antithrombotic regimen was maintained throughout the whole study period (median 2 years). The primary end point was defined as net clinical outcomes, a composite of major bleeding and major adverse cardiac and cerebral events (MACCE). Propensity score-matching analysis was also performed in 99 patient pairs.

**Results:** The net clinical outcomes of the TAT group was worse than the DAPT group (34.3% vs 21.1%, p=0.006), which was mainly driven by higher incidence of major bleeding (16.7% vs 4.6%, p<0.001), without any significant increase in MACCE (22.1% vs 17.7%, p=0.313). In multivariate analysis, the TAT was an independent predictor for worse net clinical outcomes (HR 1.67; 95% CI 1.09-2.57; p=0.018) and major bleeding (HR 3.74; 95% CI 1.74-8.02; p=0.001). After propensity score-matching, TAT group still had worse net clinical outcomes, mainly driven by higher major bleeding, than DAPT group.

**Conclusions:** In AF patients undergoing DES implantation, prolonged administration of TAT is associated with worse net clinical outcomes due to the substantial increase in major bleeding without any improvement of MACCE.

**TCT-476**

**Antithrombotic Therapy In Patients With Chronic Kidney Disease And Atrial Fibrillation Undergoing Percutaneous Coronary Intervention: Results From The AVIATOR Registry**

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**Background:** Chronic kidney disease (CKD) confers increased risk for bleeding and ischemic complications after percutaneous coronary intervention (PCI). Guidelines recommend dual antiplatelet therapy (DAPT) in patients undergoing PCI and anticoagulation in patients with atrial fibrillation (AF) undergoing percutaneous coronary intervention (PCI). The AVIATOR registry included 859 consecutive patients with AF undergoing PCI, 387 of whom had CKD (either stage 3, 4 or 5). The primary outcome was major bleeding (BARC ≥2) and major adverse cardiovascular events (MACCE) as defined by the CLARITY-TIMI 51 trial. The primary end point was defined as net clinical outcomes, a composite of major bleeding and major adverse cardiac and cerebral events (MACCE). Propensity score-matching analysis was also performed in 99 patient pairs.

**Methods:** The AVIATOR (Antithrombotic strategy Variability In Atrial fibrillation and Obstructive coronary disease Revascularized with PCI) registry, included 859 consecutive patients with AF treated with PCI, of whom 286 had CKD (eGFR < 60 ml/min/1.73 m²). Patients were stratified in 2 groups: triple therapy (TT; warfarin plus DAPT or DAPT aspirin plus clopidogrel). Major adverse cardiovascular events (MACCE) and clinically relevant bleeding (BARC ≥2) were compared between the groups at one year.

**Results:** Mean age was similar in the 2 groups (76±9 years). Patients receiving TT (n=127, 44.4%) were more often male and had higher ejection fraction compared to patients discharged on DAPT (n=159, 55.6%). Mean CHADS2 scores were identical between groups (3.1 ±1.1). MAE incidence at 1-year was similar in the TT vs DAPT groups (20 vs 11%, p=0.54) but patients on TT tended to bleed more often (15 vs 7%, p=0.04). However, after adjusting for confounding factors the association of TT with increased bleeding was attenuated. (Figure)

**Conclusions:** The most commonly prescribed regimen in these high risk patients with CKD and AF undergoing PCI is DAPT. Patients on TT had similar rates of 1-year MACE but more bleeding compared to those given DAPT.
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