Supplementary Online Content

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

eAppendix. Committees and Investigators

Executive committee

Coprincipal Investigator	M. Valgimigli
Coprincipal Investigator	P.C. Smits
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Sponsor Representative	From June 1 2018, G.B.W.E. Vos
Sponsor Representative	From October 16, 2020, E. Spitzer
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Clinical Research Organization Representative	M.C. Morice
Cardiologists	Y. Onuma; E. Frigoli
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Steering committee

National Lead Investigators

Bangladesh, India	M.S. Ajit
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Belgium	J. Bartunek
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Italy	A. Colombo
United Kingdom	D. Hildick-Smith
Portugal, Spain	A. Iñiguez
Austria, Denmark, Estonia, Germany, Sweden	F. Mahfoud
Israel	R. Kornowski
Bulgaria, Czech Republic, Hungary, Poland	M. Lesiak
Singapore, South Korea, Vietnam	P.J. Ong
Japan	Y. Ozaki
Argentina	A.E. Rodriguez
Switzerland	M. Roffi
Australia	C. Schultz
Macedonia, Serbia	G. Stankovic
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Top enrollers

Inselspital, Bern, Switzerland	Aris Moschovitis
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Chair	M. Bertrand
Biostatistician	S. Pocock
Cardiologist	P. Urban

Clinical events committee

Chair	S. Leonardi
Cardiologists	C. Hanet; R. Lopes; E.P. McFadden; P. Radke; E. Spitzer
Neurologist	R. O. Roine

Safety reporting group (Cardialysis, Rotterdam, The Netherlands)

Boudijn Ladan (Safety Specialist), Laura van der Waal (Safety Assistant), Yvonne Engelbrecht (Safety Assistant), Fred Paddenburg (Safety Manager), Ben Ren, M.D., Ph.D. (Medical Reviewer).

CEC management group (Cardialysis, Rotterdam, The Netherlands)

Ingrid de Zwart (Data Manager), Liliane Elshout (Data Manager), Judith Jonk (Data Manager), Tessa Rademaker-Havinga (Statistician).

Project management

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

Countries, investigators, and numbers of patients enrolled

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

Country	Site name	Principal investigator	Patients randomised (n=4579)	Patients consented but not randomised (n=625)
	Plovdiv, MHAT "Sveta Karidad" Plovdiv	Dr Dimitar Karageorgiev	60	10
	Sofia, National Heart Hospital	Dr Hristo Mateev	23	1
	Sofia, Tokuda Hospital	Prof. Valeri Gelev	9	
Czech Republic			134	17
	Brno, University Hospital Brno	Prof. Petr Kala	120	17
	Praha, Na Homolce Hospital	Dr Martin Mates	14	
Denmark	Roskilde, Roskilde Hospital Kogevej	Dr Henning Kelbæk	13	
Estonia	Tallinn, North-Estonia Medical Centre Foundation	Dr Peep Laanmets	259	12
France			578	67
	Massy, Hopital Prive Jacques Cartier	Dr Thomas Hovasse	129	19
	Montauban, Clinique du Pont de Chaume	Dr Laurent Delorme	124	7
	Marseille, CHU La Timone	Prof. Thomas Cuisset	41	
	Annecy, Centre Hospitalier Annecy Genvois	Dr Loïc Belle	37	
	Caen, Centre hospitalier regional universitaire de Caen	Prof. Farzin Beygui	33	9
	Nantes, Hopital Prive le Confluent	Dr Ashok Tirouvanziam	31	
	Montpellier, Clinique du Millenaire	Prof. Christophe Piot	30	4
	Caen, Hopital Prive Saint Martin	Dr Jean François Morelle	27	4
	Rouen, Clinique Saint-Hilaire	Dr Rene Koning	27	7
	Metz, Hopital de Mercy	Dr Mathieu Valla	24	3
	Dijon, GCIDB – Hopital Prive Dijon Bourgogne	Dr Philippe Brunel	23	5
	Nimes, CHU Caremeau	Dr Guillaume Cayla	18	4
	Creteil, Centre Hospitalier Universitaire Henri-Mondor	Prof. Emmanuel Teiger	12	2
	Paris, Hopital Universitaire Pitie-Salpetriere	Prof. Gilles Montalescot	10	2
	Paris, Hopital Europeen Georges-Pompidou	Prof. Christian Spaulding	9	1
	Saint-Denis, Centre Cardiologique du Nord	Dr Phillipe Guyon	3	
Germany			24	6

Country	Site name	Principal investigator	Patients randomised (n=4579)	Patients consented but not randomised (n=625)
	Homburg, Saarland University	Prof. Felix Mahfoud	20	6
	Landshut, Landshut-Archdorf Krankenhaus	Dr Pyxaras, Stylianos	4	
Hungary			68	5
	Budapest, Semmelweis University Heart and Vascular Center	Prof. Béla Merkely	46	5
	Szeged, Invasive Cardiology Unit University of Szeged	Dr Imre Ungi	22	
India			147	11
	Coimbatore, G Kuppuswamy Naidu Memorial Hospital	Dr Rajpal K Abhaichand	94	10
	Surat, Shri BD Mehta Mahavir Heart Institute	Dr Atul Damodar Abhyankar	33	
	Chennai, Apollo Hospitals, Chennai	Dr Sengottuvelu. G	13	1
	Chennai, Madras Medical Mission	Dr Ajit Mullasari. S	7	
Israel			100	33
	Safed, Ziv Medical Center, Cardiology Department	Dr Halabi Majdi	37	9
	Petach Tikva, Rabin MC	Prof. Ran Kornowski	34	11
	Haifa, Rambam Medical Center	Prof. Ariel Roguin----from 14th Oct 2018 Dr Yair Feld	16	6
	Jerusalem, Hadassah Ein Karem Medical Center	Prof. Chaim Lotan	13	7
Italy			276	37
	Rome, Policlinico Casilino	Dr Michael Donahue	99	6
	Vimercate, Ospedale di Vimercate	Dr Stefano Garducci	48	3
	Rozzano, Humanitas Research Hospital	Dr Bernhard Reimers	30	2
	Rome, Policlinico Umberto I	Dr Gennaro Sardella	20	2
	Milan, San Raffaele Hospital	Dr Antonio Colombo---from 20th June 2019 Dr Alaide Chieffo	12	1
	Catania, Ferrarotto Hospital	Prof. Corrado Tamburino	9	2
	Messina, AOU Policlinico Martino	Dr Giuseppe Andò	8	4
	Milan, Policlinico San Donato	Dr Luca Testa	8	4
	Milan, Sacco Hospital	Dr Maurizio Di Biasi	8	6
	Rome, Ospedale Sandro Pertini	Dr Alessandro Sciahbasi	8	3
	Caserta, Azienda Ospedaliera di Caserta	Prof.Dr Paolo Calabro	6	1

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

Country	Site name	Principal investigator	Patients randomised (n=4579)	Patients consented but not randomised (n=625)
	Poznan, Szpital Kliniczny Przemienienia Panskiego	Prof. Maciej Lesiak	50	1
	Wroclaw, 4 Wojskowy Szpital Kliniczny	Dr Krzysztof Reczuch	33	1
	Lubin, Miedziowe Centrum Zdrowia SA	Dr Adian Wlodarczak	18	1
	Krakow, University Hospital Krakow Poland	Prof. Dariusz Dudek	7	
Portugal	Lisbon, Hospital de Santa Maria	Dr Pedro Canas da Silva	1	
Saudi Arabia	King Fahd Armed Forces Hospital	Dr Mirvat Alasnag	16	1
Serbia			138	11
	Belgrade, Institute for Cardiovascular Disease Dedinje	Dr Ljupco Mangovski − from 17 April 2019 Dr Dragan Topic	67	4
	Belgrade, Clinical Center of Serbia	Prof. Goran Stankovic	61	7
	Sremska Kamenica, Institute of Cardiovascular Diseases	Dr Dragan Debeljacki	10	
Singapore			46	10
	Singapore, Tan Tock Seng Hospital	Prof. Paul Ong Jau Lueng	38	10
	Singapore, KhooTeck Puat Hospital	Dr Syed Saqib Imran	8	
South Korea	Seoul, Asan Medical Center	Dr Park Seung-Jung	15	
Spain			196	10
	Huelva, Juan Ramon Jimenez Hospital	Dr José Francisco Diaz Fernandez	47	1
	Vigo, Alvaro Cunqueiro	Prof. Andrés Iniguez	40	2
	Barcelona, Hospital Vall Hebron	Dr Bruno Garcia del Blanco	27	
	Alicante, Hospital General Universitario de Alicante	Dr Vicente Mainar	19	2
	Madrid, Hospital 12 de Octubre	Dr Ivan Gomez Blazquez	17	
	El Palmar, Universitario Virgen de la Arrixaca	Dr Eduardo Pinar	15	1
	Madrid, Hospital Clinico San Carlos	Prof. Javier Escaned Barbosa	11	2
	Barcelona, Bellvitge University Hospital	Dr Joan Antoni Gomez Hospital	10	2
	Santander, Hospital Universitario Valdecilla	Dr Fermin Sainz	9	
	Majadahonda, Hospital Universitario Puerta de Hierro	Dr Javier Goicolea	1	
Sweden			8	
	Orebro, Orebro University Hospital	Dr Ole Fröbert	6	

Country	Site name	Principal investigator	Patients randomised (n=4579)	Patients consented but not randomised (n=625)
	Gavle, Gavle Hospital	Dr Robert Kastberg	2	
Switzerland			499	111
	Bern, Inselspital	Dr Aris Moschovitis---from 20th Oct 2020 Prof. Stephan Windecker	308	61
	Liestal, Kantonsspital Baselland	Dr Gregor Leibundgut	68	14
	Lugano, Cardiocentro Ticino	Dr Giovanni Pedrazzini	31	9
	Geneva, University Hospital	Prof. Marco Roffi	29	13
	Bern, Lindenhofspital	Dr Ali Garachemani	28	3
	Zurich, University Hospital Zurich	Dr Patrick Siegrist	18	7
	Fribourg, HFR Hopital cantonal	Prof. Stéphane Cook	17	4
Netherlands			539	122
	Rotterdam, Maasstad Ziekenhuis	Dr Peter Smits	233	79
	Terneuzen, Zorgsaam	Dr Al Mafragi	87	5
	Emmen, Treant Zorggroep	PI Dr Jessurun---from 1st July 2020 Dr Ruifrok	67	9
	Eindhoven, Catharina Ziekenhuis	Dr Pim Tonino	54	10
	Arnhem, Rijnstate Ziekenhuis	Dr Peter Danse	29	8
	Hertogenbosch, Jeroen Bosch Ziekenhuis	Dr J. Polad	21	3
	Dordrecht, Albert Schweitzer Ziekenhuis	Dr Floris Kauer	20	6
	Enschede, Medisch Spectrum Twente	Dr Clemens von Birgelen	19	
	Nieuwegein, Antonius Ziekenhuis Nieuwegein	Dr Jurrien ten Berg	5	1
	Breda, Amphia Ziekenhuis	Dr Sander Ijsselmuiden	3	
	Den Haag, Hagahospital	Dr Samer Somi	1	1
United Kingdom			279	48
	Bristol, Bristol Heart Institute	Dr Tom Johnson	55	13
	Worcester, Worcestershire Royal Hospital	Dr Helen Routledge	43	8
	Brighton, Brighton & Sussex University Hospitals Trust	Dr David Hildick-Smith	40	3
	Bournemouth, Royal Bournemouth Hospital	Dr Jehangir Din	34	7
	Wolverhampton, Heart and Lung Centre – New Cross Hospital	Dr Shahzad Munir	22	6

Country	Site name	Principal investigator	Patients randomised (n=4579)	Patients consented but not randomised (n=625)
	Blackburn, Royal Blackburn Hospital	Dr John McDonald	20	1
	Stevenage, Lee Haynes Research Institute, Lister Hospital	Dr Neville Kukreja	20	1
	Stoke on Trent, Royal Stoke University Hospital	Prof. Mamas Mamas	20	5
	Newcastle upon Tyne, Freeman Hospital	Dr Rajiv Das	13	1
	Manchester, Wythenshawe Hospital	Dr Hussain Contractor	8	3
	Derry, Altnagelvin Hospital	Dr Aaron Peace	2	
	London, St. George's Hospitals	Dr Rupert Williams	2	
Vietnam	Vietnam National Heart Institute – Bach Mai Hospital Hanoi	Prof. Nguyen Ngoc Quang	25	2

eMethods. Additional Information

1. Criteria for High Bleeding Risk

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

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

2. Inclusion and Exclusion Criteria

Inclusion Criteria

Inclusion criteria after index PCI

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

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

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

Exclusion Criteria

Patients were not eligible if any of the following applied:

1. Treated with stent other than Ultimaster stent within 6 months prior to index PCI
2. Treated for in-stent restenosis or stent thrombosis at index PCI or within 6 months before
3. Treated with a bioresorbable scaffold at any time prior to index procedure
4. Incapable of providing written informed consent
5. Under judicial protection, tutorship or curatorship
6. Unable to understand and follow study-related instructions or unable to comply with study protocol
7. Active bleeding requiring medical attention (Bleeding Academic Research Consortium [BARC] ≥2) on randomization visit
8. Life expectancy less than 1 year

9. Known hypersensitivity or allergy to aspirin, clopidogrel, ticagrelor, prasugrel, cobalt chromium or sirolimus
10. Any planned and anticipated PCI
11. Participation in another trial
12. Pregnant or breastfeeding women

3. Treatment Regimen

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

3.1. Abbreviated DAPT regimen

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

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

3.2. Standard DAPT regimen

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

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

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

3.3. Implementation of randomized study regimens

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

- Aspirin is prescribed at the standard dose of at least 75 mg/day and up to 162 mg/day.
- Clopidogrel is prescribed in standard dose of 75 mg once daily.
- Prasugrel is prescribed at the standard dose of 10 mg/day or 5 mg/day in patients weighing less than 60 kg or who are over 75 years old. In regions where other standard dose exists (i.e. Japan), prasugrel dosage is adjusted according to the locally approved dose.
- Ticagrelor is prescribed at the standard dose of 180 mg/day (90 mg b.i.d.).
- Vitamin K antagonist is dosed to keep the international normalized ratio within the guideline range.
- Nonvitamin K oral antagonist oral anticoagulants (NOAC; rivaroxaban, edoxaban, dabigatran and apixaban) are given in locally approved doses.
- Switching from a vitamin K antagonist to NOAC or vice-versa is not allowed unless there are clinical and well documented reasons for doing so. Similarly, switching from a NOAC to a VKA during the course of the study is not allowed, unless dictated by a clinical and documented reason (e.g. change in renal function during the course of the investigation), which will be captured in the eCRF.

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

4. Outcome Definitions

4.1. Death

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

4.1.1. Cardiovascular death

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

4.1.2. Death due to acute myocardial infarction

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

4.1.3. Sudden cardiac death

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

- Death witnessed and occurring without new or worsening symptoms.
- Death witnessed within 60 min of the onset of new or worsening cardiac symptoms, unless documented (i.e. by ECG or other objective) to be due to acute myocardial infarction.
- Death witnessed and attributed to an identified arrhythmia (e.g. captured on an ECG recording, witnessed on a monitor, or unwitnessed but found on implantable cardioverter-defibrillator review).
- Death after unsuccessful resuscitation from cardiac arrest. Death after successful resuscitation from cardiac arrest and without identification of a noncardiac etiology.
- Unwitnessed death without other cause of death (information regarding the patient's clinical status preceding death should be provided, if available).

4.1.3.1. GENERAL CONSIDERATIONS

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

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

4.1.4. Death due to heart failure or cardiogenic shock

Death due to congestive heart failure referred to a death in association with clinically worsening symptoms and/or signs of heart failure not following an acute myocardial infarction. Deaths due to heart failure could have

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

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

4.1.5. Death due to stroke

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

4.1.6. Death due to cardiovascular procedures

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

4.1.7. Death due to cardiovascular hemorrhage

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

4.1.8. Death due to other cardiovascular causes

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

4.1.9. Noncardiovascular death

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

4.1.9.1. NONMALIGNANT CAUSES

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

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

4.1.9.2. MALIGNANT CAUSES

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

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

4.1.10. Undetermined cause of death

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

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

4.2. Myocardial Infarction

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

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

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

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

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

4.2.2. Type 2 myocardial infarction

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

4.2.3. Type 3 myocardial infarction

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

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

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

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

4.2.5. Type 4b myocardial infarction

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

4.2.6. Type 4c myocardial infarction

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

4.2.7. Type 5 myocardial infarction

4.2.7.1. CORONARY ARTERY BYPASS GRAFTING-RELATED MYOCARDIAL INFARCTION

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

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

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

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

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

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

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

4.3. Stent Thrombosis

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

4.3.1. Definite stent thrombosis

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

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

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

b. Pathological confirmation of stent thrombosis

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

4.3.2. Probable stent thrombosis

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

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

4.3.3. Possible stent thrombosis

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

4.4. Stroke

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

4.4.1. Ischemic stroke

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

4.4.2. Cerebral hemorrhage

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

4.4.3. Stroke caused by intracerebral hemorrhage

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

4.4.4. Stroke caused by subarachnoid hemorrhage

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

4.4.5. Stroke not otherwise specified

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

4.5. Bleeding

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

Type 0	No bleeding
Type 1	Bleeding that is not actionable and does not cause the patient to seek unscheduled performance of studies, hospitalization, or treatment by a health care professional. May include episodes leading to self-discontinuation of medical therapy by the patient, without consulting a health care professional.
Type 2	Any overt, actionable sign of hemorrhage (e.g. more bleeding than would be expected for a clinical circumstance; including bleeding found by imaging alone) that does not fit the criteria for Types 3, 4, or 5 but does meet at least one of the following criteria: Requiring nonsurgical, medical intervention by a health care professional

	Leading to hospitalization of increased level of care
	Prompting evaluation
Type 3a	Overt bleeding plus hemoglobin drop of 3 to <5* g/dL (provided hemoglobin drop is related to bleed)
	Any transfusion with overt bleeding
Type 3b	Overt bleeding plus hemoglobin drop ≥5* g/dL (provided hemoglobin drop is related to bleed)
	Cardiac tamponade
	Bleeding requiring surgical intervention for control (excluding dental / nasal / skin / hemorrhoid)
	Bleeding requiring intravenous vasoactive agents
Type 3c	Intracranial hemorrhage (does not include microbleeds or hemorrhagic transformation; does include intraspinal)
	Subcategories: confirmed by autopsy or imaging or lumbar puncture
	Intra-ocular bleed compromising vision
Type 4	CABG-related bleeding
	Perioperative intracranial bleeding within 48 h
	Reoperation following closure of sternotomy for the purpose of controlling bleeding Transfusion of ≥5 units of whole blood or packed red blood cells within 48 hour period†
	Chest tube output ≥2 L within a 24 hour period
Type 5a	Probable fatal bleeding; no autopsy or imaging confirmation, but clinically suspicious
Type 5b	Definite fatal bleeding: overt bleeding or autopsy or imaging confirmation

Platelet transfusions were recorded and reported, and were not included in these definitions until further information was obtained about the relationship to outcomes.

*Corrected for transfusion (1 unit packed red blood cells or 1 unit whole blood=1g/dL hemoglobin).

†Cell saver products were not counted.

eTable 1. Details on DAPT and SAPT at 1-, 3-, 6- and 12-mo study visit

	Male patients			Female patients			All Male patients	All Female patients	p-value
	Abbreviated DAPT	**Standard DAPT**	**p-value**	**Abbreviated DAPT**	**Standard DAPT**	**p-value**			
At 1-month visit (after randomisation)									
DAPT	n = 1590, 41 (2.6%)	n = 1581, 1573 (99.5%)	<0.001	n = 705, 11 (1.6%)	n = 703, 699 (99.4%)	<0.001	n = 3171, 1614 (50.9%)	n = 1408, 710 (50.4%)	0.773
Clopidogrel	n = 1590, 28 (1.8%)	n = 1581, 1253 (79.3%)	<0.001	n = 705, 11 (1.6%)	n = 703, 545 (77.5%)	<0.001	n = 3171, 1281 (40.4%)	n = 1408, 556 (39.5%)	0.579
Prasugrel	n = 1590, 1 (0.1%)	n = 1581, 33 (2.1%)	<0.001	n = 705, 0 (0.0%)	n = 703, 22 (3.1%)	<0.001	n = 3171, 34 (1.1%)	n = 1408, 22 (1.6%)	0.189
Ticagrelor	n = 1590, 12 (0.8%)	n = 1581, 287 (18.2%)	<0.001	n = 705, 0 (0.0%)	n = 703, 132 (18.8%)	<0.001	n = 3171, 299 (9.4%)	n = 1408, 132 (9.4%)	1.000
SAPT	n = 1590, 1542 (97.0%)	n = 1581, 6 (0.4%)	<0.001	n = 705, 692 (98.2%)	n = 703, 3 (0.4%)	<0.001	n = 3171, 1548 (48.8%)	n = 1408, 695 (49.4%)	0.749
Acetylsalycilic acid	n = 1590, 453 (28.5%)	n = 1581, 0 (0.0%)	<0.001	n = 705, 207 (29.4%)	n = 703, 1 (0.1%)	<0.001	n = 3171, 453 (14.3%)	n = 1408, 208 (14.8%)	0.682
Clopidogrel	n = 1590, 871 (54.8%)	n = 1581, 6 (0.4%)	<0.001	n = 705, 365 (51.8%)	n = 703, 2 (0.3%)	<0.001	n = 3171, 877 (27.7%)	n = 1408, 367 (26.1%)	0.280
Prasugrel	n = 1590, 19 (1.2%)	n = 1581, 0 (0.0%)	<0.001	n = 705, 8 (1.1%)	n = 703, 0 (0.0%)	0,008	n = 3171, 19 (0.6%)	n = 1408, 8 (0.6%)	1.000
Ticagrelor	n = 1590, 199 (12.5%)	n = 1581, 0 (0.0%)	<0.001	n = 705, 112 (15.9%)	n = 703, 0 (0.0%)	<0.001	n = 3171, 199 (6.3%)	n = 1408, 112 (8.0%)	0.042
At 3-month visit									
DAPT	n = 1563, 57 (3.6%)	n = 1560, 1335 (85.6%)	<0.001	n = 699, 14 (2.0%)	n = 694, 602 (86.7%)	<0.001	n = 3123, 1392 (44.6%)	n = 1393, 616 (44.2%)	0.846
Clopidogrel	n = 1563, 43 (2.8%)	n = 1560, 1034 (66.3%)	<0.001	n = 699, 13 (1.9%)	n = 694, 453 (65.3%)	<0.001	n = 3123, 1077 (34.5%)	n = 1393, 466 (33.5%)	0.519
Prasugrel	n = 1563, 1 (0.1%)	n = 1560, 34 (2.2%)	<0.001	n = 699, 0 (0.0%)	n = 694, 22 (3.2%)	<0.001	n = 3123, 35 (1.1%)	n = 1393, 22 (1.6%)	0.198
Ticagrelor	n = 1563, 13 (0.8%)	n = 1560, 267 (17.1%)	<0.001	n = 699, 1 (0.1%)	n = 694, 127 (18.3%)	<0.001	n = 3123, 280 (9.0%)	n = 1393, 128 (9.2%)	0.822

SAPT	n = 1563, 1498 (95.8%)	n = 1560, 221 (14.2%)	<0.001	n = 699, 682 (97.6%)	n = 694, 89 (12.8%)	<0.001	n = 3123, 1719 (55.0%)	n = 1393, 771 (55.3%)	0.871
Acetylsalycilic acid	n = 1563, 445 (28.5%)	n = 1560, 65 (4.2%)	<0.001	n = 699, 200 (28.6%)	n = 694, 23 (3.3%)	<0.001	n = 3123, 510 (16.3%)	n = 1393, 223 (16.0%)	0.827
Clopidogrel	n = 1563, 850 (54.4%)	n = 1560, 155 (9.9%)	<0.001	n = 699, 368 (52.6%)	n = 694, 65 (9.4%)	<0.001	n = 3123, 1005 (32.2%)	n = 1393, 433 (31.1%)	0.468
Prasugrel	n = 1563, 18 (1.2%)	n = 1560, 0 (0.0%)	<0.001	n = 699, 7 (1.0%)	n = 694, 0 (0.0%)	0.015	n = 3123, 18 (0.6%)	n = 1393, 7 (0.5%)	0.832
Ticagrelor	n = 1563, 186 (11.9%)	n = 1560, 1 (0.1%)	<0.001	n = 699, 107 (15.3%)	n = 694, 1 (0.1%)	<0.001	n = 3123, 187 (6.0%)	n = 1393, 108 (7.8%)	0.031
At 6-month visit									
DAPT	n = 1541, 50 (3.2%)	n = 1536, 917 (59.7%)	<0.001	n = 689, 20 (2.9%)	n = 684, 455 (66.5%)	<0.001	n = 3077, 967 (31.4%)	n = 1373, 475 (34.6%)	0.038
Clopidogrel	n = 1541, 39 (2.5%)	n = 1536, 640 (41.7%)	<0.001	n = 689, 19 (2.8%)	n = 684, 327 (47.8%)	<0.001	n = 3077, 679 (22.1%)	n = 1373, 346 (25.2%)	0.023
Prasugrel	n = 1541, 0 (0.0%)	n = 1536, 34 (2.2%)	<0.001	n = 689, 0 (0.0%)	n = 684, 19 (2.8%)	<0.001	n = 3077, 34 (1.1%)	n = 1373, 19 (1.4%)	0.455
Ticagrelor	n = 1541, 11 (0.7%)	n = 1536, 243 (15.8%)	<0.001	n = 689, 1 (0.1%)	n = 684, 109 (15.9%)	<0.001	n = 3077, 254 (8.3%)	n = 1373, 110 (8.0%)	0.813
SAPT	n = 1541, 1349 (87.5%)	n = 1536, 603 (39.3%)	<0.001	n = 689, 624 (90.6%)	n = 684, 223 (32.6%)	<0.001	n = 3077, 1952 (63.4%)	n = 1373, 847 (61.7%)	0.268
Acetylsalycilic acid	n = 1541, 417 (27.1%)	n = 1536, 234 (15.2%)	<0.001	n = 689, 191 (27.7%)	n = 684, 87 (12.7%)	<0.001	n = 3077, 651 (21.2%)	n = 1373, 278 (20.2%)	0.498
Clopidogrel	n = 1541, 737 (47.8%)	n = 1536, 365 (23.8%)	<0.001	n = 689, 322 (46.7%)	n = 684, 134 (19.6%)	<0.001	n = 3077, 1102 (35.8%)	n = 1373, 456 (33.2%)	0.096
Prasugrel	n = 1541, 19 (1.2%)	n = 1536, 0 (0.0%)	<0.001	n = 689, 8 (1.2%)	n = 684, 0 (0.0%)	0.008	n = 3077, 19 (0.6%)	n = 1373, 8 (0.6%)	1.000
Ticagrelor	n = 1541, 177 (11.5%)	n = 1536, 4 (0.3%)	<0.001	n = 689, 103 (14.9%)	n = 684, 2 (0.3%)	<0.001	n = 3077, 181 (5.9%)	n = 1373, 105 (7.6%)	0.029
At 12-month visit									
DAPT	n = 1515, 77 (5.1%)	n = 1497, 523 (34.9%)	<0.001	n = 670, 24 (3.6%)	n = 670, 247 (36.9%)	<0.001	n = 3012, 600 (19.9%)	n = 1340, 271 (20.2%)	0.837
Clopidogrel	n = 1515, 58 (3.8%)	n = 1497, 365 (24.4%)	<0.001	n = 670, 21 (3.1%)	n = 670, 173 (25.8%)	<0.001	n = 3012, 423 (14.0%)	n = 1340, 194 (14.5%)	0.707
Prasugrel	n = 1515, 1 (0.1%)	n = 1497, 12 (0.8%)	0.002	n = 670, 0 (0.0%)	n = 670, 10 (1.5%)	0.002	n = 3012, 13 (0.4%)	n = 1340, 10 (0.7%)	0.256

Ticagrelor	n = 1515, 18 (1.2%)	n = 1497, 146 (9.8%)	<0.001	n = 670, 3 (0.4%)	n = 670, 64 (9.6%)	<0.001	n = 3012, 164 (5.4%)	n = 1340, 67 (5.0%)	0.608
SAPT	n = 1515, 908 (59.9%)	n = 1497, 817 (54.6%)	0.003	n = 670, 464 (69.3%)	n = 670, 368 (54.9%)	<0.001	n = 3012, 1725 (57.3%)	n = 1340, 832 (62.1%)	0.003
Acetylsalycilic acid	n = 1515, 413 (27.3%)	n = 1497, 525 (35.1%)	<0.001	n = 670, 198 (29.6%)	n = 670, 251 (37.5%)	0.003	n = 3012, 938 (31.1%)	n = 1340, 449 (33.5%)	0.130
Clopidogrel	n = 1515, 356 (23.5%)	n = 1497, 288 (19.2%)	0.004	n = 670, 187 (27.9%)	n = 670, 116 (17.3%)	<0.001	n = 3012, 644 (21.4%)	n = 1340, 303 (22.6%)	0.381
Prasugrel	n = 1515, 20 (1.3%)	n = 1497, 0 (0.0%)	<0.001	n = 670, 6 (0.9%)	n = 670, 0 (0.0%)	0.031	n = 3012, 20 (0.7%)	n = 1340, 6 (0.4%)	0.524
Ticagrelor	n = 1515, 119 (7.9%)	n = 1497, 4 (0.3%)	<0.001	n = 670, 73 (10.9%)	n = 670, 1 (0.1%)	<0.001	n = 3012, 123 (4.1%)	n = 1340, 74 (5.5%)	0.040

Abbreviations: DAPT, dual antiplatelet therapy; SAPT, single antiplatelet therapy.

Data are n (%) or n/N (%).
Patients switched to routine care around 12 months visit post-qualifying PCI; switching was allowed inside a 14-day window.

eTable 2. Baseline Characteristics According to Sex

	Male patients (n = 3171)	**Female patients** (n = 1408)	**p-value**
Age, years	75.20 ± 9.04	77.92 ± 7.70	<0.001
BMI, kg/m²	27.40 ± 4.48	27.24 ± 5.19	0.296
Family history of CAD	709 (22.4%)	400 (28.4%)	<0.001
Arterial hypertension	2397 (75.6%)	1156 (82.1%)	<0.001
Diabetes mellitus	1062 (33.5%)	476 (33.8%)	0.839
Hyperlipidemia	2137 (67.4%)	960 (68.2%)	0.608
Current smoking	331 (10.5%)	83 (5.9%)	<0.001
Peripheral/Vascular disease	364 (11.5%)	121 (8.6%)	0.004
History of HF	652 (20.6%)	215 (15.3%)	<0.001
LVEF, %	52.36 ± 11.79	55.14 ± 10.96	<0.001
Prior MI	660 (20.8%)	204 (14.5%)	<0.001
Prior PCI	891 (28.1%)	297 (21.1%)	<0.001
Prior Stroke	294 (9.3%)	116 (8.2%)	0.287
Prior CABG	285 (9.0%)	56 (4.0%)	<0.001
Prior bleeding before/after qualifying PCI	256 (8.1%)	103 (7.3%)	0.404
Known Chronic pulmonary disease	392 (12.4%)	146 (10.4%)	0.059
Known Liver disease	41 (1.3%)	20 (1.4%)	0.780
Atrial fibrillation	1098 (34.6%)	392 (27.8%)	<0.001
Known Active cancer	187 (5.9%)	49 (3.5%)	<0.001
Known Haematological or Coagulation Disorders	339 (10.7%)	239 (17.0%)	<0.001
Chronic treatment with steroids or NSAIDS	285 (9.0%)	156 (11.1%)	0.030
Prior VKA	491 (15.5%)	135 (9.6%)	<0.001
Clinical indication for 12 months OAC	1248 (39.4%)	418 (29.7%)	<0.001
PRECISE DAPT score¶	25.78 ± 11.10	28.96 ± 10.40	<0.001
Prior bleeding	238 (7.5%)	82 (5.8%)	0.044
Hemoglobin, g/L	13.52 ± 1.78	12.54 ± 1.60	<0.001
WBC count¶, 109/L	8.03 ± 3.58	8.49 ± 14.25	0.086
Creatinine clearance MDRD, ml/min/1.73 m²	72.43 ± 24.31	67.34 ± 23.04	<0.001
Clinical presentation*			
Stable angina	1287 (40.6%)	562 (39.9%)	0.672
Silent ischemia	407 (12.8%)	112 (8.0%)	<0.001

NSTEMI	781 (24.6%)	372 (26.4%)	0.197
STEMI	346 (10.9%)	192 (13.6%)	0.010
Unstable angina	350 (11.0%)	170 (12.1%)	0.313
Killip class II, III or IV	351 (11.1%)	155 (11.0%)	1.000
Cardiac arrest	41 (1.3%)	17 (1.2%)	0.887

Abbreviations: BMI, body mass index; CABG, coronary artery bypass grafting; CAD, coronary artery disease; DAPT, dual antiplatelet therapy; HF, heart failure; LVEF, left ventricular ejection fraction; MI, myocardial infarction; NSAIDS: non-steroidal anti-inflammatory drugs; NSTEMI, non-ST-segment elevation myocardial infarction; OAC, oral anticoagulation; PCI, percutaneous coronary intervention; STEMI, ST-segment elevation myocardial infarction; VKA, vitamin K-antagonist; WBC, White blood cell.

Data are mean (SD), n (%), or n/n (%) in case of missing data.
*Data from first PCI only.
¶calculated at screening visit. n=1 PRECISE Score calculated without risk due to WBC.

eTable 3. Procedural Characteristics According to Sex

	Male patients (n = 3171)	**Female patients** (n = 1408)	**p-value**
Arterial access site			
femoral	434 (13.7%)	219 (15.6%)	0.099
radial	2730 (86.1%)	1184 (84.1%)	0.077
brachial	7 (0.2%)	5 (0.4%)	0.531
IABP	40 (1.3%)	14 (1.0%)	0.553
LVAD	6 (0.2%)	2 (0.1%)	1.000
Total amount of contrast, cc	170.61 ± 81.17	160.50 ± 76.60	<0.001
Medications during the procedure*			
Unfractionated heparin	3012 (95.0%)	1344 (95.5%)	0.552
Bivalirudin	6 (0.2%)	1 (0.1%)	0.684
Low molecular weight heparin	94 (3.0%)	33 (2.3%)	0.283
Cangrelor	9 (0.3%)	2 (0.1%)	0.520
Glycoprotein II/IIIa inhibitors	111 (3.5%)	51 (3.6%)	0.862
Total no. of PCIs¶			
one	2893 (91.2%)	1266 (89.9%)	0.165
two	266 (8.4%)	139 (9.9%)	0.114
three	12 (0.4%)	3 (0.2%)	0.576
Total no of vessels treated per patient¥			
one	2344 (73.9%)	1021 (72.5%)	0.327
two	698 (22.0%)	326 (23.2%)	0.398
three	129 (4.1%)	61 (4.3%)	0.688
Treated vessel(s) per patient			
Left main	178 (5.6%)	82 (5.8%)	0.782
Left arterial descending artery	1724 (54.4%)	787 (55.9%)	0.351
Left circumflex artery	963 (30.4%)	378 (26.8%)	0.017
Right coronary artery	1111 (35.0%)	549 (39.0%)	0.010
Bypass graft	61 (1.9%)	15 (1.1%)	0.044
Total no of treated lesions per patient			
one	2154 (67.9%)	961 (68.3%)	0.837
two	698 (22.0%)	327 (23.2%)	0.377
three or more	319 (10.1%)	120 (8.5%)	0.115
Total stented lesions per patient			
one	2196 (69.3%)	980 (69.6%)	0.835
two	678 (21.4%)	315 (22.4%)	0.460

three or more	297 (9.4%)	113 (8.0%)	0.145
At least one complex lesion B2 or C	2188 (69.0%)	953 (67.7%)	0.388
Number of stents per patient (mean ± SD)	1.76 ± 1.12	1.73 ± 1.12	0.380
Total stent length per patient (mean ± SD)	40.15 ± 29.03	38.07 ± 28.31	0.024
Overlapping stenting	657 (20.7%)	281 (20.0%)	0.579
Bifurcation or trifurcation stenting§	131 (4.1%)	53 (3.8%)	0.625
OCT of treated lesion	97 (3.1%)	37 (2.6%)	0.449
IVUS of treated lesion	203 (6.4%)	84 (6.0%)	0.598
Treated lesions	N = 4611	N = 2023	
Lesion location			
Left main	179 (3.9%)	84 (4.2%)	0.604
Left arterial descending artery	1969 (42.7%)	857 (42.4%)	0.790
Left circumflex artery	1071 (23.2%)	424 (21.0%)	0.036
Right coronary artery	1327 (28.8%)	640 (31.6%)	0.022
Bypass graft			
SVG	57 (1.2%)	15 (0.7%)	0.144
LIMA/RIMA/Radial graft	11 (0.2%)	4 (0.2%)	0.748
Bifurcation or trifurcation disease per lesion	756 (16.4%)	300 (14.8%)	0.121
Rotablator used per lesion	112 (2.4%)	39 (1.9%)	0.248
Final residual lesion stenosis <20%	4549 (98.7%)	2001 (98.9%)	0.423
TIMI flow before PCI per lesion	n = 4570	n = 2004	
0 or 1	621 (13.6%)	271 (13.5%)	
2	491 (10.7%)	212 (10.6%)	
3	3458 (75.7%)	1521 (75.9%)	
TIMI flow after PCI per lesion	n = 4609	n = 2022	
0 or 1	13 (0.3%)	1 (0.0%)	
2	31 (0.7%)	17 (0.8%)	
3	4565 (99.0%)	2004 (99.1%)	
Lesion treatment			
Ballooning or thrombus aspiration only	81 (1.8%)	33 (1.6%)	
Stenting	4530 (98.2%)	1990 (98.4%)	
Stented lesions	**N = 4530**	**N = 1990**	
Number of stents used per lesion	1.24 ± 0.55	1.23 ± 0.52	0.457
Overlapping stenting per lesion	705/4500 (15.7%)	302/1980 (15.3%)	0.679
Total stent length per lesion, mm	28.10 ± 16.65	26.94 ± 15.73	0.011
Average stent diameter per lesion, mm	3.02 ± 0.48	2.94 ± 0.46	0.001
Direct stenting per lesion	n = 4530, 1387 (30.6%)	n = 1990, 632 (31.8%)	0.413
Post-dilatation per lesion	n = 4530, 2847 (62.8%)	n = 1990, 1182 (59.4%)	0.021

Abbreviations: APT, antiplatelet therapy; DAPT, dual antiplatelet therapy; IABP, intra-aortic balloon pump; IVUS, intravascular ultrasound; LIMA, left internal mammary artery; LVAD, left ventricular assist device; RIMA, right internal mammary artery; SVG, saphenous vein graft; TIMI: Thrombolysis in Myocardial Infarction, OCT, optical coherence tomography; PCI, percutaneous coronary intervention.
Data are mean (SD), n (%), or n/n (%) in case of missing data.
* Data from first PCI only.
¶ One PCI and up to two staged PCIs. The last PCI was the qualifying PCI 1 month before the randomization.
§ into both main- and side-branch.
¥ Left main counted as two vessels.

eTable 4. Procedural Characteristics by Randomized Antiplatelet Regimen and Sex

	Male patients			**Female patients**		
	Abbreviated DAPT (n=1590)	**Standard DAPT** (n=1581)	**p-value**	**Abbreviated DAPT** (n=705)	**Standard DAPT** (n=703)	**p-value**
Arterial access site						
femoral	239 (15.0%)	195 (12.3%)	0.030	121 (17.2%)	98 (13.9%)	0.106
radial	1348 (84.8%)	1382 (87.4%)	0.035	582 (82.6%)	602 (85.6%)	0.126
brachial	3 (0.2%)	4 (0.3%)	0.726	2 (0.3%)	3 (0.4%)	0.687
IABP	16 (1.0%)	24 (1.5%)	0.207	8 (1.1%)	6 (0.9%)	0.789
LVAD	2 (0.1%)	4 (0.3%)	0.451	0 (0.0%)	2 (0.3%)	0.249
Total amount of contrast, cc	172.26 ± 82.09	168.94 ± 80.22	0.251	158.94 ± 75.79	162.06 ± 77.41	0.446
Medications during the procedure*						
Unfractionated heparin	1510 (95.0%)	1502 (95.1%)	0.935	674 (95.6%)	670 (95.3%)	0.800
Bivalirudin	4 (0.3%)	2 (0.1%)	0.687	1 (0.1%)	0 (0.0%)	1.000
Low molecular weight heparin	48 (3.0%)	46 (2.9%)	0.917	15 (2.1%)	18 (2.6%)	0.603
Cangrelor	6 (0.4%)	3 (0.2%)	0.507	2 (0.3%)	0 (0.0%)	0.500
Glycoprotein II/IIIa inhibitors	60 (3.8%)	51 (3.2%)	0.44	26 (3.7%)	25 (3.6%)	1.000
Total no. of PCIs ¶						
one	1456 (91.6%)	1437 (90.9%)	0.530	637 (90.4%)	629 (89.5%)	0.596
two	126 (7.9%)	140 (8.9%)	0.370	65 (9.2%)	74 (10.5%)	0.423
three	8 (0.5%)	4 (0.3%)	0.387	3 (0.4%)	0 (0.0%)	0.249
Total no. of vessels treated per patient ¥						
one	1197 (75.3%)	1147 (72.5%)	0.082	519 (73.6%)	502 (71.4%)	0.371
two	328 (20.6%)	370 (23.4%)	0.065	155 (22.0%)	171 (24.3%)	0.312
three	65 (4.1%)	64 (4.0%)	1	31 (4.4%)	30 (4.3%)	1.000

Treated vessel(s) per patient						
Left main	83 (5.2%)	95 (6.0%)	0.355	43 (6.1%)	39 (5.5%)	0.733
Left arterial descending artery	850 (53.5%)	874 (55.3%)	0.318	390 (55.3%)	397 (56.5%)	0.668
Left circumflex artery	478 (30.1%)	485 (30.7%)	0.728	174 (24.7%)	204 (29.0%)	0.071
Right coronary artery	563 (35.4%)	548 (34.7%)	0.682	291 (41.3%)	258 (36.7%)	0.081
Bypass graft	32 (2.0%)	29 (1.8%)	0.796	6 (0.9%)	9 (1.3%)	0.452
Total nr of treated lesions per patient						
one	1094 (68.8%)	1060 (67.0%)	0.304	485 (68.8%)	476 (67.7%)	0.689
two	341 (21.4%)	357 (22.6%)	0.466	162 (23.0%)	165 (23.5%)	0.850
three or more	155 (9.7%)	164 (10.4%)	0.595	58 (8.2%)	62 (8.8%)	0.704
Total stented lesions per patient						
one	1119 (70.4%)	1077 (68.1%)	0.178	492 (69.8%)	488 (69.4%)	0.908
two	329 (20.7%)	349 (22.1%)	0.363	157 (22.3%)	158 (22.5%)	0.949
three or more	142 (8.9%)	155 (9.8%)	0.428	56 (7.9%)	57 (8.1%)	0.922
At least one complex lesion B2 or C	1083 (68.1%)	1105 (69.9%)	0.283	479 (67.9%)	474 (67.4%)	0.864
Number of stents per patient	1.74 ± 1.10	1.78 ± 1.13	0.401	1.73 ± 1.18	1.72 ± 1.06	0.857
Total stent length per patient	39.65 ± 28.64	40.65 ± 29.42	0.332	38.49 ± 30.56	37.66 ± 25.87	0.584
Any overlapping stenting	342 (21.5%)	315 (19.9%)	0.274	146 (20.7%)	135 (19.2%)	0.505
Bifurcation or trifurcation stenting §	61 (3.8%)	70 (4.4%)	0.423	22 (3.1%)	31 (4.4%)	0.211
OCT of treated lesion	44 (2.8%)	53 (3.4%)	0.355	18 (2.6%)	19 (2.7%)	0.869
IVUS of treated lesion	99 (6.2%)	104 (6.6%)	0.717	36 (5.1%)	48 (6.8%)	0.178

Abbreviations: DAPT, antiplatelet therapy; IABP, intra-aortic balloon pump; IVUS, intravascular ultrasound; LVAD, left ventricular assist device; OCT, optical coherence tomography; PCI, percutaneous coronary intervention.

Data are mean (SD), n (%), or n/n (%) in case of missing data.
* Data from first PCI only.
¶ One PCI and up to two staged PCIs. The last PCI was the qualifying PCI 1 month before the randomization.
§ into both main- and side-branch.
¥ Left main counted as two vessels.

eTable 5. Treated Lesion Characteristics According to Sex and Randomly Allocated APT Regimen
Abbreviations: APT, antiplatelet therapy; DAPT, dual antiplatelet therapy; LIMA, left internal mammary artery; RIMA, right internal mammary artery; SVG, saphenous vein graft; TIMI: Thrombolysis in Myocardial Infarction.

	Male patients			**Female patients**		
	Abbreviated DAPT (n=1590)	**Standard DAPT** (n=1581)	**p-value**	**Abbreviated DAPT** (n=705)	**Standard DAPT** (n=703)	**p-value**
Treated lesions	N = 2286	N = 2325		N=1008	N = 1015	
Lesion location						
Left main	84 (3.7%)	95 (4.1%)	0.464	44 (4.4%)	40 (3.9%)	0.635
Left arterial descending artery	965 (42.2%)	1004 (43.2%)	0.505	429 (42.6%)	428 (42.2%)	0.852
Left circumflex artery	530 (23.2%)	541 (23.3%)	0.944	197 (19.5%)	227 (22.4%)	0.109
Right coronary artery	674 (29.5%)	653 (28.1%)	0.321	331 (32.8%)	309 (30.4%)	0.251
Bypass graft						
SVG	28 (1.2%)	29 (1.2%)	0.951	6 (0.6%)	9 (0.9%)	0.559
LIMA/RIMA/Radial graft	7 (0.3%)	4 (0.2%)	0.357	2 (0.2%)	2 (0.2%)	0.994
Bifurcation or trifurcation disease per lesion	382 (16.7%)	374 (16.1%)	0.574	153 (15.2%)	147 (14.5%)	0.673
Rotablator used per lesion	57 (2.5%)	55 (2.4%)	0.793	21 (2.1%)	18 (1.8%)	0.643
Final residual lesion stenosis <20%	2251 (98.5%)	2298 (98.8%)	0.301	999 (99.1%)	1002 (98.7%)	0.428
TIMI flow before PCI per lesion	n = 2265	n = 2305		n = 996	n = 1008	
0 or 1	285 (12.6%)	336 (14.6%)		139 (14.0%)	132 (13.1%)	
2	262 (11.6%)	229 (9.9%)	0.071	99 (9.9%)	113 (11.2%)	0.627
3	1718 (75.8%)	1740 (75.5%)		758 (76.1%)	763 (75.7%)	
TIMI flow after PCI per lesion	n = 2285	n = 2324		n = 1008	n = 1014	
0 or 1	10 (0.4%)	3 (0.1%)	0.955	1 (0.1%)	0 (0.0%)	
2	12 (0.5%)	19 (0.8%)		6 (0.6%)	11 (1.1%)	0.000
3	2263 (99.0%)	2302 (99.1%)		1001 (99.3%)	1003 (98.9%)	

Stented lesions	N = 2241	N = 2289		N = 997	N = 993	
Number of stents used per lesion	1.25 ± 0.55	1.23 ± 0.55	0.474	1.24 ± 0.53	1.22 ± 0.51	0.572
Overlapping stenting per lesion	365/2224 (16.4%)	340/2276 (14.9%)	0.186	160/989 (16.2%)	142/991 (14.3%)	0.263
Total stent length per lesion	28.13 ± 16.80	28.08 ± 16.51	0.916	27.21 ± 16.40	26.66 ± 15.02	0.464
Average stent diameter per lesion, mm	3.02 ± 0.48	3.01 ± 0.49	0.651	2.95 ± 0.45	2.93 ± 0.47	0.209
Direct stenting per lesion	656 (29.3%)	731 (31.9%)	0.085	320 (32.1%)	312 (31.4%)	0.772
Post-dilatation per lesion	1438 (64.2%)	1409 (61.6%)	0.111	593 (59.5%)	589 (59.3%)	0.949

Data are mean (SD), n (%), or n/n (%) in case of missing data.

eTable 6. Unadjusted and Adjusted Clinical Outcomes at 11 mo Post Randomization (12-mo Follow-Up) in Male and Female Patients

					Model 1		Model 2	
	Male patients (N =3171)	**Female patients** (N =1408)	**Unadjusted HR (95% CI)**	**p-value**	**Adj. HR (95% CI)**	**Adj. p-value**	**Adj.HR (95% CI)**	**Adj. p-value**
NACE	243 (7.70)	111 (7.91)	1.02 (0.82-1.28)	0.831	1.00 (0.79-1.27)	0.992	0.98 (0.78-1.25)	0.891
MACCE	193 (6.12)	83 (5.92)	0.96 (0.75-1.25)	0.780	0.93 (0.71-1.22)	0.590	0.92 (0.70-1.20)	0.540
MCB	250 (7.99)	109 (7.85)	0.98 (0.78-1.23)	0.859	0.93 (0.73-1.18)	0.550	0.90 (0.71-1.14)	0.369
Death	107 (3.39)	49 (3.49)	1.03 (0.74-1.45)	0.856	1.02 (0.71-1.47)	0.922	1.02 (0.71-1.45)	0.931
Cardiovascular death	54 (1.73)	27 (1.94)	1.13 (0.71-1.79)	0.613	1.17 (0.71-1.95)	0.535	1.22 (0.75-1.99)	0.430
Non-cardiovascular death	41 (1.32)	16 (1.15)	0.88 (0.49-1.57)	0.662	0.82 (0.44-1.52)	0.524	0.81 (0.44-1.50)	0.508
Undetermined death	12 (0.39)	6 (0.43)	1.13 (0.42-3.00)	0.812	0.87 (0.28-2.71)	0.810	0.95 (0.33-2.69)	0.920
Cardiovascular or Undetermined death	66 (2.10)	33 (2.37)	1.13 (0.74-1.71)	0.576	1.15 (0.73-1.81)	0.557	1.17 (0.75-1.82)	0.495
Cerebrovascular Accident	30 (0.97)	19 (1.37)	1.43 (0.81-2.54)	0.222	1.30 (0.70-2.42)	0.401	1.33 (0.72-2.43)	0.361
Stroke	22 (0.71)	13 (0.94)	1.33 (0.67-2.65)	0.412	1.18 (0.56-2.50)	0.658	1.23 (0.59-2.53)	0.583
TIA	8 (0.26)	6 (0.43)	1.69 (0.59-4.87)	0.331	1.56 (0.47-5.22)	0.469	1.64 (0.52-5.18)	0.399
Myocardial infarction	81 (2.60)	28 (2.03)	0.77 (0.50-1.19)	0.243	0.75 (0.47-1.17)	0.204	0.74 (0.47-1.17)	0.196
Definite or Probable ST	16 (0.51)	7 (0.51)	0.99 (0.41-2.39)	0.974	1.15 (0.44-2.99)	0.771	1.10 (0.43-2.81)	0.834
Definite ST	13 (0.42)	5 (0.37)	0.87 (0.31-2.43)	0.784	0.94 (0.30-2.94)	0.913	0.91 (0.30-2.71)	0.860
BARC Type 1 bleeding	121 (3.87)	53 (3.81)	0.99 (0.71-1.36)	0.937	0.98 (0.70-1.37)	0.894	0.95 (0.68-1.34)	0.772
BARC Type 2 bleeding	178 (5.70)	76 (5.49)	0.96 (0.73-1.25)	0.751	0.91 (0.69-1.21)	0.529	0.88 (0.67-1.17)	0.390
BARC Type 3 bleeding	73 (2.34)	39 (2.82)	1.21 (0.82-1.78)	0.346	1.13 (0.75-1.71)	0.568	1.09 (0.73-1.65)	0.663
BARC Type 5 bleeding	10 (0.32)	0 (0.00)	9.33 (0.55-159.11)	0.037				
BARC Type 3 or 5 bleeding	83 (2.66)	39 (2.82)	1.06 (0.72-1.55)	0.763	0.99 (0.66-1.48)	0.959	0.96 (0.64-1.43)	0.844

Nr of first events of each type (Kaplan-Meier failure %). Adjusted Hazard ratio (95% CI) from Cox's time-to-first event analyses in ITT population.

Model 1 (extended model also used for censor-weights): gender, age, BMI, family history of CAD, hypertension, diabetes mellitus, hyperlipidemia current smoking, known peripheral/vascular disease, history of heart failure, LVEF, prior MI, prior PCI, prior CVA, prior arterial or venous thromboembolism, prior CABG, prior prosthetic mechanical heart valve, prior bleeding, COPD, renal failure, liver disease, atrial fibrillation, active cancer, known hematological or coagulation disorder, chronic treatment with steroids or NSAIDS, prior OAC, clinical indication for 12-month OAC, PRECISE DAPT score, prior MI, PCI indication, Killip class II/III/IV, cardiac arrest, heart rate, systolic blood pressure, access site, IABP, LVAD, LM-LAD lesion, bi- or trifurcation, final residual stenosis <20%, TIMI flow pre-PCI, TIMI flow post-PCI, total stent length, prasugrel, ticagrelor.

Model 2 (simplified model, only including risk factors where male and females also differ): gender, age, family history of CAD, hypertension, hyperlipidemia, current smoking, known peripheral/vascular disease, history of heart failure, LVEF, prior MI, prior PCI, prior venous thromboembolism, prior CABG, COPD, renal failure, atrial fibrillation, active cancer, known hematological or coagulation disorder, chronic treatment with steroids or NSAIDS, prior OAC, clinical indication for 12-month OAC, PRECISE DAPT score, prior MI, PCI indication, heart rate, systolic blood pressure, access site, bi- or trifurcation, TIMI flow after PCI, total stent length, ticagrelor.

Abbreviations: Adj., adjusted; BARC, Bleeding Academic Research Consortium; BMI, body mass index, CABG, coronary artery bypass grafting; CAD, coronary artery disease, CI, confidence interval; COPD, chronic obstructive pulmonary disease; CVA, cerebrovascular accident; HR, hazard ratio; IABP, intra-aortic balloon pump; LAD, left anterior descending artery; LM, left main; LVAD, left ventricular assist device; LVEF, left ventricular ejection fraction; MACCE, major adverse cardiac and cerebral events; MCB, major or clinically relevant non-major bleeding; MI, myocardial infarction; NACE, net adverse clinical events; NSAIDS, non-steroidal anti-inflammatory drugs; OAC, oral anticoagulation; PCI, percutaneous coronary intervention; ST, stent thrombosis; TIA, transient ischemic attack; TIMI, Thrombolysis in Myocardial Infarction.

eTable 7. Clinical Outcomes at 11 mo After Randomization (12-mo Follow-Up) in Male and Female Patients Presenting With ACS

	Male patients					Female patients					
	Abbreviated DAPT (n = 758)	**Standard DAPT (n** = 719)	**Hazard ratio (95% CI)**	**p-value**	**Com-Nogue Risk Difference (95% CI)**	**Abbreviated DAPT (n** = 370)	**Standard DAPT (n=364)**	**Hazard ratio (95% CI)**	**p-value**	**Com-Nogue Risk Difference (95% CI)**	**interaction p-value**
NACE	68 (9.01)	61 (8.54)	1.05 (0.74-1.49)	0.774	0.46 (-2.43 to 3.36)	28 (7.57)	39 (10.73)	0.69 (0.42-1.12)	0.132	-3.16 (-7.33 to 1.01)	0.165
MACCE	60 (7.95)	47 (6.59)	1.21 (0.83-1.78)	0.320	1.36 (-1.29 to 4.01)	22 (5.95)	37 (10.18)	0.57 (0.33-0.96)	0.034	-4.23 (-8.16 to -0.30)	0.022
MCB	46 (6.19)	62 (8.76)	0.69 (0.47-1.01)	0.055	-2.58 (-5.29 to 0.13)	23 (6.29)	30 (8.47)	0.73 (0.42-1.26)	0.259	-2.18 (-6.00 to 1.64)	0.853
Death	32 (4.24)	27 (3.79)	1.12 (0.67-1.87)	0.666	0.46 (-1.55 to 2.46)	13 (3.51)	22 (6.05)	0.57 (0.29-1.13)	0.109	-2.54 (-5.62 to 0.55)	0.123
Cardiovascular death	14 (1.87)	14 (1.98)	0.94 (0.45-1.98)	0.880	-0.11 (-1.52 to 1.31)	7 (1.91)	11 (3.07)	0.62 (0.24-1.59)	0.315	-1.16 (-3.43 to 1.11)	0.484
Non-cardiovascular death	13 (1.75)	11 (1.56)	1.12 (0.50-2.49)	0.788	0.19 (-1.12 to 1.51)	5 (1.37)	6 (1.69)	0.80 (0.25-2.63)	0.718	-0.32 (-2.11 to 1.48)	0.653
Undetermined death	5 (0.67)	2 (0.29)	2.36 (0.46-12.16)	0.305	0.39 (-0.32 to 1.10)	1 (0.27)	5 (1.42)	0.19 (0.02-1.65)	0.133	-1.15 (-2.49 to 0.20)	0.069
Cardiovascular or Undetermined death	19 (2.53)	16 (2.26)	1.12 (0.58-2.18)	0.735	0.27 (-1.30 to 1.84)	8 (2.17)	16 (4.44)	0.48 (0.21-1.13)	0.093	-2.27 (-4.86 to 0.33)	0.126
Cerebrovascular Accident	6 (0.82)	11 (1.58)	0.51 (0.19-1.39)	0.189	-0.76 (-1.89 to 0.37)	1 (0.28)	7 (1.98)	0.14 (0.02-1.11)	0.063	-1.70 (-3.25 to -0.15)	0.263
Stroke¶	4 (0.54)	7 (1.00)	0.54 (0.16-1.84)	0.326	-0.46 (-1.37 to 0.45)	1 (0.28)	4 (1.13)	0.24 (0.03-2.15)	0.203	-0.86 (-2.08 to 0.37)	0.528
ischemic	3 (0.40)	4 (0.57)	0.71 (0.16-3.17)	0.653	-0.17 (-0.89 to 0.55)	1 (0.28)	4 (1.13)	0.24 (0.03-2.15)	0.203	-0.86 (-2.08 to 0.37)	0.426
hemorrhagic	1 (0.14)	3 (0.43)	0.31 (0.03-3.02)	0.316	-0.29 (-0.85 to 0.26)	0 (0.00)	0 (0.00)				
TIA	2 (0.28)	4 (0.58)	0.47 (0.09-2.57)	0.384	-0.30 (-0.98 to 0.38)	0 (0.00)	3 (0.85)	0.14 (0.01-2.70)	0.121	-0.85 (-1.80 to 0.11)	1.000
Myocardial infarction	31 (4.18)	20 (2.85)	1.47 (0.84-2.59)	0.176	1.33 (-0.57 to 3.22)	8 (2.21)	14 (3.97)	0.55 (0.23-1.30)	0.172	-1.76 (-4.30 to 0.78)	0.060
Definite or Probable ST	9 (1.22)	3 (0.43)	2.84 (0.77-10.50)	0.117	0.79 (-0.14 to 1.72)	2 (0.55)	4 (1.14)	0.48 (0.09-2.64)	0.401	-0.59 (-1.94 to 0.75)	0.105
Definite ST	7 (0.95)	2 (0.29)	3.32 (0.69-15.96)	0.135	0.66 (-0.14 to 1.47)	1 (0.27)	3 (0.87)	0.32 (0.03-3.08)	0.324	-0.59 (-1.71 to 0.52)	0.097

Probable ST	2 (0.27)	1 (0.15)	1.89 (0.17-20.82)	0.604	0.13 (-0.34 to 0.60)	1 (0.27)	1 (0.28)	0.97 (0.06-15.58)	0.985	-0.01 (-0.76 to 0.75)	0.720
Bleeding BARC classification											
Type 1	17 (2.28)	41 (5.80)	0.39 (0.22-0.68)	0.001	-3.53 (-5.56 to -1.50)	13 (3.56)	15 (4.19)	0.83 (0.40-1.75)	0.626	-0.63 (-3.45 to 2.18)	0.108
Type 2	31 (4.18)	39 (5.55)	0.74 (0.46-1.19)	0.216	-1.36 (-3.59 to 0.86)	15 (4.12)	25 (7.09)	0.57 (0.30-1.08)	0.083	-2.98 (-6.35 to 0.39)	0.515
Type 3	16 (2.15)	19 (2.69)	0.79 (0.41-1.54)	0.491	-0.53 (-2.12 to 1.05)	9 (2.46)	7 (1.98)	1.25 (0.46-3.35)	0.661	0.48 (-1.67 to 2.63)	0.452
Type 3a	9 (1.21)	14 (1.98)	0.61 (0.26-1.40)	0.240	-0.77 (-2.06 to 0.52)	3 (0.82)	4 (1.13)	0.72 (0.16-3.24)	0.673	-0.31 (-1.75 to 1.12)	0.835
Type 3b	5 (0.68)	3 (0.42)	1.57 (0.38-6.58)	0.536	0.26 (-0.50 to 1.02)	6 (1.64)	3 (0.85)	1.94 (0.49-7.76)	0.348	0.80 (-0.82 to 2.41)	0.834
Type 3c	2 (0.27)	2 (0.29)	0.95 (0.13-6.73)	0.957	-0.02 (-0.56 to 0.52)	0 (0.00)	0 (0.00)				
Type 4	0 (0.00)	0 (0.00)				0 (0.00)	0 (0.00)				
Type 5	2 (0.28)	5 (0.71)	0.38 (0.07-1.95)	0.245	-0.44 (-1.17 to 0.29)	0 (0.00)	0 (0.00)				
Type 5a	0 (0.00)	1 (0.14)	0.32 (0.01-7.84)	0.487	-0.14 (-0.41 to 0.13)	0 (0.00)	0 (0.00)				
Type 5b	2 (0.28)	4 (0.57)	0.47 (0.09-2.57)	0.385	-0.30 (-0.98 to 0.38)	0 (0.00)	0 (0.00)				
Type 3 or 5	18 (2.43)	24 (3.39)	0.70 (0.38-1.30)	0.262	-0.96 (-2.70 to 0.77)	9 (2.46)	7 (1.98)	1.25 (0.46-3.35)	0.661	0.48 (-1.67 to 2.63)	0.333

Abbreviations: BARC, Bleeding Academic Research Consortium; CI, confidence interval; MACCE, major adverse cardiac and cerebral events; MCB, major or clinically relevant non-major bleeding; NACE, net adverse clinical events; ST, stent thrombosis; TIA, transient ischemic attack.

Nr of first events of each type (Kaplan-Meier failure %). Hazard ratio (95% CI) from Cox's time-to-first event analyses in ITT population. Continuity corrected risk ratios (95% CI) in case of zero events with Fisher's exact test p-value. Interaction p-value testing for modifying effect of Gender (males or females) on the hazard ratio scale.

¶includes undetermined Strokes.

eTable 8. Clinical Outcomes at 11 mo After Randomization (12-mo Follow-Up) in Male and Female Patients Presenting With ACS or Who Had Complex PCI

	Male patients					Female patients					interaction p-value
	Abbreviated DAPT (N = 982)	**Standard DAPT (**N = 947)	**Hazard ratio (95% CI)**	**p-value**	**Com-Nogue Risk Difference (95% CI)**	**Abbreviated DAPT (**N = 451)	**Standard DAPT (**N = 456)	**Hazard ratio (95% CI)**	**p-value**	**Com-Nogue Risk Difference (95% CI)**	
NACE	86 (8.79)	78 (8.28)	1.06 (0.78-1.44)	0.715	0.50 [-2.00 to 3.00]	31 (6.89)	43 (9.44)	0.71 (0.45-1.13)	0.152	-2.55 [-6.11 to 1.01]	0.165
MACCE	76 (7.77)	58 (6.16)	1.27 (0.90-1.79)	0.172	1.60 [-0.67 to 3.88]	24 (5.33)	39 (8.56)	0.61 (0.36-1.01)	0.054	-3.23 [-6.53 to 0.08]	0.018
MCB	60 (6.22)	83 (8.87)	0.68 (0.49-0.95)	0.024	-2.65 [-5.03 to -0.28]	26 (5.84)	34 (7.61)	0.75 (0.45-1.25)	0.276	-1.78 [-5.06 to 1.51]	0.741
Death	39 (3.99)	32 (3.40)	1.17 (0.74-1.87)	0.502	0.59 [-1.10 to 2.27]	13 (2.89)	23 (5.05)	0.56 (0.29-1.11)	0.099	-2.16 [-4.70 to 0.38]	0.082
Cardiovascular death	17 (1.75)	15 (1.61)	1.09 (0.55-2.19)	0.805	0.15 [-1.01 to 1.30]	7 (1.57)	12 (2.66)	0.58 (0.23-1.48)	0.256	-1.10 [-2.98 to 0.78]	0.289
Non-cardiovascular death	15 (1.56)	14 (1.50)	1.03 (0.50-2.14)	0.932	0.05 [-1.05 to 1.16]	5 (1.12)	6 (1.34)	0.83 (0.25-2.72)	0.760	-0.22 [-1.66 to 1.23]	0.760
Undetermined death	7 (0.73)	3 (0.33)	2.25 (0.58-8.68)	0.241	0.40 [-0.25 to 1.06]	1 (0.22)	5 (1.13)	0.20 (0.02-1.71)	0.141	-0.90 [-1.98 to 0.17]	0.061
Cardiovascular or Undetermined death	24 (2.47)	18 (1.93)	1.28 (0.70-2.37)	0.423	0.54 [-0.77 to 1.86]	8 (1.79)	17 (3.76)	0.47 (0.20-1.09)	0.078	-1.97 [-4.11 to 0.17]	0.058
Cerebrovascular Accident	8 (0.84)	11 (1.19)	0.70 (0.28-1.74)	0.442	-0.35 [-1.26 to 0.56]	2 (0.45)	9 (2.03)	0.22 (0.05-1.02)	0.053	-1.57 [-3.02 to -0.12]	0.203
Stroke¶	6 (0.63)	7 (0.76)	0.83 (0.28-2.46)	0.732	-0.13 [-0.88 to 0.62]	2 (0.45)	6 (1.35)	0.33 (0.07-1.64)	0.176	-0.90 [-2.15 to 0.35]	0.355
ischemic	5 (0.52)	4 (0.43)	1.21 (0.32-4.49)	0.781	0.09 [-0.53 to 0.71]	2 (0.45)	6 (1.35)	0.33 (0.07-1.64)	0.176	-0.90 [-2.15 to 0.35]	0.222
hemorrhagic	1 (0.11)	3 (0.32)	0.32 (0.03-3.09)	0.325	-0.22 [-0.64 to 0.20]	0 (0.00)	0 (0.00)				
TIA	2 (0.21)	4 (0.43)	0.48 (0.09-2.62)	0.397	-0.22 [-0.74 to 0.30]	0 (0.00)	3 (0.67)	0.14 (0.01-2.70)	0.249	-0.67 [-1.43 to 0.09]	
Myocardial infarction	38 (3.95)	26 (2.80)	1.41 (0.86-2.33)	0.173	1.15 [-0.48 to 2.77]	9 (2.04)	15 (3.38)	0.59 (0.26-1.36)	0.216	-1.34 [-3.47 to 0.80]	0.078
Definite or Probable ST	10 (1.04)	4 (0.43)	2.41 (0.76-7.70)	0.136	0.61 [-0.16 to 1.38]	2 (0.45)	4 (0.90)	0.50 (0.09-2.73)	0.423	-0.46 [-1.53 to 0.62]	0.133

Definite ST	8 (0.83)	3 (0.32)	2.58 (0.68-9.71)	0.162	0.51 [-0.17 to 1.19]	1 (0.23)	3 (0.69)	0.33 (0.03-3.18)	0.338	-0.46 [-1.35 to 0.43]	0.126
Probable ST	2 (0.21)	1 (0.11)	1.93 (0.17-21.25)	0.592	0.10 [-0.26 to 0.46]	1 (0.22)	1 (0.22)	1.01 (0.06-16.08)	0.997	0.00 [-0.61 to 0.61]	0.725
Bleeding BARC classification											
Type 1	26 (2.69)	52 (5.57)	0.48 (0.30-0.76)	0.002	-2.88 [-4.68 to -1.09]	14 (3.14)	20 (4.47)	0.69 (0.35-1.37)	0.292	-1.33 [-3.84 to 1.18]	0.375
Type 2	42 (4.36)	57 (6.12)	0.70 (0.47-1.04)	0.079	-1.76 [-3.76 to 0.25]	17 (3.82)	27 (6.07)	0.62 (0.34-1.13)	0.120	-2.25 [-5.09 to 0.60]	0.747
Type 3	20 (2.07)	25 (2.68)	0.77 (0.43-1.38)	0.372	-0.60 [-1.97 to 0.77]	10 (2.25)	9 (2.02)	1.11 (0.45-2.73)	0.820	0.23 [-1.67 to 2.13]	0.495
Type 3a	12 (1.24)	18 (1.93)	0.64 (0.31-1.33)	0.229	-0.68 [-1.81 to 0.44]	4 (0.90)	5 (1.12)	0.80 (0.21-2.97)	0.735	-0.22 [-1.53 to 1.09]	0.770
Type 3b	6 (0.63)	4 (0.43)	1.44 (0.41-5.11)	0.570	0.20 [-0.46 to 0.85]	6 (1.35)	4 (0.90)	1.50 (0.42-5.32)	0.529	0.45 [-0.93 to 1.83]	0.964
Type 3c	3 (0.31)	3 (0.32)	0.96 (0.19-4.77)	0.964	-0.01 [-0.52 to 0.50]	0 (0.00)	0 (0.00)				
Type 4	0 (0.00)	0 (0.00)				0 (0.00)	0 (0.00)				
Type 5	2 (0.21)	5 (0.54)	0.39 (0.07-1.99)	0.254	-0.33 [-0.88 to 0.23]	0 (0.00)	0 (0.00)				
Type 5a	0 (0.00)	1 (0.11)	0.32 (0.01-7.85)	0.491	-0.11 [-0.31 to 0.10]	0 (0.00)	0 (0.00)				
Type 5b	2 (0.21)	4 (0.43)	0.48 (0.09-2.63)	0.398	-0.22 [-0.74 to 0.29]	0 (0.00)	0 (0.00)				
Type 3 or 5	22 (2.28)	30 (3.21)	0.70 (0.40-1.22)	0.206	-0.92 [-2.40 to 0.55]	10 (2.25)	9 (2.02)	1.11 (0.45-2.73)	0.820	0.23 [-1.67 to 2.13]	0.391

Abbreviations: BARC, Bleeding Academic Research Consortium; CI, confidence interval; MACCE, major adverse cardiac and cerebral events; MCB, major or clinically relevant non-major bleeding; NACE, net adverse clinical events; ST, stent thrombosis; TIA, transient ischemic attack.

Nr of first events of each type (Kaplan-Meier failure %). Hazard ratio (95% CI) from Cox's time-to-first event analyses in ITT population. Continuity corrected risk ratios (95% CI) in case of zero events with Fisher's exact test p-value. Interaction p-value testing for modifying effect of Gender (males or females) on the hazard ratio scale.

¶includes undetermined Strokes.

eTable 9. Clinical Outcomes at 11 mo After Randomization (12-mo Follow-Up) in Male and Female Patients With Clinical Indication for 12-mo OAC

	Male patients					Female patients					
	Abbreviated DAPT (n=636)	**Standard DAPT (n=612)**	**Hazard ratio (95% CI)**	**p-value**	**Com-Nogue Risk Difference (95% CI)**	**Abbreviated DAPT (n=212)**	**Standard DAPT (n=206)**	**Hazard ratio (95% CI)**	**p-value**	**Com-Nogue Risk Difference (95% CI)**	**interaction p-value**
NACE	48 (7.58)	58 (9.54)	0.78 (0.53-1.14)	0.204	-1.97 (-5.08 to 1.15)	20 (9.43)	20 (9.83)	0.97 (0.52-1.80)	0.914	-0.39 (-6.07 to 5.28)	0.562
MACCE	38 (6.00)	37 (6.09)	0.98 (0.62-1.54)	0.936	-0.09 (-2.75 to 2.56)	12 (5.67)	17 (8.36)	0.67 (0.32-1.40)	0.288	-2.69 (-7.61 to 2.22)	0.389
MCB	59 (9.40)	74 (12.23)	0.75 (0.53-1.05)	0.095	-2.83 (-6.30 to 0.64)	24 (11.40)	20 (9.93)	1.15 (0.64-2.08)	0.644	1.47 (-4.49 to 7.43)	0.217
Death	23 (3.64)	23 (3.79)	0.96 (0.54-1.71)	0.884	-0.15 (-2.26 to 1.95)	8 (3.78)	10 (4.92)	0.77 (0.30-1.95)	0.578	-1.14 (-5.07 to 2.79)	0.691
Cardiovascular death	12 (1.91)	16 (2.66)	0.72 (0.34-1.52)	0.386	-0.74 (-2.42 to 0.93)	4 (1.91)	5 (2.47)	0.77 (0.21-2.87)	0.697	-0.56 (-3.39 to 2.27)	0.932
Non-cardiovascular death	8 (1.28)	5 (0.84)	1.53 (0.50-4.68)	0.454	0.44 (-0.70 to 1.59)	3 (1.44)	2 (1.01)	1.44 (0.24-8.61)	0.690	0.43 (-1.70 to 2.56)	0.953
Undetermined death	3 (0.48)	2 (0.33)	1.44 (0.24-8.61)	0.690	0.16 (-0.55 to 0.86)	1 (0.47)	3 (1.51)	0.32 (0.03-3.07)	0.322	-1.04 (-2.97 to 0.89)	0.308
Cardiovascular or Undetermined death	15 (2.39)	18 (2.98)	0.80 (0.40-1.58)	0.519	-0.59 (-2.39 to 1.22)	5 (2.37)	8 (3.94)	0.60 (0.20-1.84)	0.371	-1.57 (-4.95 to 1.80)	0.669
Cerebrovascular Accident	2 (0.32)	10 (1.67)	0.19 (0.04-0.87)	0.033	-1.34 (-2.46 to -0.23)	1 (0.47)	3 (1.50)	0.32 (0.03-3.07)	0.322	-1.03 (-2.95 to 0.89)	0.710
Stroke¶	1 (0.16)	8 (1.33)	0.12 (0.01-0.96)	0.045	-1.17 (-2.14 to -0.21)	1 (0.47)	2 (0.99)	0.48 (0.04-5.30)	0.550	-0.52 (-2.17 to 1.13)	0.390
ischemic	1 (0.16)	7 (1.17)	0.14 (0.02-1.11)	0.063	-1.01 (-1.92 to -0.09)	1 (0.47)	2 (0.99)	0.48 (0.04-5.30)	0.550	-0.52 (-2.17 to 1.13)	0.439
hemorrhagic	0 (0.00)	2 (0.34)	0.19 (0.01-3.95)	0.240	-0.34 (-0.80 to 0.13)	0 (0.00)	0 (0.00)				1.000
TIA	1 (0.16)	2 (0.33)	0.48 (0.04-5.28)	0.548	-0.17 (-0.73 to 0.39)	0 (0.00)	1 (0.51)	0.32 (0.01-7.81)	0.493	-0.51 (-1.51 to 0.49)	
Myocardial infarction	15 (2.41)	11 (1.84)	1.31 (0.60-2.86)	0.494	0.57 (-1.04 to 2.19)	4 (1.93)	6 (3.01)	0.64 (0.18-2.25)	0.482	-1.08 (-4.10 to 1.95)	0.340
Definite or Probable ST	1 (0.16)	3 (0.50)	0.32 (0.03-3.07)	0.323	-0.34 (-0.99 to 0.31)	2 (0.96)	1 (0.51)	1.92 (0.17-21.16)	0.595	0.45 (-1.21 to 2.12)	0.287

Definite ST	0 (0.00)	2 (0.33)	0.19 (0.01-3.95)	0.240	-0.33 (-0.80 to 0.13)	2 (0.96)	1 (0.51)	1.92 (0.17-21.16)	0.595	0.45 (-1.21 to 2.12)	
Probable ST	1 (0.16)	1 (0.17)	0.96 (0.06-15.35)	0.977	-0.01 (-0.47 to 0.45)	0 (0.00)	0 (0.00)				1.000
Bleeding BARC classification											
Type 1	25 (4.00)	34 (5.66)	0.70 (0.42-1.17)	0.174	-1.66 (-4.06 to 0.74)	9 (4.29)	13 (6.37)	0.65 (0.28-1.53)	0.326	-2.08 (-6.41 to 2.25)	0.878
Type 2	46 (7.33)	48 (7.95)	0.91 (0.61-1.36)	0.647	-0.62 (-3.59 to 2.35)	14 (6.67)	17 (8.43)	0.78 (0.38-1.58)	0.489	-1.76 (-6.87 to 3.36)	0.709
Type 3	16 (2.56)	27 (4.47)	0.56 (0.30-1.04)	0.067	-1.91 (-3.97 to 0.15)	10 (4.77)	6 (3.01)	1.63 (0.59-4.47)	0.347	1.76 (-1.98 to 5.49)	0.079
Type 3a	8 (1.28)	13 (2.15)	0.59 (0.24-1.42)	0.237	-0.87 (-2.33 to 0.59)	3 (1.42)	5 (2.50)	0.57 (0.14-2.40)	0.447	-1.09 (-3.77 to 1.60)	0.984
Type 3b	7 (1.12)	11 (1.83)	0.61 (0.23-1.56)	0.300	-0.70 (-2.06 to 0.65)	6 (2.88)	1 (0.51)	5.85 (0.70-48.59)	0.102	2.37 (-0.11 to 4.85)	0.055
Type 3c	2 (0.32)	3 (0.50)	0.64 (0.11-3.82)	0.623	-0.18 (-0.90 to 0.54)	1 (0.48)	0 (0.00)	2.92 (0.12-71.27)	1.000	0.48 (-0.46 to 1.43)	
Type 4	0 (0.00)	0 (0.00)				0 (0.00)	0 (0.00)				
Type 5	1 (0.16)	3 (0.51)	0.32 (0.03-3.07)	0.323	-0.34 (-1.00 to 0.31)	0 (0.00)	0 (0.00)				
Type 5a	0 (0.00)	1 (0.17)	0.32 (0.01-7.84)	0.490	-0.17 (-0.51 to 0.16)	0 (0.00)	0 (0.00)				
Type 5b	1 (0.16)	2 (0.34)	0.48 (0.04-5.29)	0.548	-0.17 (-0.73 to 0.39)	0 (0.00)	0 (0.00)				
Type 3 or 5	17 (2.72)	30 (4.97)	0.54 (0.30-0.97)	0.040	-2.25 (-4.40 to -0.09)	10 (4.77)	6 (3.01)	1.63 (0.59-4.47)	0.347	1.76 (-1.98 to 5.49)	0.064

Abbreviations: BARC, Bleeding Academic Research Consortium; CI, confidence interval; MACCE, major adverse cardiac and cerebral events; MCB, major or clinically relevant non-major bleeding; NACE, net adverse clinical events; ST, stent thrombosis; TIA, transient ischemic attack.

Nr of first events of each type (Kaplan-Meier failure %). Hazard ratio (95% CI) from Cox's time-to-first event analyses in ITT population. Continuity corrected risk ratios (95% CI) in case of zero events with Fisher's exact test p-value. Interaction p-value testing for modifying effect of Gender (males or females) on the hazard ratio scale.

¶includes undetermined Strokes.

eTable 10. Clinical Outcomes at 11 mo After Randomization (12-mo Follow-Up) in Male and Female Patients Without Clinical Indication for 12-mo OAC

	Male patients					Female patients					
	Abbreviated DAPT (n = 954)	**Standard DAPT (n=969)**	**Hazard ratio (95% CI)**	**p-value**	**Com-Nogue Risk Difference (95% CI)**	**Abbreviated DAPT (n=493)**	**Standard DAPT (n=497)**	**Hazard ratio (95% CI)**	**p-value**	**Com-Nogue Risk Difference (95% CI)**	**interaction p-value**
NACE	72 (7.58)	65 (6.73)	1.13 (0.81-1.58)	0.470	0.85 (-1.46 to 3.16)	32 (6.53)	39 (7.85)	0.82 (0.51-1.31)	0.401	-1.32 (-4.54 to 1.90)	0.269
MACCE	66 (6.95)	52 (5.39)	1.30 (0.91-1.87)	0.153	1.56 (-0.59 to 3.72)	22 (4.49)	32 (6.44)	0.68 (0.40-1.18)	0.170	-1.95 (-4.78 to 0.88)	0.053
MCB	41 (4.38)	76 (7.94)	0.54 (0.37-0.78)	0.001	-3.56 (-5.72 to -1.41)	24 (4.94)	41 (8.37)	0.58 (0.35-0.95)	0.032	-3.44 (-6.56 to -0.32)	0.830
Death	32 (3.37)	29 (3.01)	1.12 (0.68-1.86)	0.652	0.36 (-1.21 to 1.94)	12 (2.45)	19 (3.82)	0.63 (0.31-1.30)	0.214	-1.37 (-3.55 to 0.80)	0.201
Cardiovascular death	14 (1.49)	12 (1.25)	1.19 (0.55-2.57)	0.663	0.24 (-0.81 to 1.28)	7 (1.44)	11 (2.24)	0.64 (0.25-1.64)	0.352	-0.80 (-2.48 to 0.88)	0.319
Non-cardiovascular death	13 (1.39)	15 (1.57)	0.88 (0.42-1.85)	0.740	-0.18 (-1.27 to 0.90)	5 (1.03)	6 (1.22)	0.83 (0.25-2.73)	0.765	-0.19 (-1.51 to 1.13)	0.937
Undetermined death	5 (0.53)	2 (0.21)	2.54 (0.49-13.10)	0.265	0.32 (-0.23 to 0.87)	0 (0.00)	2 (0.41)	0.20 (0.01-4.16)	0.500	-0.41 (-0.97 to 0.16)	
Cardiovascular or Undetermined death	19 (2.01)	14 (1.46)	1.38 (0.69-2.75)	0.360	0.55 (-0.62 to 1.73)	7 (1.44)	13 (2.64)	0.54 (0.22-1.35)	0.188	-1.20 (-2.96 to 0.57)	0.109
Cerebrovascular Accident	9 (0.96)	9 (0.95)	1.02 (0.40-2.56)	0.970	0.02 (-0.86 to 0.90)	5 (1.03)	10 (2.05)	0.50 (0.17-1.46)	0.205	-1.02 (-2.57 to 0.52)	0.324
Stroke¶	7 (0.75)	6 (0.63)	1.19 (0.40-3.54)	0.755	0.12 (-0.63 to 0.86)	3 (0.62)	7 (1.44)	0.43 (0.11-1.66)	0.220	-0.83 (-2.10 to 0.45)	0.250
ischemic	6 (0.64)	2 (0.21)	3.06 (0.62-15.16)	0.171	0.43 (-0.16 to 1.01)	3 (0.62)	7 (1.44)	0.43 (0.11-1.66)	0.220	-0.83 (-2.10 to 0.45)	0.066
hemorrhagic	1 (0.11)	3 (0.31)	0.34 (0.04-3.26)	0.349	-0.21 (-0.62 to 0.21)	0 (0.00)	0 (0.00)				1.000
TIA	2 (0.22)	3 (0.32)	0.68 (0.11-4.05)	0.669	-0.10 (-0.57 to 0.37)	2 (0.41)	3 (0.61)	0.67 (0.11-4.01)	0.661	-0.20 (-1.09 to 0.69)	0.991
Myocardial infarction	34 (3.62)	21 (2.20)	1.66 (0.96-2.86)	0.068	1.42 (-0.09 to 2.94)	7 (1.45)	11 (2.26)	0.63 (0.25-1.63)	0.344	-0.81 (-2.51 to 0.89)	0.085
Definite or Probable ST	10 (1.07)	2 (0.21)	5.10 (1.12-23.28)	0.035	0.86 (0.14 to 1.58)	1 (0.20)	3 (0.62)	0.33 (0.03-3.22)	0.343	-0.41 (-1.21 to 0.39)	0.050

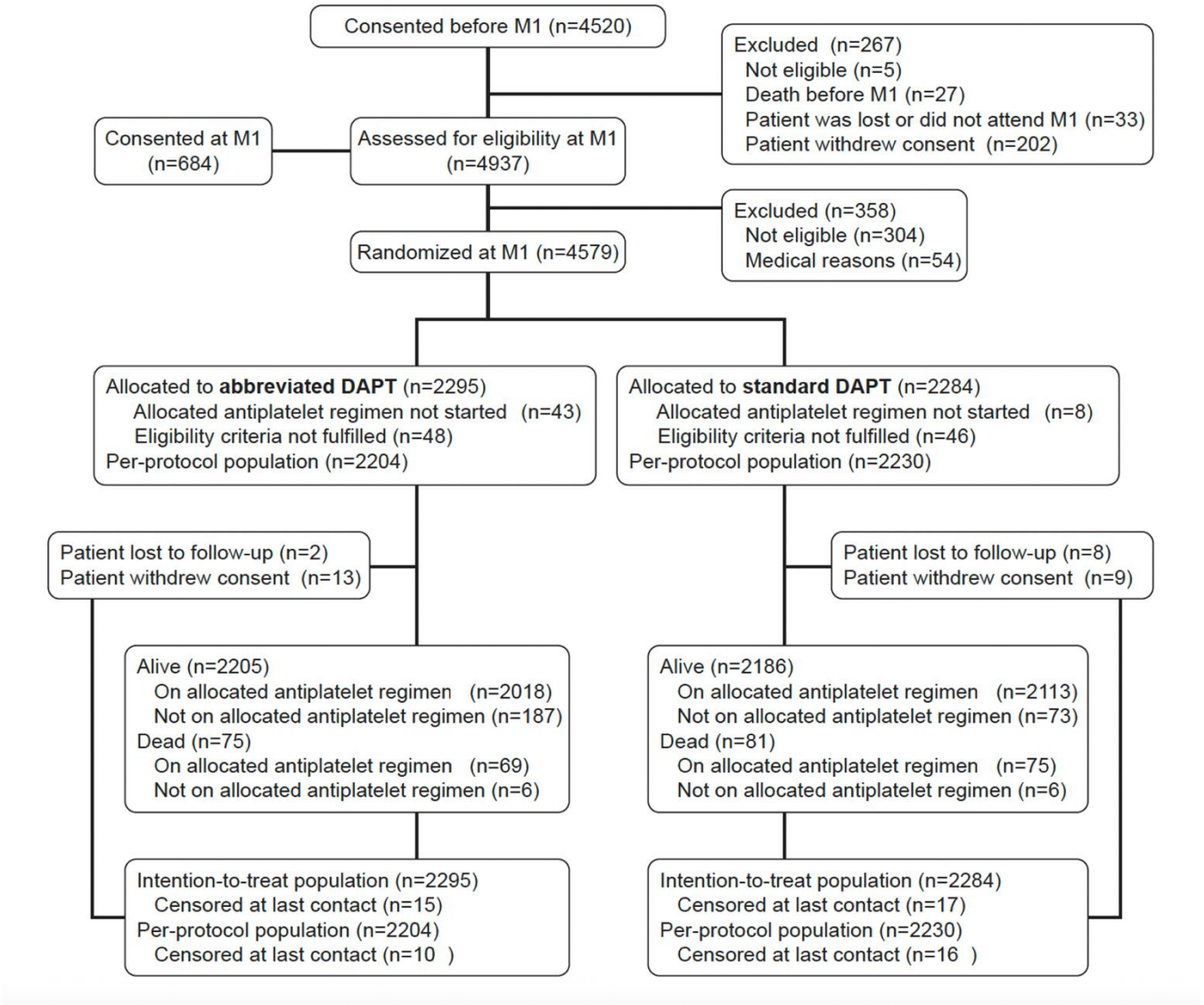
Definite ST	9 (0.96)	2 (0.21)	4.59 (0.99-21.25)	0.051	0.75 (0.07 to 1.44)	0 (0.00)	2 (0.42)	0.20 (0.01-4.16)	0.500	-0.42 (-0.99 to 0.16)	
Probable ST	1 (0.11)	0 (0.00)	3.05 (0.12-74.78)	0.496	0.11 (-0.10 to 0.31)	1 (0.20)	1 (0.20)	1.01 (0.06-16.13)	0.995	0.00 (-0.56 to 0.56)	0.000
Bleeding BARC classification											
Type 1	20 (2.12)	42 (4.38)	0.48 (0.28-0.82)	0.007	-2.26 (-3.84 to -0.67)	11 (2.26)	20 (4.09)	0.55 (0.26-1.14)	0.106	-1.83 (-4.03 to 0.36)	0.781
Type 2	28 (2.99)	56 (5.86)	0.50 (0.32-0.79)	0.003	-2.87 (-4.72 to -1.02)	14 (2.88)	31 (6.35)	0.44 (0.24-0.83)	0.012	-3.47 (-6.10 to -0.84)	0.764
Type 3	15 (1.60)	15 (1.57)	1.01 (0.50-2.07)	0.971	0.03 (-1.09 to 1.16)	12 (2.47)	11 (2.25)	1.09 (0.48-2.48)	0.829	0.23 (-1.68 to 2.13)	0.891
Type 3a	10 (1.07)	9 (0.94)	1.13 (0.46-2.78)	0.793	0.13 (-0.77 to 1.03)	5 (1.03)	3 (0.61)	1.67 (0.40-7.00)	0.481	0.43 (-0.70 to 1.56)	0.650
Type 3b	4 (0.43)	1 (0.11)	4.07 (0.46-36.44)	0.209	0.32 (-0.14 to 0.79)	4 (0.82)	7 (1.44)	0.57 (0.17-1.95)	0.373	-0.61 (-1.94 to 0.71)	0.125
Type 3c	1 (0.11)	5 (0.52)	0.20 (0.02-1.74)	0.146	-0.42 (-0.92 to 0.09)	3 (0.62)	1 (0.21)	3.01 (0.31-28.94)	0.340	0.41 (-0.40 to 1.22)	0.090
Type 4	0 (0.00)	0 (0.00)				0 (0.00)	0 (0.00)				
Type 5	1 (0.11)	5 (0.52)	0.20 (0.02-1.74)	0.146	-0.41 (-0.92 to 0.09)	0 (0.00)	0 (0.00)				
Type 5a	0 (0.00)	1 (0.10)	0.34 (0.01-8.34)	1.000	-0.10 (-0.31 to 0.10)	0 (0.00)	0 (0.00)				
Type 5b	1 (0.11)	4 (0.42)	0.25 (0.03-2.28)	0.221	-0.31 (-0.77 to 0.15)	0 (0.00)	0 (0.00)				
Type 3 or 5	16 (1.71)	20 (2.09)	0.81 (0.42-1.56)	0.532	-0.38 (-1.61 to 0.85)	12 (2.47)	11 (2.25)	1.09 (0.48-2.48)	0.829	0.23 (-1.68 to 2.13)	0.576

Abbreviations: BARC, Bleeding Academic Research Consortium; CI, confidence interval; MACCE, major adverse cardiac and cerebral events; MCB, major or clinically relevant non-major bleeding; NACE, net adverse clinical events; ST, stent thrombosis; TIA, transient ischemic attack.

Nr of first events of each type (Kaplan-Meier failure %). Hazard ratio (95% CI) from Cox's time-to-first event analyses in ITT population. Continuity corrected risk ratios (95% CI) in case of zero events with Fisher's exact test p-value. Interaction p-value testing for modifying effect of Gender (males or females) on the hazard ratio scale.

¶includes undetermined Strokes.

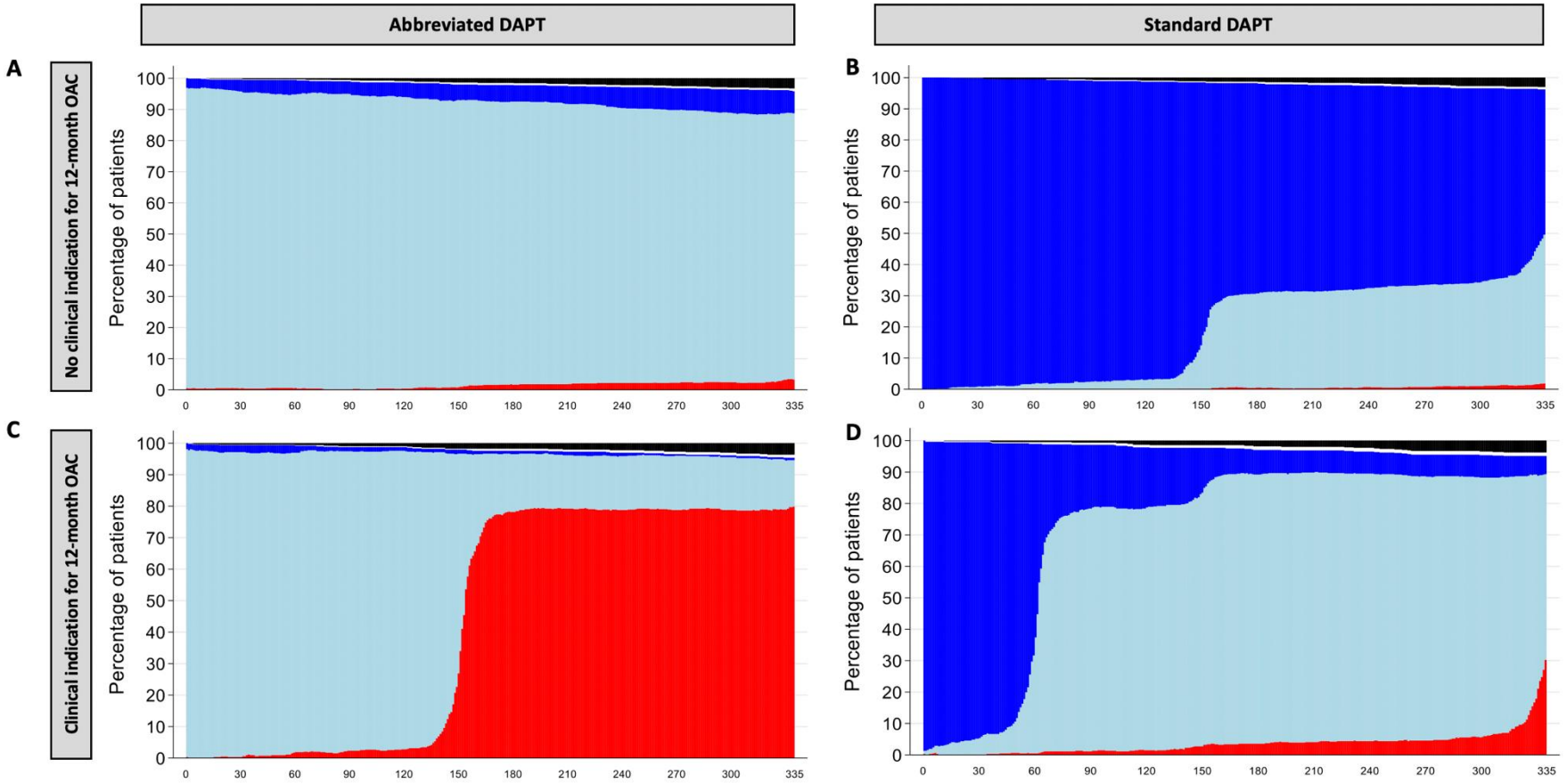
eFigure 1. CONSORT Diagram of the MASTER DAPT Study



eFigure 2. Antiplatelet Therapy Since Randomization in Male Patients Without and With Clinical Indication for Oral Anticoagulation (OAC) Therapy

The charts illustrate the variations over time of APT stratified by randomly allocated APT regimen: abbreviated (left panels) versus standard DAPT (right panels). Dark blue denotes dual antiplatelet therapy, light blue denotes single antiplatelet therapy, red denotes no antiplatelet therapy, black denotes deceased patients, white denotes no information.

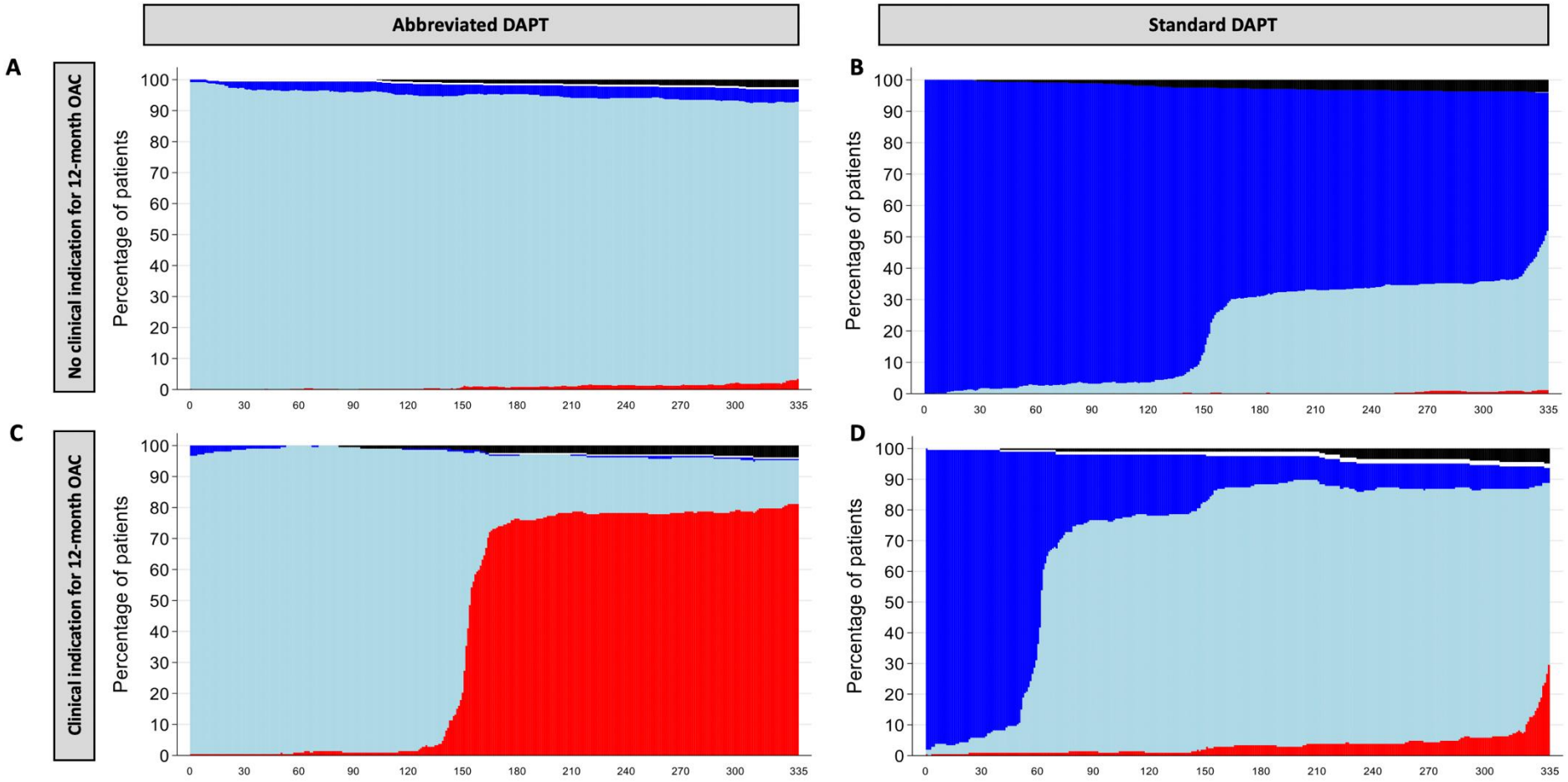
Abbreviations: DAPT, dual antiplatelet therapy; OAC, oral anticoagulation.



eFigure 3. Antiplatelet Therapy Since Randomization in Female Patients Without and With Clinical Indication for Oral Anticoagulation (OAC) Therapy

The charts illustrate the variations over time of APT stratified by randomly allocated APT regimen: abbreviated (left panels) versus standard DAPT (right panels). Dark blue denotes dual antiplatelet therapy, light blue denotes single antiplatelet therapy, red denotes no antiplatelet therapy, black denotes deceased patients, white denotes no information.

Abbreviations: DAPT, dual antiplatelet therapy; OAC, oral anticoagulation.



eFigure 4. Kaplan Meier Curves for All-Cause Mortality, Myocardial Infarction, Stroke, and BARC Type 3 or 5 Bleeding

Abbreviations: BARC, Bleeding Academic Research Consortium; CI, confidence interval; DAPT, dual antiplatelet therapy; HR, hazard ratio.