Appendix 1: Supplementary tables [posted as supplied by author]

Table A Heterogeneity across included studies.

Endpoint	Variance of random effect	H, chi^2	df	P	Tau^2	I^2
Cardiac death	0.0039	4.02	3	0.26	0.036	25.4
Total death	0.0003	3.05	3	0.38	0.001	1.6
MI	$6.68*10^{-5}$	2.29	4	0.68	0	0
Non fatal MI	$6.45*10^{-5}$	1.78	4	0.78	0	0
Fatal MI	0.0016	0.73	3	0.87	0	0
TVR	0.0245	5.77	4	0.22	0.03	30.6
TVR/MI	0.0003	2.81	3	0.42	0	0
Definite ST	0.0003	1.83	3	0.61	0	0
DP ST	0.0003	0.87	3	0.83	0	0
Cardiac death/MI	$6.59*10^{-5}$	3.35	4	0.50	0	0
Death/MI	$5.96*10^{-5}$	0.68	4	0.95	0	0

Abbreviations: Df, degree of freedom; DP, definite or probable; H, heterogeneity; I^2, inconsistency; MI, myocardial infarction; ST, stent thrombosis; Tau^2, between-study variance Tau-squared; TVR, target vessel revascularization.

Table B Competing risk subhazard estimates

Outcomes	*HR (95% CI)*	*P-Value*	*Adjusted HR (95% CI)*	*P-Value*
Myocardial Infarction	0.71(0.56-0.90)	0.005	0.70 (0.56 to 0.87)	0.001
Non fatal myocardial infarction	0.80 (0.66-0.99)	0.04	0.79 (0.65 to 0.95)	0.013
Fatal myocardial infarction	0.11 (0.03-0.35)	<0.001	0.11(0.04-0.34)	<0.001
Definite stent thrombosis	0.28 (0.18-0.45)	<0.001	0.27 (0.17 to 0.45)	<0.001
Definite or probable stent thrombosis	0.49 (0.41-0.57)	<0.001	0.47 (0.39 to 0.56)	<0.001
Target vessel revascularisation	0.29 (0.19 to 0.45)	<0.001	0.29 (0.19 to 0.43)	<0.001
Target vessel-myocardial infarction	0.27 (0.16 to 0.46)	<0.001	0.27 (0.16 to 0.45)	0.001
Cardiac death or myocardial infarction	0.74 (0.61-0.91)	0.004	0.74 (0.60 to 0.90)	0.003

HR: hazard ratio, HR calculated using Fine and Gray model with cluster as trial and with time-varying effects when needed. Adjusted HR: HR from multivariable Cox regression stratified by trial, with random-effects, adjusted for clinical syndrome (i.e. acute coronary syndrome vs. stable syndrome), history of diabetes mellitus, female sex, use of glycoprotein IIb/IIIa inhibitors and up to 1-year vs. longer duration of dual antiplatelet therapy.

Table C Number needed to treat to benefit or to harm.

	CoCr-EES vs BMS NNT
Cardiac Death	NNTB 64
All-cause death*	-
MI	NNTB 64
Non fatal MI	NNTB 113
Fatal MI	NNTB 150
TVR	NNTB 17
TVR/MI	NNTB 114
Definite ST	NNTB 130
Definite/probable ST	NNTB 75
Cardiac Death/MI	NNTB 59
Total Death/MI	NNTB 103

Abbreviations: NNT, Number needed to treat to benefit or to harm; NNTB, Number needed to treat to benefit; ;MI, myocardial infarction; TVR, target vessel revascularization; ST, stent thrombosis.
*NNT Not reported owing to lack of a statistically significant difference between groups.

Table D Subgroup interaction with treatment effect

Subgroup	Coefficient	SE	P
Sex: Men vs women	0.36	0.36	0.31
Age: ≥ 65 vs < 65 years	0.29	0.46	0.53
Diabetes mellitus: yes vs no	0.54	0.35	0.13
ACS vs stable syndrome	2.38	1.05	0.02
MVD vs no MVD	-0.16	0.32	0.60
Overlapping vs no overlapping stent	0.24	0.33	0.47
LAD vs no LAD	-0.05	0.32	0.87
DAPT > 1 year vs DAPT ≤ 1 year	-0.67	0.48	0.17
IIb-IIIa use: yes vs no	0.02	0..33	0.94

ACS, acute coronary syndrome; DAPT, dual antiplatelet therapy; LAD: left anterior descending artery; MVD, multivessel disease.

Table E Definitions of myocardial infarction across included studies

	Definitions used to adjudicate myocardial infarction endpoint across studies	
	Spontaneous MI	**Peri-procedural MI**
Trial Name		
PRODIGY	Spontaneous myocardial infarction was based on the detection of rise and/or fall of cardiac biomarkers (preferably troponin) with at least one value above the ULN together with evidence of myocardial ischemia with at least one of the following: a) symptoms of ischemia; b) EKG changes indicative of new ischemia (new ST-T changes or new left bundle branch block [LBBB]); c) development of pathological Q waves in the EKG	Peri-procedural myocardial infarction in patients without on-going ischemia was defined as any elevation of greater than three times the upper limit of normal in at least one blood sample for MB fraction of creatine kinase (CK-MB) in patients with CK-MB values before the procedure within the normal range, or at least 50% CK-MB elevation after PCI in patients with CK-MB values higher than the upper limit of normal before the procedure.
EXAMINATION	Typical rise above the upper limit of normal and fall of cardiac biomarkers.	Troponin >3 times upper limit of normal or CKMB >3 times the upper limit of normal if baseline value is within the upper limit of normal. *Reinfarction*: stable or decreasing values on 2 samples and 20% increase 3 to 6 hours after second sample.
BASKET PROVE	Typical rise and gradual fall (troponin) or more rapid rise and fall (CK-MB) of biochemical markers of myocardial necrosis with at least one of the following: (a) ischemic symptoms; (b) development of pathologic Q waves on the ECG; (c) ECG changes indicative of ischemia (ST segment elevation or depression);	Typical rise and gradual fall (troponin) or more rapid rise and fall (CK-MB) of biochemical markers of myocardial necrosis following coronary artery intervention.
SPIRIT First	A non-Q-wave myocardial infarction was defined as an increase in the creatine kinase (CK) level to greater than or equal to twice the upper limit of the normal range, with elevated	A non-Q-wave myocardial infarction was defined as an increase in the creatine kinase (CK) level to greater than or equal to twice the upper limit of the normal range, with elevated CK-MB, in

	CK-MB, in the absence of new pathological Q waves on electrocardiography.	the absence of new pathological Q waves on electrocardiography.
XIMA	Detection of rise and/or fall of cardiac biomarkers with at least one value above the 99^{th} percentile of the upper reference limit, together with at least one of the following: symptoms of ischemia, ECG changes indicative of new ischemia or development of pathological Q wave in the ECG	Patients with normal baseline troponin values or cardiac markers: elevations of cardiac biomarkers above the 3X 99^{th} percentile upper limit of normal. Patients with abnormal baseline troponin values or cardiac markers: recurrent infarction is diagnosed if at the blood sample taken 3-6 hour thereafter there is a at least 20% increase of the value observed in the first blood sample, exceeding the upper limit of normal.