



The effectiveness of rosuvastatin, aspirin and clopidogrel in secondary cardiovascular prevention in Post-PCI patients

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Abstract

Background: Coronary artery disease (CAD) remains a leading cause of morbidity and mortality worldwide. Although percutaneous coronary intervention (PCI) effectively restores coronary blood flow, patients remain at risk of recurrent cardiovascular events. This study evaluated the effectiveness of rosuvastatin, aspirin, and clopidogrel in cardiovascular prevention among post-PCI patients.

Methods: This observational, questionnaire-based surveillance study was conducted among healthcare professionals (HCPs) across India. A 37-question questionnaire evaluated the real-world effectiveness of rosuvastatin, aspirin, and clopidogrel in secondary cardiovascular prevention based on HCPs' last 10 post-PCI patients. The survey assessed prescribing practices, perceived effectiveness, safety, tolerability, medication adherence, and overall clinical experience with combination therapy.

Results: A total of 189 HCPs participated in the study. Baseline Low-density lipoprotein (LDL) cholesterol was the primary factor guiding rosuvastatin initiation (41.27%), while prior stent thrombosis was the main reason for extending dual antiplatelet therapy (DAPT) beyond 12 months (37.04%). Clopidogrel was the medication most frequently associated with missed doses (51.32%), and bleeding risk was the primary determinant of aspirin dose selection (46.03%). Notably, 37.04% of HCPs reported no recurrence of angina among their last 10 post-PCI patients receiving rosuvastatin, aspirin, and clopidogrel. Overall, recurrent cardiovascular events were considered the preferred measure of treatment effectiveness (41.80%), and rosuvastatin was the most preferred medication for long-term cardiovascular risk reduction in diabetic post-PCI patients (35.98%).

Conclusion: This questionnaire-based survey provided real-world insights into HCPs' prescribing practices and perceived effectiveness, safety of the rosuvastatin, aspirin and clopidogrel in Post-PCI Patients.

Keywords: Rosuvastatin, aspirin, clopidogrel, percutaneous coronary intervention, secondary cardiovascular prevention

Introduction

Cardiovascular diseases (CVDs) are chronic non-communicable diseases that continue to be the leading cause of morbidity and mortality globally [1]. Cardiovascular diseases represent a major health challenge worldwide, according to the Global Burden of Disease 2019 study and the European Society of Cardiology. The global burden of CVDs is expected to rise by some 90% between 2025 and 2050. By 2050, the number of cardiovascular deaths is predicted to be 35.6 million. This creates an urgent need to identify effective preventive and standard treatments [2]. Coronary artery disease (CAD) is a chronic atherosclerotic disease characterized by progressive accumulation of atherosclerotic plaques within the coronary arteries that may be asymptomatic until significant luminal obstruction or plaque rupture occurs. Coronary heart disease (CHD), also called ischemic heart disease (IHD), is the clinical manifestation of CAD and includes stable angina, acute coronary syndrome (ACS), and silent myocardial ischemia. Coronary artery disease is the principal underlying cause of morbidity and mortality associated with CHD [3].

Percutaneous coronary intervention (PCI) is an endovascular catheter-based coronary revascularization procedure that is minimally invasive and used to relieve coronary blood flow in patients with significant coronary stenosis or occlusion. Usually, the procedure is done with

balloon angioplasty, with stent implantation afterward to maintain vessel patency and to improve myocardial perfusion [4]. Secondary prevention is a key component of long-term management following PCI. The aim is to prevent recurrent cardiovascular events, improve survival and long-term clinical outcomes through comprehensive risk factor modification, lifestyle changes, cardiac rehabilitation and guideline-directed medical therapy. However, the use of secondary prevention strategies and their effectiveness in everyday clinical practice differ despite existing guideline recommendations, highlighting the importance of real-world assessment in patients after PCI [5]. Pharmacologic therapy is the foundation for secondary cardiovascular prevention after PCI and current clinical guidelines recommend high-intensity statins and dual antiplatelet therapy (DAPT) [6].

Rosuvastatin is a high potency HMG-CoA reductase inhibitor that reduces low density lipoprotein (LDL) cholesterol by inhibiting hepatic cholesterol synthesis and upregulating the expression of hepatic LDL receptors, thereby increasing LDL clearance. Rosuvastatin has pleiotropic actions in addition to its lipid-lowering effects. Rosuvastatin reduces vascular inflammation and high-sensitivity C-reactive protein levels, improves endothelial function, modulates platelet activity and has anticoagulant effects, all of which contribute to improved cardiovascular outcomes [7]. Aspirin irreversibly inhibits cyclooxygenase-1

(COX-1), blocking thromboxane A₂ production and subsequent platelet activation and aggregation. Through its antiplatelet action, aspirin reduces the risk of atherothrombotic complications and plays a central role in secondary cardiovascular prevention following PCI [8]. Clopidogrel is an oral P2Y₁₂ receptor antagonist that inhibits adenosine diphosphate-mediated platelet activation and aggregation. In combination with aspirin as DAPT, clopidogrel significantly reduces the risk of stent thrombosis, recurrent myocardial infarction, and other major adverse cardiovascular events following PCI. Consequently, it is recommended as an integral component of secondary cardiovascular prevention in patients undergoing PCI [9]. The combination of rosuvastatin, aspirin, and clopidogrel constitutes the foundation of guideline-directed medical therapy for secondary cardiovascular prevention following PCI. By targeting complementary mechanisms involved in atherosclerosis and thrombosis, this therapeutic strategy reduces recurrent myocardial infarction, stent thrombosis, stroke, repeat revascularization, and cardiovascular mortality, thereby improving long-term clinical outcomes in post-PCI patients [10]. Despite substantial advances in secondary cardiovascular prevention and strong evidence supporting the use of high-intensity statins and antiplatelet therapy after myocardial infarction and PCI, successful implementation of guideline-directed medical therapy in routine clinical practice remains challenging. Variations in treatment adherence, optimization of evidence-based therapies, and long-term secondary prevention strategies may influence patient outcomes. Therefore, continued evaluation of the effectiveness of guideline-recommended pharmacological therapy in real-world post-PCI populations is warranted [10]. Accordingly, the present study was undertaken to evaluate the effectiveness of rosuvastatin, aspirin, and clopidogrel in secondary cardiovascular prevention among post-PCI patients.

Methods

Study design

This Surveillance questionnaire-based observational study was conducted among Indian healthcare professionals (HCPs). Participation was entirely voluntary. All completed questionnaires were reviewed for completeness, and any missing or unclear response were clarified before data analysis. The study was conducted in accordance with the principles of Good Clinical Practice (GCP) and was approved by the Central Independent Ethics Committee (approval no: CIEC/2025/0149; date of approval: 03 June, 2025).

Study questionnaire

The questionnaire was developed based on current clinical guidelines, investigators clinical experience with post-PCI patients treated with combined therapy. It included of total 37 questions that focused on recurrence of cardiovascular events, treatment adherence, patient reported outcomes, perceived effectiveness and safety

of the combination regimen, and clinical factors influencing treatment decisions.

Inclusion and exclusion criteria

The study included participants undergone PCI and prescribed the combination of Rosuvastatin, Aspirin, and Clopidogrel in the real-world setting. Participants with limited clinical experience, shorter treatment duration, or incomplete patient data were excluded.

Data collection

Data were collected from HCPs through structured questionnaires based on their clinical experience with post-PCI patients receiving combination therapy with rosuvastatin, aspirin, and clopidogrel.

Data analysis

Data collected and analyzed the responses of the HCPs; data entered into Microsoft excel and descriptive analysis was performed and outcome was presented as frequencies and percentages.

Results

A total of 189 HCPs participated in the study. Among them 78 (41.27%) reported that baseline low-density lipoprotein (LDL) was the primary factor guiding the initiation of rosuvastatin in post PCI patients, while 91(48.15%) indicated that renal function influenced rosuvastatin dose selection only in patients with chronic kidney disease (CKD) stage 3 or higher. High-dose rosuvastatin (40 mg) was most commonly prescribed for recurrent ACS by 75 (39.68%) HCPs, whereas 65 (34.39%) reported monitoring aspartate aminotransferase (AST) and alanine aminotransferase (ALT) as the preferred laboratory parameters for assessing rosuvastatin safety. Furthermore, 75 (39.68%) of respondents identified plaque stabilisation as the primary therapeutic goal of rosuvastatin beyond LDL reduction, followed by inflammation control 52 (27.51%), improved endothelial function 32 (16.93%), and all of the above 30 (15.87%).

Monitoring and management of rosuvastatin therapy showed that 85 (44.97%) HCPs routinely used creatine kinase (CK) for detecting statin-associated myopathy, while 84 (44.44%) preferred reducing the dose and monitoring patients who developed rosuvastatin-induced myalgia. When LDL cholesterol remained above target, 68 (35.98%) preferred adding ezetimibe, followed by increasing the rosuvastatin dose to 80 mg 57 (30.16%), switching to another statin 43 (22.75%), and intensifying lifestyle modifications 21 (11.11%). In patients reporting muscle cramps, 71 (37.57%) recommended checking CK levels and reducing the dose, whereas 72 (38.10%) reported always assessing medication adherence when follow-up LDL levels remained elevated. Among the last 10 treated patients, 72 (38.10%) indicated that only one patient required rosuvastatin dose adjustment because of adverse effects (Table1).

Table 1: Rosuvastatin Use and Lipid Management in Post-PCI Patients

Questions	Options	Response (N=189)
Which factor most frequently guided your decision to initiate rosuvastatin post-PCI in patients with borderline LDL levels?	Baseline LDL level	78 (41.27)
	Number of stents placed	48 (25.40)
	Family history of CAD	34 (17.99)

	Smoking status	29 (15.34)
When choosing rosuvastatin in post-PCI patients, how often does renal function significantly influence your dosage decision?	Only in patients with CKD stage 3 or higher	91 (48.15)
	It does not influence the decision	45 (23.81)
	In almost all cases	43 (22.75)
	Rarely, unless GFR is below 30	10 (5.29)
What is the most common reason you opt for high-dose rosuvastatin (40 mg) in the secondary prevention setting?	Recurrent ACS	75 (39.68)
	Persistent high LDL despite therapy	64 (33.86)
	High inflammatory markers	30 (15.87)
	Severe coronary calcification	20 (10.58)
Which laboratory finding do you most frequently monitor to assess the safety of ongoing rosuvastatin therapy?	AST/ALT	65 (34.39)
	Creatinine	61 (32.28)
	Haemoglobin	32 (16.93)
	Uric acid	31 (16.40)
What do you consider the primary goal of using rosuvastatin in post-PCI patients beyond LDL reduction?	Plaque stabilization	75 (39.68)
	Inflammation control	52 (27.51)
	Improved endothelial function	32 (16.93)
	All of the above	30 (15.87)
What test do you most routinely use to assess potential myopathy related to rosuvastatin?	CK (Creatine Kinase)	85 (44.97)
	Troponin	50 (26.46)
	LDH	30 (15.87)
	ESR	24 (12.70)
Among patients experiencing rosuvastatin-induced myalgia, what is your most common clinical response?	Reduce dose and monitor	84 (44.44)
	Stop therapy entirely	42 (22.22)
	Add coenzyme Q10 and continue	33 (17.46)
	Switch to another statin	30 (15.87)
What is your typical response if LDL remains above target despite 40 mg rosuvastatin for 6 weeks?	Add ezetimibe	68 (35.98)
	Increase to 80 mg	57 (30.16)
	Switch statin	43 (22.75)
	Intensify lifestyle changes	21 (11.11)
For a patient who reports muscle cramps and is on rosuvastatin, what is your preferred approach?	Check CK, reduce dose	71 (37.57)
	Switch to atorvastatin	53 (28.04)
	Add vitamin D	34 (17.99)
	Discontinue statin	31 (16.40)
Among the last treated 10 patients, how many required dosage adjustments of rosuvastatin due to side effects?	1	72 (38.10)
	2-3	34 (17.99)
	More than 3	29 (15.34)
	None	54 (28.57)
How often do you screen for drug compliance when follow-up LDL remains elevated on rosuvastatin therapy?	Always	72 (38.10)
	Often	32 (16.93)
	Occasionally	31 (16.40)
	Rarely	54 (28.57)

Data presented as n (%).

ACS, acute coronary syndrome; ALT, alanine aminotransferase; AST, aspartate aminotransferase; CAD, coronary artery disease; CK, creatine kinase; CKD, chronic kidney disease; ESR, erythrocyte sedimentation rate; GFR, glomerular filtration rate; LDH, lactate dehydrogenase; LDL, low-density lipoprotein.

Dual antiplatelet therapy practices revealed that 70 (37.04%) HCPs continued DAPT beyond 12 months primarily because of a history of prior stent thrombosis. Clopidogrel was considered the least well-tolerated medication by 63 (33.33%) respondents. Among the last 10 treated patients, 39 (20.63%) HCPs reported switching clopidogrel to another P2Y₁₂ inhibitor in one to two patients because of high ischaemic risk, while 58 (30.69%) observed medication non-adherence in one to three patients. Bleeding complications requiring modification of aspirin or

clopidogrel therapy were reported to occur rarely (<5%) by 82 (43.39%) respondents, and 97 (51.32%) identified clopidogrel as the medication most commonly associated with missed doses. The type of coronary stent (77, 40.74%) was the principal determinant for extending clopidogrel therapy beyond one year after PCI. In cases of minor bleeding, 79 (41.80%) preferred reassessing the risk-benefit profile while continuing DAPT, whereas 77 (40.74%) identified active bleeding as the most common reason for delaying clopidogrel initiation (Table 2).

Table 2: Antiplatelet Therapy, Safety, and Adherence

Questions	Options	Response (N=189)
What is your usual reason for continuing dual antiplatelet therapy (DAPT) beyond 12 months post-PCI in stable patients?	History of prior stent thrombosis	70 (37.04)
	Presence of diabetes	47 (24.87)
	Use of drug-eluting stents	37 (19.58)
	Ongoing angina symptoms	35 (18.52)

Among the last treated 10 patients, in how many did you switch from clopidogrel to a newer P2Y12 inhibitor due to high ischemic risk?	1-2	39 (20.63)
	3-5	33 (17.46)
	More than 5	41 (21.69)
	None	76 (40.21)
How frequently do you encounter bleeding complications that require altering aspirin or clopidogrel therapy in stable post-PCI patients?	Rarely (<5%)	82 (43.39)
	Occasionally (5-10%)	31 (16.40)
	Moderately (10-20%)	41 (21.69)
	Often (>20%)	35 (18.52)
When evaluating therapy adherence, which component do patients most commonly miss doses of, based on your recent observations?	Clopidogrel	97 (51.32)
	Rosuvastatin	47 (24.87)
	Aspirin	24 (12.70)
	Beta-blocker	21 (11.11)
Among the last treated 10 patients, in how many did you observe medication non-adherence as a likely cause of recurrent chest pain post-PCI?	1-3	58 (30.69)
	4-6	22 (11.64)
	More than 6	50 (26.46)
	None	59 (31.22)
When reducing cardiovascular risk post-PCI, which drug do you find patients tolerate least effectively?	Clopidogrel	63 (33.33)
	Aspirin	49 (25.93)
	Rosuvastatin	37 (19.58)
	All are equally tolerated	40 (21.16)
In your experience, which factor most often dictates whether to maintain clopidogrel beyond one-year post-PCI?	Type of stent used	77 (40.74)
	Prior thrombotic events	56 (29.63)
	Cardiologist preference	28 (14.81)
	Patient compliance	28 (14.81)
When faced with minor bleeding in a post-PCI patient on DAPT, what is your most common approach?	Reassess risk-benefit and continue therapy	79 (41.80)
	Refer for hematology consultation	41 (21.69)
	Reduce clopidogrel dose	36 (19.05)
	Stop aspirin temporarily	33 (17.46)
Which clinical factor most often delays initiation of clopidogrel post-PCI in your practice?	Active bleeding	77 (40.74)
	Patient refusal	44 (23.28)
	Delayed renal function test results	36 (19.05)
	Drug availability	32 (16.93)
When selecting aspirin dose post-PCI (e.g., 75 mg vs. 325 mg), what is your typical guiding factor?	Bleeding risk	87 (46.03)
	Body weight	41 (21.69)
	Regional guidelines	34 (17.99)
	Patient preference	27 (14.29)
What is your preferred method of monitoring clopidogrel efficacy in high-risk post-PCI patients?	Platelet function testing	68 (35.98)
	Bleeding risk scores	48 (25.40)
	Serial CRP	40 (21.16)
	Routine ECGs	33 (17.46)
In what type of patient do you find aspirin resistance most clinically problematic post-PCI?	Diabetics	83 (43.92)
	Smokers	42 (22.22)
	Chronic kidney disease patients	32 (16.93)
	Elderly with multiple comorbidities	32 (16.93)
Among the 10 last treated patients, how many had clopidogrel replaced due to suspected poor metabolizer status?	1	45 (23.81)
	2	32 (16.93)
	More than 2	31 (16.40)
	None	81 (42.86)
What is your usual action when a post-PCI patient on clopidogrel develops gastrointestinal bleeding?	Add PPI and reassess	88 (46.56)
	Stop clopidogrel only	47 (24.87)
	Replace clopidogrel with ticagrelor	33 (17.46)
	Stop both antiplatelets	21 (11.11)
What patient habit most frequently compromises clopidogrel efficacy in your observations?	Missing doses	104 (55.03)
	Alcohol use	35 (18.52)
	Smoking	27 (14.29)
	Over-the-counter medication	23 (12.17)
In patients undergoing non-cardiac surgery within 6 months post-PCI, how do you most often adjust aspirin?	Stop 3 days before	73 (38.62)
	Continue without change	58 (30.69)
	Switch to LMWH temporarily	43 (22.75)
	Stop and restart after surgery	15 (7.94)
What factor most affects your decision to transition from clopidogrel to monotherapy after one year?	Bleeding risk	86 (45.50)
	Diabetes status	38 (20.11)

In elderly patients, what drug most often requires discontinuation or adjustment first due to tolerability issues?	Stent type	33 (17.46)
	Patient preference	32 (16.93)
	Rosuvastatin	70 (37.04)
	Clopidogrel	47 (24.87)
	Aspirin	33 (17.46)
	None routinely	39 (20.63)

Data presented as n (%).

CKD, chronic kidney disease; CRP, C-reactive protein; DAPT, dual antiplatelet therapy; ECG, electrocardiogram; LMWH, low molecular weight heparin; mg, milligram; P2Y12, purinergic receptor; PCI, percutaneous coronary intervention; PPI, proton pump inhibitor.

Aspirin and clopidogrel management demonstrated that bleeding risk was the main factor guiding aspirin dose selection according to 87 (46.03%) HCPs, while 68 (35.98%) preferred platelet function testing for evaluating clopidogrel efficacy. Aspirin resistance was considered most clinically significant in patients with diabetes by 83 (43.92%) respondents, whereas 104 (55.03%) reported missed doses as the factor most frequently compromising clopidogrel effectiveness. Among the last 10 treated patients, 45 (23.81%) HCPs replaced clopidogrel in one patient because of suspected poor metaboliser status. Following gastrointestinal bleeding, 88 (46.56%) preferred adding a proton pump inhibitor (PPI) and reassessing therapy, while 73 (38.62%) stopped aspirin three days before non-cardiac surgery performed within six months after PCI. Bleeding risk 86 (45.50%) was also the primary factor influencing

the transition to clopidogrel monotherapy after one year, whereas 70 (37.04%) reported rosuvastatin as the medication most frequently requiring dose adjustment in elderly patients because of tolerability concerns (Table 2). Follow-up findings showed that 70 (37.04%) HCPs reported no recurrence of angina among their last 10 treated patients despite adherence to combination therapy. Anticoagulants 69 (36.51%) were identified as the most common cause of clinically relevant drug-drug interactions, while recurrent chest pain 95 (50.26%) was considered the strongest indication for early imaging following PCI. A rise in liver enzymes 85 (44.97%) was regarded as the most concerning laboratory abnormality during long-term therapy. Furthermore, 77 (40.74%) respondents reported that diabetic patients with multivessel CAD derived the greatest benefit from combination therapy with rosuvastatin, aspirin, and clopidogrel after PCI (Table 3).

Table 3: Follow-up Assessment and Clinical Outcomes

Questions	Options	Response (N=189)
Among the last treated 10 patients, how many had a recurrence of angina despite being compliant with triple therapy?	1–2	32 (16.93)
	3–4	54 (28.57)
	More than 4	33 (17.46)
	None	70 (37.04)
Which of the following most often contributes to drug–drug interactions requiring regimen changes in post-PCI patients?	Anticoagulants	69 (36.51)
	Proton pump inhibitors	47 (24.87)
	Antidepressants	37 (19.58)
	Antifungals	36 (19.05)
What clinical sign most strongly prompts early imaging after PCI despite ongoing triple therapy?	Recurrent chest pain	95 (50.26)
	Drop in BP	36 (19.05)
	T-wave inversion	30 (15.87)
	Rise in troponin	28 (14.81)
In your clinical experience of last 10 patients treated, which profile is most benefited from aspirin, clopidogrel, and rosuvastatin in combination after PCI?	Diabetic with multivessel disease	77 (40.74)
	Young patient with single-vessel disease	45 (23.81)
	Elderly patient with heart failure	34 (17.99)
	Hypertensive patient with preserved EF	33 (17.46)
What lab trend is most concerning during long-term triple therapy?	Rise in liver enzymes	85 (44.97)
	Decline in platelet count	38 (20.11)
	LDL rebound	35 (18.52)
	All the above	31 (16.40)

Data presented as n (%).

PCI, Percutaneous Coronary Intervention; BP, blood pressure; LDL, low density lipoprotein; EF, Ejection Fraction.

A total of 65 (34.39%) HCPs reported that bleeding and thrombocytopenia were the most common adverse effects leading to clopidogrel discontinuation in post-PCI patients, followed by rash with gastrointestinal upset 48 (25.40%), headache with dizziness 46 (24.34%), and fatigue with palpitations 30 (15.87%) (Figure 1). A total of 79 (41.80%) HCPs reported that recurrent cardiovascular events were the preferred metric for assessing the effectiveness of triple

therapy, followed by a combination of all parameters 57 (30.16%), patient symptoms 27 (14.29%), and lipid profile 26 (13.76%) (Figure 2). Furthermore, 68 (35.98%) HCPs reported that rosuvastatin was the first medication preferred for long-term cardiovascular risk reduction in diabetic post-PCI patients, followed by aspirin 49 (25.93%), no difference among the three medications 42 (22.22%), and clopidogrel 30 (15.87%) (Figure 3).

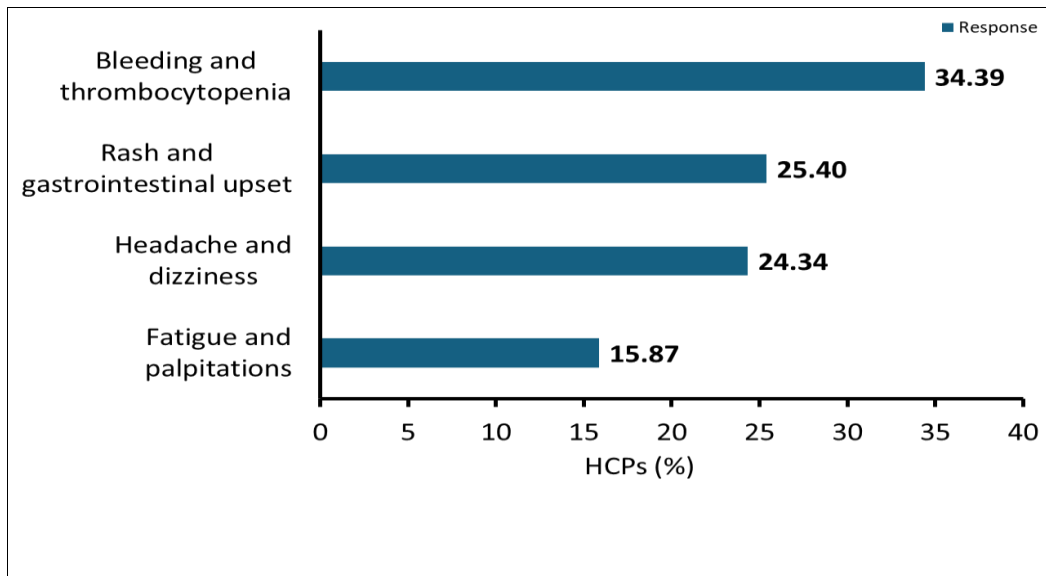


Fig 1: Common Adverse Effects Leading to Clopidogrel Discontinuation in Post-PCI Patients

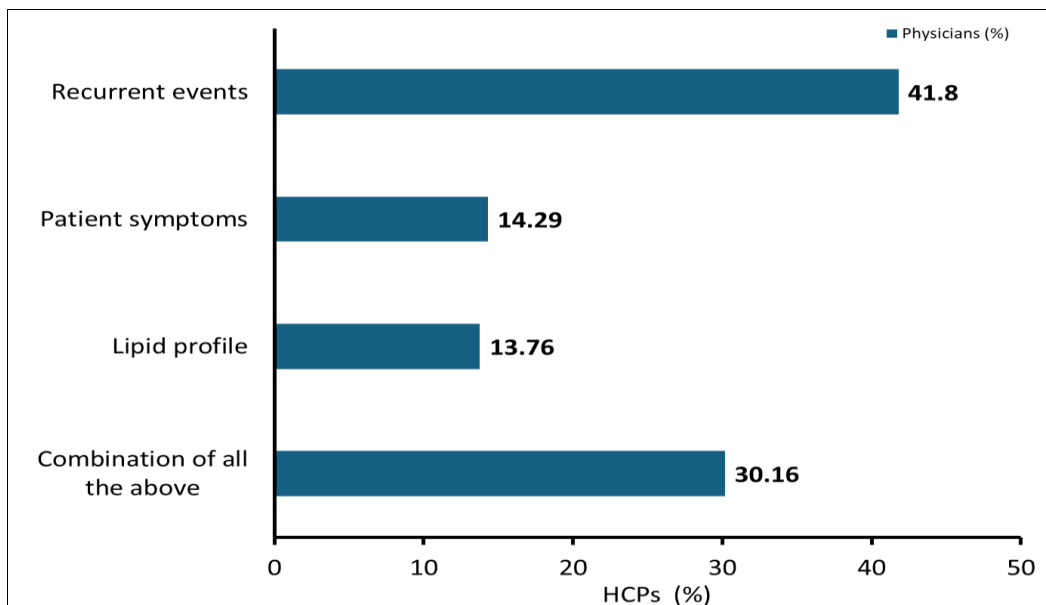


Fig 2: HCPs Preferred Metrics for Assessing the Effectiveness of Triple Therapy During Follow-up

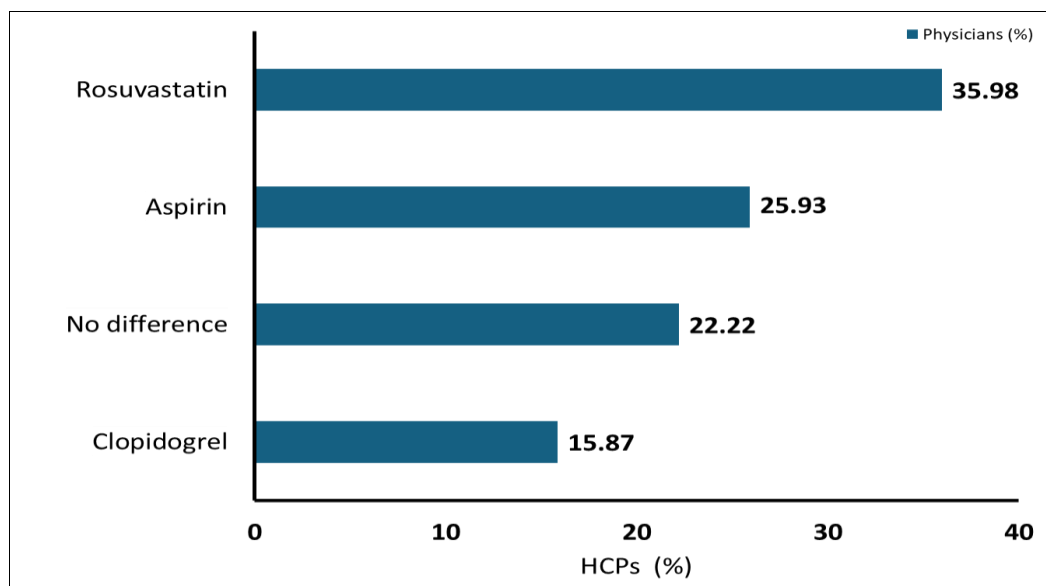


Fig 3: Preferred First Medication Optimized for Long-Term Risk Reduction in Diabetic Post-PCI Patients

Discussion

The present questionnaire-based survey provides valuable real-world insights into HCPs' prescribing practices and clinical perceptions regarding the combination of Rosuvastatin, Aspirin, and Clopidogrel in secondary cardiovascular prevention among post-PCI patients. Overall, HCPs primarily considered baseline LDL-C levels, recurrent ACS, thrombotic risk, and bleeding risk when making treatment decisions. HCPs also perceived favourable clinical outcomes with the combination regimen, with recurrent cardiovascular events considered the most important measure of treatment effectiveness, while medication adherence, tolerability, and safety remained important considerations in routine post-PCI management.

In the present survey, baseline LDL-C was the main factor guiding rosuvastatin initiation in post-PCI patients for 41.27% of HCPs. The use of high-dose rosuvastatin (40 mg) for recurrent ACS was reported by 39.68% of HCPs in the present survey. This finding is in line with the ROSUVEES-2 observational study, in which rosuvastatin 40 mg/day significantly reduced LDL-C by 46.9 mg/dL at 6 weeks and 40.5 mg/dL at 12 weeks ($P<0.001$). In the present survey, 34.39% of HCPs preferred AST and ALT monitoring to assess the safety of rosuvastatin. Similarly, the ROSUVEES-2 study monitored AST, ALT, Creatine phosphokinase (CPK), serum creatinine, and estimated glomerular filtration rate (eGFR) during treatment and reported no clinically significant changes in ALT, CPK, serum creatinine, or eGFR [11]. In the present survey, 44.44% of HCPs preferred reducing the rosuvastatin dose and monitoring patients who developed myalgia, while 37.57% recommended checking creatine kinase levels and reducing the dose in patients with muscle cramps. These findings are consistent with a structured approach to managing statin-related muscle symptoms, which helps identify true statin-related symptoms and avoid unnecessary discontinuation of statin therapy. Jeeyavudeen MS *et al.* (2023) also highlighted the importance of a structured approach to managing statin-related muscle symptoms, particularly in patients at very high cardiovascular risk, to minimize unnecessary interruption of statin therapy and maintain cardiovascular protection [12]. In the present survey, 37.04% of HCPs continued DAPT beyond 12 months, primarily in patients with a history of prior stent thrombosis, highlighting the importance of individualizing DAPT duration according to thrombotic risk. This finding is consistent with the findings of Bularga *et al.* (2021), whose sensitivity analyses evaluated shorter DAPT durations (≤ 3 months) and examined the impact of DAPT duration on mortality and efficacy and safety outcomes. Additionally, 33.33% of HCPs considered clopidogrel the least well-tolerated P2Y12 inhibitor, highlighting the potential role of P2Y12 inhibitor selection in DAPT management, consistent with analyses evaluating outcomes according to the type of P2Y12 inhibitor used [13]. In the present survey, bleeding risk was the main factor guiding aspirin dose selection for 46.03% of HCPs, consistent with evidence emphasizing individualized antiplatelet therapy according to bleeding risk. Xu *et al.* (2025) highlighted that bleeding risk is influenced by antiplatelet treatment intensity and duration, supporting the need to balance thrombotic benefit against bleeding complications. Platelet function testing was preferred by 35.98% of HCPs for evaluating clopidogrel efficacy, reflecting recognition of interindividual variability

in P2Y12 inhibitor response. Aspirin resistance was considered most clinically significant in patients with diabetes by 43.92% of respondents, while 55.03% identified missed doses as the factor most frequently compromising clopidogrel effectiveness. Furthermore, 23.81% of HCPs reported replacing clopidogrel because of suspected poor metabolizer status. Following gastrointestinal bleeding, 46.56% preferred adding a PPI and reassessing therapy, while 45.50% identified bleeding risk as the primary factor influencing transition to clopidogrel monotherapy after one year. These findings collectively indicate that bleeding risk, treatment response, adherence and individual patient characteristics play an important role in tailoring antiplatelet therapy [14]. In the present survey, 36.51% of HCPs identified anticoagulants as the most common cause of clinically relevant drug-drug interactions, highlighting the importance of assessing concomitant medications during antiplatelet therapy. This is consistent with Huang *et al.* (2025), who reported that interactions between antiplatelet agents and anticoagulants can increase bleeding risk and emphasized the need for individualized treatment [15]. In the present survey, 41.80% of HCPs considered recurrent cardiovascular events the preferred measure of treatment effectiveness. This finding is consistent with the SMART-CHOICE 3 trial, in which all-cause death, myocardial infarction and stroke were used as the primary composite outcome to assess the efficacy of long-term antiplatelet therapy following PCI, highlighting the importance of cardiovascular events as clinically meaningful measures of treatment effectiveness [16].

Conclusion

This survey provides real-world insights into the clinical use of rosuvastatin, aspirin, and clopidogrel for secondary cardiovascular prevention in post-PCI patients. Healthcare professionals' responses highlighted the importance of LDL cholesterol levels in guiding statin initiation, prior stent thrombosis in determining prolonged DAPT, and bleeding risk in aspirin management. Adherence, tolerability, and potential drug interactions were also important considerations in routine practice. Overall, the findings suggest that individualised treatment based on ischaemic and bleeding risk, medication adherence, and ongoing monitoring of clinical outcomes is essential to optimise long-term cardiovascular prevention after PCI.

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