Background: Clopidogrel added to aspirin improved outcomes after hospitalization in patients with non-ST-segment elevation acute coronary syndromes (NSTE ACS) in the Clopidogrel in Unstable angina to prevent Recurrent Events (CURE) trial, regardless of in-hospital treatment approach. The American College of Cardiology/American Heart Association (ACC/AHA) Guidelines for treating NSTE ACS thus recommend prescribing clopidogrel plus aspirin at discharge for all patients, not just for those undergoing percutaneous coronary intervention (PCI).

Methods: We studied 61,052 patients with high-risk NSTE ACS (defined as the presence of positive cardiac markers and/or ischemic ST-segment changes) from January 2002 through December 2003 at 461 US hospitals participating in the CRUSADE (Can Rapid Risk Stratification of Unstable Angina Patients Suppress Adverse Outcomes With Early Implementation of the ACC/AHA Guidelines) Quality Improvement Initiative. We evaluated temporal trends in application of the revised ACC/AHA Guidelines update and examined variables associated with receiving clopidogrel at discharge in patients who did not undergo PCI.

Results: A total of 34,319 patients (56.2%) received clopidogrel when they were discharged from the hospital. Among patients who did not undergo PCI, variables associated with receiving clopidogrel at discharge included prior PCI, coronary artery bypass grafting (CABG), stroke, or myocardial infarction; hypercholesterolemia; elevated cardiac markers; and cardiology inpatient care. By late 2003, 96.3% of patients who underwent PCI received clopidogrel at discharge, compared with 42.8% of patients who did not undergo cardiac catheterization and 23.5% of the patients who underwent CABG, although clopidogrel prescription at discharge increased in each of these treatment groups from 2002 to 2003.

Conclusion: Since release of the ACC/AHA Guidelines recommendations for treatment of NSTE ACS, prescription of clopidogrel at hospital discharge in patients with NSTE ACS who are treated with medical therapy alone and in those who undergo CABG has increased, but most of these patients still do not receive clopidogrel at discharge.

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hospital treatment strategy (revascularization vs no revascularization), variables associated with prescription of clopidogrel at discharge, and temporal trends in the prescription of clopidogrel at discharge since the release of the revised guideline recommendations.

**METHODS**

**DATA COLLECTION**

Patients included in the national ongoing CRUSADE Quality Improvement Initiative have ischemic symptoms at rest within 24 hours of presentation (lasting for at least 10 minutes) and high-risk characteristics, including ST-segment depression, transient ST-segment elevation, and/or positive cardiac markers (troponin I or T and/or creatine kinase-MB levels greater than the upper limit of the reference range for assays used at participating institutions).

Data were collected in an anonymous fashion (without informed consent) only during the index hospitalization, and the institutional review board of each institution approved participation in the CRUSADE initiative. Data collection included baseline clinical characteristics, use of acute medications (within 24 hours of hospital admission), use and timing of invasive cardiac procedures, laboratory results, in-hospital clinical outcomes, and discharge therapies and interventions. Decisions about the use of medications and invasive procedures were made by the treating physicians. Contraindications to specific therapies given class IA or IB recommendations by the ACC/AHA Guidelines were recorded.

**STUDY POPULATION**

We included patients treated at 461 hospitals in the United States between January 1, 2002, and December 31, 2003, who survived the hospitalization. From this population, we excluded patients with any contraindications to clopidogrel or aspirin recorded in the data collection form, including active or recent bleeding, allergy, platelet count of less than 100 000/mm³, gastric ulcer or serious gastrointestinal/genitourinary bleeding, or severe comorbid illness. We also excluded patients who were transferred to other hospitals (because their discharge treatment information was not available), those without discharge medications listed on the data collection form, and patients with missing information on procedures performed during their hospitalization.

**STATISTICAL ANALYSIS**

For the descriptive analysis, patient baseline demographics, clinical characteristics, care patterns, and in-hospital outcomes of patients who were prescribed clopidogrel at discharge vs those who were not were compared. Median values were used to describe continuous variables, and percentages were reported for categorical variables. The Wilcoxon rank sum test for continuous variables and the χ² test for categorical variables were used to test for differences.

Comparisons of patients who were prescribed clopidogrel at discharge were based on in-hospital treatment approaches and the occurrence of nonfatal clinical events. Patients were stratified by treatment approach: no cardiac catheterization, cardiac catheterization with no revascularization, percutaneous coronary interventions (PCI), and coronary artery bypass grafting (CABG). The group of patients with cardiac catheterization and no subsequent revascularization was further stratified by whether they had insignificant coronary artery disease (≤50% stenosis in all coronary lesions) or significant coronary artery disease (>50% stenosis in at least 1 coronary lesion). The entire group of patients who did not undergo a PCI or CABG was considered to have been medically treated. Temporal changes in discharge patterns during the study period (the first quarter of 2002 through the fourth quarter of 2003) were analyzed according to treatment approach and by primary inpatient service (cardiology and noncardiology). Finally, we compared prescribing clopidogrel at discharge based on the occurrence of in-hospital reinfarction, nonhemorrhagic stroke, and the composite outcome of these events to determine how nonfatal recurrent ischemic events during the hospitalization influence whether clopidogrel is prescribed.

We observed that most patients undergoing PCI received a coronary stent and were very likely to receive clopidogrel at discharge; thus, we analyzed variables associated with receiving clopidogrel only in patients who had not undergone PCI. We did not include postadmission events or procedures in the model. We used the generalized estimating equations method. Identification of all baseline patient and hospital characteristics that were likely to have an impact on clopidogrel prescription was based on clinical judgment. Then, we conducted univariate analyses to determine which factors could be expected to have an independent effect on whether clopidogrel was prescribed. We then tested all variables in multivariable analyses and evaluated the results sequentially; we eliminated nonsignificant variables (those the investigator did not consider to be important) and retained significant variables (those the investigator considered to be important). We used the generalized estimating equations method to adjust for correlations among clustered responses (eg, within hospital correlations). The correlation occurs due to factors such as hospital peculiarities or characteristics common to patients visiting that hospital. The technique renders not only unbiased but also more accurate estimates of the parameters associated with the variable of interest and covariates.

Statistical significance was established at P < .05 for all tests. We used SAS software (version 8.2; SAS Institute, Cary, NC) to perform all statistical analyses.

**RESULTS**

**STUDY POPULATION AND CHARACTERISTICS OF PATIENTS AND HOSPITALS**

The initial population for this analysis consisted of 83 790 patients with high-risk NSTE ACS who were treated at 461 US hospitals between January 1, 2002, and December 31, 2003. We excluded 2302 patients whose information regarding procedure use was missing, 3370 who died during the hospitalization, 10 130 who were transferred to other hospitals, 2631 who did not have reported discharge medications, 811 who had contraindications to clopidogrel, and 3494 who had contraindications to aspirin. The final population for our analysis was thus 61 052 patients.

During the study period, 34 319 patients (56.2%) were discharged with a prescription for clopidogrel and 26 733 (43.8%) were not. Patients receiving clopidogrel at discharge were younger, more frequently male, and more commonly had a history of PCI and CABG, but they less frequently had a history of congestive heart failure or congestive heart failure on presentation (Table 1). They also more frequently were admitted to a cardiology inpatient unit and more frequently were treated at hospitals with full capabilities for performing revascularization, including CABG facilities (Table 1).

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Patients who received clopidogrel at discharge more frequently underwent cardiac catheterization and PCI but less frequently underwent CABG (Table 2). Furthermore, 65.7% of the patients who were prescribed clopidogrel at discharge had received it during the first 24 hours of the hospitalization, whereas 15.8% of the patients who were not prescribed clopidogrel at discharge received it during the first 24 hours. Of the patients who underwent catheterization, 7.6% of those who received clopidogrel at discharge had insignificant coronary artery disease compared with 21.4% of those who did not receive it on discharge.

Patients who received clopidogrel at discharge more frequently were treated with other discharge medications recommended by the ACC/AHA Guidelines (Table 3). These patients also more frequently received secondary prevention interventions at discharge, such as counseling for smoking cessation and diet modification and referral for cardiac rehabilitation.

The variables most strongly associated with receiving clopidogrel at discharge in patients who had not undergone PCI included a prior PCI, CABG, stroke or myocardial infarction; hypercholesterolemia; elevated cardiac markers; slower heart rate; and cardiology inpatient care (Table 4). The receiver operating characteristic, also known as the c-index, of the model was 0.62.
Heart failure; CI, confidence interval; MI, myocardial infarction; OR, odds ratio.11,12 Furthermore, even though cardiologists more frequently use evidence-based therapies for patients with NSTE ACS, patterns and trends for receiving clopidogrel at discharge were similar among patients who were treated in cardiology and noncardiology inpatient services.13,14 Nonetheless, the c-index for the model identifying variables associated with prescribing clopidogrel at discharge were shown during the period, indicating an incremental adoption of the updated ACC/AHA Guidelines recommendations for patients with NSTE ACS.

**VARIABLES ASSOCIATED WITH USE OF CLOPIDOGREL AT DISCHARGE**

Prescription of clopidogrel at hospital discharge in the overall study population was concentrated in patients who underwent PCI and tended to be younger male patients with lower-risk features, but these characteristics define a low-risk population of patients with NSTE ACS who are more likely to undergo invasive procedures and PCI with expected widespread use of clopidogrel.16 In the population who did not undergo PCI, however, variables indicating higher baseline risk and more extensive vascular disease (ie, prior revascularization procedures or stroke, hypercholesterolemia) and possible aspirin resistance (prior myocardial infarction with expected chronic aspirin use) were the variables most strongly associated with receiving clopidogrel at discharge. Clinicians may perceive that patients with NSTE ACS who have known vascular disease and those receiving ongoing antiplatelet therapy may have an enhanced benefit from a dual antiplatelet therapy. However, other high-risk features that correlate with left ventricular dysfunction, such as faster heart rate, lower blood pressure, and signs of congestive heart failure on admission, were negatively associated with receiving clopidogrel at discharge. These observed treatment patterns are similar to other studies that have documented treatment disparities in patients with ACS and concomitant heart failure.11,12 Furthermore, even though cardiologists more frequently use evidence-based therapies for patients with acute myocardial infarction, patterns and trends for receiving clopidogrel at discharge were similar for patients who had received cardiology and noncardiology inpatient services.13,14
the Clopidogrel for the Reduction of Events During Observational treatment, PCI, and CABG. In addition, the treatment effect of clopidogrel was consistent across treatment strategies, including medical treatment, PCI, and CABG. In addition, the Clopidogrel for the Reduction of Events During Observation (CREDO) trial established that clopidogrel administered for up to 12 months after placement of a bare-metal stent reduced the risk of long-term recurrent ischemic events. In both the CREDO and CURE trials, the impact of clopidogrel was consistent in reducing long-term recurrent ischemic events. Clopidogrel appears to provide added benefits to other standard discharge medications in patients with NSTE ACS, regardless of treatment strategy and revascularization approach. However, we observed temporal increases in clopidogrel use after discharge in patients with insignificant CAD, but the use of long-term, dual antiplatelet therapy in this population has not been studied carefully and thus may not be justified.

**BARRIERS TO DISCHARGE CLOPIDOGREL USE**

Multifactorial issues seem to limit the use of clopidogrel to treat patients who have not undergone PCI. First, the high costs of long-term clopidogrel use, which are usually shifted directly to patients (who have increasingly limited prescription drug coverage), may have a significant impact on physicians' decisions at hospital discharge. Second, the lack of widespread knowledge among some physicians about the long-term benefits of clopidogrel after an episode of ACS in patients who have not undergone PCI and confusion about the guideline recommendations for prescribing clopidogrel for patients undergoing CABG are likely obstacles to prescribing clopidogrel at discharge. The ACC/AHA Guidelines for patients with NSTE ACS recommend withholding clopidogrel for 5 to 7 days before a patient undergoes CABG, given the increased risk of bleeding found in the CURE trial when CABG was performed less than 5 days after clopidogrel was discontinued. Even though this recommendation does not address use of clopidogrel after discharge, when the bleeding risks would be expected to be minimized after recovery from the CABG, there may be uncertainty among cardiac surgeons about guideline recommendations for prescribing clopidogrel after a patient undergoes a CABG (which are not clearly stated), as well as other evidence-based medications. Finally, because prescribing clopidogrel at discharge was associated with higher uptake of other guideline recommendations, this practice may be a marker of hospitals with a greater commitment to quality improvement and better systems in place to ensure consistent, evidence-based discharge care.

During the observation period of our study (January 2002 to December 2003), hospitals participating in the CRUSADE initiative received quarterly data feedback and were offered quality improvement tools such as discharge checklists and educational programs to improve their understanding of the guidelines revisions. However, the relative temporal change in prescribing clopidogrel at discharge was modest over the study period. Therefore, novel approaches to quality improvement are needed to overcome the barriers that limit the use of clopidogrel and promote widespread adherence to guidelines for treating patients with NSTE ACS at all hospitals.

**STUDY LIMITATIONS**

This study has certain limitations. First, data were collected by retrospective chart review, and valid reasons for not prescribing clopidogrel at discharge may not have been consistently documented. Second, the use of clopidogrel after discharge was associated with higher uptake of other guideline recommendations, which may indicate that prescribing clopidogrel at discharge is a marker of hospitals with a greater commitment to quality improvement. Third, the results of this study may not be generalizable to other populations or settings. Finally, the study was limited by the lack of information on the specific reasons for not prescribing clopidogrel at discharge, which may have influenced the decision to prescribe or not prescribe clopidogrel after discharge.
been well documented. Second, hospitals involved in the CRUSADE initiative may not be representative of all US hospitals because participation is voluntary, and hospitals that agreed to participate may be more interested in adherence to guidelines and more receptive to quality improvement initiatives. Third, we could not ascertain when clopidogrel was prescribed at discharge for patients transferred from community hospitals to tertiary hospitals (most likely for invasive procedures) because current privacy regulations prohibit anonymous data collection after interhospital discharge. Finally, information on postdischarge medication compliance could not be collected in the CRUSADE initiative, so the impact and duration of long-term clopidogrel use was not assessed.

In conclusion, receiving clopidogrel at discharge for patients with NSTE ACS is concentrated in those undergoing PCI and is prescribed for fewer than half of patients who are medically treated despite guideline recommendations for consistent use of clopidogrel at discharge regardless of the in-hospital treatment approach. Because adherence to comprehensive guidelines at hospital discharge is associated with lower long-term mortality in patients with NSTE ACS, further investigation into the barriers that limit the prescription of clopidogrel at discharge and the key factors for successful quality improvement interventions at hospitals is needed to improve the treatment at discharge of patients with NSTE ACS.^{2,20,21}

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