HIGH TECH MARSEILLE

28-30 JANVIER 2026

MARSEILLE
PALAIS DU PHARO

LES ÉTUDES QUI POURRAIENT CHANGER MA PRATIQUE

La gestion post-angioplastie du patient anticoagulé : étude AQUATIC

Nicolas Meneveau CHU Besançon

CONFLITS D'INTÉRÊTS

Consulting fees - Abbott Medical

Consulting fees - Boston Scientific

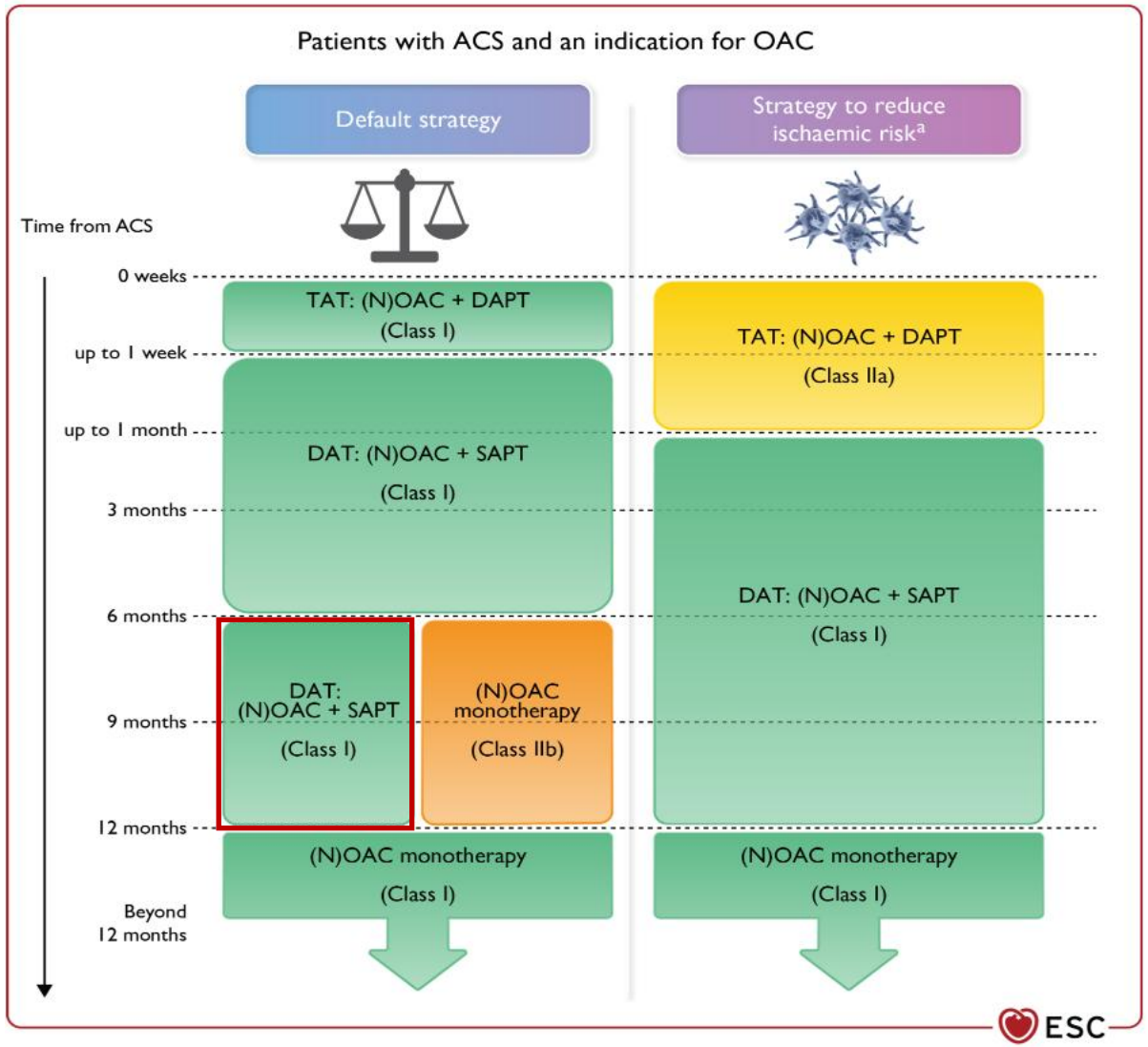
Consulting fees - INARI

Consulting fees - Edwards Lifesciences

Consulting fees - TERUMO

Honoraria - AstraZeneca Honoraria - Alliance BMS/Pfizer

AT after PCI in pts with indication for OAC : What is currently recommended ?



After uncomplicated PCI in CCS patients with concomitant indication for OAC:

- early cessation of aspirin (≤1 week);
- followed by continuation of OAC and clopidogrel:
  - up to 6 months in patients not at high ischaemic risk or
  - up to 12 months in patients at high ischaemic risk;
- followed by OAC alone;

is recommended.

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CCS Guidelines ESC 2024

ACS Guidelines ESC 2023

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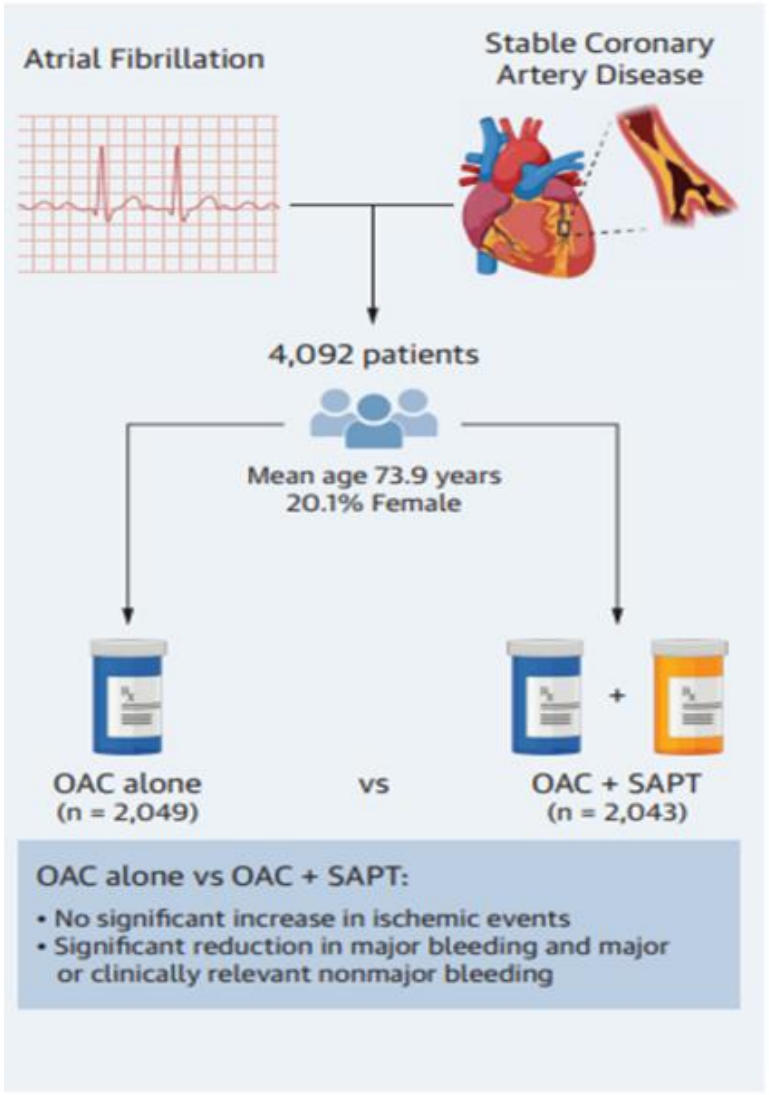
Can we shorten SAPT in Pts with AF & Stable CAD ?



4 Randomized Controlled Trials

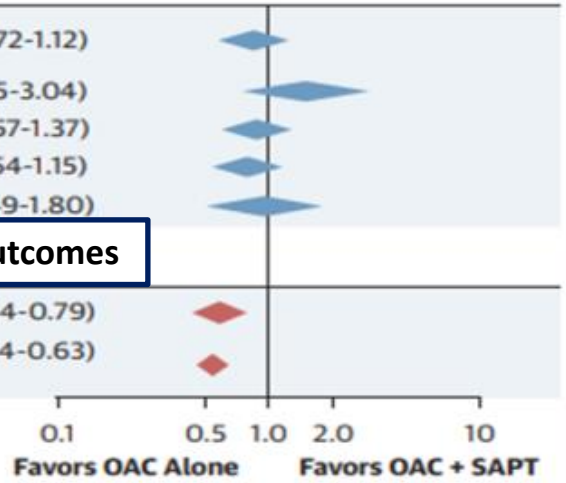
EPIC-CAD (N=1040)	PRAEDO-AF (N=147)	AFIRE (N=2215)	OAC-ALONE (N=690)
Edoxaban	Edoxaban	Rivaroxaban	Warfarin (75.2%) DOACs (24.8%)
Aspirin (61.8%) $P2Y_{12}$ Inhibitor (37.8%)	$P2Y_{12}$ Inhibitor	Aspirin (70.2%) $P2Y_{12}$ Inhibitor (26.8%)	Aspirin (86.4%) $P2Y_{12}$ Inhibitor (13.6%)

Effectiveness Outcomes

Prespecified Outcomes	HR (95% CI)
Composite of MI, Ischemic Stroke, Systemic Embolism, or Death	0.90 (0.72-1.12)
Myocardial Infarction	1.51 (0.75-3.04)
Ischemic Stroke	0.89 (0.57-1.37)
Cardiovascular Death	0.79 (0.54-1.15)
All-Cause Death	0.94 (0.49-1.80)

Safety Outcomes

Major Bleeding	0.59 (0.44-0.79)
Major or Clinically-Relevant Nonmajor Bleeding	0.53 (0.44-0.63)



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Rashedi S, et al. JACC. 2025;85(11):1189–1203.

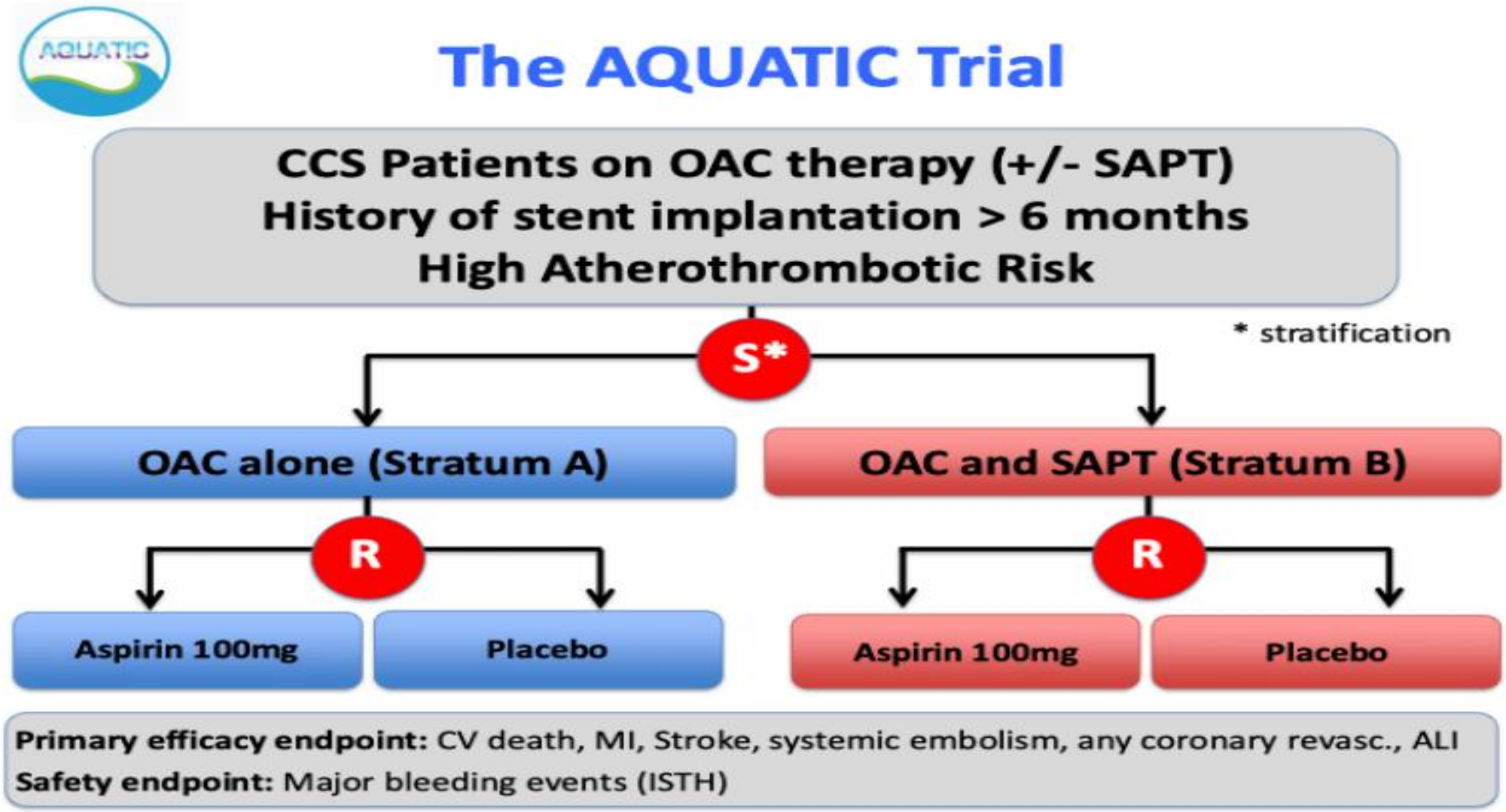
Atherothrombotic risk profile

	OAC-ALONE	AFIRE	PRAEDO-AF	EPIC-CAD
Diabetes (%)	42	42	42.9	40.4
$CHAD_2DS_2$-VASc	4.6	4	4	4.3
History of stroke (%)	15	14.5	14.3	14.8
History of MI (%)	38.6	35	75.5	16.4
PCI (%)	100	70.6	84.4	60.2
Delay PCI - enrollment	>1 year	>1 year	>6-12 months*	>6-12 months**
PAD (%)	11.9	-	-	7.5
Heart Failure (%)	42.2	-	-	19.7

* > 6 months after PCI with 3rd generation DES & > 12 after PCI with other stents

** > 6 months after PCI/CABG in CCS pts & > 12 months after PCI/CABG in ACS pts

Design : prospective; double-blind; randomized; placebo-controlled; multicenter (51 french centers).



Didier R et al. Archives of Cardiovascular Disease 118 (2025) 296–303.

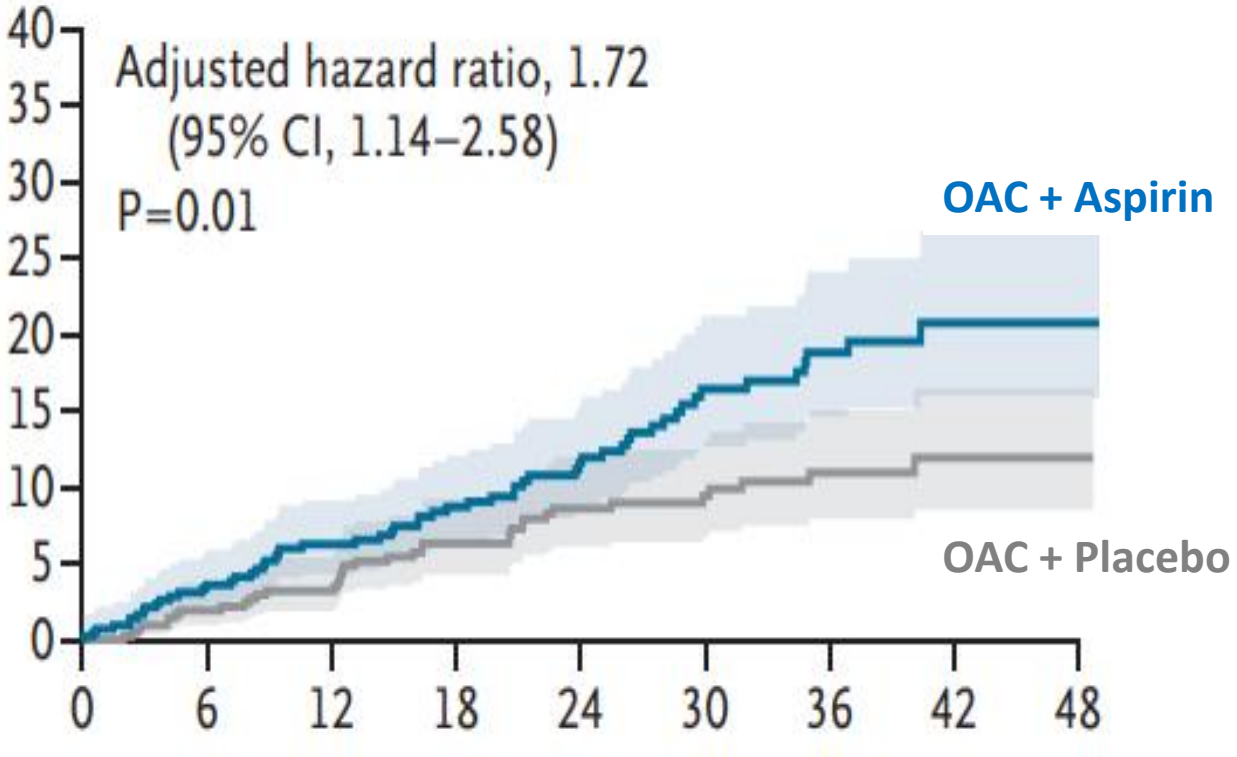
AQUATIC = high residual atherothrombotic risk

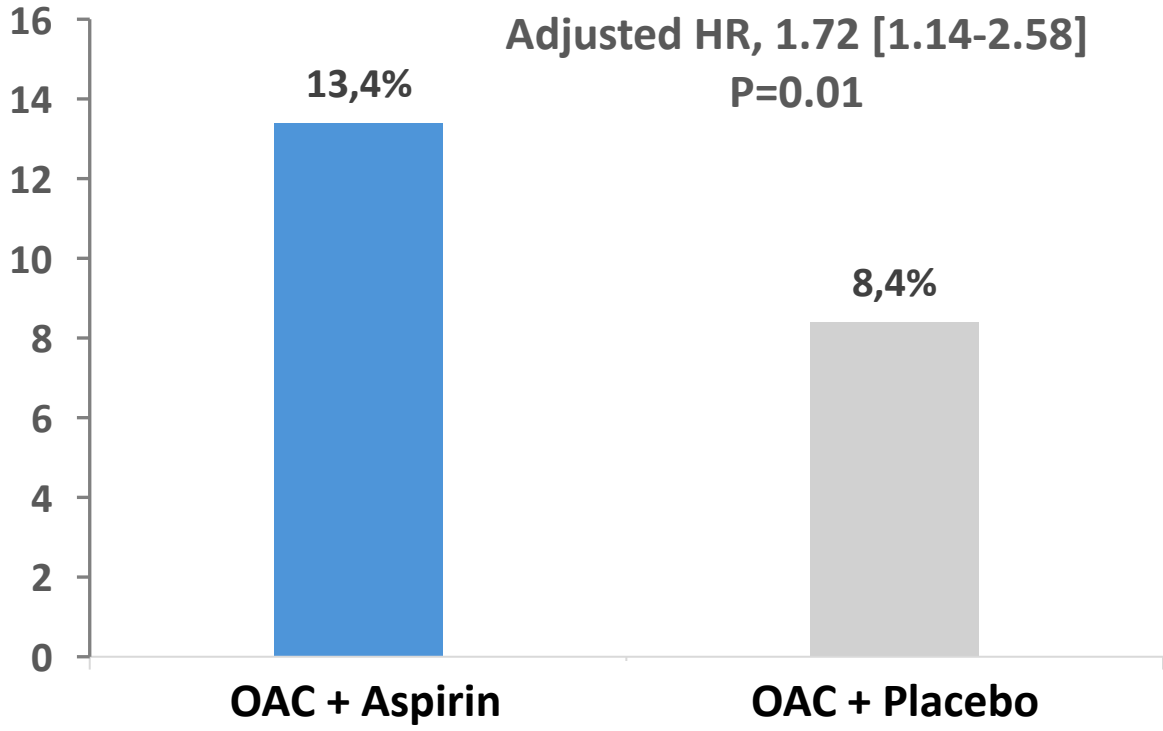
	OAC-ALONE	AFIRE	PRAEDO-AF	EPIC-CAD	AQUATIC
Diabetes (%)	42	42	42.9	40.4	37.4
$CHAD_2DS_2$-VASc	4.6	4	4	4.3	4
History of stroke (%)	15	14.5	14.3	14.8	10.7
History of MI (%)	38.6	35	75.5	16.4	72.1
PCI (%)	100	70.6	84.4	60.2	100
Delay PCI - enrollment	>1 year	>1 year	>6-12 months	>6-12 months	>6 months
PAD (%)	11.9	-	-	7.5	14.4
Heart Failure (%)	42.2	-	-	19.7	26.5

High residual atherothrombotic risk = PCI in ACS pts or in pts with diabetes, diffuse 3 vessel disease, CKD (CrCl < 50 mL/min), previous stent thrombosis, peripheral artery disease, or a history of complex PCI

Excess of death from any cause
=> trial stopped early after a median FUP of 2.2 yrs

872 randomized pts : 433 assigned to the aspirin group & 439 to the placebo group





Lemesle G, et al. NEJM 2025;393:1578-88.

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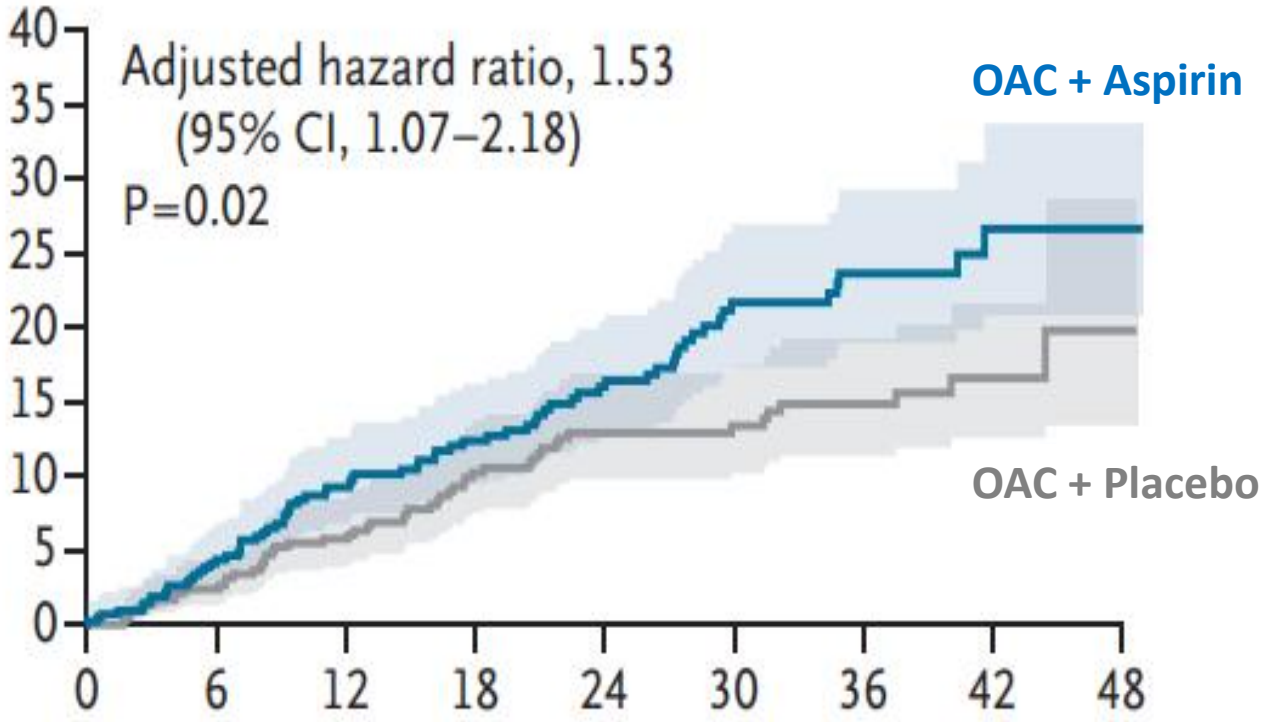
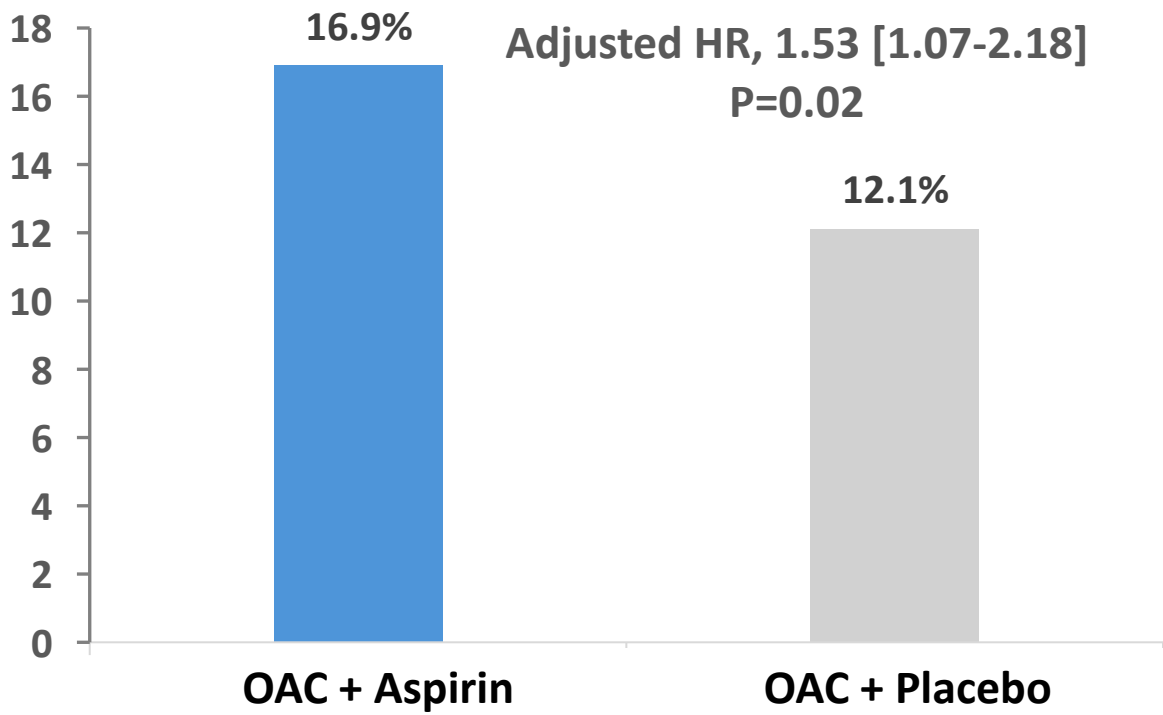
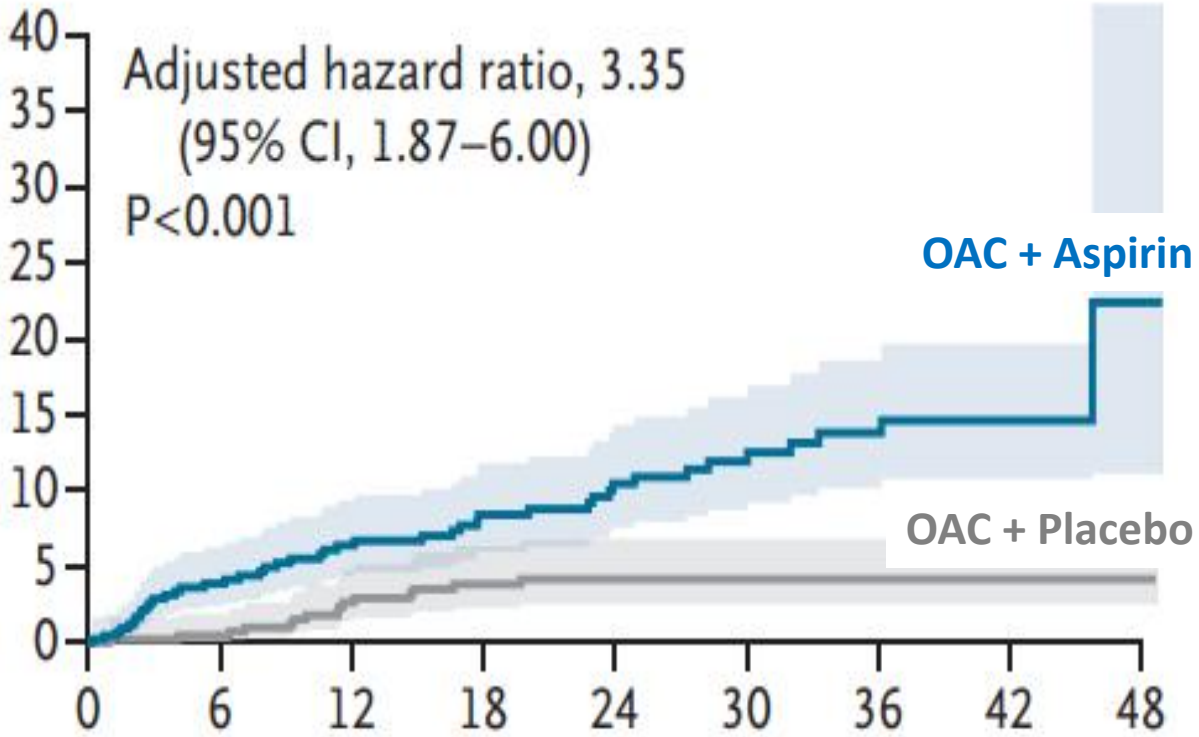
Cardiovascular Death, MI, Stroke, Embolism, Coronary Revascularization, or Limb Ischemia

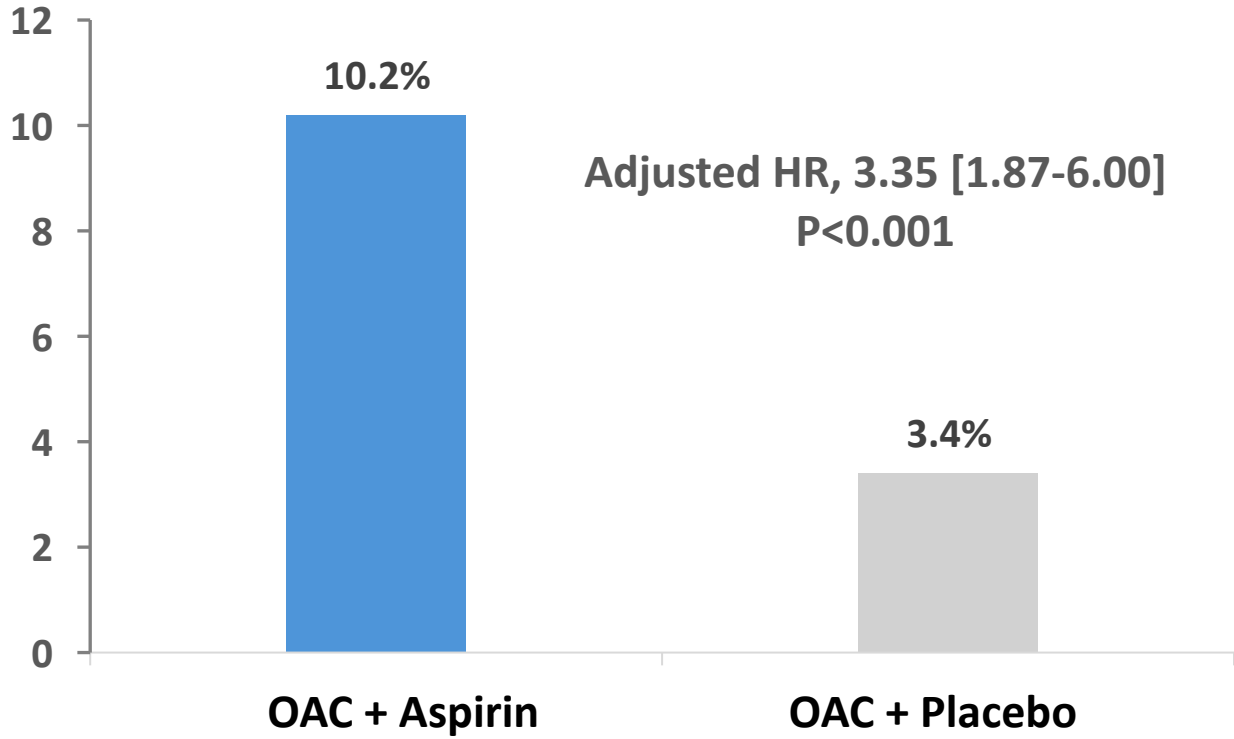




Lemesle G, et al. NEJM 2025;393:1578-88.

Major Bleeding according to ISTH criteria





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Discussion

In pts with CCS at high atherothrombotic risk receiving OAC, addition of aspirin :

⇒ higher risks of CV events / death from any cause / bleedings

Putting the results in perspective with other RCTs :

- **AFIRE** : stopped early stop because of excess all-cause death in aspirin group
- **AFIRE & EPIC-CAD** : adding aspirin to OAC substantially increased the risk of major bleeding

=> bleeding events associated with higher risk of death

- **AQUATIC** population : incidence of atherothrombotic events 7 – 8x higher than in previous RCTs
- **ADAPT-AF DES** : NOAC monotherapy non-inferior to NOAC + clopidogrel for net adverse events

=> OAC alone without antiplatelet drugs should be the default strategy from 6 months after PCI

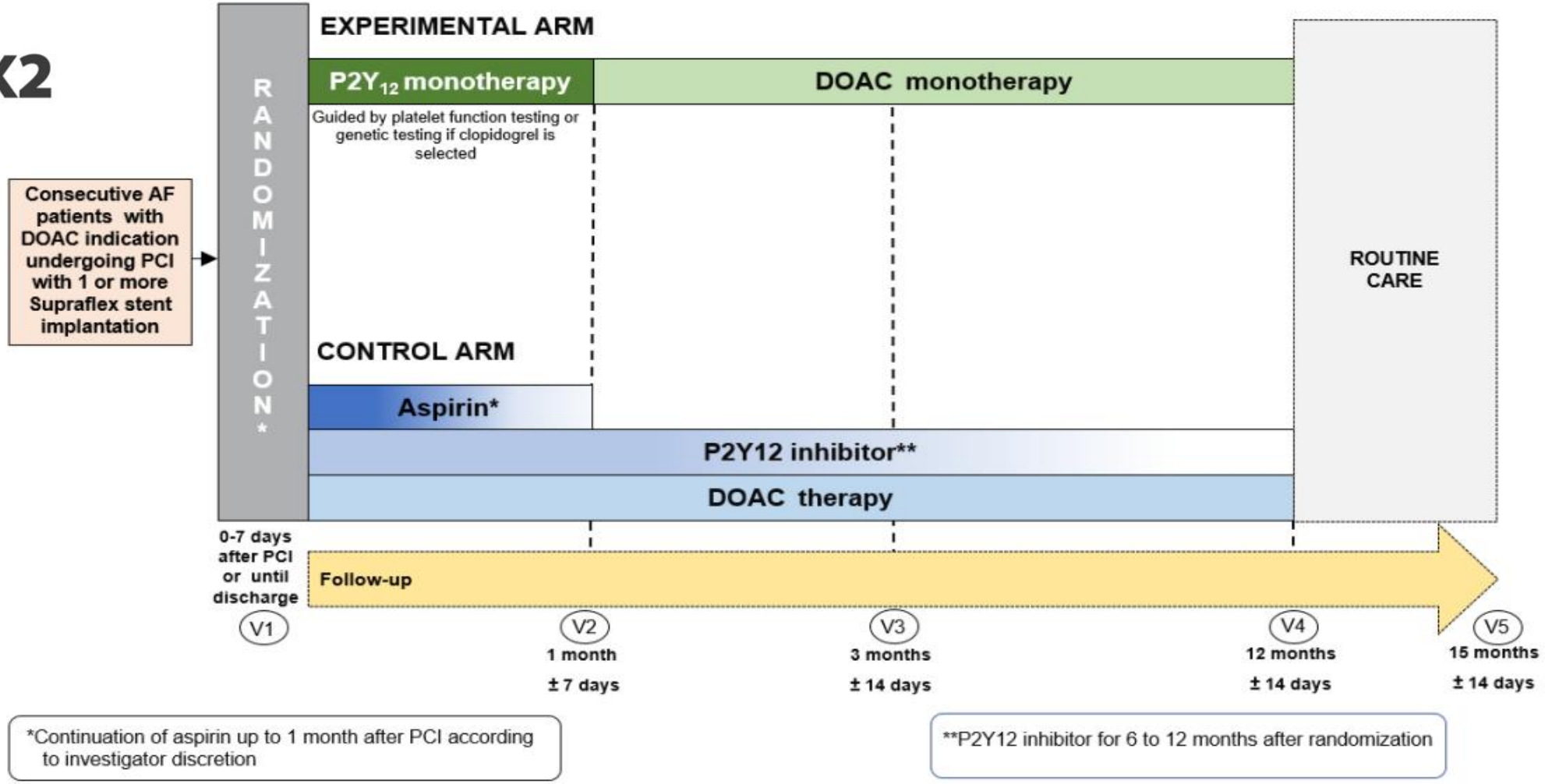
Discussion

Remaining questions & limitations :

- **Superiority of dual-pathway therapy for atherothrombotic events ?**
  - early stop => ↘ statistical power ?
- **Under-representation of women (15%) :**
  - sex-related ≠ in the efficacy & safety of AT regimens ?
- **Optimal AT treatment regimen within the 1st 6 months after PCI ?**
  - antiplatelet effect of clopidogrel subject to interindividual variations
  - more reliable effects of prasugrel/ticagrelor
  - => completely aspirin-free strategy feasible ?

What's next ?

MATRIX2



*Continuation of aspirin up to 1 month after PCI according to investigator discretion

**P2Y12 inhibitor for 6 to 12 months after randomization

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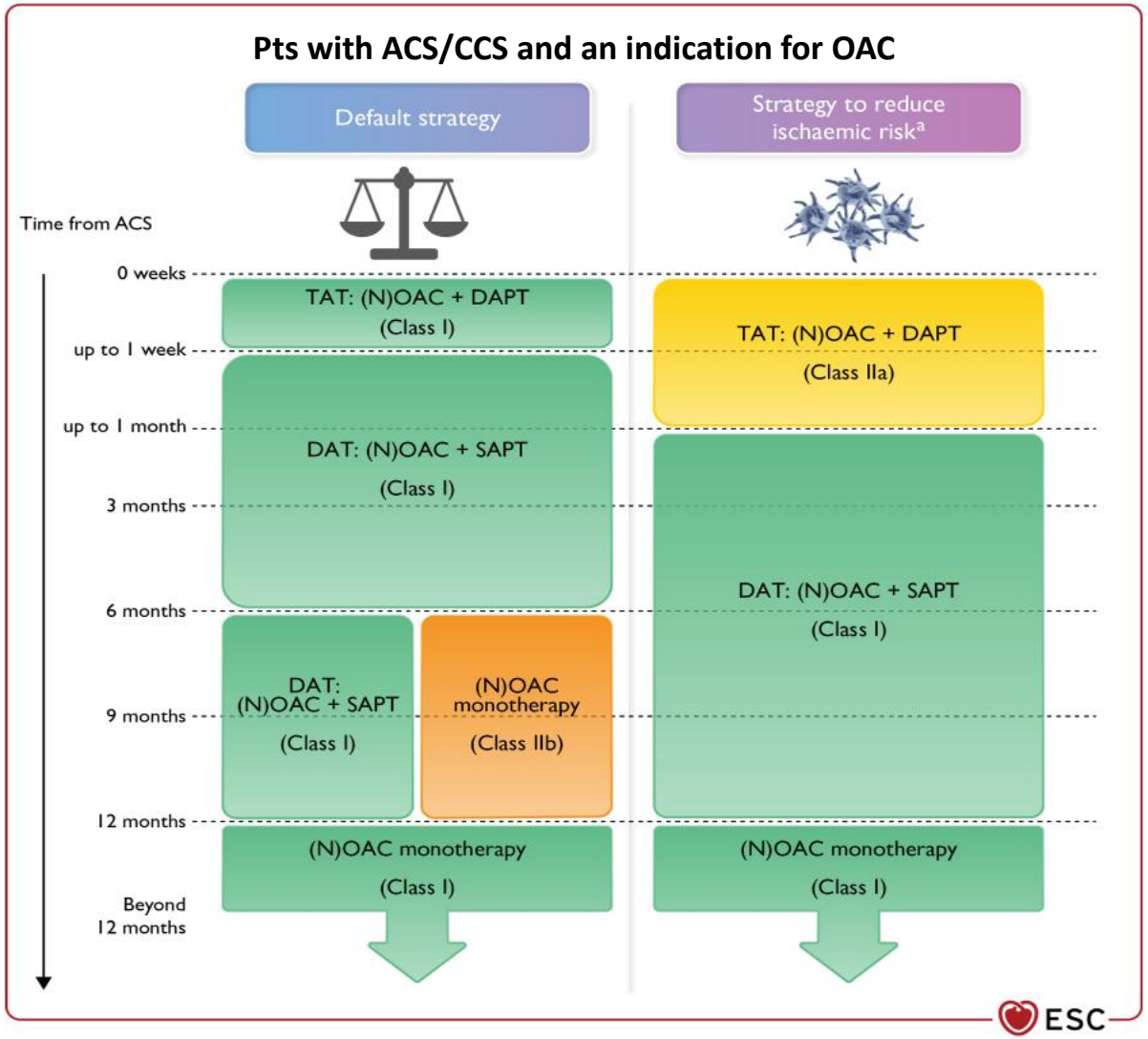
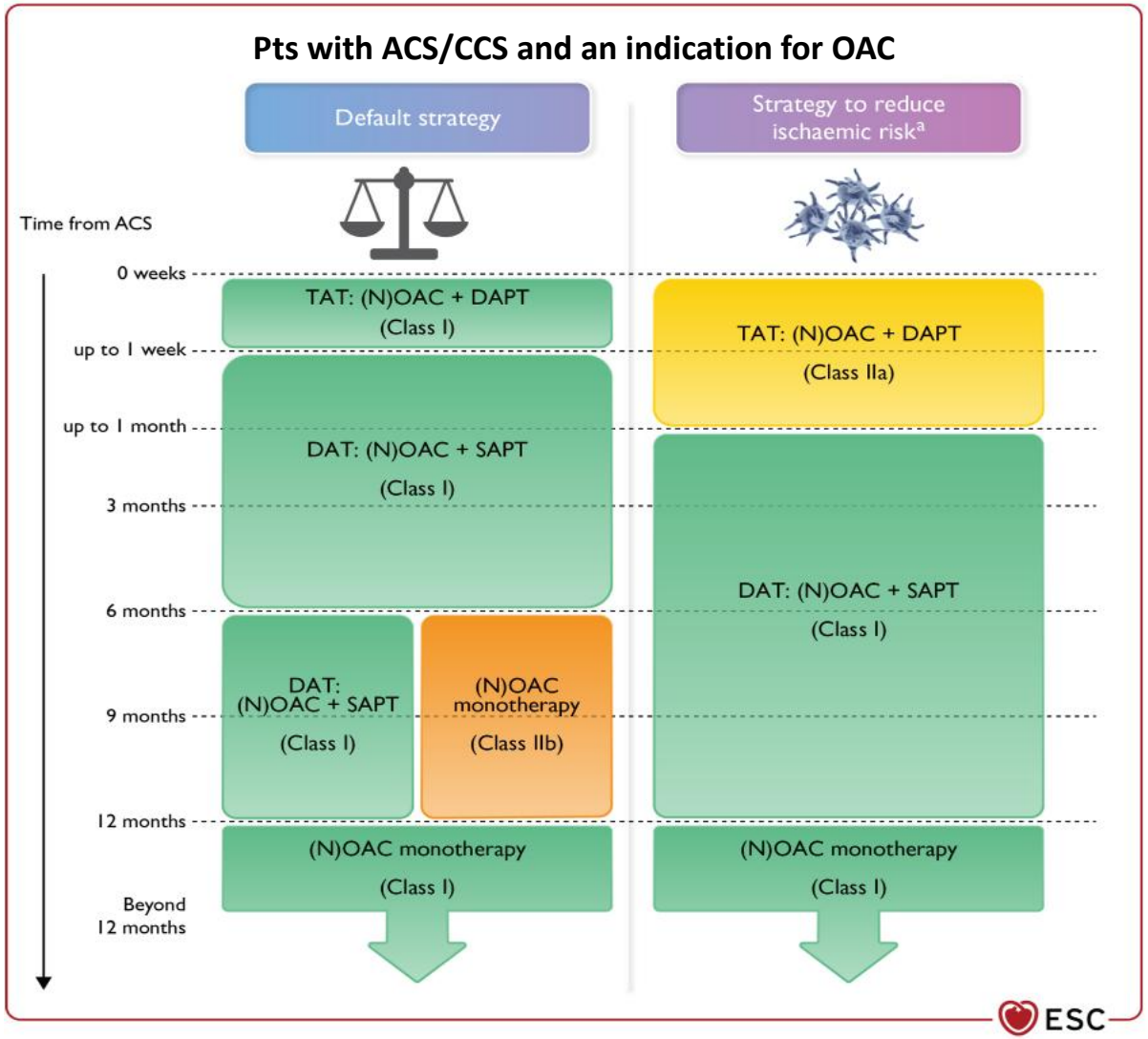
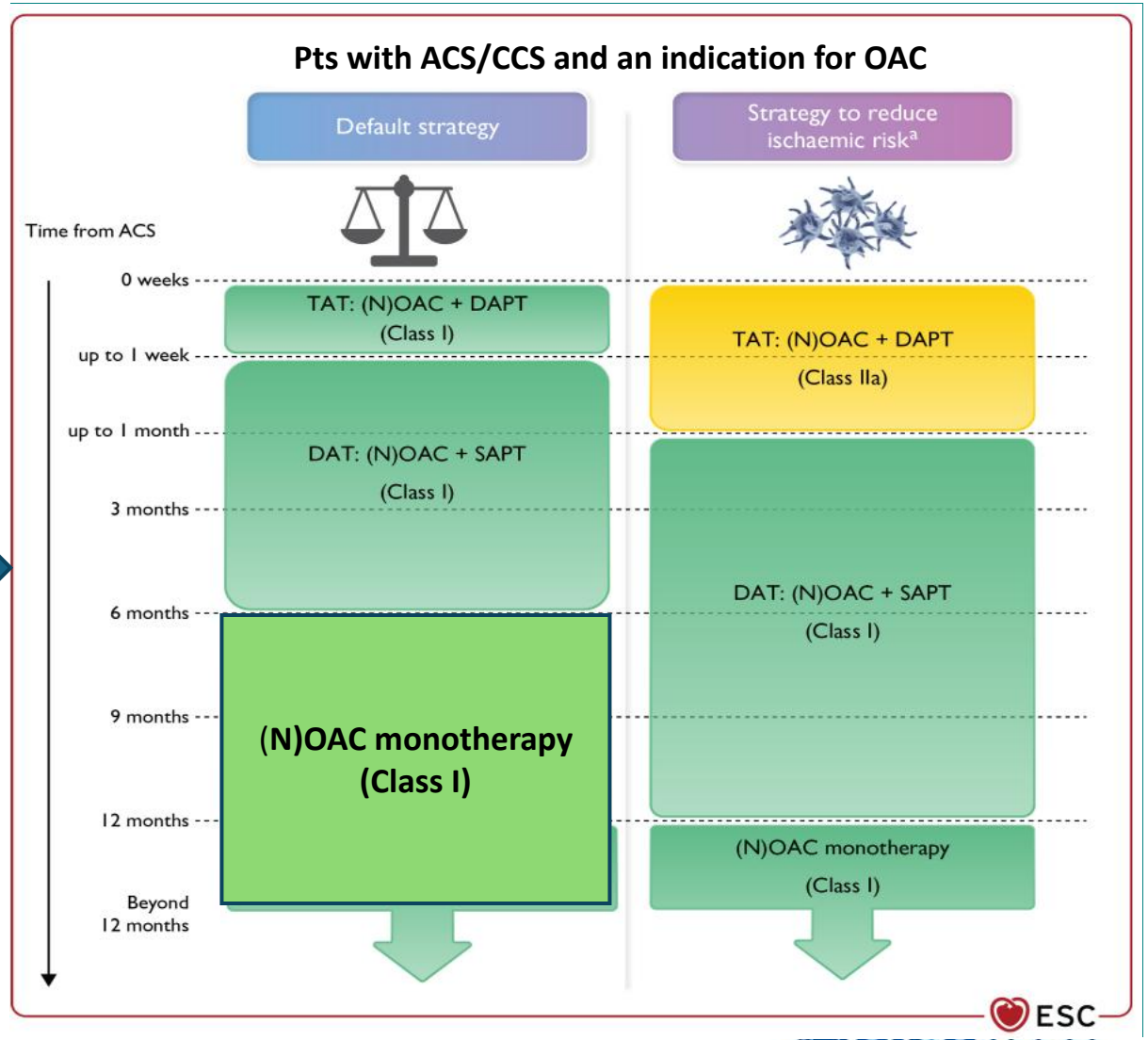
Will AQUATIC change our practice ?



Will AQUATIC change our practice ? … for sure





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