

**Comprehensive ascertainment of bleeding in patients prescribed different combinations of dual antiplatelet therapy (DAPT) and triple therapy (TT, DAPT plus an anticoagulant) after coronary interventions in the UK: a population based cohort study**  
**The ADAPTT Study**

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**Key words:** Dual antiplatelet therapy (DAPT); acute coronary syndrome (ACS); percutaneous coronary intervention (PCI), coronary artery bypass grafting (CABG); bleeding; Clinical Practice Research Datalink (CPRD); Hospital Episode Statistics (HES).

**Abbreviations:** ACS, acute coronary syndrome; AP, aspirin and prasugrel; AT, aspirin and ticagrelor; BARC, Bleeding Academic Research Consortium; CABG, coronary artery bypass grafting; CI, confidence interval; CIPS, Continuous inpatient stays; CPRD, Clinical Practice

Research Datalink; DAPT, dual antiplatelet therapy; GP, General Practitioner; HES; Hospital Episode Statistics; HR, hazard ratios, ICD, International Classification of Diseases; MI, myocardial infarction; NICE, National Institute for Health and Care Excellence; NIHR, National Institute for Health Research; NHS, National Health Service; ONS, Office for National Statistics; OPCS, Office of Population Censuses and Surveys; PCI, percutaneous coronary intervention; RCT, Randomized controlled trial; RR, relative risk; TT, triple therapy.

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## **Abstract**

**INTRODUCTION:** ‘Real world’ bleeding in patients exposed to different regimens of dual antiplatelet therapy (DAPT) and triple therapy (TT, DAPT plus an anticoagulant) have a clinical and economic impact but have not been previously quantified.

**METHODS AND ANALYSIS:** We will use linked Clinical Practice Research Datalink (CPRD) and Hospital Episode Statistics (HES) data to assemble populations eligible for three “target trials” in patient groups: percutaneous coronary intervention (PCI); coronary artery bypass grafting (CABG); conservatively managed (medication only) acute coronary syndrome (ACS). Patients  $\geq 18$  years old will be eligible if, in CPRD records, they have:  $\geq 1$  year of data before the index event; no prescription for DAPT or anticoagulants in the preceding three months; a prescription for aspirin or DAPT within two months after discharge from the index event. The primary outcome will be any bleeding event (CPRD or HES) up to 12 months after the index event. We will estimate adjusted hazard ratios for time to first bleeding event comparing: aspirin and clopidogrel (reference) vs. aspirin and prasugrel or aspirin and ticagrelor after PCI; and aspirin (reference) vs. aspirin and clopidogrel after CABG and ACS. We will describe rates of bleeding in patients prescribed triple therapy (DAPT plus an anticoagulant). Potential confounders will be identified systematically using literature review, semi-structured interviews with clinicians and a short survey of clinicians. We will conduct sensitivity analyses addressing the robustness of results to the study’s main limitation – that we will not be able to identify the intervention group for patients whose bleeding event occurs before a DAPT prescription in CPRD.

**ETHICS AND DISSEMINATION:** This protocol was approved by the Independent Scientific Advisory Committee for the UK Medicines and Healthcare Products Regulatory Agency Database Research (protocol 16\_126R) and the South West Cornwall and Plymouth Research Ethics Committee (17/SW/0092). The findings will be presented in peer-reviewed journals, lay summaries, and briefing papers to commissioners/other stakeholders.

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## **Strengths and limitations of this study**

This study has four main strengths:

- We designed our study using the framework recommended by the Cochrane Bias and Non-Randomized Studies Methods Groups for establishing appropriate patient populations, interventions and follow-up to emulate three hypothetical RCTs (target trials).
- We will describe (using linked Hospital Episode Statistics, HES, and Clinical Practice Research Datalink, CPRD) the frequency of “real world” bleeding events in populations of patients who undergo coronary interventions (percutaneous coronary intervention, PCI, and coronary artery bypass grafting, CABG) or have acute coronary syndrome (ACS) and are managed conservatively (medication only) and have treatment initiated with different antiplatelet regimens or antiplatelet and anticoagulant (e.g. warfarin, dabigatran, rivaroxaban, apixaban) regimens.
- We will compare the frequency of bleeding events by DAPT regimen in the different populations: PCI (aspirin and clopidogrel versus aspirin and prasugrel or aspirin and ticagrelor); CABG and ACS (aspirin versus aspirin and clopidogrel).
- We will identify potential confounders systematically using literature review, semi-structured interviews with clinicians (cardiologists, cardiac surgeons and general practitioner) and a short survey with an additional group of clinicians.

This study has two main limitations:

- Because there are no medication data in HES, we cannot identify the DAPT regimen that patients were prescribed at the time of their index event (PCI, CABG or ACS). We will assume that patients’ first DAPT prescription that appears in CPRD after their hospital admission is what they were prescribed at discharge.
- For the same reason, we will not know the intervention group of patients who had major bleeding before leaving hospital or before their first prescription in CPRD and either died, stopped or changed antiplatelet therapy. We will conduct sensitivity analyses to address the robustness of results to different assumptions about the unknown intervention group in patients who died or had a bleeding event before a DAPT prescription in CPRD.

## Introduction

Dual antiplatelet therapy (DAPT), a combination of aspirin and either clopidogrel, prasugrel, or ticagrelor, is recommended for secondary prevention of ischaemic events (heart attack and stroke) in people with coronary artery disease. Guidelines recommend that patients are treated with DAPT for 6 to 12 months following myocardial infarction (MI) and coronary interventions (percutaneous coronary intervention, PCI, and coronary artery bypass grafting, CABG) [1-3] and support the use of the more potent antiplatelet inhibitors ticagrelor and prasugrel [2]. Antiplatelet agents reduce the risk of ischaemic events, by preventing the formation of clots in atherosclerotic coronary arteries and within stents (following PCI) or grafts (following CABG), but increase the risk of bleeding [4]. Randomized controlled trials (RCTs) have shown that adding clopidogrel to aspirin leads to 1% excess risk of major bleeding (requiring admission to hospital) compared with aspirin alone [5, 6]. Prasugrel and ticagrelor reduce the risk of ischemic events further but also further increase the risk of bleeding [7]. Some patients (e.g. those with existing atrial fibrillation or those who develop atrial fibrillation after PCI, CABG or ACS) are prescribed an anticoagulant (e.g. warfarin, dabigatran, rivaroxaban, apixaban) in addition to DAPT (triple therapy, TT), which further increases the risk of bleeding.

“Real world” bleeding events that do not require any intervention are likely to be much more frequent than those reported in RCTs, which excluded patients at high risk of bleeding and mainly reported only on major bleeding. Bleeding events that do not result in hospitalisation are largely managed in primary care and may have a significant clinical and economic impact [8]. Minor and nuisance bleeding (nose and gum bleeds, bruising and prolonged bleeding from cuts) may also reduce adherence to DAPT and therefore the benefit of DAPT in non-adherent patients [9] who are at increased risk of a secondary ischaemic coronary episode [10]. Only three studies have reported the incidence and consequences of nuisance bleeding after DAPT [11-13]; these suggest that nuisance bleeding is common (affecting 29-38% of patients) and impacts on adherence (11% of patients in one study discontinued clopidogrel [12]). A nested case control study using the Health Improvement Network (a UK primary care database) reported an increased risk of upper gastrointestinal bleeding with clopidogrel and aspirin compared with aspirin alone (relative risk [RR], 2.08; 95% confidence interval [CI], 1.34 to 3.21) [14].

The economic impact of bleeding events associated with DAPT is also poorly characterized, in particular for minor bleeding events and their impact on health-related quality of life [8]. This is not surprising given that health economic analyses often lack detailed data on adverse effects of interventions, despite consensus that such effects should be considered [15, 16]. To ensure appropriate decisions are made about which DAPT regimens to use in clinical practice, the health and resource use consequences of minor and major bleeding events should be incorporated into assessments of cost-effectiveness. For DAPT, this entails accounting for uncertainty in the absolute risk of bleeding, the impact of different bleeding events on health-related quality of life and treatment adherence and subsequent risk of secondary ischaemic events, and the cost implications of managing these bleeding events.

We propose to use Hospital Episode Statistics (HES) and the Clinical Practice Research Datalink (CPRD) databases to estimate the incidence of all bleeding events occurring in patients prescribed different DAPT or TT regimens after undergoing coronary interventions (PCI and CABG) and in conservatively-managed ACS patients. Our study will also provide parameter estimates to update existing cost effectiveness models. We will use the framework recommended by the Cochrane Bias and Non-Randomized Studies Methods Groups for establishing appropriate patient populations, interventions and follow-up to emulate the following three hypothetical RCTs (hereafter referred to as the target trials, **Table 1**) [17]:

1. In patients who have undergone PCI, estimate the effect on bleeding events of assignment to aspirin and clopidogrel (reference) versus aspirin and prasugrel or aspirin and ticagrelor.
2. In patients who have undergone CABG, estimate the effect on bleeding events of assignment to aspirin (reference) versus aspirin and clopidogrel.
3. In patients who are conservatively-managed patients after presenting with ACS, estimate the effect on bleeding events of assignment to aspirin (reference) versus aspirin and clopidogrel.

## Methods

### Data sources

CPRD is a database of primary care electronic health record data (available online via CPRD GOLD) from participating general practices, covering 7% of the UK population [18]. Patients included in CPRD are largely representative of the UK population in terms of age, sex, ethnicity, and body mass index. HES covers all hospital admissions for all English patients whose treatment is funded by the UK National Health Service (NHS), whether treated by the NHS or by independent providers [19]. Seventy-five percent of English general practices included in CPRD are linked to HES data [18]. We obtained data from 1 April 2009 to 31 July 2017; this period covers the introduction of the newer antiplatelet agents prasugrel and ticagrelor. This study protocol has been approved by the Independent Scientific Advisory Committee (ISAC) of the CPRD (protocol number 16\_126R).

### Study populations

Eligibility and exclusion criteria for the three target trials (for patients undergoing PCI, patients undergoing CABG; or patients hospitalised and conservatively-managed for ACS) are listed in **Table 1**. We will identify eligible patients who are included in CPRD and eligible for linkage with HES and Office for National Statistics (ONS) mortality data (because they have a valid NHS number and are registered at a practice that was participating in the linkage programme). Patients are included if they had a PCI, CABG or ACS (index event) a record in HES during the study period (1 April 2010 – 6 January 2017), and have at least 1 year of linked CPRD-HES data before the date of their index event. They must also have been prescribed one of the treatment regimens being compared in the target trial corresponding to their index event. One year's data preceding eligibility for the target trial is adequate to apply most of the exclusion criteria and determine co-morbidities and medication history: such information would be collected at baseline in a randomized trial. The following Office of Population Censuses and Surveys (OPCS) procedure codes (PCI and CABG) and International Classification of Diseases (ICD-10) codes (ACS no procedure) will be used to identify patients: PCI, K49, K50 & K75; CABG, K40, K41, K42, K43, K44, K45 & K46; ACS without a procedure, I20.0, I21, I22, I24.9 (with no OPCS code for PCI or CABG in the same hospital admission). **Figure 1** shows full details of the inclusion and exclusion criteria.

**Table 1. Summary of three target trials and how observational data will be used to emulate these**

<b>PICO component</b>	<b>Target trial</b>	<b>Issues in emulating the target trial using observational data</b>
Eligibility criteria	<p><b>Target trial 1 (PCI)</b> Consecutive patients (age <math>\geq 18</math> years) undergoing PCI (emergency or elective). Exclusions: DAPT or anticoagulant use in the previous 3 months; major bleed requiring hospitalization in previous 12 months; renal failure requiring dialysis; intolerance/allergy to aspirin, clopidogrel, prasugrel or ticagrelor.</p> <p><b>Target trial 2 (CABG)</b> Consecutive patients (age <math>\geq 18</math> years) undergoing CABG (urgent and elective). Exclusions: DAPT or anticoagulant use in the previous 3 months; other concomitant cardiac surgery (e.g. valve surgery); major bleed requiring hospitalization in previous 12 months; renal failure requiring dialysis; intolerance/allergy to aspirin, clopidogrel, prasugrel or ticagrelor.</p> <p><b>Target trial 3 (conservatively-managed ACS)</b> Consecutive patients (age <math>\geq 18</math> years) hospitalized for an acute coronary syndrome (ACS): myocardial infarction (MI) with or without ST-elevation or unstable angina. Exclusions: PCI or CABG performed at time of ACS diagnosis; major bleed requiring hospitalization in previous 12 months; renal failure requiring dialysis; intolerance/allergy to aspirin, clopidogrel, prasugrel or ticagrelor.</p>	<p>CPRD-HES linked dataset contains information that allows us to identify all eligible patients for the three target trials. The study period is April 2009-July 2017. All eligible patients will have sufficient data (1 year) preceding their index event to apply the exclusion criteria and characterize the population (e.g. co-morbidities) and sufficient follow-up data (1 year) to identify outcomes. It is not possible to capture intolerance/allergy to aspirin, clopidogrel, prasugrel or ticagrelor.</p>
Interventions	<p><b>Target trial 1 (PCI)</b> Clopidogrel (75mg daily) or prasugrel (5mg or 10mg daily) or ticagrelor (90mg twice daily). All patients will receive aspirin (at a dose of 75mg daily, in line with current guidelines).</p> <p><b>Target trial 2 (CABG)</b></p>	<p>Relevant interventions can be identified as CPRD has information on all medications (including doses) prescribed in primary care.</p>



	<p>Clopidogrel (75mg) in addition to aspirin (at a dose of 75mg daily, in line with current guidelines) or aspirin only (any dose, reflecting variation in usual care).</p> <p><b>Target trial 3 (conservatively-managed ACS)</b></p> <p>As for target trial 2.</p>	
Assignment to interventions	Participants are assigned to DAPT interventions in hospital.	<p>Participants enter the study at index procedure date for PCI and CABG, and episode start date for ACS, and will be assigned to DAPT interventions using first prescription in CPRD (within 2 months of hospitalization) as a proxy for what they were prescribed in hospital (there are no medications data in HES). This assignment will exclude a proportion of eligible patients (those who died or experienced a major bleed that caused them to stop DAPT, or patients who have no prescription for DAPT within the 2 month window); we will identify and describe the characteristics of these excluded patients.</p> <p>In sensitivity analyses, we will address the robustness of results to different assumptions about the intervention group in those patients where the DAPT medication is unknown or a major bleed occurs prior to the first DAPT medication, by using multiple imputation models for handling missing data. Prior known information regarding the likely prescription based on patient characteristics or general policies will be incorporated in these analyses.</p>
Follow-up	Starts at assignment to intervention and ends at first bleed or 12 months from assignment (whichever comes first).	Starts at time of hospitalization for PCI, CABG or ACS and ends at first bleed or 12 months from hospitalization (whichever comes first).
Primary outcome	Any bleed within 12 months of the start of DAPT (DAPT is prescribed at hospitalization for PCI, CABG or ACS).	Any bleed within 12 months of hospitalization for PCI, CABG or ACS.

Analysis	Intention to treat	According to first prescription for DAPT in CPRD
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## Interventions

The interventions of interest for the three target trials are shown in **Table 1**. Guidelines recommend low dose aspirin (75 to 100mg/d) plus either clopidogrel (75mg/d), prasugrel (5mg/d or 10mg/d), or ticagrelor (90mg twice/d) for PCI and conservatively-managed ACS patients. For PCI patients, the interventions of interest are aspirin and clopidogrel, aspirin and prasugrel, and aspirin and ticagrelor. In conservatively-managed ACS patients, clopidogrel is the most commonly prescribed second antiplatelet agent (in addition to aspirin) and a large proportion of patients are prescribed aspirin only, therefore the interventions of interest are aspirin only (75 to 100mg/d) and aspirin and clopidogrel. There is variation in aspirin prescription for CABG patients; some surgeons choose 75mg/d, others 150mg/d, or 300mg/d. Surgeons may also prescribe an additional antiplatelet agent, most commonly clopidogrel. Therefore, the comparisons of interest in CABG patients are aspirin only (any dose, reflecting variations in usual care in different hospitals) and aspirin and clopidogrel (doses as for PCI). We have specified these comparisons based on preliminary feasibility counts from CPRD, which indicate that few CABG and conservatively-managed ACS patients are prescribed aspirin and prasugrel or aspirin and ticagrelor.

In the target trials the interventions would be assigned during the hospital stay, as soon as patients are eligible for antiplatelet therapy. Our observational dataset does not have information on medication given to patients at discharge, because HES does not include medications data. Therefore, the first time at which we have information on the antiplatelet regimen to which patients were assigned in hospital is when they receive their first primary care prescription/s for aspirin or DAPT, recorded in CPRD. It is reasonable to use these as a proxy for the medications that patients started in hospital, because patients' general practitioners are unlikely to change the prescriptions that were started in hospital.

We will classify patients according to the first prescription recorded in CPRD during the first two months after hospitalization for PCI, CABG, or ACS. This two-month window is based on variability in the amount of DAPT medication provided to patients in hospital following their PCI, CABG or ACS and hence variability in the time when they first request a repeat prescription from their general practice. A preliminary investigation showed that more than 80% of eligible patients have a prescription for one or more antiplatelet agents during this time period. If a patient only has a prescription for aspirin during the 2-month window after

hospital discharge, they will be assigned to an aspirin only intervention. If patients also receives a prescription for clopidogrel, prasugrel or ticagrelor, they will be assigned to aspirin/clopidogrel, aspirin/prasugrel or aspirin/ticagrelor. If there is a prescription for more than one additional antiplatelet agent in the 2-month window, we will assign the patient to an intervention based on the agent prescribed first. For example, if a patient has an aspirin prescription and a prescription for clopidogrel before a prescription for ticagrelor, the patient will be assigned to the aspirin/clopidogrel intervention. Patients with no prescriptions in CPRD for aspirin, or aspirin and clopidogrel, prasugrel or ticagrelor within the 2-month window will be excluded from the main analysis. We will conduct sensitivity analyses of all eligible patients including those with unknown DAPT regimens or a major bleed prior to first DAPT prescription, by estimating assignment to DAPT interventions for those with no prescription data using multiple imputation based on a range of assumptions [20].

## **Outcomes**

The primary outcome will be any bleeding event, classified as type 2-5 by the Bleeding Academic Research Consortium (BARC) bleeding scale [21]. For each patient, we will identify all bleeding events in HES and CPRD during follow-up. We will not be able to identify BARC type 1 bleeding events (bleeding that is not actionable and does not cause the patient to seek treatment) as type 1 assumes there is no interaction with the health system or healthcare professionals therefore no bleed event will be recorded in HES or CPRD. We have specified a comprehensive list of bleeding codes in CPRD and HES (see **Appendix 1**). These will be categorised according to anatomical site for descriptive purposes. Secondary outcomes will be: any major bleeding event; any minor bleeding event; all-cause mortality; cardiovascular mortality; mortality from bleeding (these will be identified from linked ONS data); hospital admission for a bleeding event (inpatient HES); MI; stroke; additional coronary intervention.

## **Follow up**

The start of follow up (the index event) will be the date of the index hospital procedure (PCI, CABG) or start date of the hospital episode that contains the ACS diagnosis (ACS). Patients will be followed up until 12 months after the index event, since DAPT is prescribed for 12 months in accordance to guidelines.

## Confounding and co-interventions

Potential confounders (variables that predict both risk of bleeding and intervention group) will be specified *a priori* [22, 23]. We will identify confounders and co-interventions using literature review and clinician expertise as recommended by the Cochrane Bias and Non-Randomized Studies Methods Groups [17]. We will carry out a comprehensive and systematic literature search to identify all RCT and cohort studies of DAPT interventions, or cohort studies that identify predictors of bleeding. The literature searches for the review are included in **Appendix 2**. Abstracts will be screened by one researcher and full text papers will be obtained. Data on confounders and co-interventions will be extracted by two researchers independently using a data extraction form specifically designed for the study; variables extracted will include study characteristics, population characteristics (reported in the tables of baseline characteristics), factors adjusted for in the statistical analyses, and factors reported to predict risk of bleeding in our populations. We will not perform a risk of bias assessment because the aim of the review is only descriptive (i.e. the output will be lists of confounders and co-interventions) and there are no established criteria for assessing the validity with which primary researchers consider potential confounders and co-interventions; therefore it would be inappropriate to apply a risk-of-bias tool for studies estimating a treatment effect. We will use “saturation” as a criterion for discontinuing data collection, defined as review of 10 consecutive studies without identifying an additional confounder/co-intervention.

In parallel, we will conduct semi quantitative interviews with six clinicians in each of three groups: cardiologists; cardiac surgeons and general practitioners (GPs, to determine whether DAPT prescriptions are changed in primary care). The main aim of the clinician interviews is to understand DAPT prescribing practice in the UK and identify the factors (relating to patients, centres and prescribing practices of the individual doctors) that influence the decision about which antiplatelet regimen to prescribe. All factors that influence DAPT prescribing (confounders) identified from the literature review and clinician interviews will be combined in a short survey (SurveyMonkey®). The survey questionnaire will be administered online to all consultant members of the British Cardiovascular Society (cardiologists) and the Society for Cardiothoracic Surgery (cardiac surgeons). The survey will be either emailed to all members individually (if the professional bodies agree) or advertised in weekly/monthly newsletters. Confounders will be grouped in confounding

domains [17]. We will attempt to identify each potential confounder (identified through the literature review, clinician interviews and survey) in the CPRD or HES dataset but acknowledge that there may be missing data across patients (and time) for some confounders.

## Sample size

Estimated rates of bleeding with the different therapies are 5% for aspirin, 9% for aspirin/clopidogrel, and 12% for aspirin/prasugrel and aspirin/ticagrelor [5, 6, 24, 25].

Preliminary feasibility counts provided by CPRD suggest that there will at least the following numbers of patients eligible for each target trial:

- PCI: aspirin/clopidogrel (reference, 6738 patients) vs aspirin/prasugrel (842 patients) or aspirin/ticagrelor (770 patients)
- CABG: aspirin (reference, 2556 patients) vs aspirin/clopidogrel (595 patients)
- Conservatively-managed ACS: aspirin (reference, 8148 patients) vs aspirin/clopidogrel (3082 patients)

These estimates give expected event rates of at least 700 for PCI, 180 for CABG and 680 for ACS, assuming a ratio of 8:1 (aspirin/clopidogrel:aspirin/prasugrel or aspirin/clopidogrel:aspirin/ticagrelor) for PCI, 4:1 (aspirin:aspirin/clopidogrel) for CABG and 2.5:1 (aspirin:aspirin/clopidogrel) for ACS. The hazard ratios detectable with 90% and 80% power at the 5% statistical significance, assuming the group ratios given above are shown in **Table 2**. The correlation of the DAPT with other covariates adjusted for is unknown and we assessed the impact of a range of correlations (0, 0.3 and 0.5).

**Table 2.** Hazard ratios for a range of correlations for PCI, CABG and ACS

Ratio of presence: absence of covariate	Squared correlation with other covariates	Hazard ratio detectable	
		90% power	80% power
PCI			
8:1	0 (i.e. unadjusted)	1.48	1.41
	0.3	1.60	1.50
	0.5	1.74	1.62
CABG			

4:1	0 (i.e. unadjusted)	1.83	1.69
	0.3	2.06	1.87
	0.5	2.35	2.10
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<b>Conservatively-managed ACS</b>			
2.5:1	0 (i.e. unadjusted)	1.32	1.27
	0.3	1.39	1.33
	0.5	1.48	1.40
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## Statistical analyses

We will describe temporal changes in DAPT prescribing and bleeding for PCI, CABG and ACS populations. We will use descriptive statistics to summarize the characteristics of the different intervention groups and standardised mean differences to compare them. We will estimate rates of bleeding (number of events/person time) with 95% confidence intervals (CIs) for each group. We will separate major and minor bleeding since adverse events of each type have different health and resource use consequences.

Analyses will estimate the effects of assigned intervention (analogous to an intention-to-treat analysis of a randomized trial) for the antiplatelet regimens corresponding to the first prescription of aspirin or DAPT in CPRD (see Interventions). We will use parametric survival models to estimate adjusted hazard ratios (HRs) with 95% CIs for the time to first bleeding event, comparing intervention groups for each target trial. Exploratory analyses, including assessment of proportional hazards assumptions, will be used to inform the choice of survival distribution (e.g. Weibull). Estimated time-dependent event probabilities will be used to update existing cost-effectiveness models [26]. The confounding factors to be included in the model (which will be identified as described previously and grouped into confounding domains from our dataset), the modelling strategy and the approach to handling correlated covariates will be documented in a data analysis plan. Participants free from a bleeding event will be censored at 12 months after the index event. For secondary endpoints we will use survival models to estimate adjusted hazard ratios (HRs) with 95% CIs for time

to first event. For mortality outcomes, we will take account of the competing risks of death due to other causes.

We will perform three sets of sensitivity analyses:

1. We will address the unknown intervention group of eligible patients who have no prescription data and therefore cannot be assigned to an intervention (i.e. those that died before receiving their first prescription, had a major bleed which caused them to stop DAPT, or have no aspirin/DAPT prescription recorded in CPRD within the 2 month window). These analyses will be undertaken using multiple imputation methods to deal with missing information on DAPT medication and will take patient characteristics, procedure/diagnosis and general medication policies into account, using a range of assumptions.
2. We will address the possibility that some minor bleeding events are not documented in CPRD but nevertheless prompt medication changes. We anticipate that most bleeding events will occur soon after the index event and before any medication change. Medication changes will be described relative to bleeding events observed (e.g. before event, after event, no bleeding event observed). If a substantial proportion (>10%) of people change medication before their first bleeding event, we will perform a sensitivity analysis excluding these patients.
3. We will assess the sensitivity of our findings when the analysis is restricted to a sub-population of patients at low risk of bleeding (i.e. excluding people at high risk for bleeding) who, we hypothesise, have the lowest risk of residual confounding.

We will attempt to identify an instrumental variable (e.g. clinician/GP practice prescribing practice) to control for confounding by indication. If we are successful we will repeat the above analyses for the PCI, CABG and ACS populations.

We will explore the consistency of treatment effect estimates in the following subgroups: ACS vs non-ACS (PCI and CABG populations); diabetic vs non-diabetic; chronic kidney disease vs. non-chronic kidney disease; concurrent prescription for proton pump inhibitors vs. no prescription for proton pump inhibitors. All subgroups will be defined in the data analysis plan and chosen based on the characteristics of the analysis populations before carrying out any analyses by intervention group. We will report p values from tests of interaction.



### **Triple therapy (TT)**

We will establish additional groups of patients (PCI or CABG or conservatively-managed ACS) based on triple therapy (TT) prescription. The main reason for prescribing an anticoagulant is to treat atrial fibrillation in a patient otherwise eligible for either of the three target trials. Atrial fibrillation can precede (long-term anticoagulation for pre-existing atrial fibrillation) or follow the index event (anticoagulation for new-onset atrial fibrillation).

**Figure 2** shows how the patient groups receiving TT will be constructed.

We will identify patients on long-term anticoagulation by identifying prescriptions of oral anticoagulants (warfarin, dabigatran, rivaroxaban, apixaban) in the 3 months before their index event and a concomitant prescription of any anticoagulant (TT) with DAPT and in the first two months after the index admission. Patients who develop atrial fibrillation after the index event will be identified from any new anticoagulant prescription during follow-up. We have compiled a list of all drug codes in CPRD for antiplatelet agents (aspirin, clopidogrel, prasugrel and ticagrelor) and anticoagulants (warfarin, dabigatran, rivaroxaban, apixaban) (see **Appendix 3**).

In patients receiving various TT regimens (grouped by pre-index event anticoagulant prescription and post-index event anticoagulant prescription in PCI, CABG and ACS separately, see Figure 2), we will describe rates of bleeding (number of events/person time) with 95% CIs for each group. We have not specified comparison groups because we know there is large variation in prescribing of anticoagulants; TT is usually prescribed for a relatively short period of time (1-6 months, depending on a patient's individual risks of thrombosis and bleeding) after which an antiplatelet agent (usually aspirin) is removed and patients continue to receive an anticoagulant and single antiplatelet for the remainder of the 12 months after the index admission.

### **Patient and public involvement**

We set up a patient advisory group comprising of patients from our three cohorts (PCI, CABG and conservatively-managed ACS). The group was consulted about several aspects of the proposed study. Group members confirmed the importance of the research topic and

agreed that the choice of antiplatelet regimen should be based on shared decision making, with clinicians and patients weighing the potential benefits against the adverse side effects and practical inconvenience. Our PPI group will attend regular meetings to discuss results from the study and will also contribute and collaborate on the development of our results dissemination strategy.

### **Ethics and dissemination**

This study protocol has approval from the Independent Scientific Advisory Committee for the UK Medicines and Healthcare products Regulatory Agency Database Research (protocol 16\_126R). We also obtained ethical approval for the semi-structured interviews with clinicians and survey from South West Cornwall and Plymouth Research Ethics Committee, 17/SW/0092. The findings will be presented at national/international conferences, published in peer-reviewed academic journals and accessible formats in newsletters to patients (where available). The findings will also be reported as a briefing paper to commissioners (e.g. commissioning groups, National Institute for Health and Care Excellence, NICE) and to other health care stakeholders with an interest in the research through the Cardiac & Stroke Networks. We will also present and discuss our results at local CPRD working groups to disseminate our methods to other researchers using the CPRD database.

### **Author contributions**

MP: designed and will conduct the study and wrote the manuscript.

JH: study statistician responsible for data linkage and analysis.

JACS: provided strategic direction with respect to study design and analysis.

TJ: conceived the research question and provided cardiology expertise.

DL: provided general practice expertise, clinical epidemiological expertise

AM: conceived the research question and provided haematology expertise.

BD: provided health economics expertise.

SW: provided health economics expertise.

UB: provided cardiac surgery expertise.

CAR: provided guidance with respect to the statistical analysis.

YL: provided pharmacoepidemiology expertise.

CP: responsible for conduct of the qualitative study with clinicians.

SR: will oversee conduct and reporting of the qualitative study with clinicians.

BCR: provided strategic direction with respect to study design and analysis.

All authors read and approved the final version of the manuscript.

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## **Competing interests**

TJ has received speaker & consultancy fees from Astra Zeneca & Daichi-Sankyo

None of the other authors have competing interests to declare.

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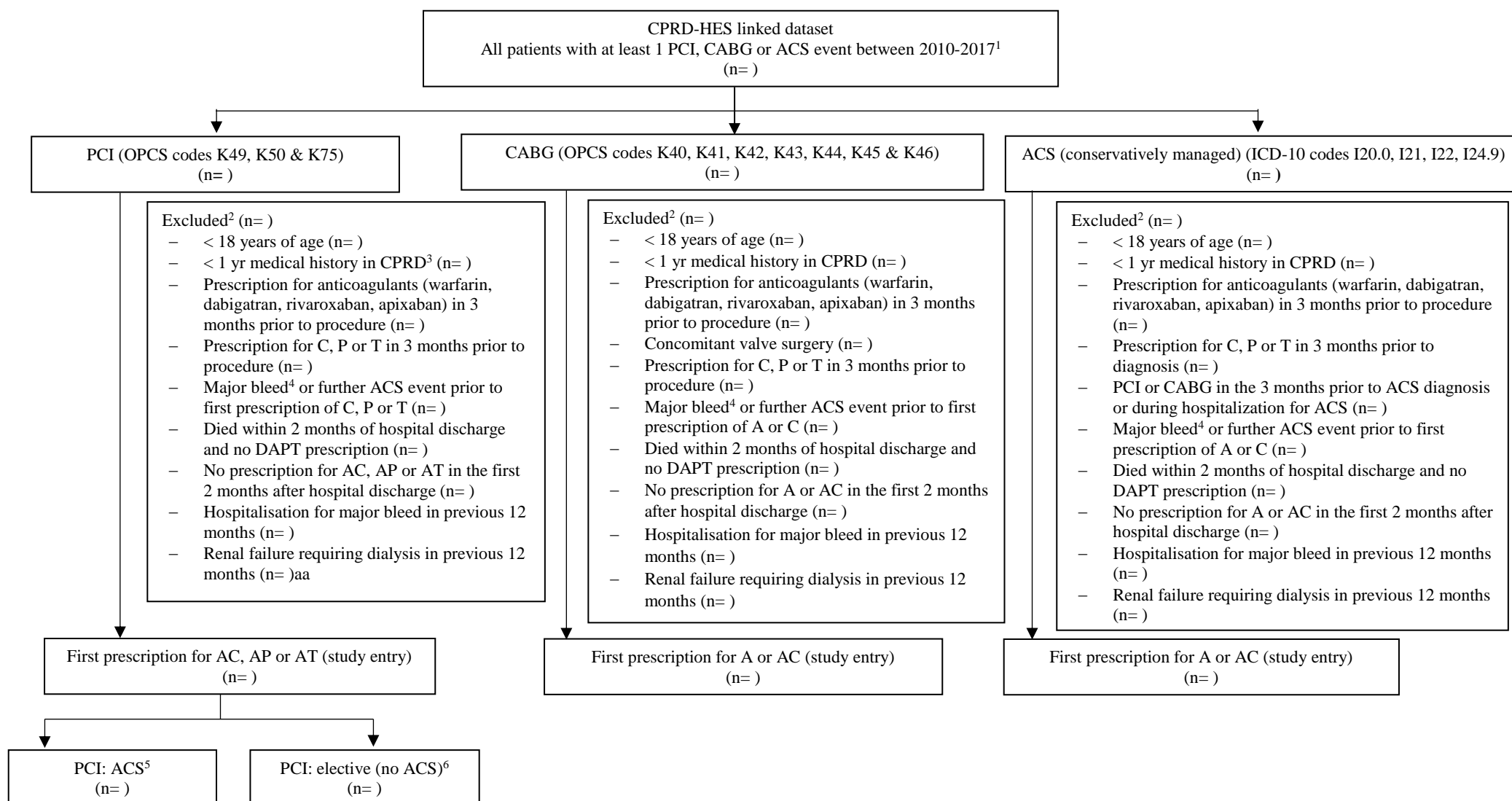
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**Figure 1.** Study diagram describing the construction of the PCI, CABG and ACS (conservatively managed) populations

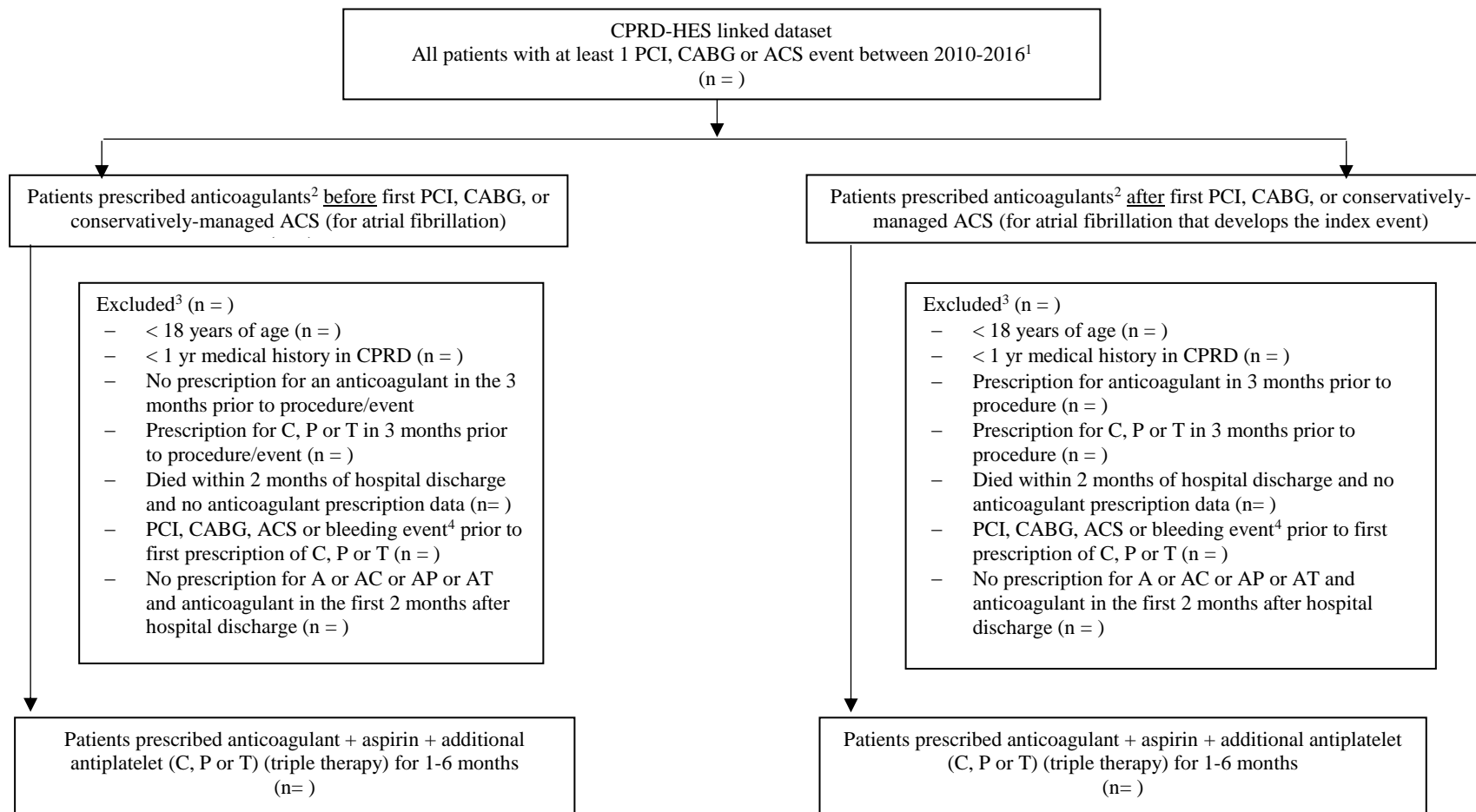


C: clopidogrel; P: prasugrel; T: ticagrelor; AC: aspirin + clopidogrel; AP: aspirin + prasugrel; AT: aspirin + ticagrelor

ACS: acute coronary syndrome; CABG: coronary artery bypass grafting; CPRD, Clinical Practice Research Datalink; HES; Hospital Episode Statistics; ICD International Classification of Diseases; OPCS, Office of Population Censuses and Surveys; PCI: percutaneous coronary intervention.

<sup>1</sup>Continuous inpatient stays (CIPS) that include both PCI and CABG are considered CABG; CIPS that include both ACS and PCI are considered PCI; CIPS that include both ACS and CABG are considered CABG. <sup>2</sup>Patients may be excluded for more than one reason. <sup>3</sup>At least one year of CPRD data available prior to event plus not “transferred out” before the event plus GP practice up to standard date precedes event date by at least 12 months. <sup>4</sup>Major bleed captured within hospital admission. <sup>5</sup>PCI and ACS in the

**Figure 2.** Study diagram describing the construction of the triple therapy (TT) populations



C: clopidogrel; P: prasugrel; T: ticagrelor; AC: aspirin + clopidogrel; AP: aspirin + prasugrel; AT: aspirin + ticagrelor

ACS: acute coronary syndrome; CABG: coronary artery bypass grafting; CPRD, Clinical Practice Research Datalink; HES, Hospital Episode Statistics; ICD International Classification of Diseases; OPCS, Office of Population Censuses and Surveys; PCI: percutaneous coronary intervention.



<sup>1</sup>Continuous inpatient stays (CIPS) that include both PCI and CABG are considered CABG; CIPS that include both ACS and PCI are considered PCI; CIPS that include both ACS and CABG are considered CABG. <sup>2</sup>Warfarin, dabigatran, rivaroxaban, apixaban. <sup>3</sup>Patients may be excluded for more than one reason. <sup>4</sup>Bleeding event captured within hospital admission or GP appointment.