Appendix 3: Supplementary tables

Table A-Study characteristics

The characteristics and quality assessment in terms of Cochrane risk of bias assessment of included RCTs

Trial	*DAPT Group*	*DAPT Regimen*	*Mean age, years*	*Male(%)*	*ACS(%)*	*Diabetes(%)*	*Time of randomization*	*Stent type*	*Random sequence generation (selection ias)*	*Allocation concealment (selection bias)*	*Blinding of participants and personnel (performance bias)*	*Blinding of outcome assessment (detection bias)*	*Incomplete outcome data (attrition bias)*	*Selective reporting (reporting bias)*	*Other bias*
OPTIMA-C	6 months	Aspirin (100mg/d) +	62.8	478(70.0)	344(50.4)	199(29.1)	At index PCI	BES/ZES	+	+	+	+	+	+	?
NCT03056118, South Korea	12 months	clopidogrel (75mg/d)	64.4	464(67.8)	348(50.9)	203(29.7)									
I-LOVE-IT 2	6 months	Aspirin (100mg/d) +	60.4	611(67.2)	752(82.7)	211(23.2)	At index PCI	BP-SES	+	-	?	?	+	+	-
NCT01681381, China	12 months	clopidogrel (75mg/d)	60	632(68.7)	744(80.9)	203(22.1)									
IVUS-XPL study	6 months	Aspirin (100mg/d) +	63	470(67.2)	343(49.1)	249(35.6)	At index PCI	EES	+	+	?	+	+	?	-
NCT01308281, South Korea	12 months	clopidogrel (75mg/d)	64	494(70.5)	343(48.9)	257(36.7)									
ISAR-SAFE	6 months	Aspirin (81-200mg/d) +	67.2	1661(83.2)	794(39.8)	495(24.8)	6(-1/+2)months	PES/SES/EES/	+	+	+	?	+	+	?
NCT00661206, worldwide	12 months	clopidogrel (75mg/d)	67.2	1612(80.5)	807(40.3)	484(24.2)	after PCI	ZES/BES/BMS							
SECURITY	6 months	Aspirin + clopidogrel (75mg/d)	64.9	529(77.6)	213(31.2)	206(30.2)	At index PCI	ZES/BES/EES	+	+	?	?	?	+	-
NCT00944333, worldwide	12 months		65.5	551(76.8)	229(31.9)	223(31.1)									
OPTIMIZE	3 months	Aspirin (100-200mg/d) +	61.3	992(64.5)	494(31.6)	554(35.4)	At index PCI	ZES	+	+	+	+	+	+	-
NCT01113372, Brazil	12 months	clopidogrel (75mg/d)	61.9	982(63.1)	502(32.3)	549(35.3)									
EXCELLENT	6 months	Aspirin (100-200mg/d) +	63	470(65.1)	369(51.1)	272(37.7)	At index PCI	EES/SES	+	+	?	-	+	+	?
NCT00698607, South Korea	12 months	clopidogrel (75mg/d)	62.4	461(63.9)	375(52.0)	278(38.6)									

RESET NCT01145079, South Korea	3 months 12 months	Aspirin (100mg/d) + clopidogrel (75mg/d)	62.4 62.4	682(64.4) 665(62.9)	588(55.6) 568(53.6)	316(29.9) 305(28.8)	At index PCI	ZES/SES/EES	+	+	?	?	+	+	?
SMART-DATE NCT01701453, South Korea	6 months 12.6-18 months	Aspirin (100mg/d) + clopidogrel (75mg/d) /prasugrel (10 mg/d) / ticagrelor (90mg twice per day)	62.0 62.2	1016(74.9) 1028(75.9)	1357(100) 1355(100)	365(26.9) 379(28.1)	At index PCI	EES/ZES/BES	+	+	+	?	+	+	?
NIPPON NCT01514227, Japan	6 months 18 months	Aspirin (81-162mg/d) + clopidogrel (75mg/d) /ticlopidine (200mg/d)	67.4 67.2	1304(78.8) 1312(79.4)	619(37.4) 635(38.4)	527(31.9) 552(33.4)	At index PCI	BES	+	+	?	?	+	+	+
ITALIC NCT01476020, France	6 months 24 months	Aspirin + clopidogrel (75mg/d)/prasugrel (10mg/d) / ticagrelor (90mg twice per day)	61.6 61.5	750(81.0) 733(79.3)	400(43.2) 406(43.9)	336(36.3) 349(37.8)	6 months after PCI	EES	+	?	?	?	+	+	-
PRODIGY NCT00611286, Italy	6 months 24 months	Aspirin (80-160mg/d) + clopidogrel (75mg/d)	67.9 67.8	747(76.0) 764(77.4)	733(74.6) 702(71.1)	233(23.7) 244(24.7)	30 days after PCI	EES/PES/ZES/ BMS	+	+	?	+	?	+	?
OPTIDUAL NCT00822536, France	12 months 48 months	Aspirin (75-160mg/d) + clopidogrel (75mg/d)	64.2 64.1	547(79.3) 568(81.7)	262(38.0) 239(34.4)	222(32.2) 213(30.6)	12±3 months after PCI	SES/PES/ZES/ EES	+	+	?	+	+	+	?
DAPT Study NCT00977938, worldwide	12 months 30 months	Aspirin (75-162mg/d) + clopidogrel (75mg/d) / prasugrel (10 or 5mg/d)	61.6 61.8	3657(74.0) 3778(75.3)	2103(42.6) 2148(42.8)	1481(30.0) 1556(31.0)	12 months after PCI	EES/PES/ZES/ SES	?	?	+	-	+	+	-
DES LATE NCT01186146, South Korea	12 months 36 months	Aspirin(100-200mg/d) + clopidogrel (75mg/d)	62.3 62.5	1749(69.6) 1749(69.1)	1551(61.7) 1512(59.7)	709(28.2) 709(28.0)	12-18 months after PCI	SES/PES/ZES/ EES/others	+	?	-	-	+	+	?
ARCTIC-Interruption NCT00827411, France	12 months 18-30 months	Aspirin + clopidogrel (75-150mg/d) / purasugrel (10 mg/d)	64 64	503(80.6) 508(80.0)	167(26.8) 156(24.6)	222(35.6) 198(31.1)	12 months after PCI	First /second generation DES	+	+	+	?	+	+	?

REAL-ZEST LATE NCT00484926+NCT00590174, South Korea	12 months 36 months	Aspirin (100-200mg/d) + clopidogrel (75mg/d)	61.9 62.0	933(69.4) 950(70.0)	844(62.8) 843(62.1)	364(27.1) 340(25.1)	12 months after PCI	SES/PES/ZES/ other	+	+	-	-	+	+	?

Table B1-Definition of clinical endpoints of the included RCTs

Trial	Cardiac death	Myocardial infarction	Definite or probable ST	Stroke
OPTIMA-C (Lee *et al*. 2018)	ARC criteria[1].	ARC criteria[1].	ARC criteria[1].	ARC criteria[1].
I-LOVE-IT 2 (Han *et al*. 2016)	Any death due to an evident cardiac cause, any death related to PCI, unwitnessed death, or death of unknown causes[2].	ARC criteria[2].	NA	NA
IVUS-XPL study (Hong *et al*.2016)	All deaths were considered cardiac deaths unless a definite noncardiac cause could be established[3].	The presence of consistent clinical symptoms, ECG changes, or abnormal imaging findings, combined with a creatine kinase myocardial band fraction increase greater than ULN or an increase in troponin T or troponin I to >99th percentile of the ULN[3].	ARC criteria[3].	Detected by the occurrence of a new neurological deficit, was confirmed using a neurological examination and imaging studies[3].
ISAR-SAFE (Schulz-Schupke *et al*. 2015)		New Q-waves on the electrocardiography(ECG) distinct from the baseline ECG, pathologic evidence(such as autopsy) showing a new myocardial infarction(MI) felt to have occurred during study follow-up, ST-segment elevation (>l mm in 2 contiguous leads) accompanied by ischemic chest pain lasting for >20minutes or hemodynamic decompensation(online Appendix)[4].	ARC criteria[5].	Acute neurological event of at least 24 hours of duration, with focal signs and symptoms and without evidence supporting any alternative explanation. Diagnosis of stroke requires confirmation by computed tomography or magnetic resonance imaging or pathological confirmation[4].
SECURITY (Colombo *et al*. 2014)	Including any death without a non-cardiac cause[6].	Cardiac enzyme elevation (troponin T/I or creatine kinase-myocardial band) above the ULN associated with at least 1 ischemic symptom; development of Q waves on the ECG; ECG changes indicative of ischemia or coronary artery intervention[6].	ARC criteria[6].	Any new neurological deficit lasting >24 h associated with neuroimaging evidence (computed tomography or magnetic resonance imaging)[6].
OPTIMIZE (Feres *et al*. 2013)	Any unknown causes of death or death that cannot be clearly attributed to a non-cardiac cause will be considered cardiac[7].	Classified as Q wave (new pathological Q waves in 2 or more continuous ECG leads) or non-Q wave, and: Periprocedural—within 48 hours post-PCI with baseline biomarker <ULN (upper limit of normal), rise in CKMB or troponin >3 times ULN. (For CABG related: baseline biomarker <ULN, rise in CKMB or troponin >5 times ULN, and new Q wave/LBBB or new native or graft vessel occlusion or loss of viable myocardium); Spontaneous—CK-MB or troponin >ULN; Re-infarction—stable or decreasing biomarker values on 2 samples and >20% increase 3 to 6 hours post-intervention as compared to baseline samples[7].	ARC criteria[7].	Acute neurological event with duration ⩾24 hours with confirmation by either computed tomography or magnetic resonance imaging or pathological confirmation[7].
EXCELLENT (Gwon *et al*. 2012)	All deaths were considered cardiac unless a definite noncardiac cause	During the first 48 hours after PCI, defined as an increase of cardiac enzyme (creatine kinase-MB fraction or troponin T/troponin I) 3 times above the ULN in	ARC criteria[8].	Detected by the occurrence of a new neurological deficit, was confirmed by a neurologist and on

	could be established[8].	stable patients; In patients with elevated baseline levels of cardiac enzyme, myocardial infarction was defined as a subsequent increase of ＞2-fold from baseline values; After the first 48hours, myocardial infarction was defined as the presence of clinical signs of MI combined with a creatine kinase-MB fraction or troponin T/troponin I increase higher than ULN[8].		Imaging[8].
RESET (Kim *et al*. 2012)		Presence of clinical symptoms, ECG change or abnormal imaging findings of MI combined with an increase in creatine kinase myocardial band fraction to greater than three times the ULN or troponin-T/troponin-I more than the 99th percentile of the ULN, unrelated to an interventional procedure (online Appendix)[9].	ARC criteria[9].	A sudden onset of vertigo, numbness, aphasia, or dysarthria resulting from vascular lesions of the brain, including hemorrhage, embolism, thrombosis, or rupturing aneurysm(online Appendix)[9].
SMART-DATE (Hahn *et al*. 2018)	All deaths were considered cardiac unless a definite non-cardiac cause could be established[10].	Elevated cardiac enzymes (cardiac troponin or myocardial band fraction of creatine kinase) above the upper reference limit with ischaemic symptoms or electrocardiography findings indicative of ischaemia that was not related to the index procedure[10].	ARC criteria[10].	any non-convulsive focal or global neurological deficit of abrupt onset lasting more than 24 h or leading to death, which was caused by ischaemia or haemorrhage within the brain[10].
NIPPON (Nakamura *et al*. 2017)		1.Periprocedural: A serum CK-MB level exceeding the ULN should not be considered as new MI, but as MI at registration;, a serum troponin or serum CK-MB level exceeding 3 times the ULN within 48 hours after PCI; a serum troponin or serum CK-MB level exceeding 5 times the ULN within 72 hours after CABG; and a new Q-wave, left bundle block, new occlusion of the native vessel or graft, or reduction of viable myocardium on diagnostic imaging. 2.Spontaneous: When myocardial enzymes are at or above the ULN, it should be considered as MI at registration, and when the serum level of troponin or CK-MB exceeds ULN more than 48 hours after PCI or within 72 hours after CABG. 3.Re-infarction: Blood levels of biomarkers measured twice after the onset of MI are stable or decrease and the values at 3 to 6 hours after PCI show a > 20% increase compared with those obtained at index PCI[11].	ARC criteria[11].	Occurrence of cerebral infarction (ischemic stroke) or cerebral hemorrhage or subarachnoid hemorrhage (hemorrhagic stroke). Stroke was defined as the sudden onset of vertigo, numbness, dysphasia, weakness, visual field defects, dysarthria or other focal neurological deficits due to vascular lesions of the brain such as hemorrhage, embolism, thrombosis, or ruptured aneurysm[11].
ITALIC (Didier *et al*. 2017)	All deaths unless an unequivocal non-cardiac cause could be established[12].	Q-wave MI was defined by recurrence of symptoms and/or development of new pathological Q waves in 2 or more contiguous leads with elevated creatine kinase (CK), CK-MB, or troponin levels.; Non–Q-wave MI was defined by >2-fold CK elevation with elevated CK-MB or troponin without new pathological Q waves[12].	ARC criteria[12].	Acute new neurological deficit ending in death or lasting longer than 24 h, diagnosed as stroke by a physician[12].
PRODIGY (Valgimigli *et al*. 2012)		New pathologic Q waves or CK-MB or troponin I/T elevation above the upper limit of normal, accompanied by ischemic symptoms and/or ECG changes[13].	ARC criteria[14].	Detected by the occurrence of a new neurological deficit, was confirmed by a neurologist and on imaging, whereas the occurrence of a transient ischemic attack required hospitalization and clinical confirmation by a neurologist[14].
OPTIDUAL (Helft *et al*. 2015)		Presence of clinical or ECG changes consistent with myocardial ischaemia in the setting of increased cardiac biomarkers above ULN in accordance with the	ARC criteria[15].	Acute episode of neurologic dysfunction attributed to a central nervous system vascular cause. Stroke

		universal definition(details were provided in online appendix)[15].		should be documented by imaging. Evidence obtained from autopsy can confirm the diagnosis[15].
DAPT Study (Mauri *et al*. 2014)	Any death due to immediate cardiac cause. Unwitnessed death and death of unknown cause will be classified as cardiac death[16].	The categories includes peri-procedual PCI, peri-procedual CABG, spontaneous, silent, sudden death, and reinfarction, more details were provided in the online appendix of the original article[16].	ARC criteria[16].	Sudden onset of vertigo, numbness, dysphasia, weakness, visual field defects, dysarthria or other focal neurological deficits due to vascular lesions of the brain such as hemorrhage, embolism, thrombosis, or rupturing aneurysm that either: 1. persists more than 24 hours or results in death in less than 24 hours; 2. persists <24 hours duration if the following treatments were used: a. pharmacologic, i.e. thrombolytic drug administration, or b. non-pharmacologic, i.e. neuro- interventional procedure (e.g. intracranial angioplasty); 3. persists <24 hours but has neuro-radiological (MRI or CT) diagnostic changes suggestive of acute tissue injury[16].
DES LATE (Lee *et al*. 2014)	All deaths were considered to have resulted from cardiac causes unless an unequivocal noncardiac cause could be established[17].	ARC criteria[17].	ARC criteria*[17].	Detected by the occurrence of a new neurological deficit, was confirmed by a neurologist and imaging[17].
ARCTIC-Interruption (Collet *et al*. 2014)		(i) In patients with elevated biomarkers before PCI, positive diagnosis of reinfarction is made when all of the following criteria are present: documentation that troponin level (or CK in the absence of CPK-MB) was decreasing; (2) troponin (or CPK-MB) measured 6 hours after PCI is N3×ULN; (3) peak troponin (or CPK-MB) level measured within 24 hours after the event is elevated by at least 50% above the previous level. (ii) In patients in whom biomarkers are normal or have returned to normal prior to PCI, periprocedural MI is defined when troponin (or CPKMB) measured 6 hours after PCI is N3× ULN. Measurements of biomarkers are requested before and 6 hours after PCI and at discharge[18].	ARC criteria*[18].	NA
REAL-ZEST LATE (Park *et al*. 2010)	All deaths were considered to be from cardiac causes unless an unequivocal noncardiac cause could be established[19].	Universal definition of myocardial infarction[19 20].	ARC criteria*[19].	Detected by the occurrence of a new neurologic deficit, was confirmed by a neurologist and on imaging[19].

*Definite stent thrombosis only.

NA refers to that though the endpoint was listed in the paper, the concrete definition was not available.

The blank represented no results were provided in original articles or the definition of the result might incur unacceptable bias.

Table B2-Definition of clinical endpoints of the included RCTs

Trial	Major bleeding	Any bleeding	Net adverse clinical events
OPTIMA-C (Lee *et al*. 2018)	TIMI major bleeding		
I-LOVE-IT 2 (Han *et al*. 2016)	BARC type≥3 bleeding.	BARC criteria.	A composite of all-cause death, all MI, stroke and BARC type≥3 bleeding.
IVUS-XPL study (Hong *et al*.2016)	TIMI Major bleeding.		A composite of cardiac death, myocardial infarction, stroke, or TIMI major bleeding.
ISAR-SAFE (Schulz-Schupke *et al*. 2015)	TIMI major bleeding.	BARC criteria.	A composite of death, MI ,stent thrombosis(ST), stroke or TIMI major bleeding
SECURITY (Colombo *et al*. 2014)	BARC 3 or 5 type bleeding.	BARC criteria.	A composite of cardiac death, MI, stroke, definite or probable ST, and BARC 3 or 5 bleeding.
OPTIMIZE (Feres *et al*. 2013)	Incorporated modified major REPLACE-2 and severe or life-threatening GUSTO criteria[7].	Major bleeding plus bleeding events that did not meet criteria for either major or severe or life-threatening bleeding according to modified major REPLACE-2 and severe or life- threatening GUSTO criteria[7].	A composite of death, myocardial infarction, stroke and major bleeding.
EXCELLENT (Gwon *et al*. 2012)	TIMI Major bleeding.	TIMI criteria.	A composite of death, MI, stroke, ST, and TIMI major bleeding.
RESET (Kim *et al*. 2012)	TIMI Major bleeding.	TIMI criteria.	
SMART-DATE (Hahn *et al*. 2018)	BARC type 3-5 bleeding.	BARC type 2–5 bleeding.	
NIPPON (Nakamura *et al*. 2017)	BARC 3 or 5 type bleeding.		A composite of all-cause mortality, myocardial infarction, stroke, and REPLACE-2 major bleeding.
ITALIC (Didier *et al*. 2017)	TIMI Major bleeding.		
PRODIGY (Valgimigli *et al*. 2012)	TIMI Major bleeding.	BARC criteria.	
OPTIDUAL (Helft *et al*. 2015)	TIMI major bleeding.	BARC criteria.	A composite of all-cause mortality, non-fatal myocardial infarction, stroke, and TIMI major bleeding.
DAPT Study (Mauri *et al*. 2014)	GUSTO severe bleeding.	BARC criteria.	

DES LATE (Lee *et al*. 2014)	TIMI Major bleeding.		A composite of cardiac death, myocardial infarction, stroke, stent thrombosis and TIMI major bleeding.
ARCTIC-Interruption (Collet *et al*. 2014)	STEEPLE major bleeding.	STEEPLE criteria.	
REAL-ZEST LATE (Park *et al*. 2010)	TIMI Major bleeding.		

GUSTO refers to The Global Use of Strategies to Open Occluded Arteries; ARC refers to Academic Research Consortium; STEEPLE refers to Enoxaparin versus Unfractionated Heparin in Elective Percutaneous Coronary Intervention; REPLACE refers to Randomized Evaluation of PCI Linking Angiomax to Reduced Clinical Events; TIMI refers to thrombolysis in Myocardial Infarction; BARC refers to Bleeding Academic Research Consortium.

NA refers to that though the endpoint was listed in the paper, the concrete definition was not available.

The blank represented no results were provided in original articles or the definition of the result might incur unacceptable bias.

Table C1-Assessment of heterogeneity and consistency, for all endpoints in the study group with long-term arm as >12 months DAPT

Endpoints	Comparison	Direct			indirect			Network			Heterogeneity	Consistency	
		OR	LL	UL	OR	LL	UL	OR	LL	UL	T^2	Global P>X^2	Local P>z
All-cause death	Long-term vs Short-term	1.04	0.80	1.33	1.51	1.05	2.17	1.18	0.93	1.49	0	0.092	0.094
	Standard-term vs Short-term	1.24	0.93	1.65	0.85	0.61	1.18	1.08	0.82	1.43	0		
	Long-term vs Standard-term	1.22	0.98	1.52	0.84	0.57	1.23	1.09	0.85	1.39	0		
Cardiac death	Long-term vs Short-term	1.27	0.73	2.20	1.29	0.78	2.16	1.28	0.88	1.86	0	0.956	0.955
	Standard-term vs Short-term	1.13	0.75	1.69	1.11	0.59	2.09	1.12	0.80	1.58	0		
	Long-term vs Standard-term	1.15	0.84	1.57	1.12	0.57	2.22	1.14	0.86	1.52	0		
Non-cardiac death	Long-term vs Short-term	1.28	0.71	2.30	2.18	1.16	4.11	1.63	1.03	2.59	0.018	0.226	0.185
	Standard-term vs Short-term	1.28	0.75	2.17	0.75	0.35	1.59	1.09	0.67	1.77	0.018		
	Long-term vs Standard-term	1.71	1.14	2.57	1.00	0.47	2.14	1.50	1.00	2.26	0.019		
Major bleeding	Long-term vs Short-term	1.62	1.06	2.46	2.11	1.21	3.67	1.78	1.27	2.49	0	0.458	0.600
	Standard-term vs Short-term	1.42	0.92	2.20	1.09	0.64	1.88	1.28	0.91	1.80	0		
	Long-term vs Standard-term	1.48	1.05	2.09	1.14	0.62	2.09	1.39	1.03	1.87	0		
Any bleeding	Long-term vs Short-term	1.82	1.10	3.01	2.64	1.47	4.77	2.13	1.46	3.10	0.290	0.346	0.390
	Standard-term vs Short-term	1.51	1.05	2.18	1.04	0.52	2.07	1.39	1.01	1.92	0.290		
	Long-term vs Standard-term	1.75	1.10	2.80	1.21	0.65	2.25	1.53	1.06	2.22	0.290		
Myocardial infarction	Long-term vs Short-term	0.70	0.46	1.07	0.55	0.34	0.88	0.63	0.46	0.86	0.173	0.464	0.113
	Standard-term vs Short-term	0.87	0.64	1.17	1.12	0.61	2.04	0.92	0.70	1.21	0.173		
	Long-term vs Standard-term	0.63	0.43	0.91	0.81	0.48	1.36	0.68	0.51	0.92	0.173		
Definite or probable ST	Long-term vs Short-term	0.70	0.39	1.25	0.39	0.17	0.90	0.57	0.34	0.95	0.271	0.271	0.088
	Standard-term vs Short-term	0.83	0.47	1.47	1.50	0.61	3.65	0.98	0.59	1.64	0.271		
	Long-term vs Standard-term	0.47	0.25	0.89	0.84	0.37	1.88	0.58	0.34	0.98	0.271		
Stroke	Long-term vs Short-term	1.21	0.78	1.87	0.90	0.52	1.54	1.08	0.77	1.51	0	0.397	0.397
	Standard-term vs Short-term	0.93	0.60	1.44	1.25	0.73	2.14	1.04	0.74	1.47	0		
	Long-term vs Standard-term	0.97	0.71	1.33	1.31	0.71	2.42	1.03	0.78	1.37	0		
Net adverse clinical events	Long-term vs Short-term	0.70	0.41	1.19	0.95	0.70	1.30	0.88	0.67	1.15	0	0.328	0.328
	Standard-term vs Short-term	0.94	0.78	1.12	0.69	0.38	1.24	0.91	0.77	1.08	0		
	Long-term vs Standard-term	1.02	0.79	1.31	0.75	0.43	1.31	0.97	0.77	1.22	0		

Table C2-Assessment of heterogeneity and consistency, for all endpoints in the study group with long-term arm as ≥18 months DAPT

Endpoints	Comparison	Direct			indirect			Network			Heterogeneity	Consistency	
		OR	LL	UL	OR	LL	UL	OR	LL	UL	T^2	Global P>X^2	Local P>z
All-cause death	Long-term vs Short-term	1.00	0.72	1.39	1.51	1.03	2.21	1.20	0.90	1.59	0.082	0.107	0.113
	Standard-term vs Short-term	1.25	0.90	1.74	0.83	0.54	1.27	1.12	0.83	1.50	0.082		
	Long-term vs Standard-term	1.21	0.91	1.60	0.80	0.50	1.28	1.07	0.82	1.40	0.082		
Cardiac death	Long-term vs Short-term	1.00	0.29	3.47	1.29	0.78	2.16	1.25	0.78	2.00	0	0.709	0.709
	Standard-term vs Short-term	1.13	0.75	1.69	0.87	0.24	3.15	1.10	0.75	1.62	0		
	Long-term vs Standard-term	1.15	0.84	1.57	0.89	0.24	3.28	1.13	0.83	1.53	0		
Non-cardiac death	Long-term vs Short-term	2.53	0.98	6.55	2.18	1.16	4.10	2.28	1.35	3.86	0	0.800	0.842
	Standard-term vs Short-term	1.28	0.76	2.13	1.48	0.53	4.10	1.31	0.83	2.07	0		
	Long-term vs Standard-term	1.71	1.18	2.48	1.98	0.67	5.84	1.74	1.23	2.47	0		
Major bleeding	Long-term vs Short-term	1.61	1.01	2.55	2.11	1.21	3.67	1.79	1.26	2.56	0	0.462	0.643
	Standard-term vs Short-term	1.42	0.92	2.20	1.08	0.61	1.93	1.29	0.91	1.82	0		
	Long-term vs Standard-term	1.48	1.05	2.09	1.13	0.60	2.13	1.39	1.03	1.88	0		
Any bleeding	Long-term vs Short-term	2.23	1.07	4.66	2.65	1.43	4.91	2.46	1.61	3.77	0.311	0.725	0.789
	Standard-term vs Short-term	1.52	1.04	2.22	1.28	0.53	3.10	1.46	1.06	2.02	0.311		
	Long-term vs Standard-term	1.75	1.07	2.85	1.47	0.64	3.37	1.68	1.15	2.47	0.311		
Myocardial infarction	Long-term vs Short-term	0.85	0.55	1.32	0.52	0.33	0.84	0.67	0.48	0.94	0.126	0.159	0.027
	Standard-term vs Short-term	0.87	0.66	1.14	1.40	0.76	2.58	0.95	0.71	1.26	0.126		
	Long-term vs Standard-term	0.61	0.42	0.88	0.98	0.58	1.65	0.71	0.52	0.96	0.126		
Definite or probable ST	Long-term vs Short-term	0.71	0.32	1.56	0.41	0.17	0.98	0.55	0.30	1.00	0.319	0.368	0.193
	Standard-term vs Short-term	0.83	0.46	1.50	1.45	0.50	4.21	0.95	0.55	1.63	0.319		
	Long-term vs Standard-term	0.49	0.25	0.95	0.85	0.32	2.28	0.58	0.33	1.02	0.319		
Stroke	Long-term vs Short-term	1.03	0.75	2.10	0.90	0.52	1.54	1.07	0.74	1.56	0	0.372	0.372
	Standard-term vs Short-term	0.93	0.60	1.44	1.30	0.71	2.37	1.04	0.73	1.48	0		
	Long-term vs Standard-term	0.97	0.71	1.33	1.36	0.69	2.67	1.03	0.77	1.37	0		
Net adverse clinical events	Long-term vs Short-term	0.70	0.41	1.19	0.95	0.70	1.30	0.88	0.67	1.15	0	0.328	0.328
	Standard-term vs Short-term	0.94	0.78	1.12	0.69	0.38	1.24	0.91	0.77	1.08	0		
	Long-term vs Standard-term	1.02	0.79	1.31	0.75	0.43	1.31	0.97	0.77	1.22	0		

Table D-Assessment of Bayesian random effects model fit and inconsistency, for all endpoints in the study group with long-term arm as ≥18 months DAPT

Endpoints	Model fit			Node-splitting inconsistency *P*-values		
	Data points	Total residual variance[1]	DIC[2]	Standard-term vs Short-term	Long-term vs Short-term	Long-term vs Standard-term
All-cause death	32	31.4	54.0	0.176	0.179	0.187
Cardiac death	20	15.9	29.3	0.678	0.684	0.677
Non-cardiac death	20	15.2	28.7	0.814	0.803	0.821
Major bleeding	32	33.6	54.7	0.530	0.532	0.521
Any bleeding	20	20.4	36.8	0.684	0.685	0.681
Myocardial infarction	32	29.5	52.2	0.279	0.282	0.266
Definite or probable ST	32	32.9	56.4	0.410	0.423	0.414
Stroke	32	29.7	50.1	0.798	0.766	0.782
Net adverse clinical events	18	15.3	28.0	0.429	0.427	0.419

[1]Once total residual variance approximated the number of data points, it means a good model fit; [2]DIC refers to deviance information criterion, lower values of DIC are better.

Table E- GRADE quality of evidence and anticipated absolute effects of all endpoints. Long-term arm in this study group was >12 months DAPT.

Endpoints	Direct evidence	Indirect evidence	Network meta-analysis		
	Quality of evidence	Quality of evidence	Quality of evidence	Anticipated absolute effects	
				Risk with shorter DAPT	Risk difference with longer DAPT
Long-term vs Short-term					
All-cause death	⨁⨁⨁◯ Moderate[1]	⨁⨁◯◯ Low[3,4]	Moderate	27 per 1,000	5 more per 1,000 (2 fewer to 13 more)
Cardiac death	⨁⨁⨁◯ Moderate[1]	⨁◯◯◯Very low[1,3,4]	Moderate	13 per 1,000	4 more per 1,000 (2 fewer to 11 more)
Non-cardiac death	⨁⨁⨁◯ Moderate[1]	⨁⨁◯◯ Low[3,4]	Moderate	13 per 1,000	8 more per 1,000 (0 fewer to 20 more)
Major bleeding	⨁⨁⨁⨁ High	⨁⨁⨁◯ Moderate[4]	High	9 per 1,000	7 more per 1,000 (2 more to 12 more)
Any bleeding	⨁⨁⨁◯ Moderate[2]	⨁◯◯◯Very low[2,3,4]	Moderate	53 per 1,000	53 more per 1,000 (23 more to 95 more)
Myocardial infarction	⨁⨁◯◯ Low[1,2]	⨁◯◯◯Very low[2,3,4]	Low	12 per 1,000	4 fewer per 1,000 (6 fewer to 2 fewer)
Definite or probable ST	⨁⨁◯◯ Low[1,2]	⨁⨁◯◯ Low[2,4]	Low	5 per 1,000	2 fewer per 1,000 (4 fewer to 0 fewer)
Stroke	⨁⨁⨁◯ Moderate[1]	⨁⨁◯◯ Low[1,4]	Moderate	9 per 1,000	1 more per 1,000 (2 fewer to 5 more)
Net adverse clinical events	⨁⨁⨁◯ Moderate[1]	⨁⨁◯◯ Low[1,4]	Moderate	15 per 1,000	2 fewer per 1,000 (5 fewer to 2 more)
Standard-term vs Short term					
All-cause death	⨁⨁◯◯ Low[1,3]	⨁⨁◯◯ Low[1,4]	Low	13 per 1,000	1 more per 1,000 (2 fewer to 5 more)
Cardiac death	⨁⨁◯◯ Low[1,3]	⨁⨁◯◯ Low[1,4]	Low	10 per 1,000	1 more per 1,000 (2 fewer to 6 more)
Non-cardiac death	⨁⨁◯◯ Low[1,3]	⨁⨁◯◯ Low[1,4]	Low	7 per 1,000	1 more per 1,000 (2 fewer to 5 more)
Major bleeding	⨁⨁⨁◯ Moderate[1]	⨁⨁◯◯ Low[1,4]	Moderate	6 per 1,000	2 more per 1,000 (1 fewer to 5 more)
Any bleeding	⨁⨁◯◯ Low[2,3]	⨁◯◯◯Very low[1,2,3,4]	Low	26 per 1,000	28 more per 1,000 (11 more to 50 more)
Myocardial infarction	⨁⨁◯◯ Low[1,2]	⨁◯◯◯Very low[1,2,3,4]	Low	14 per 1,000	1 fewer per 1,000 (4 fewer to 3 more)
Definite or probable ST	⨁⨁◯◯ Low[1,2]	⨁◯◯◯Very low[1,2,4]	Low	3 per 1,000	0 fewer per 1,000 (1 fewer to 2 more)
Stroke	⨁⨁⨁◯ Moderate[1]	⨁⨁◯◯ Low[1,4]	Moderate	5 per 1,000	0 fewer per 1,000 (1 fewer to 2 more)
Net adverse clinical events	⨁⨁⨁◯ Moderate[1]	⨁⨁◯◯ Low[1,4]	Moderate	37 per 1,000	3 fewer per 1,000 (8 fewer to 3 more)
Long-term vs Standard-term					
All-cause death	⨁⨁⨁◯ Moderate[1]	⨁◯◯◯Very low[1,3,4]	Moderate	18 per 1,000	2 more per 1,000 (3 fewer to 7 more)
Cardiac death	⨁⨁⨁◯ Moderate[1]	⨁◯◯◯Very low[1,3,4]	Moderate	10 per 1,000	1 more per 1,000 (1 fewer to 5 more)
Non-cardiac death	⨁⨁⨁⨁ High	⨁◯◯◯Very low[1,3,4]	High	9 per 1,000	4 more per 1,000 (0 fewer to 11 more)
Major bleeding	⨁⨁⨁⨁ High	⨁⨁◯◯ Low[1,4]	High	8 per 1,000	3 more per 1,000 (0 fewer to 7 more)
Any bleeding	⨁⨁◯◯ Low[2,3]	⨁◯◯◯Very low[1,2,3,4]	Low	46 per 1,000	23 more per 1,000 (3 more to 51 more)
Myocardial infarction	⨁⨁◯◯ Low[2,3]	⨁◯◯◯Very low[1,2,4]	Low	14 per 1,000	5 fewer per 1,000 (7 fewer to 1 fewer)
Definite or probable ST	⨁⨁⨁◯ Moderate[2]	⨁◯◯◯Very low[1,2,4]	Moderate	3 per 1,000	1 fewer per 1,000 (2 fewer to 0 fewer)
Stroke	⨁⨁⨁◯ Moderate[1]	⨁⨁◯◯ Low[1,4]	Moderate	8 per 1,000	0 fewer per 1,000 (2 fewer to 3 more)
Net adverse clinical events	⨁⨁⨁◯ Moderate[1]	⨁⨁◯◯ Low[1,4]	Moderate	40 per 1,000	1 fewer per 1,000 (9 fewer to 8 more)

[1] Serious imprecision since 95% confidence interval includes null effect; [2]Serious inconsistency when $0.16<\tau^2<0.36$; [3]Strongly suspected publication bias when funnel plot is not symmetrical; [4]Serious indirectness because of indirect comparisons.

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