The secondary analysis of the FREEDOM (Future Revascularization Evaluation in Patients With Diabetes Mellitus: Optimal Management of Multivessel Disease) study data (1) leaves unanswered the question of whether patients with acute coronary syndromes (ACS) undergoing coronary artery bypass grafting (CABG) derive benefit from dual antiplatelet therapy (DAPT). However, the subgroup analysis stratified by the indications (ACS or stable angina) that demonstrated no significant benefit in either subgroup provides an additional insight into whether the ongoing distinction between ACS and stable ischemic heart disease in evaluating the effect of DAPT in patients post-CABG is meaningful. This distinction by the clinical indication is largely derived from the historical sequence of trials that initially demonstrated benefits of DAPT use in patients presenting with ACS with or without further percutaneous coronary intervention, culminating in the subgroup analysis of the CABG cohort in the CURE (Clopidogrel in Unstable Angina to Prevent Recurrent Ischemic Events) trial (2). Whether the presenting symptoms would translate into clinical differences relevant to antiplatelet therapy following CABG, however, is questionable.

Potential benefits of DAPT in patients undergoing CABG are derived from stabilization of existing plaque, improving vein graft patency, and continued protection of existing stents (3). Revascularization with CABG alters the coronary perfusion architecture with bypassing grafts. Therefore, although patients with ACS may be more susceptible to subsequent plaque rupture and stent thrombosis, the event may not be as clinically significant in the bypassed coronary anatomy. On the other hand, the benefit of DAPT in preserving vein graft patency has been demonstrated in small trials (4), perhaps implying that the myocardial territory perfused by the vein grafts may be an important baseline parameter in evaluating outcomes of DAPT post-CABG in the future. Clarification of the relevance of the indication would aid in future trial designs, as recent trials have enrolled mixed populations of ACS and non-ACS patients (4).

REFERENCES

REPLY: Relevance of Indications for CABG in Evaluating the Effect of Dual Antiplatelet Therapy

We thank Drs. Mori and Geirsson for their interest in our FREEDOM (Future Revascularization Evaluation in Patients With Diabetes Mellitus: Optimal Management of Multivessel Disease) study secondary analysis (1) examining aspirin monotherapy versus dual antiplatelet therapy (DAPT) in diabetic patients with multivessel coronary artery bypass grafting (CABG). We concur with the authors that the postulated benefits of DAPT after CABG include stabilization of the culprit lesion and preservation of both coronary stent and vein graft patency. In addition, DAPT treatment can theoretically: 1) reduce the risk of acute coronary syndrome (ACS) recidivism in nonculprit arteries irrespective of bypass grafting; 2) augment platelet inhibition in aspirin nonresponders; 3) reduce the risks of associated noncoronary conditions (e.g., stroke in patients not receiving anticoagulation for atrial fibrillation); and 4) mediate improved outcomes through nonplatelet receptor interactions (e.g., decreased infarct size via ticagrelor erythrocyte adenosine reuptake inhibition) (2–4).

However, as the authors have astutely highlighted, the evidence supporting routine DAPT post-CABG for