

## CLINICAL OUTCOMES IN PATIENTS ON ORAL ANTICOAGULATION THERAPY UNDERGOING CORONARY ARTERY STENTING

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**Background:** This study aims to further evaluate and refine the understanding of the efficacy and safety of various antithrombotic regimens in patients receiving oral anticoagulation (OAC) who undergo percutaneous coronary intervention with stent implantation (PCI-S). Specifically, the regimens examined include triple therapy (TT) comprising warfarin, aspirin, and clopidogrel; dual therapy (DT) consisting of warfarin plus a single antiplatelet agent (either aspirin or clopidogrel); and dual antiplatelet therapy (DAPT) with aspirin and clopidogrel.

**Materials and Methods:** We analyzed the database of the prospective, multicenter Warfarin and coronary Stenting (WAR-STENT) registry, only including the post-discharge period.

**Results:** Of the 103 patients discharged alive following the index hospitalization, 72 (85%) were prescribed triple therapy (TT), 10 (5%) dual therapy (DT), and 21 (10%) dual antiplatelet therapy (DAPT). Over a mean follow-up period of  $184.3 \pm 11.4$  days, the incidence of major adverse cardiovascular events (MACE)—including cardiovascular death, myocardial infarction, repeat revascularization, stent thrombosis, and thromboembolism—as well as total bleeding, major bleeding, and the composite outcome of MACE plus total bleeding, was comparable across the three treatment groups. The absolute rate of major bleeding in the TT group was 2/5%. Among patients who experienced major bleeding, the antithrombotic regimen in use at the time was TT in 41% of cases, DT in 52%, and DAPT in 7%.

**Conclusion :** In this real-world cohort of patients receiving oral anticoagulation (OAC) and undergoing percutaneous coronary intervention with stenting (PCI-S) from the WAR-STENT registry, the three antithrombotic strategies—triple therapy (TT), dual therapy (DT), and dual antiplatelet therapy (DAPT)—demonstrated comparable safety and efficacy profiles. However, given the study's inherent limitations, our findings should not be interpreted as definitive evidence against current clinical guidelines recommending the use of TT.