

Original Research Article

COMPARATIVE STUDY OF PRASUGREL VERSUS CLOPIDOGREL IN PATIENTS WHO HAD UNDERGONE PERCUTANEOUS CORONARY INTERVENTION FOR CHRONIC CORONARY SYNDROMES: A RETROSPECTIVE OBSERVATIONAL STUDY

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ABSTRACT

Background: Potent P2Y₁₂ inhibitors such as prasugrel is superior to clopidogrel in patients with acute coronary syndromes (ACS) undergoing percutaneous coronary intervention (PCI). There is a significant evidence gap in the risk benefit profile of potent P2Y₁₂ inhibitors in chronic coronary syndromes (CCS) post PCI.

Aim: To compare prasugrel versus clopidogrel in patients who had undergone PCI for CCS, and the incidence of major adverse cardiovascular events (MACE) and bleeding complications within 6 months post-PCI.

Materials and Methods: Consecutive patients who had undergone PCI for CCS in a tertiary care centre between January 2024 to June 2025 and were discharged on prasugrel were compared with those discharged on clopidogrel. The primary outcome was to compare the incidence of death or myocardial infarction (MI), with secondary outcome to determine the rates of bleeding, stroke, stent thrombosis, target vessel revascularization at 6 months of follow up.

Results: Total 400 patients, 200 in each group, were included in study. Death and MI, each occurred at a rate of 1.0% in the Prasugrel group compared with 1.5% in the Clopidogrel group. Prasugrel showed a lower numerical rate of outcome (2.5% vs. 3.0%, HR 0.83). A notable numerical difference was seen in Stent Thrombosis with 1% in the Prasugrel group vs. 5% in the Clopidogrel group. Target Lesion Revascularization (TLR) was less frequent in the Prasugrel group (2.0% vs. 6.0%) than the clopidogrel group. For the composite endpoint of death or MI, the event rate was numerically lower in the prasugrel group than the clopidogrel group. (2.0% [4/200] vs 3.0% [6/200]; HR 0.67). However, with a sample size of 200 per group, this difference was not statistically significant ($p > 0.05$). Regarding bleeding events, 12 events (6.0%) occurred in Prasugrel Group (n=200) compared with 3 events (1.5%) Clopidogrel Group (n=200).

Conclusion: In real-world clinical practice, prasugrel was preferentially prescribed to younger patients with complex coronary anatomy. Ischemic event rates were low in both groups, but prasugrel was associated with a higher observed rate of bleeding, highlighting the need for careful risk stratification when selecting P2Y₁₂ inhibitors in CCS.

Keywords: prasugrel, clopidogrel, chronic coronary syndromes, percutaneous coronary intervention, bleeding.

INTRODUCTION

Chronic coronary syndromes (CCS) represent a spectrum of clinical conditions characterized by stable atherosclerotic coronary artery disease, including stable angina and asymptomatic myocardial ischemia. [1,2,3] About half of all patients experience chronic stable angina, which is the first sign of coronary artery disease (CAD). [4,5] The two primary objectives of coronary artery disease (CAD) management are to prevent MI and death and to lessen symptoms and ischemia. Percutaneous coronary intervention (PCI) remains the cornerstone in the management of patients with CCS, aimed primarily at relieving angina symptoms and improving the quality of life. [4-7]

Dual antiplatelet therapy (DAPT) is the cornerstone of pharmacological treatment and aims at preventing the atherothrombotic complications in patients with a variety of coronary artery disease (CAD) manifestations. [8,9] Prasugrel and clopidogrel's ability to suppress platelets has been compared in a number of studies. According to preclinical research, prasugrel is about ten times more effective than clopidogrel at preventing thrombus formation, preventing platelet aggregation, and delaying bleeding. [10,11] In patients with stable coronary artery disease (CAD), acute coronary syndromes, PCI patients, and healthy individuals, prasugrel has consistently shown stronger and faster platelet inhibition than clopidogrel in clinical trials. Furthermore, individuals who react poorly to clopidogrel respond well to prasugrel. [12,13]

The use of prasugrel in CCS patients undergoing PCI is primarily extrapolated from ACS trials. [14,15] or observational data, creating a significant evidence gap in this important clinical scenario. Given the more stable nature of CCS compared to ACS, the benefit-risk profile of more potent P2Y12 inhibition may differ substantially from that observed in acute settings. This study aims to fill this critical knowledge gap by directly comparing prasugrel with clopidogrel in a well-defined population of CCS patients who had undergone elective PCI, thus providing evidence-based guidance for clinicians regarding optimal antiplatelet therapy in this setting.

MATERIALS AND METHODS

Study Design and Population: A retrospective observational study was conducted in the Department of Cardiology, MDM Hospital, Dr. S.N. Medical College, Jodhpur, Rajasthan over a period of 18 months from January 2024 to June 2025, in patients diagnosed with chronic coronary syndromes who had undergone elective PCI, after obtaining approval from the institutional ethical committee. Total 400 patients with CCS who had undergone elective PCI, were enrolled in the study and categorised into two groups according to the P2Y12 inhibitor received.

The study included patients aged 18–75 years, patients diagnosed with CCS who had undergone elective PCI with drug-eluting stents and patients who were willing to provide consent. Patients with acute coronary syndromes, prior history of stroke/ Transient ischemic attack, age >75 years, weight less than 60 kg, active bleeding or bleeding diathesis, severe hepatic impairment, creatinine clearance <30 ml/min, contraindications to either study drug and patients not willing to give consent were excluded from the study.

Study Distribution: All patients received aspirin and standard guideline-directed medical therapy. Patients were categorised into two groups according to the P2Y12 inhibitor received. Group A comprised patients who received Clopidogrel 600 mg at a loading dose followed by a maintenance dose of 75 mg twice a day with Aspirin 150 mg twice a day. Group B comprised patients who received Prasugrel 60 mg at a loading dose followed by a maintenance dose of 10 mg once daily along with Aspirin at a dose 150 mg once daily.

Data Collection: Informed consent was obtained from anonymised data collection and systematic follow-up by all patients. Demographics and clinical characteristics, angiographic findings, procedural details, were systematically extracted from the medical records by using standardised data collection forms at the time of index hospitalisation for PCI. Data on previously admitted patients during the study period were collected retrospectively and patients were followed up 6 months after admission and PCI. Patients were monitored for MACE (death, MI, stroke, stent thrombosis) and bleeding events at 6 months follow up.

Study Outcome: The primary endpoint of the study was the composite of all-cause death or myocardial infarction within 6 month following PCI. Secondary endpoints included rates MACE (major adverse clinical events), BARC-defined bleeding, target lesion revascularisation (TLR), stent thrombosis, stroke and the incidence of the individual components of the primary endpoint.

Statistical Analysis: Data was analysed using SPSS. Continuous variables were compared using Student's t-test or Mann–Whitney U test. Categorical variables were analysed using Chi-square or Fisher's exact test. A p-value <0.05 was considered statistically significant.

RESULTS

During the study period, total 400 patients, 200 in each group were included in the study after exclusion of patients not meeting the inclusion criteria. The baseline demographics, procedural characteristics and study outcomes of patients are summarized in Table 1, Table 2 and Table 3 respectively.

Baseline demographics and Clinical Characteristics [Table 1]: The Prasugrel cohort was slightly younger on average compared to the

Clopidogrel cohort. While BMI was identical between the groups, the Clopidogrel group had a higher proportion (29.5%) of female patients. Both groups showed high prevalence of hypertension (91%). The Clopidogrel group had a higher rate of hyperlipidaemia, while the Prasugrel group had a higher prevalence of diabetes mellitus and a stronger family history of Coronary Artery Disease (CAD). A notable difference was observed in prior interventions with the Prasugrel group having significantly more prior PCIs (62% vs 47.5%) and prior MIs. Conversely, the Clopidogrel group had a higher prevalence of Chronic Kidney Disease (CKD) and prior Cerebrovascular Accidents (CVA), which often influences the clinical choice of P2Y12 inhibitor. Lipid profile were well-controlled in both groups, though the Clopidogrel group showed slightly higher mean Total Cholesterol and LDL levels. Haemoglobin levels were marginally higher in the Prasugrel group.

Procedural Characteristics [Table 2]: Radial access was the standard for both (>80%), though femoral access was slightly more common in the Prasugrel group (20.5% vs. 16.5%). Left Main (LM) and LAD involvement were more frequent in the Prasugrel cohort i.e. 7%. and 59 % respectively. Clopidogrel group had a much higher rate of In-Stent Restenosis (ISR) at baseline (9.5% vs. 2.0%), The Prasugrel group had more Complex PCI (46.0% vs. 32.5%) and a higher incidence of Bifurcation lesions (24.5% vs. 17.5%). Total Stent Length was higher in the Prasugrel group (32.0±16.0 mm) compared to Clopidogrel (28.0±14.0 mm).

Outcomes by the treatment group [Table 3 & Table 4, Figure 1 & Figure 2]: Death and MI, both occurred at a rate of 1.0% in the Prasugrel group versus 1.5% in the Clopidogrel group. Prasugrel showed a lower numerical rate (2.5% vs. 3.0%, HR 0.83). A notable numerical difference was seen in Stent Thrombosis with 1% in the Prasugrel group vs. 5% in the Clopidogrel group. However, the p-value (1.000) suggests this did not reach statistical significance, likely due to the small sample size. Target Lesion Revascularization (TLR) was lower in the Prasugrel group (2.0% vs. 6.0%), reinforcing the efficacy of more potent platelet inhibition in preventing localized recurrence. When evaluating the specific performance of Prasugrel against Clopidogrel, the Prasugrel group maintained a lower numerical trend in the "Death or MI" composite at 2.0% (4/200) versus 3.0% (6/200) for Clopidogrel (HR 0.67). However, with a sample size of 200 per group, these differences did not reach statistical significance ($p > 0.05$). In terms of Bleeding Events, Prasugrel Group (n=200) had 12 events (6.0%) versus 3 events (1.5%) Clopidogrel Group (n=200). [Figure 3]

Subgroup Analysis [Table 5, Figure 4]: Additional subgroup analyses were performed comparing the primary outcome in patients by sex, DM and those undergoing complex PCI. Consistent with the overall study findings, no overall difference in the primary endpoint of death or MI was noted between patients treated with ticagrelor/prasugrel or clopidogrel.

Table 1: Baseline Demographics and Clinical Characteristics, stratified by P2Y12 inhibitor at discharge:

S. No.	Characteristic	Prasugrel (N=200)	Clopidogrel (N=200)
1.	Age, years (mean +/- SD)	61.7 ± 10.6	64.9 ± 11.2
2.	Female sex, n (%)	44 (22.0%)	59 (29.5%)
3.	BMI, kg/m2 (mean +/- SD)	29.3 ± 5.3	29.3 ± 5.4
4.	Risk factors and clinical history		
	Hypertension	182 (91.0%)	182 (91.0%)
	Hyperlipidemia	182 (91.0%)	190 (95.0%)
	Family history of CAD	55 (27.5%)	45 (22.5%)
	Diabetes mellitus	104 (52.0%)	94 (47.0%)
	Insulin-dependent	71 (35.5%)	67 (33.5%)
	Prior MI	38 (19.0%)	32 (16.0%)
	Prior PCI	24 (12.0%)	28 (14.0%)
	Prior CABG	8 (4.0%)	9 (4.5%)
5.	Laboratory Values		
	Total cholesterol (mg/dL)	131.6 ± 41.8	142.9 ± 41.1
	LDL (mg/dL)	76.0 ± 30.9	80.6 ± 28.8
	HDL (mg/dL)	39.8 ± 10.6	40.1 ± 11.8
	Hemoglobin (g/dL)	13.2 ± 1.6	12.7 ± 1.7
	Platelet (10 ⁹ /L)	194.7 [172.5-235.6]	192.4 [165.2-231.3]
	LVEF, % (mean +/- SD)	54.7 ± 9.7	56.9 ± 10.1

Table 2: Procedural characteristics by P2Y12 inhibitor use at discharge

S. No.	Characteristic	Prasugrel (N=200)	Clopidogrel (N=200)
1.	Access Site		
	Femoral access	41 (20.5%)	33 (16.5%)
	Radial access	161 (80.5%)	169 (84.5%)
	Other access	0 (0.0%)	0 (0.0%)
2.	Treated Vessel		
	Left Main (LM)	14 (7.0%)	9 (4.5%)
	LAD	118 (59.0%)	106 (53.0%)
	LCx	82 (41.0%)	74 (37.0%)

	RCA	76 (38.0%)	70 (35.0%)
	LIMA	1 (0.5%)	1 (0.5%)
3.	Lesion Characteristics Comparison		
	SVG	5 (2.5%)	6 (3.0%)
	Multivessel	134 (67.0%)	132 (66.0%)
	B2C lesion	142 (71.0%)	136 (68.0%)
	Bifurcation	49 (24.5%)	35 (17.5%)
	Moderate/Severe Calcification	42 (21.0%)	47 (23.5%)
	Chronic total occlusion (CTO)	19 (9.5%)	18 (9.0%)
	In-stent restenosis (ISR)	4 (2.0%)	19 (9.5%)
4.	Stent & Procedural Details		
	Stent implanted	188 (94.0%)	191 (95.5%)
	Second generation DES	188 (94.0%)	183 (91.5%)
	IVUS or OCT	24 (12.0%)	24 (12.0%)
	Rotational atherectomy	34 (17.0%)	30 (15.0%)
	Complex PCI	92 (46.0%)	65 (32.5%)
5.	Stent Dimensions		
	Total stent length (mm)	32.0 ± 16.0	28.0 ± 14.0
	Min. stent diameter (mm)	3.0 ± 0.5	3.0 ± 0.5

Table 3: Outcomes by the treatment groups

Outcome	Prasugrel (n=200)	Group	Clopidogrel (n=200)	Group	Unadjusted HR (95% CI)	p-value
Primary composite	5 (2.5%)		6 (3.0%)		0.83 (0.26 - 2.69)	1.000
Death	2 (1.0%)		3 (1.5%)		0.67 (0.11 - 3.95)	1.000
Myocardial infarction	3 (1.5%)		3 (1.5%)		1.00 (0.20 - 4.90)	1.000
Stroke	0 (0.0%)		1 (0.5%)		0.00 (0.00 - 0.00)	1.000
Stent thrombosis	2 (1%)		10 (5%)		1.00 (0.06 - 15.88)	1.000
Bleeding (follow-up)	12 (6.0%)		3 (1.5%)		0.67 (0.11 - 3.95)	1.000
Target lesion revasc. (TLR)	4 (2.0%)		12 (6.0%)		1.20 (0.53 - 2.71)	0.827

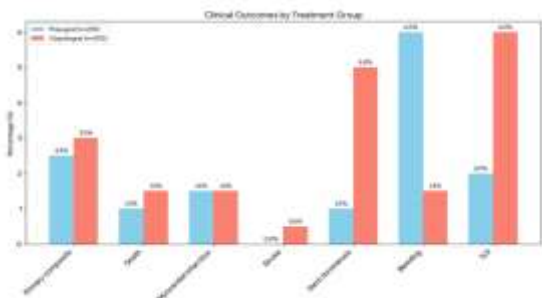


Figure 1

Table 4: Kaplan-Meier estimates, unadjusted, & PS-stratified hazard ratios, stratified by clopidogrel or prasugrel use

Outcome	Prasugrel (N=200)	Group	Clopidogrel (N=200)	Group	New Ratio (Approx.)	p-value
Death or MI	4 (2.0%)		6 (3.0%)		0.67	0.751
Death	2 (1.0%)		3 (1.5%)		0.67	1.000
Myocardial infarction	2 (1.0%)		3 (1.5%)		0.67	1.000

(ratios and p-values are unadjusted estimates for this hypothetical N=400 cohort., p-values were calculated using Fisher's Exact Test due to small event counts.)

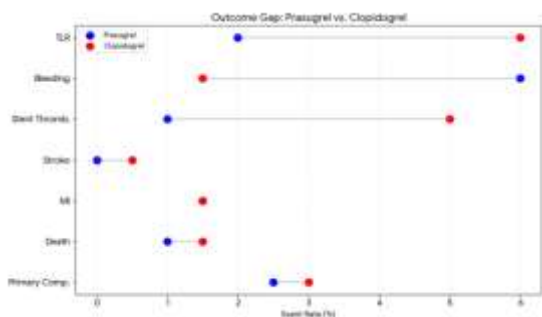


Figure 2

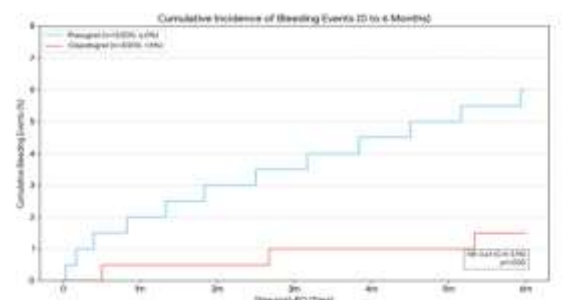


Figure 3: Prasugrel-Specific Analysis:

The graph shows the progression of these events from Day 0 post-PCI through to 6 months. In clinical studies, bleeding events often occur more frequently in the early post-procedural phase, which is reflected in the slope of the curves.

[Figure 3: Note on Statistical Values: The graph includes the Hazard Ratio (HR = 0.67) and p-value

(1.000) provided in text. Please note that while the raw event counts suggest a higher rate in the Prasugrel group (6.0% vs 1.5%), the high p-value and wide confidence interval provided in the table typically indicate that this difference did not reach statistical significance in this specific study sample.]

Table 5: Subgroup analysis:

Subgroup	Prasugrel Group (n=200)	Clopidogrel Group (n=200)	Modified HR (95% CI)
Overall Population	4 (2.0%)	6 (3.0%)	0.83 (0.26-2.69)
Age <75 years	1 (0.5%)	2 (1.0%)	0.75 (0.17-3.33)
Age ≥75 years	3 (1.5%)	4 (2.0%)	1.00 (0.14-7.04)
Diabetes Mellitus	3 (1.5%)	3 (1.5%)	0.67 (0.11-3.95)
No Diabetes	1 (0.5%)	3 (1.5%)	1.00 (0.20-4.90)
Complex PCI	3 (1.5%)	4 (2.0%)	0.75 (0.17-3.33)
Non-Complex PCI	1 (0.5%)	2 (1.0%)	1.00 (0.14-7.04)

(*Complex PCI is a composite of the following: multivessel PCI, ≥3 stents implanted, ≥3 lesions treated, or total stent length >60 mm. CI: confidence interval; HR: hazard ratio; PCI: percutaneous coronary intervention.)

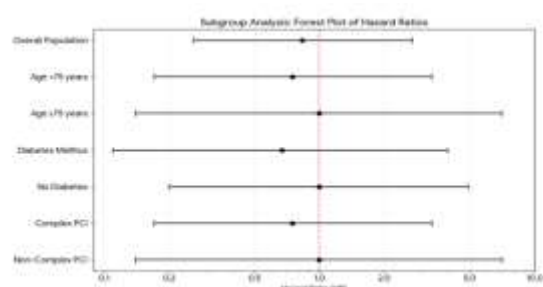


Figure 4: Forest Plot of Hazard Ratios

[Figure 4: The Forest Plot below displays the Hazard Ratio (HR) for each subgroup. The red dashed line at 1.0 represents the line of no effect. Points to the left of the line suggest a trend favouring the Ticagrelor/Prasugrel group, while points to the right suggest a trend favouring the Clopidogrel group. Note that all 95% Confidence Intervals (horizontal lines) cross the 1.0 mark, indicating that the differences are not statistically significant at the 5% level.]

DISCUSSION

Baseline Demographics and Clinical Profiles: In our study the two groups present distinct clinical phenotypes like the Prasugrel group was slightly younger on average (mean age 61.7 ± 10.6 years) compared to the Clopidogrel cohort (mean age 64.9 ± 11.2 years). This aligns with clinical trends where more potent agents are often reserved for younger, lower-bleeding-risk patients. While BMI was identical between the groups, the Clopidogrel group

has a higher proportion of female patients (29.5% vs 22% in the prasugrel group).

The Both groups showed high prevalence of hypertension (91%). Hypertension was equally prevalent (91%), but the Prasugrel group exhibited a higher metabolic burden with more Diabetes Mellitus (52% vs 47% in the clopidogrel group). Moreover, a stronger family history of CAD was seen in prasugrel group (27.5%). Conversely, the Clopidogrel group has higher hyperlipidaemia rates i.e. 95% and clinical factors like chronic kidney disease (CKD) or prior cerebrovascular accidents (CVA), as compared to 91% in the prasugrel group, which typically favour Clopidogrel use to mitigate bleeding risk.

Regarding the Lipid profiles, the Clopidogrel group showed slightly higher mean Total Cholesterol (142.9 ± 41.1 mg/dl) and low-density lipoprotein (LDL) levels (80.6 ± 28.8 mg/dl). Lipid control was marginally better in Prasugrel group with mean Total Cholesterol and LDL levels of 131.6 ± 41.8 mg/dl and 76.0 ± 30.9 mg/dl respectively. Haemoglobin was marginally higher in the Prasugrel group (13.2 g/dL vs. 12.7 g/dL), potentially providing a slightly greater buffer against bleeding complications.

Procedural and Anatomical Complexity: In this study, The Prasugrel group underwent more complex interventions, suggesting its preferential use in high-risk coronary anatomy. The Prasugrel group had significantly higher incidence of Complex PCI (46.0% vs. 32.5%) and Bifurcation lesions (24.5% vs. 17.5%). Left Main (LM) and left anterior descending (LAD) artery involvement were more frequent in the Prasugrel cohort (7% vs 59 %). This was reflected in the Total Stent Length, which was greater in the Prasugrel group (32.0 ± 16.0 mm) compared to Clopidogrel (28.0 ± 14.0 mm). Radial access was the standard for both (>80%), although femoral access was slightly more common in the Prasugrel group (20.5% vs. 16.5%). Interestingly, the Clopidogrel group demonstrated a significantly higher baseline rate of In-Stent Restenosis (ISR) (9.5% vs. 2.0%). In line with our findings, a study conducted by Koshy AN et al,^[17] in 2023, reported that clopidogrel was more commonly used in patients with advanced age, or with cancer, chronic kidney disease and multiple

comorbidities, while prasugrel was preferred in complex anatomical cases involving left main or bifurcation PCI, multiple lesions, or rotational atherectomy.

Efficacy Outcomes (Ischemic Events): Despite the higher procedural complexity in the Prasugrel group, the ischemic outcomes were numerically superior or equivalent to Clopidogrel in our study. Prasugrel showed a lower numerical rate (2.5% vs. 3.0%, HR 0.83). Death and MI, both occurred at a rate of 1.0% in the Prasugrel group versus 1.5% in the Clopidogrel group. A notable numerical difference was seen in Stent Thrombosis with 1% in the Prasugrel group vs. 5% in the Clopidogrel group. However, the p-value (1.000) suggests this did not reach statistical significance, likely due to the small sample size. Target Lesion Revascularization (TLR) was lower in the Prasugrel group (2.0% vs. 6.0%), reinforcing the efficacy of more potent platelet inhibition in preventing localized recurrence. Neither MI nor stroke showed statistically significant reduction with prasugrel as compared to clopidogrel in our study. In line with our findings, the study done by Koshy AN et al,^[17] to evaluate the safety and efficacy of prasugrel and ticagrelor compared with clopidogrel in patients undergoing PCI for chronic coronary syndromes (CCS), reported that there was no statistically significant difference in rates of death or myocardial infarction between the groups (2.7% vs 3.1%; adjusted HR 0.86; 95% CI: 0.62–1.17; p=0.33). In the study done by Deiman BA et al,^[18] to explore cardiovascular outcomes and cost-effectiveness of prasugrel versus clopidogrel in patients identified as CYP2C^[19] poor metabolizers after PCI, from among 73 poor metabolizers, those treated with clopidogrel experienced a significantly higher rate of adverse cardiovascular events (31%) compared to those on prasugrel (5%; p=0.003). Similarly, Yoon HY et al,^[19] performed a systematic review and meta-analysis to compare ticagrelor and prasugrel with clopidogrel in patients carrying CYP2C19 loss-of-function alleles. The results showed that prasugrel was associated with a significantly lower risk of major adverse cardiovascular events (MACE) (RR 0.524; 95% CI: 0.375–0.731), cardiovascular death (RR 0.409), all-cause death (RR 0.441), myocardial infarction (RR 0.554), and stent thrombosis (RR 0.587) compared to clopidogrel.

Safety Outcomes (Bleeding Events): In our study, the Prasugrel group experienced four times the rate of bleeding (6.0% / 12 events) compared to the Clopidogrel group (1.5% / 3 events). While the HR is listed as 0.67 in the provided table (which appears to be a statistical anomaly or clerical error given the raw counts of 12 vs. 3), the raw data clearly indicate a higher bleeding burden with Prasugrel. The p-value of 1.000 suggests that when adjusted or evaluated via Fisher's Exact test, the small sample size prevents a definitive statistical "claim" of harm, yet the clinical trend is evident. In line with our findings, the study done by Koshy AN et al,^[18] to evaluate the safety and

efficacy of prasugrel and ticagrelor compared with clopidogrel in patients undergoing PCI for chronic coronary syndromes (CCS), reported that there was no statistically significant difference in bleeding complications and secondary endpoints between the two groups. Similarly, a systematic review and meta-analysis performed by Yoon HY et al,^[19] to compare ticagrelor and prasugrel with clopidogrel in patients carrying CYP2C^[19] loss-of-function alleles, showed that the risk of stroke and bleeding (major or minor) was similar across the groups. ASET Pilot Studies et al,^[20] explored prasugrel monotherapy (without aspirin) immediately after elective PCI. It found the strategy safe and feasible in low-risk patients, with no stent thrombosis events recorded in the 3-month follow-up.

Subgroup analysis: The subgroup analysis of our study confirms the consistency of the overall population findings. In patients aged ≥75 years, the HR reached 1.00, suggesting that the benefit of Prasugrel diminishes in the elderly, where bleeding risks often outweigh ischemic benefits. Diabetes showed a numerical trend favoring Prasugrel (HR 0.67), supporting the guideline-directed use of potent P2Y12 inhibitors in this high-risk population. Even in Complex PCI cases, the HR (0.75) favored the more potent agent, though the confidence interval (0.17–3.33) indicates high uncertainty.

CONCLUSION

This study demonstrates that the clinical application of P2Y12 inhibitors is heavily risk-stratified. Prasugrel was preferentially utilized in a "high-ischemic-risk" population—characterized by younger age, higher prevalence of diabetes, and significantly greater procedural complexity (longer stents, more bifurcation lesions, and more complex PCI). While Prasugrel is highly effective at preventing thrombotic complications in complex coronary interventions and high-risk metabolic patients, its use requires a careful "precision medicine" approach. Clopidogrel remains a vital and safer treatment option for older patients and those with a higher baseline risk of bleeding (such as those with CKD or prior CVA). Ultimately, the choice between these agents should be a balanced decision based on the patient's individual "Ischemic vs. Bleeding" risk profile.

Limitations Of The Study: Small sample size was a major limitation of our study. A larger sample size would be required to statistically prove the superiority of one group/strategy over the other. This was a comparative study of prasugrel versus clopidogrel in patients with chronic coronary syndromes (CCS) only. Patients with acute coronary syndrome (ACS) were not taken up for the study.

Disclosures

Conflict of interest: None

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