Post PCI Procedural Recommendations

Standards of care for ensuring appropriate management of patients after PCI are found in the *2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention*. The following table lists the post-procedural recommendations for patients undergoing PCI.

Table 14. Postprocedural Recommendations for Patients Undergoing PCI

Recommendations	COR	LOE	References
Aspirin			
After PCI, use of aspirin should be continued indefinitely.	I	A	560–563
After PCI, it is reasonable to use aspirin 81 mg/d in preference to higher maintenance doses.	IIa	B	302,573–576
$P2Y_{12}$ inhibitors			
In patients receiving a stent (BMS or DES) during PCI for ACS, $P2Y_{12}$ inhibitor therapy should be given for at least 12 mo. Options include clopidogrel 75 mg/d, prasugrel 10 mg/d, and ticagrelor 90 mg twice daily.	I	B	567,568,570
In patients receiving DES for a non-ACS indication, clopidogrel 75 mg/d should be given for at least 12 mo if patients are not at high risk of bleeding.	I	B	208,212,571
In patients receiving BMS for a non-ACS indication, clopidogrel should be given for a minimum of 1 mo and ideally up to 12 mo (unless the patient is at increased risk of bleeding; then it should be given for a minimum of 2 wk).	I	B	572
Patients should be counseled on the importance of compliance with DAPT and that therapy should not be discontinued before discussion with their cardiologist.	I	C	208
PPIs should be used in patients with a history of prior GI bleeding who require DAPT.	I	C	794
If the risk of morbidity from bleeding outweighs the anticipated benefit afforded by a recommended duration of $P2Y_{12}$ inhibitor therapy after stent implantation, earlier discontinuation (eg, <12 mo) of $P2Y_{12}$ inhibitor therapy is reasonable.	IIa	C	N/A
Use of PPIs is reasonable in patients with an increased risk of GI bleeding (eg, advanced age, concomitant use of warfarin, steroids, NSAIDs, *Helicobacter pylori* infection) who require DAPT.	IIa	C	794
Continuation of clopidogrel, prasugrel, or ticagrelor beyond 12 mo may be considered in patients undergoing placement of DES.	IIb	C	N/A
Routine use of a PPI is not recommended for patients at low risk of GI bleeding, who have much less potential to benefit from prophylactic therapy.	III: No Benefit	C	794
Exercise testing			
For patients entering a formal cardiac rehabilitation program after PCI, treadmill exercise testing is reasonable.	IIa	C	567,568
Routine periodic stress testing of asymptomatic patients after PCI without specific clinical indications should not be performed.	III: No Benefit	C	795
Cardiac rehabilitation			
Medically supervised exercise programs (cardiac rehabilitation) should be recommended to patients after PCI, particularly for patients at moderate to high risk, for whom supervised exercise training is warranted.	I	A	795–804
Secondary prevention (recommendations included from the 2011 AHA/ACCF Secondary Prevention and Risk Reduction Therapy Guideline)[805]			
Lipid management with lifestyle modification and lipid-lowering pharmacotherapy			
Lifestyle modification	I	B	806,807
Statin therapy	I	A	344,806,808–810,810a
Statin therapy which lowers LDL cholesterol to <100 mg/dL and achieves at least a 30% lowering of LDL cholesterol	I	C	344,806,808–810,810a
Statin therapy which lowers LDL cholesterol to <70 mg/dL in very high-risk* patients	IIa	B	345,808–810,810a,811,812
Blood pressure control (with a blood pressure goal of <140/90 mm Hg			
Lifestyle modification	I	B	813–817
Pharmacotherapy	I	A	813,818,819
Diabetes management (eg, lifestyle modification and pharmacotherapy) coordinated with the patient's primary care physician and/or endocrinologist	I	C	N/A
Complete smoking cessation	I	A	820–822

*Presence of established cardiovascular disease plus 1) multiple major risk factors (especially diabetes), 2) severe and poorly controlled risk factors (especially continued cigarette smoking), 3) multiple risk factors of the metabolic syndrome (especially high triglycerides ≥200 mg/dL plus non–HDL cholesterol ≥130 mg/dL with low HDL cholesterol [<40 mg/dL]), and 4) acute coronary syndromes.

ACS indicates acute coronary syndromes; BMS, bare-metal stent(s); COR, class of recommendation; DAPT, dual antiplatelet therapy; DES, drug-eluting stent(s); GI, gastrointestinal; HDL, high-density lipoprotein; LDL, low-density lipoprotein; LOE, level of evidence; N/A, not applicable; NSAID, nonsteroidal anti-inflammatory drug; PCI, percutaneous coronary intervention; and PPI, proton pump inhibitor.

This tool is a part of the Bleeding Risk Toolkit available through the ACC Quality Improvement for Institutions program on CVQuality.ACC.org.