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## REPLY: Lights and Shadows of Antiplatelet Therapy in Primary Percutaneous Coronary Intervention

We thank Lozano et al. for their thoughtful comments on our ETAMI (Early Thienopyridine Treatment to Improve Primary PCI in Patients With Acute Myocardial Infarction) trial (1) and fully agree with their statement that in antithrombotic therapy, there should always be a balance between efficacy and safety. Our study has investigated the very acute phase of primary percutaneous coronary intervention (PCI) in ST-segment elevation myocardial infarction (STEMI) in which a faster onset of action of a platelet inhibition effect is desirable to reduce ischemic complications of the procedure. In the recently published ATLANTIC (A 30 Day Study to Evaluate Efficacy and Safety of Pre-hospital vs. In-hospital Initiation of Ticagrelor Therapy in STEMI Patients Planned for Percutaneous Coronary Intervention) trial, a very early initiation of ticagrelor in the pre-hospital phase leading to clinical relevant difference in platelet inhibition 1 h after PCI was associated with a reduction in stent thrombosis compared with the same loading dose started on average 31 min later in the hospital (2). In addition, there are several reports linking inadequate platelet inhibition at the time of PCI to ischemic complications, underscoring the importance of an effective platelet periprocedural inhibition during primary PCI (3). In the TRITON (Trial to Assess Improvement in Therapeutic Outcomes by Optimizing Platelet Inhibition With Prasugrel) trial, patients with STEMI have especially benefited from prasugrel compared with clopidogrel without an increase in bleeding complications (4). These results were confirmed by recent reports from real-life experience of registries. Bleeding complications in TRITON accumulated over time but were not statistically different between clopidogrel and prasugrel in the primary PCI group at 30 days as well as at 15 months (4). The net clinical benefit was clearly in favor of prasugrel. The statement about a differential effect of prasugrel between secondary and primary PCI in STEMI is not correct, and this reference indicated no statistical heterogeneity between the 2 groups (4). This has been now well evaluated, and there is no significant interaction for the primary and secondary endpoints and a consistent effect of prasugrel across all types of PCI performed in STEMI patients (5). The numerical differences are related to the difficulties in measuring periprocedural MI in primary PCI versus secondary PCI and not related to the efficacy of prasugrel (5). The statement about contraindications against prasugrel majorly relates to patients with prior stroke, which is present in up to 3% of STEMI patients. Elderly or patients with low body weight <60 kg might be treated with the same loading dose of 60 mg and a lower maintenance dose of 5 mg to reduce bleeding complications.

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## Triple Antithrombotic Therapy Following Anterior ST-Segment Elevation Myocardial Infarction

We would like to commend LeMay et al. (1) for their work addressing the important clinical conundrum of whether to provide triple antithrombotic therapy (TATT) for patients presenting apical akinesis/