Supplementary material

**SUPPLEMENTARY TABLE 1** Inclusion and exclusion criteria

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|  | **Inclusion criteria** | **Exclusion criteria** |
| Population (P) | * Adult patients with CAD and PADa
 | * Patients, children, adolescents without CAD or PAD
 |
| Interventions (I) | * No intervention specified
 | * Not applicable
 |
| Comparators (C) | * No comparators specified
 | * Not applicable
 |
| Outcomes (O) | * Epidemiology (incidence and prevalence)
* Disease and complication risk factors
* Treatment pattern (clinical guidelines)
* Humanistic burden (QoL patient satisfaction, mortality, and morbidity)
* Economic burden (resource use including hospitalizations, cost, and absenteeism)
 | * Other outcomes
 |
| Study design (S) | * Observational studies
* Reviews
 | * Other studies
 |

aThe geographic scope of the review included Canada, France, Germany, Sweden, the UK and the USA

CAD, coronary artery disease; PAD, peripheral artery disease; QoL, quality of life

**SUPPLEMENTARY TABLE 2** Guideline recommendations on the use of antiplatelet therapy in patients with stable angina/stable CAD

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| Guideline/Country  | Population  | Recommendations  |
| ESC (2013)1EU | Patients with stable CAD  | * Long-term low-dose aspirin (75–150 mg per day), or clopidogrel in case of aspirin intolerance, in all patients with established CAD
* DAPT is not routinely recommended
* DAPT is indicated after BMS implantation for at least 1 month
* DAPT is indicated for 6–12 months after implantation of second-generation DES
 |
| HAS, (2016a)2 France | Patients with stable CAD  | * Long-term low-dose aspirin (75–160 mg per day) as monotherapy, or:
	+ Aspirin (75–160 mg per day) + clopidogrel (75 mg per day) post MI for 1 year
	+ Aspirin (75–160 mg per day) + prasugrel (100 mg per day) post MI for 1 year
	+ Aspirin (75–160 mg per day) + ticagrelor (180 mg per day) post MI for 1 year
 |
| NICE, (2011 updated in 2016)3UK | Patients with stable angina  | * Long-term low-dose aspirin (75 per day)
 |
| SIGN (2007)a,4Scotland | Patients with stable angina  | * Long-term aspirin (75–150 mg per day)
 |
| ACCF/AHA/ACP/AATS/PCNA/SCAI/STS (2012)5USA | Patients with stable ischemic heart disease  | * Aspirin (75–162 mg per day) continued indefinitely in the absence of contraindications, or clopidogrel when aspirin is contraindicated
* Treatment with aspirin (75–162 mg per day) and clopidogrel (75 mg per daily) might be reasonable in certain high-risk patients
 |
| ACC/AHA (2016)6USA | Patients with SIHD | * DAPT for a minimum of 1 month after BMS implantation
* DAPT for a minimum of 6 months in patients with stable CAD treated with DES implantation (3 months may be reasonable in patients with a high risk of bleeding or who develop significant overt bleeding)
* DAPT for more than 12 months for an MI within the previous 1–3 years may be reasonable, but only in patients at low bleeding risk
* DAPT for 12 months after CABG may be reasonable to improve vein graft patency
* In patients treated with DAPT, aspirin 81 mg per day (ranging from 75 mg to 100 mg per day) is recommended alongside clopidogrel
* DAPT is not beneficial in patients without a history of ACS, coronary stent implantation, or CABG ≤12 months
 |
| CCS (2014)7Canada | Patients with SIHD | * Aspirin (81 mg per day) or clopidogrel (75 mg per day) in case of aspirin intolerance
* DAPT should not be used in routine management of SIHD or beyond the time period required as a result of stenting
 |

aAn update to these guidelines was published in April 2018 (SIGN151)
ACC, American College of Cardiology; AATS, American Association for Thoracic Surgery; ACCF, American College of Cardiology Foundation; ACP, American College of Physicians; AHA, American Heart Association; BMS, bare-metal stent; CABG, coronary artery bypass grafting; CAD, coronary artery disease; CCS, Canadian Cardiology Society; DAPT, dual antiplatelet therapy; DES, drug-eluting stent; ESC, European Society of Cardiology; HAS, National Authority for Health; MI, myocardial infarction; NICE, National Institute for Health and Care Excellence; PCNA, Preventive Cardiovascular Nurses Association; SCAI, Society for Cardiovascular Angiography and Interventions; SIGN, Scottish Intercollegiate Guidelines Network; SIHD, stable ischemic heart disease; STS, Society of Thoracic Surgeons

**Supplementary Table 3** Guideline recommendations on the use of antiplatelet therapy in patients with PAD

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| Guideline/Country  | Population  | Recommendations  |
| ESC (2017)EU | Symptomatic carotid stenosis | * Long-term single antiplatelet therapy, aspirin (75–100 mg per day) or clopidogrel (75 mg per day) as an alternative in patients with aspirin intolerance
* DAPT with aspirin and clopidogrel is recommended for at least 1 month after CAS
 |
| Symptomatic patients with LEAD  | * Long-term single antiplatelet therapy, aspirin (75–100 mg per day) or clopidogrel (75 mg per day) in symptomatic patients, in all patients who have undergone revascularization, and after infra-inguinal bypass surgery
* In patients requiring antiplatelet therapy, clopidogrel may be preferred over aspirin
 |
| Patients with PAD and CAD  | * DAPT may be prolonged beyond 1 month when there is a prior history (<1 year) of ACS and/or percutaneous coronary intervention
 |
| HAS (2016b) France | Patients with LEAD  | * Lifelong aspirin therapy (75–325 mg per day) or clopidogrel (75 mg per day) in case of aspirin intolerance
 |
| AHA/ACC (2016) USA8 | Patients with LEAD  | * Aspirin alone (75–325 mg per day) or clopidogrel alone (75 mg per day)
* DAPT (aspirin and clopidogrel) may be reasonable to reduce the risk of limb-related events in patients with symptomatic PAD after lower extremity revascularization
* Cilostazol to improve symptoms and increase walking distance in patients with claudication
 |
| CCS (2005) Canada | Patients with symptomatic PAD  | * Lifelong aspirin therapy (75–325 mg per day) or clopidogrel (75 mg per day) in case of aspirin intolerance
 |
| CCS (2011) Canada | Patients with symptomatic PAD  | * Low-dose aspirin (75–162 mg per day) or clopidogrel (75 mg per day) providing the bleeding risk is low (Class IIb, Level B)
* Choice of drug may depend on patient preference and cost considerations
 |
| Patients with symptomatic PAD with overt CAD or CeVD  | * Antiplatelet therapy as indicated for CAD and/or CeVD (Class I, Level A)
 |

ACC, American College of Cardiology; ACS, acute coronary syndrome; AHA, American Heart Association; CAD, coronary artery disease; CAS, carotid artery stenosis; CCS, Canadian Cardiology Society; CeVD, cerebrovascular disease; DAPT, dual antiplatelet therapy; ESC, European Society of Cardiology; HAS, National Authority for Health; LEAD, lower extremity artery disease; PAD, peripheral artery disease



**SUPPLEMENTARY FIGURE 1** PRISMA diagram of the search

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