Combination (44.2%) for SAPT. In elderly ACS patients, 60.5% adopted an abbreviated DAPT strategy, with clopidogrel monotherapy (48.7%) as the preferred regimen. Clopidogrel was also favored over aspirin for long-term maintenance (90%), aligning with the HOST-EXAM trial.

Conclusion: Expert opinions largely align with contemporary guidelines, emphasizing individualized risk stratification and early DAPT de-escalation in patients with high HBR and low ischemic risk. Clopidogrel-based monotherapy or fixed-dose combinations are preferred, reflecting real-world adaptations to optimize long-term cardiovascular protection post-PCI.

Keywords: Acute coronary syndrome, Antiplatelet de-escalation, Chronic coronary syndrome, Clopidogrel monotherapy, Dual antiplatelet therapy, High bleeding risk, Percutaneous coronary intervention, Postpercutaneous coronary intervention management, Real-world clinical practice in India, Single antiplatelet therapy.

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INTRODUCTION

The management of acute coronary syndrome (ACS) and chronic coronary syndrome (CCS) has undergone significant advancements, with dual antiplatelet therapy (DAPT) remaining the cornerstone of secondary prevention following percutaneous coronary intervention (PCI). The transition of antiplatelet therapy has been from prolonged DAPT with aspirin and clopidogrel toward more personalized therapy regimens. Most ACS cases use commonly preferred ticagrelor and prasugrel, due to their superior efficacy compared with clopidogrel. Current ECS guidelines (2025) now focus on customizing DAPT duration based on individual factors,

such as high bleeding risk, which may require early transition to monotherapy (often ticagrelor) after just 1 month, while those at higher ischemic risk may benefit from extended DAPT. The integration of genetic and platelet function testing supports precise adjustment of therapy. The overall approach prioritizes maximizing protection from ischemia while minimizing bleeding risk, with a strong focus on individualized care. DAPT, typically consisting of aspirin and a P2Y₁₂ inhibitor (clopidogrel, ticagrelor, or prasugrel), effectively reduces the risk of stent thrombosis, recurrent myocardial infarction, and stroke.^{1,2} As per the existing literature, such as high bleeding risk (HBR) patients, the elderly, and those with comorbidities such as chronic

kidney disease (CKD) or prior bleeding events have increased risk with continued prolonged DAPT.^{3,4} Major trials such as ticagrelor with Aspirin or Alone in High-risk Patients after Coronary Intervention (TWILIGHT), Short and Optimal Duration of Dual Antiplatelet Therapy After Everolimus-eluting Cobalt-chromium Stent-2 (STOPDAPT-2), and Smart Management of Antiplatelet Regimen by Tailoring CHOICE of therapy (SMART-CHOICE) suggest that shortened DAPT (3–6 months) followed by single antiplatelet therapy (SAPT) can provide noninferior ischemic protection while reducing bleeding complications.^{5–7}

Although there is growing evidence supporting patient-centric de-escalation strategies, SAPT post-DAPT is still not widely accepted in real-world clinical settings. The low acceptability can be attributed to demographic features such as differences in patient characteristics, clinical opinion owing to physician preference, and drug availability. The choice of SAPT, which can include aspirin, clopidogrel, or ticagrelor, is variable in different settings, with paucity in data on prescribing trends in India. The transition from DAPT to

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SAPT after initiating the treatment is aimed at reducing the risk of significant bleeding events while still effectively preventing thrombotic events. Transitioning to SAPT after 6–12 months, as supported by clinical evidence, in those at higher bleeding risk should be individualized on the basis of assessment of patient risk as per the current guidelines.⁸

The main benefit of this shift is a lower bleeding risk without a meaningful increase in ischemic complications. For understanding Indian cardiologists' approach to DAPT duration and DAPT-to-SAPT transition, and long-term secondary prevention, this expert opinion was compiled by gathering feedback on clinical practices from cardiologists across multiple centers. The expert opinion review aims to assess screening practices for HBR patients, preferred timelines for transitioning from DAPT to SAPT, and commonly used antiplatelet regimens in real-world practice, based on insights gathered through focus group discussions with cardiologists across India, to better understand current prescribing patterns and identify opportunities to optimize post-PCI antiplatelet therapy.

MATERIALS AND METHODS

This expert opinion was designed to evaluate prevailing clinical practices and preferences regarding antiplatelet therapy following PCI, with particular focus on HBR patients and elderly individuals with ACS. An expert panel of interventional cardiologists developed and finalized a structured questionnaire comprising nine focused questions. These questions were organized into three thematic categories: (1) bleeding risk stratification, (2) transition from DAPT to SAPT, and (3) preference for clopidogrel versus aspirin in long-term maintenance therapy. The questionnaire explored key areas such as screening methods for HBR patients, timing of de-escalation from DAPT to SAPT, and preferred monotherapy regimens for elderly and stabilized patients. Responses were collected to capture real-world clinical patterns and to evaluate how Indian cardiologists' decision-making aligns with

current guideline recommendations and evidence from major clinical trials.

Development of Expert-framed Questionnaire

The expert opinion developed by a panel of experienced interventional cardiologists was based on a structured set of questions initially framed after a thorough literature review. Depending on their clinical expertise, nine key questions were decided upon to explore ongoing practices in antiplatelet therapy across various patient archetypes. These questions were designed to elicit clinical insights into decision-making regarding DAPT duration, timing of DAPT-to-SAPT transition, and long-term maintenance strategies, with a comparative analysis of clopidogrel and aspirin, particularly focusing on high bleeding risk and elderly ACS patients.

Study Population and Data Collection

The approved questionnaire was discussed during regional-level advisory board meetings held across India. Each meeting was moderated by a senior expert cardiologist and attended by approximately 162 practicing cardiologists with expertise in managing ACS and CCS patients post-PCI. The expert responses were evaluated based on clinical experience, interpretation of current scientific evidence, and consensus-based judgment. Opinions and clinical perspectives gathered from these discussions were compiled and analyzed for the development of this expert opinion review.

Data Analysis

Expert responses were qualitatively assessed and categorized based on the overall level of agreement among participating cardiologists (Table 1).

RESULTS

Bleeding Risk Stratification

A total of 162 cardiologists participated in this expert opinion survey, with a substantial majority, 77.8%, routinely screening for HBR in patients who have undergone revascularization following ACS or CCS. Among the respondents,

over half (56.2%) relied on clinical parameters and the patient's medical history to identify bleeding risk despite various other approaches (score-based) existing for HBR assessment. Structured bleeding risk scores such as the DAPT score or the PRECISE-DAPT score, which incorporate laboratory and clinical variables to predict bleeding complications during antiplatelet therapy, were seemingly utilized by 39.5% of respondents. A smaller proportion, 9.3%, incorporated the ARC-HBR (Academic Research Consortium for High Bleeding Risk) score, which is a consensus-based standardized tool encompassing major and minor bleeding criteria. The most commonly acknowledged risk factors cited by cardiologists, presented in decreasing order of occurrence are advancing age (71.0%), underlying kidney disease (65.4%), prior history of stroke or bleeding events (64.2%), anemia or low platelet count (59.9%), liver disease (59.3%), current use of oral anticoagulants (56.8%), active cancer (50.6%), and prior blood transfusion (24.7%). These findings highlight the central role of thorough clinical evaluation supplemented with validated scoring systems in identifying patients at elevated bleeding risk, which is crucial for tailoring antiplatelet therapy post-revascularization and optimizing patient outcomes (Fig. 1).

Shift from DAPT to SAPT

The expert opinion with the cardiologist panel, it was recorded that more than half (56.2%) reported moving from DAPT to SAPT at 3 months in HBR patients with low ischemic risk, reflecting a preference for early de-escalation to reduce bleeding complications. Approximately one-fourth (25.9%) opted for a 1-month transition, while 18.5% continued DAPT for 6 months before shifting to SAPT. In the context of preferred monotherapy regimens following a

Table 1: Classification of expert opinion strength

Level of agreement	Definition	Threshold
Strong agreement	Broad consensus among experts	≥75% endorsement
Moderate agreement	Majority support, though less than strong consensus	50–74% endorsement
Mild agreement	Limited support from experts	25–49% endorsement
Neutral/no clear consensus	Opinions varied significantly or limited endorsement	<25% endorsement

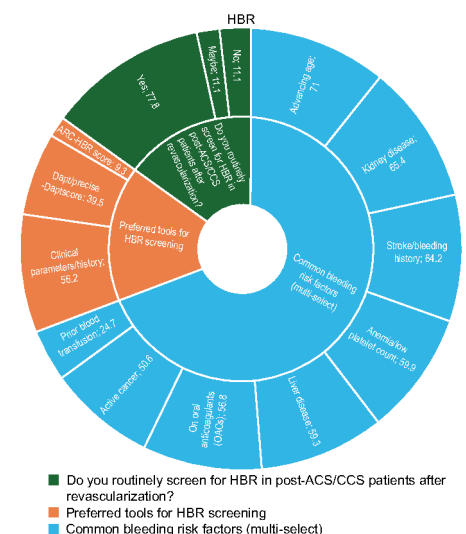


Fig. 1: Expert opinions on bleeding risk stratification

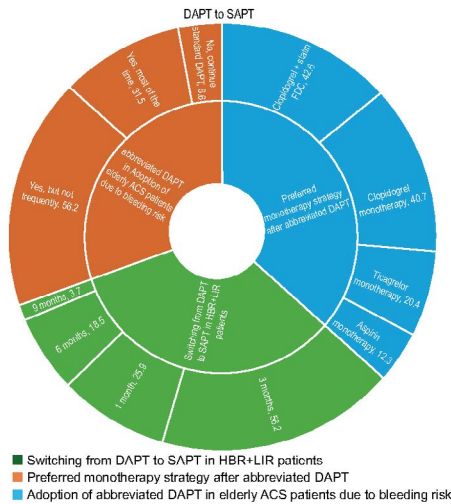


Fig. 2: Expert opinions on switching from DAPT to SAPT

shorter DAPT, 42.6% preferred the fixed-dose combination (FDC) of clopidogrel with a statin, followed by clopidogrel alone (40.7%). Among the less commonly chosen were ticagrelor and aspirin monotherapy, at 20.4% and 12.3%, respectively. However, a majority (56.2%) showed inclination towards abbreviated DAPT selectively in elderly patients with ACS, while 31.5% used it most of the time, reflecting a trend towards balancing ischemic and bleeding risks through individualized antiplatelet strategies (Fig. 2).

Preference for Clopidogrel vs Aspirin

In the present expert survey involving 162 cardiologists, clopidogrel-based regimens emerged as the dominant preference for long-term antiplatelet therapy, particularly among elderly patients with ACS. Among the various antiplatelet regimens reported, clopidogrel monotherapy emerged as the most prescribed (43.8%), followed by the FDC of clopidogrel and statin (35.2%). In contrast, aspirin monotherapy (9.8%) and ticagrelor monotherapy (9.2%) were less frequently used. A strong consensus (81.5%) was observed in agreement with the HOST-EXAM trial findings that clopidogrel is superior to aspirin for long-term secondary prevention. Continued use of clopidogrel + statin FDC postcompletion of 12-month DAPT was approved and followed by 77.8% of cardiologists, indicating a progressive landscape of confidence in clopidogrel-centric maintenance therapy for sustainable vascular protection in stable post-ACS patients (Fig. 3).

DISCUSSION

The management of antiplatelet therapy in patients with ACS and CCS post-PCI continues to evolve, particularly in the context of

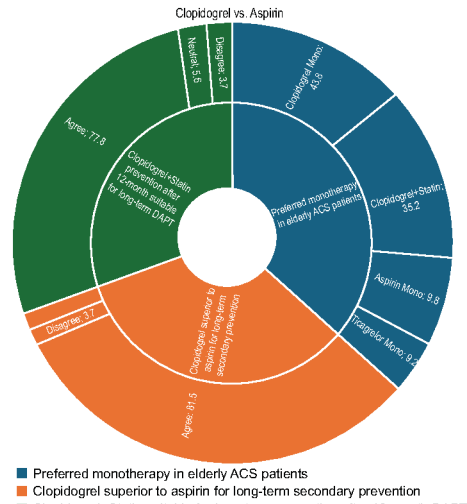


Fig. 3: Expert opinions on preferred monotherapy

balancing ischemic protection with bleeding risk mitigation. While DAPT has been the standard of care, recent clinical evidence suggests that abbreviated DAPT strategies followed by SAPT may provide a safer and equally effective alternative for select patients, especially those at high bleeding risk. Given these evolving paradigms, it is critical to evaluate both published literature and expert clinical perspectives to determine the optimal approach in Indian clinical practice.

Evolution of DAPT and Shift Toward Individualized Strategies Based on Bleeding Risks

Since the inception of PCI in 1977, developments in antithrombotic therapy have enhanced patient outcomes. The advancement of DAPT has been propelled by improvements in stent design and an enhanced comprehension of thrombosis and hemorrhagic dangers. Initially, bare-metal stents (BMS) necessitated extended dual antiplatelet therapy (DAPT) due to elevated thrombosis rates, whereas first-generation drug-eluting stents (DES) prolonged the recommended period to 12 months. Next-generation DES enhance safety, and studies advocate for abbreviated DAPT (3–6 months) followed by SAPT for patients with elevated bleeding risk. The current ESC guidelines (2023) advise a duration of 3–6 months for stable CAD, 12 months for ACS, and 1 month of DAPT in situations of high bleeding risk.⁸ A comprehensive study on stroke in India underscores its increasing impact, positioning it as the fourth major cause of mortality and the fifth leading cause of disability. Analysis of data from nine studies conducted in large cities revealed that stroke incidence varied from 108 to 172 per 100,000 annually, with 1-month case fatality rates between 18% and 42%, elevated in

males. The scarcity of high-quality data throughout India obstructs policy formulation. The research underscores the necessity for enhanced stroke surveillance, improved hospital accessibility, and consistent data collection, promoting population-based registries and WHO surveillance frameworks to advance stroke prevention and treatment methodologies.⁹

The review by Tersalvi et al. highlights the critical balance between ischemic prevention and bleeding risk in DAPT for ACS.¹⁰ Unexpected discontinuation of DAPT is frequently prompted by bleeding events, a complication that significantly increases the risk of subsequent ischemic episodes. Furthermore, following a bleeding incident, patients often cease use of other cardioprotective medications, including beta-blockers, renin-angiotensin-aldosterone system (RAAS) inhibitors, and statins, further elevating their risk for adverse cardiovascular outcomes. Given the strong association between bleeding and poor prognosis, including increased mortality, contemporary clinical guidelines emphasize the implementation of bleeding-avoidance strategies starting at the revascularization stage and recommend maintaining these preventive measures well beyond the initial acute phase.¹⁰ While DAPT reduces stent thrombosis and recurrent ischemic events, it significantly increases bleeding risk, necessitating individualized therapy. The study endorses abbreviated DAPT (3–6 months) followed by SAPT in HBR patients, using instruments such as PRECISE-DAPT and ARC-HBR to enable risk evaluation. Urban et al. established HBR criteria and identified significant risk variables including advanced age, chronic kidney disease (CKD), malignancy, previous stroke, and anticoagulant usage. In relation to the Bleeding Academic Research Consortium (BARC), HBR in patients receiving PCI is defined as having at least a 4% risk of significant bleeding (category 3 or 5) or a 1% risk of cerebral hemorrhage within 1 year of PCI.¹¹

The ARC-HBR criteria include a combination of major and minor clinical factors, such as older age (≥ 75 years), anemia, use of oral anticoagulants, and recent bleeding events. These patients have a higher chance of bleeding problems, so DAPT needs to be carefully managed. In HBR patients, DAPT duration is often shortened to minimize bleeding risk while maintaining protection against ischemic events such as stent thrombosis. This approach balances the benefits of reducing clot formation with the increased risk of bleeding in patients. The study shows that people with a high bleeding

risk (HBR) are often left out of PCI trials. This makes it difficult to create standard treatment guidelines. These findings demonstrate that decreasing DAPT for 6 months or less by switching to SAPT can minimize bleeding risk without increasing ischemic events. This highlights the need for personalized antiplatelet strategies in post-PCI care.¹¹

A fixed-duration approach to DAPT toward a more personalized, risk-based strategy has been largely shaped by evidence showing that shorter DAPT followed by SAPT can benefit patients with HBR. Although current guidelines recommend using risk assessment tools such as PRECISE-DAPT and ARC-HBR to identify these high-risk patients, their real-world use differs widely among clinicians and healthcare settings. In our study, 77.8% of experts reported that they routinely screen HBR patients after revascularization, emphasizing its critical role in informing antiplatelet therapy decisions. 39.5% of patients used DAPT or PRECISE-DAPT scores, but most (56.2%) depended on clinical parameters and patient history. This shows individuals in the real world prefer individualized assessment to tools.

Advancing age (71.0%) was the most reported bleeding risk factor, followed by kidney disease (65.4%), prior stroke or bleeding history (64.2%), and anemia or low platelet count (59.9%). These findings reinforce the importance of personalized risk stratification to balance ischemic and bleeding risks in post-PCI management.

Expert Opinion

The experts emphasized that individualized risk assessment remains central to determining the optimal duration of dual antiplatelet therapy (DAPT), particularly among patients with a high bleeding risk profile. While validated tools such as the PRECISE-DAPT and ARC-HBR scores were acknowledged for structured evaluation, the panel noted that clinical decision-making in real-world settings is more often guided by patient history, comorbid conditions, and physician judgment. According to the experts, key factors influencing early transition to single antiplatelet therapy (SAPT) include advanced age, renal impairment, prior bleeding episodes, and low platelet counts, which together help balance ischemic protection with bleeding safety in post-revascularization management.

Optimizing Antiplatelet Therapy (DAPT to SAPT transition): SAPT and De-escalation Strategies

The management of antiplatelet therapy post-PCI is increasingly shifting toward individualized risk-based strategies, especially in HBR patients. According to the 2023 ESC Guidelines recommendations, it is highly advised for individualized antiplatelet therapy following PCI for HBR patients in particular (Fig. 4).² While considering the low ischemic risk in HBR patients, DAPT can possibly be shortened to 3–6 months, with

a preference for a P2Y₁₂ inhibitor over aspirin for maintaining long-term patient on SAPT.

In elderly patients, the higher bleeding risk necessitates early DAPT de-escalation, with clopidogrel favored over potent P2Y₁₂ inhibitors. For HBR cases, 1-month DAPT may be considered. The guidelines also propose alternative antiplatelet therapy to reduce bleeding risk within the first 12 months after ACS. In stabilized patients, early de-escalation from potent P2Y₁₂ inhibitors (ticagrelor/prasugrel) to clopidogrel after 1 month can decrease bleeding while maintaining ischemic protection.

Optimal antiplatelet strategies for patients undergoing complex PCI were discussed in a review by Bhatt, and emphasis was given on individualized therapy based on ischemic and bleeding risk.¹² 1-month DAPT regimen followed by clopidogrel monotherapy was recommended for HBR patients. A 3-month DAPT followed by ticagrelor (90 mg BID) is suggested, with a potential dose reduction (60 mg BID) after 1 year in patients with moderate ischemic risk. For those with high ischemic risk but low bleeding risk, 12-month DAPT is maintained, with reassessment of bleeding risk annually. This patient-specific approach balances the risk of bleeding against ischemic protection, emphasizing therapy guided by clinical judgment, platelet function testing, or genotyping where available. The recommendation highlights that while shorter DAPT followed by SAPT is suitable for stable or HBR patients, those with higher thrombotic risk require prolonged DAPT to optimize outcomes.¹²

The SHARE trial evaluated P2Y₁₂ inhibitor monotherapy after 3 months of DAPT compared with 12-month DAPT in patients undergoing PCI with a drug-eluting stent.¹³ The study demonstrated that early aspirin withdrawal with P2Y₁₂ monotherapy was noninferior to 12-month DAPT regarding net adverse clinical events, including major bleeding and ischemic outcomes. The occurrence of major bleeding was lower in the monotherapy group (0.2% vs 0.8%), with no significant increase in ischemic events. These results support a shorter DAPT duration in selected patients, particularly those at high bleeding risk, aligning with recent trends favoring individualized antiplatelet strategies. The OPT-BIRISK randomized clinical trial evaluated extended clopidogrel monotherapy against continued DAPT in ACS patients at both high ischemic and bleeding risk who had completed 9–12 months of DAPT after PCI.¹⁴ Among 7,758 patients, those randomized to clopidogrel monotherapy experienced a 25% reduction in BARC types 2, 3, or 5 bleeding (2.5% vs 3.3%; HR: 0.75, $p = 0.03$). Importantly, major adverse cardiac and cerebral events

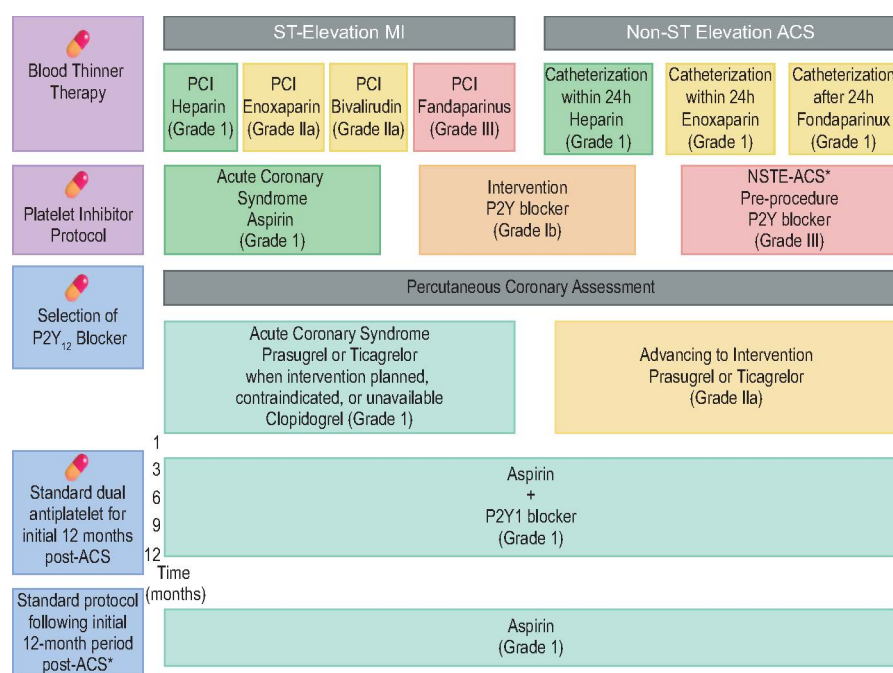


Fig. 4: Algorithm for the management of acute coronary syndromes (ACS), including ST-elevation myocardial infarction and non-ST-elevation ACS. Adapted from the European Society of Cardiology (ESC) Heart Failure Guidelines, 2023

(MACCE) were also significantly lower in the monotherapy group (2.6% vs 3.5%; HR: 0.74, $p = 0.02$ for superiority), demonstrating that clopidogrel alone maintained ischemic protection while reducing bleeding risk. These findings emphasize extended P2Y₁₂ monotherapy as a safer alternative for bi-risk patients post-DAPT, aligning with recent trends favoring aspirin-free long-term antiplatelet regimens to optimize bleeding safety without compromising ischemic outcomes.

The POPular AGE study examined clopidogrel in comparison to ticagrelor/evaluating bleeding risk and clinical outcomes in elderly patients aged 70 years and above with NSTEMI-ACS (non-ST-elevation acute coronary syndrome) over a 12-month period.¹⁵ In nearly 1,002 patients, clopidogrel noticeably reduced bleeding incidences (18% against 24%, $p = 0.02$) while being noninferior in attributed clinical benefit (comprising mortality, myocardial infarction, stroke, and bleeding) in comparison to ticagrelor/prasugrel (28% vs 32%, $p = 0.03$). In nearly 47% of patients on ticagrelor/prasugrel therapy, therapy was ceased early owing to hemorrhage, dyspnea, or the necessity for anticoagulation. In accordance with the data, it can be inferred that clopidogrel is a safer and effective alternative, especially for elderly individuals at elevated bleeding risk, as it balances the management regimen by reducing bleeding complications without raising ischemic events. The reduction of DAPT is mostly determined by the rationalized balance between ischemic and hemorrhagic events. Current guidelines advocate for 6 months of dual antiplatelet therapy (DAPT) for stable coronary artery disease (CAD) following drug-eluting stent (DES) implantation and 12 months for acute coronary syndrome (ACS). In HBR patients, DAPT may be reduced to 3–6 months without elevating ischemic events.¹⁶

Among participating clinicians, 56.2% preferred switching from DAPT to SAPT at 3 months in HBR patients with low ischemic risk, aligning with guideline-backed de-escalation strategies. The clopidogrel + statin FDC was the most preferred for SAPT (42.6%), closely followed by clopidogrel monotherapy (40.7%) and ticagrelor monotherapy (20.4%), whereas aspirin alone was the least favored (12.3%). Among elderly ACS patients, 56.2% selectively adopted abbreviated DAPT, with clopidogrel monotherapy (43.8%) being the preferred choice, reinforcing real-world preference for individualized, bleeding-conscious strategies.

Expert Opinion

The experts agreed that early de-escalation from dual antiplatelet therapy (DAPT) to

single antiplatelet therapy (SAPT) is a safe and appropriate approach, particularly in high bleeding risk and elderly patients. They identified clopidogrel-based regimens, either as standalone therapy or as fixed-dose combinations with statins, as the most preferred options due to their favorable balance between efficacy and safety. According to the panel, timely transition to SAPT helps minimize bleeding complications without compromising ischemic protection, especially in clinically stabilized patients following revascularization.

Long-term Maintenance Therapy Post-DAPT

The HOST-EXAM trial investigated the optimal antiplatelet monotherapy in patients undergoing PCI with DES and who had completed 6–18 months of DAPT without adverse events.¹⁷ The study randomized 5,438 patients to receive either clopidogrel (75 mg daily) or aspirin (100 mg daily) for 24 months. The primary composite endpoint, comprising all-cause death, nonfatal myocardial infarction, stroke, readmission due to acute coronary syndrome, and BARC type 3 or greater bleeding, was significantly lower in the clopidogrel group (5.7%) than in the aspirin group (7.7%; HR 0.73, $p = 0.0035$). Clopidogrel also showed lower rates of stroke (0.7% vs 1.6%), readmission due to ACS (2.5% vs 4.1%), and major bleeding (1.2% vs 2.0%).¹⁷ The SMART-CHOICE 3 trial also demonstrated that in high-risk patients post-PCI who had completed standard DAPT, after which the patients were randomized to clopidogrel or aspirin monotherapy. Clopidogrel monotherapy was more effective than aspirin for long-term maintenance. Over a 3-year follow-up, clopidogrel significantly reduced the composite endpoint of all-cause death, myocardial infarction, and stroke in comparison to aspirin (4.4% vs 6.6%; HR 0.71; $p = 0.013$), primarily driven by lower rates of MI (1.0% vs 2.2%) and mortality, without an increase in bleeding events (3.0% vs 3.0%) or other adverse outcomes.¹⁸ These findings establish clopidogrel as a superior option to aspirin for chronic maintenance therapy post-PCI, reducing both ischemic and bleeding risks in stable patients transitioning from DAPT in both ACS and CCS populations.

In the current study, 81.5% of the respondents came to an agreement that clopidogrel monotherapy is preferable to aspirin for long-term maintenance. This aligns with the findings of the HOST-EXAM trial with its lower ischemic and bleeding risk profile. Considering low-risk ACS patients who have completed 12 months of DAPT,

the clopidogrel + statin FDC stood out as a practical long-term strategy for secondary prevention. Among the respondents, 77.8% supported FDC usage, reflecting real-world endorsement of dual-benefit therapy beyond standard monotherapy.

Expert Recommendation

The experts indicated that clopidogrel is predominantly preferred over aspirin for long-term maintenance therapy following completion of dual antiplatelet therapy (DAPT), aligning with evidence from major trials such as HOST-EXAM. They further endorsed the use of fixed-dose combinations of clopidogrel and statins as a practical, dual-benefit approach that enhances both antiplatelet efficacy and lipid control. According to the panel, this regimen is particularly suitable for stable, low-risk patients with acute coronary syndrome (ACS) who have completed 12 months of DAPT, as it supports better adherence, sustained vascular protection, and a lower risk of bleeding complications.

CONCLUSION

This expert opinion survey highlights real-world practices of Indian cardiologists regarding antiplatelet therapy post-PCI, emphasizing individualized risk stratification and early de-escalation strategies. A majority of clinicians (77.8%) routinely screen for high bleeding risk (HBR), predominantly relying on clinical parameters and patient history rather than formal scoring tools, reflecting a pragmatic, experience-driven approach. Regarding DAPT duration, 56.2% of experts favored de-escalation to SAPT at 3 months in HBR patients with low ischemic risk, consistent with contemporary ESC recommendations and evidence from trials such as SHARE, STOPDAPT-2, and SMART-CHOICE. The clopidogrel + statin fixed-dose combination (42.6%) was the most preferred SAPT strategy, closely followed by clopidogrel monotherapy (40.7%), while aspirin monotherapy was the least favored. Among elderly ACS patients, 56.2% selectively adopted abbreviated DAPT, with clopidogrel monotherapy (43.8%) as the preferred regimen, supporting findings from the POPular AGE trial. For long-term maintenance, 81.5% of experts endorsed clopidogrel over aspirin, aligning with the HOST-EXAM and SMART-CHOICE 3 trials, and 77.8% supported continued use of the clopidogrel + statin FDC beyond 12 months of DAPT. Collectively, these findings demonstrate that Indian cardiologists' practices largely align with contemporary international guidelines, while also reflecting regional adaptations, most notably a stronger reliance

on clopidogrel-based regimens and fixed-dose combinations. These real-world insights underscore the need for further prospective research and India-specific recommendations to optimize post-PCI antiplatelet therapy.

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