Supplementary Online Content


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This supplementary material has been provided by the authors to give readers additional information about their work.
Data Collection
### eTable 1. PRISMA checklist

<table>
<thead>
<tr>
<th>Section/topic</th>
<th>#</th>
<th>Checklist item</th>
<th>Reported on page #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>1</td>
<td>Identify the report as a systematic review, meta-analysis, or both.</td>
<td>1</td>
</tr>
<tr>
<td><strong>ABSTRACT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structured summary</td>
<td>2</td>
<td>Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.</td>
<td>1</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rationale</td>
<td>3</td>
<td>Describe the rationale for the review in the context of what is already known.</td>
<td>2</td>
</tr>
<tr>
<td>Objectives</td>
<td>4</td>
<td>Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).</td>
<td>2</td>
</tr>
<tr>
<td><strong>METHODS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol and registration</td>
<td>5</td>
<td>Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.</td>
<td>2</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>6</td>
<td>Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.</td>
<td>2</td>
</tr>
<tr>
<td>Information sources</td>
<td>7</td>
<td>Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.</td>
<td>2</td>
</tr>
<tr>
<td>Search</td>
<td>8</td>
<td>Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.</td>
<td>eTable 2</td>
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<tr>
<td>Study selection</td>
<td>9</td>
<td>State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).</td>
<td>2</td>
</tr>
<tr>
<td>Data collection process</td>
<td>10</td>
<td>Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.</td>
<td>2</td>
</tr>
<tr>
<td>Data items</td>
<td>11</td>
<td>List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.</td>
<td>eTables 3 and 5</td>
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<tr>
<td>Risk of bias in individual studies</td>
<td>12</td>
<td>Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.</td>
<td>3</td>
</tr>
<tr>
<td>Summary measures</td>
<td>13</td>
<td>State the principal summary measures (e.g., risk ratio, difference in means).</td>
<td>3</td>
</tr>
<tr>
<td>Synthesis of results</td>
<td>14</td>
<td>Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I²) for each meta-analysis.</td>
<td>3</td>
</tr>
<tr>
<td>Risk of bias across studies</td>
<td>15</td>
<td>Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).</td>
<td>3</td>
</tr>
<tr>
<td>Additional analyses</td>
<td>16</td>
<td>Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.</td>
<td>3</td>
</tr>
<tr>
<td><strong>RESULTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study selection</td>
<td>17</td>
<td>Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.</td>
<td>eFigure 1</td>
</tr>
<tr>
<td>Study characteristics</td>
<td>18</td>
<td>For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.</td>
<td>eTable 3</td>
</tr>
<tr>
<td>Risk of bias within studies</td>
<td>19</td>
<td>Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).</td>
<td>3</td>
</tr>
<tr>
<td>Results of individual studies</td>
<td>20</td>
<td>For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.</td>
<td>eTable 7</td>
</tr>
<tr>
<td>Synthesis of results</td>
<td>21</td>
<td>Present results of each meta-analysis done, including confidence intervals and measures of consistency.</td>
<td>4</td>
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<tr>
<td>Risk of bias across studies</td>
<td>22</td>
<td>Present results of any assessment of risk of bias across studies (see Item 15).</td>
<td>eTable 4</td>
</tr>
<tr>
<td>Additional analysis</td>
<td>23</td>
<td>Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression)</td>
<td>Supplement</td>
</tr>
<tr>
<td><strong>DISCUSSION</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Summary of evidence</td>
<td>24</td>
<td>Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).</td>
<td>4</td>
</tr>
<tr>
<td>Limitations</td>
<td>25</td>
<td>Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).</td>
<td>7</td>
</tr>
<tr>
<td>Conclusions</td>
<td>26</td>
<td>Provide a general interpretation of the results in the context of other evidence, and implications for future research.</td>
<td>8</td>
</tr>
<tr>
<td><strong>FUNDING</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Funding</td>
<td>27</td>
<td>Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.</td>
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### eTable 2. Search code

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<th>Total</th>
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<td>+355</td>
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<tr>
<td>2. Ovid</td>
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<td>+744</td>
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<tr>
<td>3. CINAHL</td>
<td>101</td>
<td>+302</td>
</tr>
<tr>
<td>4. Cochrane #1</td>
<td>23</td>
<td>+7</td>
</tr>
<tr>
<td>5. Cochrane #2</td>
<td>11</td>
<td>+6</td>
</tr>
<tr>
<td>6. Updated search</td>
<td>357</td>
<td>+34</td>
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</tbody>
</table>

**1448 studies to screen**

### PubMed/MEDLINE search:

<table>
<thead>
<tr>
<th>Name search</th>
<th>Search #</th>
<th>PubMed query</th>
<th>Hits</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCI or Acute coronary syndrome</td>
<td>1</td>
<td>((((((Percutaneous coronary intervention[MeSH Major Topic]) OR &quot;percutaneous coronary intervention&quot;[tiab]) OR angioplasty, transluminal, percutaneous coronary[MeSH Terms]) OR &quot;PCI&quot;[tiab]) OR &quot;coronary stenting&quot;[tiab])))) OR acute coronary syndrome[MeSH Terms]) OR “acute coronary syndrome”[tiab] OR “ACS”[tiab])</td>
<td>93536</td>
</tr>
<tr>
<td>NOAC or VKA</td>
<td>2</td>
<td>((((((((((((((((((((((((new oral anticoagulants[Tiab]) OR direct oral anticoagulants[Tiab]) OR direct thrombin inhibitors[Tiab]) OR factor Xa inhibitor[Tiab]) OR dabigatran[Tiab]) OR rivaroxaban[Tiab]) OR apixaban[Tiab]) OR edoxaban[Tiab]) OR novel oral anticoagulants[Tiab]) OR non-vitamin K antagonist oral anticoagulant[Tiab]) OR NOAC[Tiab]) OR direct acting oral anticoagulant[Tiab]) OR DOAC[Tiab]) OR warfarin[MeSH Terms]) OR “warfarin”[Tiab]) OR “vitamin K antagonist”[Tiab]) OR anticoagulants[MeSH Terms]) OR anticoagulants[Tiab]) OR anticoagulant drugs[MeSH Terms]) OR anticoagulant agents[MeSH Terms]) OR “anticoagulant drugs”[Tiab]) OR “anticoagulant agents”[Tiab])</td>
<td>101276</td>
</tr>
<tr>
<td>Antiplatelets</td>
<td>3</td>
<td>((((((antiplatelet agents[MeSH Terms]) OR antiplatelet drugs[MeSH Terms]) OR “antiplatelet agents”[Tiab]) OR “antiplatelet drugs”[Tiab]) OR &quot;antiplatelet drugs&quot;[Tiab]) OR &quot;antiplatelets&quot;[Tiab]) OR &quot;aspirin&quot;[Tiab]) OR &quot;thienopyridine&quot;[Tiab]) OR &quot;clopidogrel&quot;[Tiab]) OR Platelet Aggregation Inhibitors[MeSH Major Topic]) OR “dual antiplatelet therapy”[Tiab]) OR “DAPT”[Tiab]) OR “triple therapy”[Tiab]) OR “TAT”[Tiab])</td>
<td>96967</td>
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<tr>
<td>Atrial fibrillation</td>
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</tr>
<tr>
<td>Combined search</td>
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<td>#1 AND #2 AND #3 AND #4</td>
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OVID/EMBASE Search:

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<th>Search #</th>
<th>Embase query</th>
<th>Hits</th>
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</thead>
<tbody>
<tr>
<td>PCI or Acute coronary syndrome</td>
<td>1</td>
<td>percutaneous coronary intervention.sh. or percutaneous coronary intervention.af. or percutaneous transluminal coronary angioplasty.af. or PCI.af. or coronary stenting.af. or Acute coronary syndrome.sh. or acute coronary syndrome.af. or ACS.af.</td>
<td>164535</td>
</tr>
<tr>
<td>NOAC or VKA</td>
<td>2</td>
<td>new oral anticoagulants or direct oral anticoagulants or direct thrombin inhibitors or factor Xa inhibitor or dabigatran or rivaroxaban or apixaban or edoxaban or novel oral anticoagulants or non-vitamin K antagonist oral coagulant or NOAC or direct acting oral anticoagulant or DOAC.af. or warfarin.sh. or warfarin.af. or vitamin K antagonist.af. or anticoagulants.sh. or anticoagulants.af. or anticoagulant drugs.sh. or anticoagulant drugs.af. or anticoagulant agents.sh. or anticoagulant agents.af.</td>
<td>128043</td>
</tr>
<tr>
<td>Antiplatelets</td>
<td>3</td>
<td>antiplatelet agents or antiplatelet drugs.sh. or antiplatelet agents.af. or antiplatelet drugs.af. or antiplatelets.af. or aspirin.af. or thienopyridine.af. or clopidogrel.af. or platelet aggregation inhibitors.sh. or dual antiplatelet therapy.af. or DAPT.af. or triple therapy.af. or TAT.af.</td>
<td>195369</td>
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<td>Atrial fibrillation.sh. or atrial fibrillation.af. or AF.af.</td>
<td>168830</td>
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<td>#1 AND #2 AND #3 AND #4</td>
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EBSCO/CINAHL:

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<th>Search #</th>
<th>EBSCO query</th>
<th>Hits</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCI or Acute coronary syndrome</td>
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<td>MW percutaneous coronary intervention OR TX percutaneous coronary intervention OR MW percutaneous transluminal coronary angioplasty OR TX PCI OR TX coronary stenting OR MW acute coronary syndrome OR TX acute coronary syndrome OR TX ACS</td>
<td>35998</td>
</tr>
<tr>
<td>NOAC or VKA</td>
<td>2</td>
<td>TX new oral anticoagulants OR TX direct oral anticoagulants OR TX direct thrombin inhibitor OR TX factor xA inhibitor OR TX dabigatran OR TX rivaroxaban OR TX apixaban OR TX edoxaban OR TX noac OR TX anticoagulants OR TX warfarin OR TX vitamin k antagonist</td>
<td>32209</td>
</tr>
<tr>
<td>Antiplatelets</td>
<td>3</td>
<td>TX antiplatelet therapy OR TX antiplatelet drugs OR TX antiplatelets OR TX aspirin OR TX clopidogrel OR TX platelet aggregation inhibitors OR TX dual antiplatelet therapy OR TX triple therapy OR TX DAPT OR TX TAT</td>
<td>39840</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>4</td>
<td>MJ atrial fibrillation OR MW atrial fibrillation OR TX atrial fibrillation</td>
<td>36219</td>
</tr>
<tr>
<td>Combined search</td>
<td>5</td>
<td>#1 AND #2 AND #3 AND #4</td>
<td>403</td>
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</table>

Cochrane Database search:

<table>
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<tr>
<th>Search #</th>
<th>Query</th>
<th>Hits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Percutaneous coronary intervention AND antiplatelet therapy AND oral anticoagulant therapy AND atrial fibrillation (Word variations have been searched)</td>
<td>30 trials</td>
</tr>
<tr>
<td>2</td>
<td>Acute coronary syndrome AND antiplatelet therapy AND oral anticoagulant therapy AND atrial fibrillation (Word variations have been searched)</td>
<td>17 trials</td>
</tr>
<tr>
<td>Combined search</td>
<td>#1 OR #2</td>
<td>47 trials</td>
</tr>
</tbody>
</table>
eFigure 1. Flowchart of literature review

1,448 studies screened

1,424 studies irrelevant

24 full-text studies assessed for eligibility

20 studies excluded
wrong study design (observational, trial-design, review, etc)

1 study re-included (ISAR-TRIPLE)
(for sensitivity analysis)

5 studies included

Primary analysis (4 studies)
WOEST, REDUAL-PCI, PIONEER-AF-PCI, AUGUSTUS

Sensitivity analysis (5 studies)
+ ISAR-TRIPLE 6-week landmark
**eTable 3. Definitions of trial-defined primary bleeding and MACE outcomes in each study**

<table>
<thead>
<tr>
<th>Primary bleeding outcome</th>
<th>WOEST</th>
<th>PIONEER AF-PCI</th>
<th>RE-DUAL PCI</th>
<th>AUGUSTUS</th>
<th>ISAR-TRIPLE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up</td>
<td>1 year</td>
<td>1 year</td>
<td>14 months**</td>
<td>6 months</td>
<td>6 months minus 6 weeks</td>
</tr>
</tbody>
</table>

**Primary bleeding outcome**

<table>
<thead>
<tr>
<th>Definition</th>
<th>WOEST</th>
<th>PIONEER AF-PCI</th>
<th>RE-DUAL PCI</th>
<th>AUGUSTUS</th>
<th>ISAR-TRIPLE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Any bleeding event classified separately according to TIMI, GUSTO, and BARC</td>
<td>A composite of major bleeding or minor bleeding according to the TIMI or bleeding requiring medical attention</td>
<td>Major or clinically relevant nonmajor bleeding event according to ISTH</td>
<td>A composite of major and clinically relevant nonmajor bleeding event according to ISTH</td>
<td>A composite of death, MI, definite stent thrombosis, stroke, or TIMI major bleeding</td>
</tr>
</tbody>
</table>

**Primary MACE outcome**

<table>
<thead>
<tr>
<th>Definition</th>
<th>WOEST</th>
<th>PIONEER AF-PCI</th>
<th>RE-DUAL PCI</th>
<th>AUGUSTUS</th>
<th>ISAR-TRIPLE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>A composite of death, MI, stroke, target-vessel revascularization, or stent thrombosis</td>
<td>A composite of death from cardiovascular causes, myocardial infarction, or stroke</td>
<td>A composite of MI, stroke, systemic embolism, death or unplanned revascularization</td>
<td>All-cause death or ischemic event</td>
<td>A composite of cardiac death, MI, definite stent thrombosis, or ischemic stroke</td>
</tr>
</tbody>
</table>

TIMI=Thrombolysis in Myocardial Infarction; GUSTO=Global Utilization of Streptokinase and Tissue Plasminogen Activator for Occluded Coronary Arteries; BARC=Bleeding Academic Research Consortium; ISTH=International Society on Thrombosis and Hemostasis; MI=Myocardial Infarction; MACE=Major Adverse Cardiovascular Events

* Only landmark analysis was included in a sensitivity analysis.

** Average follow-up
**eTable 4. Risk of bias of included trials using the Cochrane risk assessment tool**

<table>
<thead>
<tr>
<th></th>
<th>WOEST</th>
<th>PIONEER AF-PCI</th>
<th>RE-DUAL PCI</th>
<th>AUGUSTUS</th>
<th>ISAR-TRIPLE****</th>
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</thead>
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<tr>
<td><strong>Selection bias</strong></td>
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<td>(random sequence</td>
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<td>generation)</td>
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<td>(allocation</td>
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<td>concealment)</td>
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<td><strong>Performance bias</strong></td>
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<td>(blinding of</td>
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<td>participants and</td>
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<td>personnel*)</td>
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<td><strong>Attrition bias</strong></td>
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<td>(incomplete outcome</td>
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<td>data**)</td>
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<td>reporting)</td>
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<td>**Other sources of</td>
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<td>bias***</td>
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</tbody>
</table>

* Despite that the trials used an open label trial design, the outcome assessment was blinded, and therefore the study design did not influence reported outcomes and hereby negatively effecting the quality of evidence.

** all trials reported minimal loss to follow-up.

*** We rated the extracted data from the ISAR-TRIPLE study as intermediate risk of bias, given that the trial involved unblinded outcome assessment, but more importantly the 6-week landmark analyses data that we used in our analysis involves an inherent bias as most of the early fatal and major non-fatal bleeding events have already occurred prior to 6 weeks of follow-up.

**** Only landmark analysis was included in a sensitivity analysis.
<table>
<thead>
<tr>
<th>Population</th>
<th>Patients taking oral anticoagulants and undergoing PCI</th>
<th>Patients who had paroxysmal, persistent, or permanent nonvalvular AF (defined as atrial fibrillation not considered to be caused by a primary valve stenosis) and who had just undergone PCI with stent placement</th>
<th>Patients who had nonvalvular AF and had successfully undergone PCI with a bare-metal or drug-eluting stent within the previous 120 hours</th>
<th>Patients with AF with recent ACS and/or PCI</th>
<th>Patient receiving oral anticoagulation who undergo drug-eluting stent implantation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trial type</td>
<td>Open-label; multicenter; randomized controlled trial</td>
<td>Open-label; international; multicenter; randomized controlled trial</td>
<td>Open-label; multicenter; randomized controlled trial</td>
<td>Open-label; international; multicenter; randomized controlled trial</td>
<td>Open-label; multicenter; randomized controlled trial</td>
</tr>
<tr>
<td>Inclusion criteria</td>
<td>• Age 18-80</td>
<td>• Age ≥ 18 years</td>
<td>• Age ≥ 18 years</td>
<td>• Age ≥ 18 years</td>
<td>• Age ≥ 18 years</td>
</tr>
<tr>
<td></td>
<td>• Long-term indication for oral anticoagulation treatment</td>
<td>• AF that occurred within last 1 year, or AF that occurred more than 1 year and the participant had been receiving oral anticoagulation for AF for the last 3 months</td>
<td>• Patients with nonvalvular AF who just underwent PCI with a bare-metal or drug-eluting stent for ACS or unstable angina</td>
<td>• Patients with either active or a history of AF or flutter with planned or existing use of an oral anticoagulant for prophylaxis of thromboembolism</td>
<td>• Patients who have been receiving oral anticoagulant for at least 12 months and receiving a drug-eluting stent for stable angina or ACS</td>
</tr>
<tr>
<td></td>
<td>• Severe coronary lesion with indication for PCI</td>
<td>• History of stroke or transient ischemic attack</td>
<td>• Patients who have a history of AF and/or PCI within the prior 14 days</td>
<td>• Planned use of an approved P2Y12 inhibitor for at least 6 months</td>
<td>• Patients who have had an ACS and/or PCI in the prior 6 months</td>
</tr>
<tr>
<td>Exclusion criteria</td>
<td>• History of intracranial bleeding</td>
<td>• History of stroke or transient ischemic attack</td>
<td>• Presence of bioprosthesis</td>
<td>• Patients with other conditions that require anticoagulation (such as prosthetic valves or moderate or severe mitral stenosis)</td>
<td>• Previous stent thrombosis, drug-eluting stent implantation in the left main stem</td>
</tr>
<tr>
<td></td>
<td>• Cardiogenic shock</td>
<td>• Significant gastrointestinal bleeding within 12 months</td>
<td>• Mechanical heart valves</td>
<td>• Severe renal insufficiency</td>
<td>• Active bleeding or bleeding diathesis</td>
</tr>
<tr>
<td></td>
<td>• Contraindication to use of aspirin, clopidogrel, or both</td>
<td>• Calculated creatinine clearance of less than 30 ml per minute</td>
<td>• Creatinine clearance &lt;30 ml per minute</td>
<td>• History of intracranial hemorrhage</td>
<td>• History of intracranial bleeding</td>
</tr>
<tr>
<td></td>
<td>• Peptic ulcer in the previous 6 months</td>
<td>• Anemia with a hemoglobin concentration of less than 10 g per deciliter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Thrombocytopenia (platelet concentration lower than 50×10^9/L)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• TIMI major bleeding in the past 12 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analysis</td>
<td>ITT</td>
<td>Modified ITT**</td>
<td>ITT</td>
<td>Modified ITT and ITT</td>
<td>ITT</td>
</tr>
<tr>
<td>Randomization sequence</td>
<td>A computer-generated randomization sequence (blocked randomization per centre)</td>
<td>Central randomization by a computer-generated randomization</td>
<td>Interactive response technology</td>
<td>Interactive voice response system</td>
<td>A computer-generated sequence and a computer-generated web-based system</td>
</tr>
<tr>
<td>Funding</td>
<td>R&amp;D Cardiologie</td>
<td>Boehringer Ingelheim</td>
<td>Janssen Scientific Affairs</td>
<td>Pfizer, Duke Clinical Research Institute</td>
<td>Abbott, Deutsches Herzzentrum München, and PCI Research at Aarhus University Hospital</td>
</tr>
</tbody>
</table>

**ITT=Intention-to-treat; AF=Atrial Fibrillation; PCI=Percutaneous Coronary Intervention; ACS=Acute Coronary Syndrome**

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* Only landmark analysis was included in a sensitivity analysis.
** Modified ITT includes all participants who underwent randomization and received at least one dose of a trial drug after randomization.
### eTable 6. Treatment strategies in each study

<table>
<thead>
<tr>
<th>Trial</th>
<th>Group</th>
<th>Treatment strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>WOEST</td>
<td>VKA + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</td>
<td>Clopidogrel 75 mg daily</td>
</tr>
<tr>
<td></td>
<td>VKA + DAPT</td>
<td>Clopidogrel 75 mg daily; aspirin 80-100 mg</td>
</tr>
<tr>
<td>PIONEER AF-</td>
<td>NOAC + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</td>
<td>Rivaroxaban 15 mg once daily; clopidogrel 75 mg once daily</td>
</tr>
<tr>
<td>PCI</td>
<td>NOAC + DAPT</td>
<td>Rivaroxaban 2.5 mg twice daily; aspirin 75-100 mg daily; clopidogrel 75 mg once daily</td>
</tr>
<tr>
<td></td>
<td>VKA + DAPT</td>
<td>Warfarin; aspirin 75-100 mg daily; clopidogrel 75 mg once daily</td>
</tr>
<tr>
<td>RE-DUAL PCI</td>
<td>NOAC (L) + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</td>
<td>Dabigatran etexilate 110 mg twice daily; either clopidogrel or ticagrelor</td>
</tr>
<tr>
<td></td>
<td>NOAC (H) + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</td>
<td>Dabigatran etexilate 150 mg twice daily; either clopidogrel or ticagrelor</td>
</tr>
<tr>
<td></td>
<td>VKA + DAPT</td>
<td>Warfarin (INR 2.0-3.0); aspirin ≤100 mg daily; either clopidogrel or ticagrelor</td>
</tr>
<tr>
<td>AUGUSTUS</td>
<td>NOAC + DAPT</td>
<td>Apixaban 5 mg twice daily; aspirin 81 mg daily</td>
</tr>
<tr>
<td></td>
<td>NOAC + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</td>
<td>Apixaban 5 mg twice daily</td>
</tr>
<tr>
<td></td>
<td>VKA + DAPT</td>
<td>Warfarin (INR 2.0-3.0); aspirin 81 mg daily</td>
</tr>
<tr>
<td></td>
<td>VKA + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</td>
<td>Warfarin (INR 2.0-3.0)</td>
</tr>
<tr>
<td>ISAR-TRIPLE*</td>
<td>VKA + Aspirin</td>
<td>Aspirin 75-200 mg once daily; VKA with either phenprocoumon or warfarin</td>
</tr>
<tr>
<td></td>
<td>VKA + DAPT</td>
<td>Clopidogrel 75 mg daily; aspirin 75-200 mg once daily; VKA with either phenprocoumon or warfarin</td>
</tr>
</tbody>
</table>

VKA=Vitamin K Antagonist; DAPT=Dual AntiPlatelet Therapy (P2Y<sub>12</sub> inhibitor + aspirin); INR=International Normalized Ratio; NOAC=Non-VKA Oral Anticoagulant

* Only landmark analysis was included in a sensitivity analysis.
## eTable 7. Network meta-analysis data: sample size and the number of participants who had each outcome in each study

<table>
<thead>
<tr>
<th>Treatment</th>
<th>WOEST</th>
<th>PIONEER AF-PCI</th>
<th>RE-DUAL PCI</th>
<th>AUGUSTUS</th>
<th>ISAR-TRIPLE *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety Outcome</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N (ITT) TIMI (Major)</td>
<td>279</td>
<td>284</td>
<td>696</td>
<td>706</td>
<td>697</td>
</tr>
<tr>
<td>TIMI (Major and Minor)</td>
<td>9</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Trial-defined primary bleeding outcome</td>
<td>39</td>
<td>89</td>
<td>21</td>
<td>19</td>
<td>33</td>
</tr>
<tr>
<td>Intracranial hemorrhage</td>
<td>54</td>
<td>126</td>
<td>109</td>
<td>117</td>
<td>167</td>
</tr>
<tr>
<td><strong>Efficacy outcome</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N (ITT) Trial-defined primary MACE outcome</td>
<td>279</td>
<td>284</td>
<td>694</td>
<td>704</td>
<td>695</td>
</tr>
<tr>
<td>All cause death</td>
<td>31</td>
<td>50</td>
<td>41</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Cardiovascular death</td>
<td>3</td>
<td>7</td>
<td>15</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>MI (Any)</td>
<td>9</td>
<td>13</td>
<td>17</td>
<td>21</td>
<td>14</td>
</tr>
<tr>
<td>Stroke (Any)</td>
<td>3</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Stent thrombosis (Any)</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Hospitalization (Any)</td>
<td>60</td>
<td>86</td>
<td>221**</td>
<td>207**</td>
<td>257***</td>
</tr>
</tbody>
</table>

VKA=Vitamin K Antagonist; DAPT=Dual AntiPlatelet Therapy (P2Y_12-inhibitor + aspirin); NOAC=Non-VKA Oral AntiCoagulant; MACE=Major Adverse Cardiovascular Events

* Only landmark analysis was included in a sensitivity analysis.

** PIONEER AF-PCI specified the hospitalization outcome as a safety measure.
**eTable 8.** Baseline characteristics with additional variables and detailed information. Sample mean and standard deviation (in parenthesis) are reported for continuous variables, and the number of participants and proportion (in parenthesis) are reported for binary or categorical variables.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>WOEST</th>
<th>PIONEER AF-PCI</th>
<th>RE-DUAL PCI</th>
<th>AUGUSTUS</th>
<th>ISAR-TRIPLE†</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (Randomization)</td>
<td>279 (24.3%)</td>
<td>279 (24.3%)</td>
<td>279 (24.3%)</td>
<td>275 (24.3%)</td>
<td>279 (24.3%)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>70.3 (70)</td>
<td>70.4 (70)</td>
<td>71.5 (70)</td>
<td>70.7 (70)</td>
<td>70.8 (70)</td>
</tr>
<tr>
<td>Male</td>
<td>214 (76.7%)</td>
<td>234 (74.8%)</td>
<td>518 (74.2%)</td>
<td>728 (69.0%)</td>
<td>840 (72.9%)</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>27.5 (4.3)</td>
<td>27.9 (4.2)</td>
<td>28.4 (25.6, 32.4)</td>
<td>29.0 (25.8, 32.8)</td>
<td>27.5 (4.2)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>68 (24.3%)</td>
<td>72 (25.4%)</td>
<td>199 (28.1%)</td>
<td>221 (31.3%)</td>
<td>214 (27.6%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>193 (69.2%)</td>
<td>193 (73.3%)</td>
<td>532 (75.4%)</td>
<td>1018 (88.3%)</td>
<td>206 (86.3%)</td>
</tr>
<tr>
<td>Hypercholesterolaemia</td>
<td>191 (68.5%)</td>
<td>205 (72.2%)</td>
<td>295 (41.6%)</td>
<td>316 (44.8%)</td>
<td>277 (73.9%)</td>
</tr>
<tr>
<td>Current smoker</td>
<td>60 (21.5%)</td>
<td>42 (14.8%)</td>
<td>56 (7.9%)</td>
<td>48 (6.8%)</td>
<td>28 (9.1%)</td>
</tr>
<tr>
<td>History MI</td>
<td>96 (34.4%)</td>
<td>140 (35.2%)</td>
<td>157 (22.2%)</td>
<td>237 (24.2%)</td>
<td>28 (9.1%)</td>
</tr>
<tr>
<td>History heart failure</td>
<td>71 (25.4%)</td>
<td>70 (25.4%)</td>
<td>187 (26.4%)</td>
<td>492 (42.7%)</td>
<td>490 (29.3%)</td>
</tr>
<tr>
<td>History stroke</td>
<td>49 (17.6%)</td>
<td>50 (17.6%)</td>
<td>74 (5.2%)</td>
<td>492 (42.7%)</td>
<td>490 (29.3%)</td>
</tr>
<tr>
<td>History PCI</td>
<td>86 (30.8%)</td>
<td>101 (35.6%)</td>
<td>101 (31.3%)</td>
<td>100 (10.2%)</td>
<td>492 (42.7%)</td>
</tr>
<tr>
<td>History CABG</td>
<td>56 (20.1%)</td>
<td>74 (26.1%)</td>
<td>97 (9.9%)</td>
<td>97 (10.4%)</td>
<td>73 (23.8%)</td>
</tr>
<tr>
<td>History gastrointestinal bleeding</td>
<td>14 (5.0%)</td>
<td>14 (1.0%)</td>
<td>7 (1.3%)</td>
<td>157 (16.0%)</td>
<td>118 (16.0%)</td>
</tr>
<tr>
<td>History renal failure</td>
<td>51 (18.3%)</td>
<td>48 (16.9%)</td>
<td>116 (15.2%)</td>
<td>492 (42.7%)</td>
<td>490 (29.3%)</td>
</tr>
<tr>
<td>CHA2DS2-VASc score</td>
<td>≤ 2</td>
<td>189 (26.7%)</td>
<td>168 (23.7%)</td>
<td>147 (20.8%)</td>
<td>189 (26.7%)</td>
</tr>
<tr>
<td></td>
<td>≥ 3</td>
<td>520 (73.3%)</td>
<td>541 (76.3%)</td>
<td>559 (79.2%)</td>
<td>520 (73.3%)</td>
</tr>
<tr>
<td>HAS-BLED score</td>
<td>≤ 2</td>
<td>196 (27.6%)</td>
<td>227 (32.0%)</td>
<td>208 (29.5%)</td>
<td>196 (27.6%)</td>
</tr>
<tr>
<td></td>
<td>≥ 3</td>
<td>520 (73.3%)</td>
<td>541 (76.3%)</td>
<td>559 (79.2%)</td>
<td>520 (73.3%)</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th></th>
<th>513 (72.3%)</th>
<th>482 (68.0%)</th>
<th>498 (70.5%)</th>
<th>655 (66.8%)</th>
<th>454 (59.5%)</th>
<th>693 (70.6%)</th>
<th>545 (49.5%)</th>
<th>533 (48.3%)</th>
<th>540 (49.1%)</th>
<th>556 (50.4%)</th>
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<tbody>
<tr>
<td><strong>Medication on admission</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Beta blocker</td>
<td>211 (75.6%)</td>
<td>230 (81.0%)</td>
<td>586 (82.7%)</td>
<td>541 (76.3%)</td>
<td>537 (76.1%)</td>
<td>265 (86.3%)</td>
<td>269 (87.6%)</td>
<td></td>
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<tr>
<td>ACE inhibitor or ARB</td>
<td>193 (69.2%)</td>
<td>188 (66.2%)</td>
<td>571 (80.5%)</td>
<td>532 (75.0%)</td>
<td>537 (76.1%)</td>
<td>197 (64.2%)</td>
<td>198 (64.5%)</td>
<td></td>
<td></td>
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<tr>
<td>Statin</td>
<td>196 (70.3%)</td>
<td>226 (79.6%)</td>
<td>596 (84.1%)</td>
<td>557 (78.6%)</td>
<td>552 (78.2%)</td>
<td>262 (85.3%)</td>
<td>260 (84.7%)</td>
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<tr>
<td>Aspirin</td>
<td>74 (26.5%)</td>
<td>118 (41.5%)</td>
<td>9 (1.3%)</td>
<td>702 (99.0%)</td>
<td>669 (94.8%)</td>
<td>307 (100.0%)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Proton pump inhibitor</td>
<td>95 (34.1%)</td>
<td>110 (38.7%)</td>
<td>274 (38.6%)</td>
<td>276 (38.9%)</td>
<td>259 (36.7%)</td>
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<td><strong>Arterial access</strong></td>
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<tr>
<td>Radial</td>
<td>74 (26.5%)</td>
<td>71 (25.0%)</td>
<td></td>
<td>618 (63.0%)</td>
<td>502 (65.8%)</td>
<td>611 (62.3%)</td>
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<tr>
<td>Femoral</td>
<td>204 (73.1%)</td>
<td>208 (75.0%)</td>
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<td>359 (36.6%)</td>
<td>252 (33.0%)</td>
<td>361 (36.8%)</td>
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<tr>
<td><strong>Stent type</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>5 (1.8%)</td>
<td>4 (1.4%)</td>
<td>0 (0.0%)</td>
<td>0/705 (0.0%)</td>
<td>0/704 (0.0%)</td>
<td>0/762 (0.0%)</td>
<td>0/976 (0.0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bare metal</td>
<td>89 (31.9%)</td>
<td>86 (30.3%)</td>
<td>231 (32.6%)</td>
<td>220/705 (31.2%)</td>
<td>224/704 (31.8%)</td>
<td>148/979 (15.2%)</td>
<td>123/762 (16.1%)</td>
<td>133/976 (13.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug eluting</td>
<td>181 (64.9%)</td>
<td>183 (64.4%)</td>
<td>464 (65.4%)</td>
<td>471/705 (66.8%)</td>
<td>468/704 (66.5%)</td>
<td>804/979 (82.1%)</td>
<td>621/762 (81.5%)</td>
<td>826/976 (84.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bare metal and drug eluting</td>
<td>3 (1.1%)</td>
<td>11 (3.9%)</td>
<td>14 (2.0%)</td>
<td>14/705 (1.7%)</td>
<td>12/704 (1.9%)</td>
<td>19/979 (1.9%)</td>
<td>10/762 (1.3%)</td>
<td>12/976 (1.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>8/979</td>
<td>8/762</td>
<td>5/976</td>
<td>(0.8%)</td>
<td>(1.0%)</td>
<td>(0.5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Creatinine clearance (ml/min)</strong></td>
<td>78.3 (31.3)</td>
<td>77.5 (31.8)</td>
<td>80.7 (30.0)</td>
<td>76.3 (28.9)</td>
<td>83.7 (31.0)</td>
<td>75.4 (29.1)</td>
<td>78.5 (31.5)</td>
<td>79.4 (30.2)</td>
<td>78.7 (30.2)</td>
<td>80.0 (36.8)</td>
</tr>
<tr>
<td><strong>Type of index event</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-STEMI</td>
<td>130/701 (18.5%)</td>
<td>129/703 (18.3%)</td>
<td>123/691 (17.8%)</td>
<td>203 (20.7%)</td>
<td>179 (23.5%)</td>
<td>206 (21.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STEMI</td>
<td>86/701 (12.3%)</td>
<td>97/703 (13.8%)</td>
<td>74/691 (10.7%)</td>
<td>144** (14.7%)</td>
<td>114** (14.9%)</td>
<td>143** (14.6%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstable angina</td>
<td>145/701 (20.7%)</td>
<td>148/703 (21.1%)</td>
<td>164/691 (23.7%)</td>
<td>195 (19.9%)</td>
<td>126 (16.5%)</td>
<td>166 (16.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type of atrial fibrillation</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent</td>
<td>146/708 (20.7%)</td>
<td>146 (20.6%)</td>
<td>149/705 (21.1%)</td>
<td>174 (17.7%)</td>
<td>132 (17.3%)</td>
<td>178/980 (18.2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent</td>
<td>262/708 (37.4%)</td>
<td>238 (33.6%)</td>
<td>243/705 (34.5%)</td>
<td>320 (32.6%)</td>
<td>302 (32.8%)</td>
<td>318/980 (32.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paroxysmal</td>
<td>300/708 (42.8%)</td>
<td>325/705 (46.1%)</td>
<td>313/705 (44.4%)</td>
<td>487 (49.6%)</td>
<td>380 (49.8%)</td>
<td>484/980 (49.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VKA=Vitamin K Antagonist; DAPT=Double AntiPlatelet Therapy (P2Y12 inhibitor + aspirin); NOAC=Non-VKA Oral Anticoagulant; BMI=Body Mass Index; MI=Myocardial Infarction; PCI=Percutaneous Coronary Intervention; CABG=Coronary Artery Bypass Graft; ACE=Angiotensin-Converting-Enzyme; ARB=Angiotensin-II-Receptor Blocker; STEMI=ST-Elevation Myocardial Infarction

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* Only landmark analysis was included in a sensitivity analysis.
** The number of patients combined in three ACS categories: STEMI within 24 hour, STEMI > 24 hour previous, and post STEMI
*** Interquartile range
Additional results of NMA with primary outcomes
eAppendix 1. Comments on the prior distribution selection for between-study heterogeneity

All our network meta-analysis models were conducted using the gemtc package (version 0.8-2) in R 3.5.1. The gemtc package was written based on van Valkenhoef et al. (2012) which borrowed the Lu and Ades network meta-analysis model in Dias et al. (2011). The gemtc package was designed to generate network meta-analysis models automatically by specifying prior distributions and starting values for MCMC chains given data. The purpose of this automation is (1) to specify prior distributions that are sufficiently vague to minimize bias and (2) to choose starting values that are over-dispersed enough to explore the complete parameter space and assess convergence. The performance of the gemtc package was validated with many published network meta-analysis examples (van Valkenhoef et al. (2012)).

In our analysis, we used the default settings for hyperprior distributions offered by the gemtc package. The default hyperprior distribution for the heterogeneity parameter $\tau$ is a uniform$(0, \nu)$, where $\nu$ is determined from the data. (Technical details are available in van Valkenhoef et al. (2012)). With the log odds ratio scale, it is known that a uniform distribution with upper limit between 2 and 5 is acceptable (Lu and Ades (2004)). However, the gemtc default hyperprior setting could determine $\nu$ could smaller than 2.

It is known that the posteriors of other parameters are not sensitive to the choice of prior distribution of $\tau$, especially for network meta-analysis with a reasonably large number of studies. However, since our data included only 4 (and 5 in Sensitivity analysis 5) trials, we investigated how sensitive our results would be under different prior distributions. We considered three different prespecified prior distributions of $\tau$: (1) uniform$(0, 2)$, (2) uniform$(0, 5)$, and (3) inverse-gamma$(0.01, 0.01)$ (Turner et al. (2012)). Although the estimates of $\tau$ slightly varied under different prior specifications (and partially due to MC errors as well), posterior distributions of odds ratios were not influenced by different priors and the inference remained the same in network meta-analyses with all outcomes and sensitivity analyses, except two cases: Sensitivity analyses 1 and 5 with the TIMI major bleeding outcome. Note that, Sensitivity analysis 1 had the fully split network and Sensitivity 5 included ISAR-TRIPLE which added large heterogeneity in the TIMI major bleeding outcome. In these two cases, the default prior and the two uniform priors provided similar results, whereas the inverse-gamma prior provided somewhat different posteriors of odds ratios from when using the other priors. We also compared DIC, a measure of model fit analogous to AIC, of models using different prior specifications, but the difference in DIC values was less than 1 unit, which is not a significant difference. Although we do not have a solid explanation about the discrepant results between uniform and inverse-gamma priors for the two specific cases, we reported the results obtained by using the default prior specification in the manuscript as this method has been validated in other network meta-analysis studies.

Reference:


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**eFigure 2.** Summary estimates for safety outcomes from network meta-analysis

Odds ratio (95% credible intervals) between column and row treatment regimens are reported. Odds ratio smaller than 1 means that the odds of having an event for the column treatment regimen is lower than the row treatment regimen. Statistically significant results, where the 95% credible interval does not include 1, are in bold. The estimated between-trial effect heterogeneity and its 95% credible interval (in standard deviation of the log odds ratio scale) from NMA for each outcome is 0.24 (0.01-0.71), 0.35 (0.03, 0.88), 0.46 (0.16, 1.03), and 0.52 (0.02, 1.52).

**eFigure 2A. TIMI major bleeding**

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odds ratio (95% credible interval)</td>
<td>0.45 (0.21; 0.92)</td>
<td>1.44 (0.60; 3.49)</td>
<td>1.41 (0.74; 2.61)</td>
<td>2.31 (1.32; 3.99)</td>
</tr>
<tr>
<td></td>
<td>0.64 (0.31; 1.31)</td>
<td>0.72 (0.34; 1.51)</td>
<td>1.38 (0.66; 2.90)</td>
<td>1.12 (0.53; 2.34)</td>
</tr>
<tr>
<td></td>
<td>0.47 (0.25; 0.85)</td>
<td>1.04 (0.45; 2.40)</td>
<td>1.41 (0.74; 2.61)</td>
<td>1.46 (0.71; 2.78)</td>
</tr>
</tbody>
</table>

**eFigure 2B. TIMI major or minor bleeding**

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odds ratio (95% credible interval)</td>
<td>0.49 (0.26; 0.92)</td>
<td>1.29 (0.58; 2.75)</td>
<td>0.77 (0.36; 1.73)</td>
<td>0.69 (0.36; 1.41)</td>
</tr>
<tr>
<td></td>
<td>0.63 (0.33; 1.17)</td>
<td>1.59 (0.85; 3.11)</td>
<td>1.43 (0.81; 2.62)</td>
<td>2.31 (1.32; 3.99)</td>
</tr>
<tr>
<td></td>
<td>0.43 (0.25; 0.76)</td>
<td>0.54 (0.15; 1.92)</td>
<td>0.49 (0.21; 0.92)</td>
<td>2.05 (1.09; 3.90)</td>
</tr>
</tbody>
</table>

**eFigure 2C. Trial-defined primary safety outcome**

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odds ratio (95% credible interval)</td>
<td>0.69 (0.19; 2.51)</td>
<td>0.64 (0.31; 1.31)</td>
<td>0.72 (0.34; 1.51)</td>
<td>0.69 (0.36; 1.41)</td>
</tr>
<tr>
<td></td>
<td>1.86 (0.52; 6.88)</td>
<td>1.44 (0.60; 3.49)</td>
<td>1.41 (0.74; 2.61)</td>
<td>2.31 (1.32; 3.99)</td>
</tr>
<tr>
<td></td>
<td>2.68 (0.58; 12.77)</td>
<td>1.44 (0.60; 3.49)</td>
<td>1.41 (0.74; 2.61)</td>
<td>2.31 (1.32; 3.99)</td>
</tr>
<tr>
<td></td>
<td>0.37 (0.08; 1.71)</td>
<td>1.04 (0.45; 2.40)</td>
<td>1.41 (0.74; 2.61)</td>
<td>1.46 (0.71; 2.78)</td>
</tr>
</tbody>
</table>

**eFigure 2D. Intracranial hemorrhage**

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y&lt;sub&gt;12&lt;/sub&gt;-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odds ratio (95% credible interval)</td>
<td>0.69 (0.19; 2.51)</td>
<td>0.64 (0.31; 1.31)</td>
<td>0.72 (0.34; 1.51)</td>
<td>0.69 (0.36; 1.41)</td>
</tr>
<tr>
<td></td>
<td>1.86 (0.52; 6.88)</td>
<td>1.44 (0.60; 3.49)</td>
<td>1.41 (0.74; 2.61)</td>
<td>2.31 (1.32; 3.99)</td>
</tr>
<tr>
<td></td>
<td>2.68 (0.58; 12.77)</td>
<td>1.44 (0.60; 3.49)</td>
<td>1.41 (0.74; 2.61)</td>
<td>2.31 (1.32; 3.99)</td>
</tr>
<tr>
<td></td>
<td>0.37 (0.08; 1.71)</td>
<td>1.04 (0.45; 2.40)</td>
<td>1.41 (0.74; 2.61)</td>
<td>1.46 (0.71; 2.78)</td>
</tr>
</tbody>
</table>

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**Figure 3.** Summary estimates for efficacy outcomes from network meta-analysis

Odds ratio (95% credible intervals) between column and row treatment regimens are reported. Odds ratio smaller than 1 means that the odds of having an event for the column treatment regimen is lower than the row treatment regimen. Statistically significant results, where the 95% credible interval does not include 1, are in bold. The estimated between-trial effect heterogeneity and its 95% credible interval (in standard deviation of the log odds ratio scale) from the NMA for each outcome is 0.23 (0.01-0.50), 0.31 (0.01, 0.83), 0.22 (0.01, 0.66), 0.17 (0.01, 0.37), 0.47 (0.03, 0.94), 0.34 (0.01, 0.72), and 0.22 (0.05, 0.43).

**eFigure 3A. MACE**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VKA + DAPT</td>
<td>0.96 (0.60; 1.64)</td>
</tr>
<tr>
<td>VKA + P2Y12-inhibitor</td>
<td>1.04 (0.69; 1.68)</td>
</tr>
<tr>
<td>NOAC + DAPT</td>
<td>0.98 (0.69; 1.66)</td>
</tr>
<tr>
<td>NOAC + P2Y12-inhibitor</td>
<td>0.98 (0.68; 1.52)</td>
</tr>
</tbody>
</table>

**eFigure 3B. All-cause death**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VKA + DAPT</td>
<td>0.64 (0.40; 1.56)</td>
</tr>
<tr>
<td>VKA + P2Y12-inhibitor</td>
<td>1.19 (0.64; 2.50)</td>
</tr>
<tr>
<td>NOAC + DAPT</td>
<td>0.97 (0.51; 1.87)</td>
</tr>
<tr>
<td>NOAC + P2Y12-inhibitor</td>
<td>0.98 (0.58; 1.69)</td>
</tr>
</tbody>
</table>

**eFigure 3C. Cardiovascular death**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VKA + DAPT</td>
<td>0.82 (0.42; 1.49)</td>
</tr>
<tr>
<td>VKA + P2Y12-inhibitor</td>
<td>1.22 (0.67; 2.37)</td>
</tr>
<tr>
<td>NOAC + DAPT</td>
<td>0.88 (0.42; 1.73)</td>
</tr>
<tr>
<td>NOAC + P2Y12-inhibitor</td>
<td>0.90 (0.57; 1.42)</td>
</tr>
</tbody>
</table>

**eFigure 3D. MI**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VKA + DAPT</td>
<td>1.25 (0.77; 1.99)</td>
</tr>
<tr>
<td>VKA + P2Y12-inhibitor</td>
<td>0.80 (0.50; 1.30)</td>
</tr>
<tr>
<td>NOAC + DAPT</td>
<td>0.88 (0.56; 1.39)</td>
</tr>
<tr>
<td>NOAC + P2Y12-inhibitor</td>
<td>0.85 (0.58; 1.23)</td>
</tr>
</tbody>
</table>

**eFigure 3E. Stroke**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VKA + DAPT</td>
<td>1.02 (0.36; 2.66)</td>
</tr>
<tr>
<td>VKA + P2Y12-inhibitor</td>
<td>0.98 (0.38; 2.76)</td>
</tr>
<tr>
<td>NOAC + DAPT</td>
<td>1.12 (0.43; 3.49)</td>
</tr>
<tr>
<td>NOAC + P2Y12-inhibitor</td>
<td>1.30 (0.60; 2.97)</td>
</tr>
</tbody>
</table>

**eFigure 3F. Stent thrombosis**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VKA + DAPT</td>
<td>1.08 (0.46; 2.31)</td>
</tr>
<tr>
<td>VKA + P2Y12-inhibitor</td>
<td>0.93 (0.43; 2.49)</td>
</tr>
<tr>
<td>NOAC + DAPT</td>
<td>1.08 (0.46; 2.49)</td>
</tr>
<tr>
<td>NOAC + P2Y12-inhibitor</td>
<td>0.71 (0.36; 1.40)</td>
</tr>
</tbody>
</table>

**eFigure 3G. Hospitalization**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VKA + DAPT</td>
<td>0.86 (0.57; 1.33)</td>
</tr>
<tr>
<td>VKA + P2Y12-inhibitor</td>
<td>1.17 (0.82; 1.75)</td>
</tr>
<tr>
<td>NOAC + DAPT</td>
<td>1.08 (0.68; 1.66)</td>
</tr>
<tr>
<td>NOAC + P2Y12-inhibitor</td>
<td>1.25 (0.93; 1.71)</td>
</tr>
</tbody>
</table>

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eTable 9. Rank probabilities for safety outcomes

Rank probabilities for each treatment at every ranking position are presented. It reads as probability of being the best treatment, second best, and so on.

### eTable 9A. TIMI major bleeding

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.00</td>
<td>0.29</td>
<td>0.08</td>
<td>0.63</td>
</tr>
<tr>
<td>Second</td>
<td>0.01</td>
<td>0.45</td>
<td>0.25</td>
<td>0.30</td>
</tr>
<tr>
<td>Third</td>
<td>0.11</td>
<td>0.23</td>
<td>0.59</td>
<td>0.07</td>
</tr>
<tr>
<td>Fourth</td>
<td>0.88</td>
<td>0.03</td>
<td>0.09</td>
<td>0.00</td>
</tr>
</tbody>
</table>

### eTable 9B. TIMI major and minor bleeding

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.00</td>
<td>0.32</td>
<td>0.06</td>
<td>0.62</td>
</tr>
<tr>
<td>Second</td>
<td>0.01</td>
<td>0.50</td>
<td>0.19</td>
<td>0.31</td>
</tr>
<tr>
<td>Third</td>
<td>0.06</td>
<td>0.17</td>
<td>0.70</td>
<td>0.07</td>
</tr>
<tr>
<td>Fourth</td>
<td>0.93</td>
<td>0.01</td>
<td>0.05</td>
<td>0.00</td>
</tr>
</tbody>
</table>

### eTable 9C. Trial-defined primary safety outcome

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.00</td>
<td>0.52</td>
<td>0.06</td>
<td>0.42</td>
</tr>
<tr>
<td>Second</td>
<td>0.01</td>
<td>0.35</td>
<td>0.17</td>
<td>0.47</td>
</tr>
<tr>
<td>Third</td>
<td>0.09</td>
<td>0.12</td>
<td>0.69</td>
<td>0.11</td>
</tr>
<tr>
<td>Fourth</td>
<td>0.90</td>
<td>0.01</td>
<td>0.08</td>
<td>0.01</td>
</tr>
</tbody>
</table>

### eTable 9D. Intracranial hemorrhage

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.01</td>
<td>0.01</td>
<td>0.14</td>
<td>0.84</td>
</tr>
<tr>
<td>Second</td>
<td>0.13</td>
<td>0.06</td>
<td>0.67</td>
<td>0.14</td>
</tr>
<tr>
<td>Third</td>
<td>0.63</td>
<td>0.22</td>
<td>0.14</td>
<td>0.01</td>
</tr>
<tr>
<td>Fourth</td>
<td>0.24</td>
<td>0.72</td>
<td>0.05</td>
<td>0.00</td>
</tr>
</tbody>
</table>
**eTable 10.** Rank probabilities for safety outcomes

Rank probabilities for each treatment at any ranking position are presented. It reads as probability of being the best treatment, second best, and so on.

### eTable 10A. Trial-defined primary MACE outcome

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.16</td>
<td>0.32</td>
<td>0.38</td>
<td>0.14</td>
</tr>
<tr>
<td>Second</td>
<td>0.29</td>
<td>0.23</td>
<td>0.24</td>
<td>0.24</td>
</tr>
<tr>
<td>Third</td>
<td>0.33</td>
<td>0.19</td>
<td>0.19</td>
<td>0.29</td>
</tr>
<tr>
<td>Fourth</td>
<td>0.23</td>
<td>0.26</td>
<td>0.19</td>
<td>0.32</td>
</tr>
</tbody>
</table>

### eTable 10B. All-cause death

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.15</td>
<td>0.53</td>
<td>0.17</td>
<td>0.15</td>
</tr>
<tr>
<td>Second</td>
<td>0.31</td>
<td>0.21</td>
<td>0.23</td>
<td>0.26</td>
</tr>
<tr>
<td>Third</td>
<td>0.32</td>
<td>0.14</td>
<td>0.23</td>
<td>0.31</td>
</tr>
<tr>
<td>Fourth</td>
<td>0.22</td>
<td>0.12</td>
<td>0.37</td>
<td>0.29</td>
</tr>
</tbody>
</table>

### eTable 10C. Cardiovascular death

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0.12</td>
<td>0.56</td>
<td>0.27</td>
<td>0.05</td>
</tr>
<tr>
<td>Second</td>
<td>0.31</td>
<td>0.22</td>
<td>0.33</td>
<td>0.14</td>
</tr>
<tr>
<td>Third</td>
<td>0.38</td>
<td>0.12</td>
<td>0.22</td>
<td>0.28</td>
</tr>
<tr>
<td>Fourth</td>
<td>0.19</td>
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</table>

### eTable 10D. MI

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<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
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</thead>
<tbody>
<tr>
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<tr>
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<td>0.28</td>
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### eTable 10E. Stroke

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<td>0.23</td>
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</tr>
<tr>
<td>Fourth</td>
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<td>0.40</td>
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</table>

### eTable 10F. Stent thrombosis

<table>
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<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
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<td>First</td>
<td>0.29</td>
<td>0.23</td>
<td>0.45</td>
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<td>Second</td>
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<tr>
<td>Third</td>
<td>0.26</td>
<td>0.30</td>
<td>0.19</td>
<td>0.25</td>
</tr>
<tr>
<td>Fourth</td>
<td>0.08</td>
<td>0.20</td>
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### eTable 10G. Hospitalization

<table>
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<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
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<td>First</td>
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<td>Second</td>
<td>0.04</td>
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<td>0.34</td>
<td>0.39</td>
</tr>
<tr>
<td>Third</td>
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<td>0.39</td>
<td>0.19</td>
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<tr>
<td>Fourth</td>
<td>0.74</td>
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<td>0.06</td>
<td>0.04</td>
</tr>
</tbody>
</table>
eFigure 4. Cumulative rank probability plot for safety outcomes

**eFigure 4A. TIMI major bleeding**

**eFigure 4B. TIMI major and minor bleeding**

**eFigure 4C. Trial-defined primary safety outcome**

**eFigure 4D. Intracranial hemorrhage**

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eFigure 5. Cumulative rank probability plot for efficacy outcomes

eFigure 5A. Trial-defined primary MACE outcome

eFigure 5B. All-cause death

eFigure 5C. Cardiovascular death

eFigure 5D. MI
eFigure 5E. Stroke

eFigure 5F. Stent thrombosis

eFigure 5G. Hospitalization
eFigure 6. Model diagnostics of the NMA under the assumption of evidence consistency

We checked model convergence using the Gelman-Rubin diagnostics statistics (left) and trace plots (right) for all model parameters. We reported diagnostics for the NMA models under the assumption of evidence consistency for the two primary outcomes. All the other outcomes provided similar results. We found that Gelman-Rubin statistics got close to 1 fast, showing that the four Markov chain Monte Carlo (MCMC) chains mixed well regardless of their different initial starting points. Similarly, trace plots showed that every MCMC chains converged well.

eFigure 6A. TIMI major bleeding outcome

eFigure 6B. MACE outcome
NMA with the assumption of evidence inconsistency
eAppendix 2. Checking the assumption of evidence inconsistency

We assessed statistical evidence inconsistency in our NMA. Evidence inconsistency is defined as discrepancy between direct and indirect comparisons of treatment effects. We applied three methods: (1) loop-specific approach, (2) node-splitting approach, and (3) comparing Bayesian model fit with and without the assumption of evidence inconsistency. We conducted this investigation for the two primary outcomes (TIMI major bleeding and major adverse cardiovascular events [MACE]) under the main network structure. Note that the outputs below used a treatment code as follows: A=VKA+DAPT; B=VKA+P2Y$_{12}$-inhibitor; C=NOAC+DAPT; and D=NOAC+P2Y$_{12}$-inhibitor.

For both outcomes, the loop-specific approach failed to assess evidence inconsistency due to insufficient data (i.e., the small number of trials). The node-splitting approach detected two comparisons (C vs. B and D vs. B) for which we could estimate both direct and indirect comparisons and compare their differences. There were no statistically significant differences for both bleeding and MACE outcomes. Finally, we compared the model fit of Bayesian NMA models with and without the assumption of evidence inconsistency using the deviance information criterion (DIC). DIC measures goodness of fit and an effective number of parameters of a fitted model, similar to the Akaike information criterion. For both outcomes, the two NMA models assuming consistency or inconsistency provided almost identical DIC values and odds ratio estimates, showing neglectable evidence inconsistency.

Results from node-splitting approach
(a) TIMI major bleeding

<table>
<thead>
<tr>
<th>Study</th>
<th>P-value</th>
<th>Odds Ratio (95% CrI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C vs B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>direct</td>
<td></td>
<td>1.4 (0.52, 3.7)</td>
</tr>
<tr>
<td>indirect</td>
<td>0.6075</td>
<td>0.91 (0.21, 4.2)</td>
</tr>
<tr>
<td>network</td>
<td></td>
<td>1.2 (0.57, 2.5)</td>
</tr>
<tr>
<td>D vs B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>direct</td>
<td></td>
<td>0.70 (0.23, 2.1)</td>
</tr>
<tr>
<td>indirect</td>
<td>0.6404</td>
<td>1.0 (0.27, 4.2)</td>
</tr>
<tr>
<td>network</td>
<td></td>
<td>0.85 (0.42, 1.8)</td>
</tr>
</tbody>
</table>

(b) MACE
<table>
<thead>
<tr>
<th>Study</th>
<th>P-value</th>
<th>Odds Ratio (95% CrI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C vs B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>direct</td>
<td></td>
<td>0.84 (0.48, 1.5)</td>
</tr>
<tr>
<td>indirect</td>
<td>0.1687</td>
<td>1.6 (0.68, 3.9)</td>
</tr>
<tr>
<td>network</td>
<td></td>
<td>0.97 (0.59, 1.7)</td>
</tr>
<tr>
<td><strong>D vs B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>direct</td>
<td></td>
<td>0.85 (0.47, 1.5)</td>
</tr>
<tr>
<td>indirect</td>
<td>0.0894</td>
<td>1.9 (0.86, 4.1)</td>
</tr>
<tr>
<td>network</td>
<td></td>
<td>1.0 (0.66, 1.8)</td>
</tr>
</tbody>
</table>

**eAppendix 3. Sensitivity analyses**
eAppendix 3A Sensitivity analysis 1

This network did not lump any treatment regimen groups. Api=apixaban; Dabi(H)= dabigatran etexilate 150mg; Dabi(L)=dabigatran etexilate 110mg; DAPT= dual antiplatelet therapy; Riva=rivaroxaban; VKA=vitamin K antagonist

Figure A. Network of treatment strategies

Table A. League table of summary estimates

Odds ratio smaller than 1 means that the odds of having an event for the column treatment regimen is lower than the row treatment regimen. Statistically significant results, where the 95% credible interval does not include 1, are in bold. Upper triangle is for TIMI major bleeding and lower triangle is for MACE. The estimated between-trial effect heterogeneity and its 95% credible interval (in standard deviation of the log odds ratio scale) for the TIMI major bleeding and MACE outcomes is 0.40 (0.02, 0.93) and 0.34 (0.07, 0.52), respectively.

<table>
<thead>
<tr>
<th>VKA + DAPT</th>
<th>0.36 (0.11; 1.20)</th>
<th>0.54 (0.16; 1.75)</th>
<th>0.58 (0.24; 1.39)</th>
<th>0.82 (0.28; 2.46)</th>
<th>0.42 (0.13; 1.31)</th>
<th>0.58 (0.16; 1.99)</th>
<th>0.68 (0.20; 2.34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.86 (0.39; 1.92)</td>
<td>Dabi(L) + P2Y12-Inhibitor</td>
<td>1.49 (0.43; 5.16)</td>
<td>1.60 (0.36; 7.03)</td>
<td>2.27 (0.44; 11.47)</td>
<td>1.15 (0.22; 6.05)</td>
<td>1.58 (0.28; 8.85)</td>
<td>1.90 (0.34; 10.49)</td>
</tr>
<tr>
<td>1.15 (0.52; 2.59)</td>
<td>Dabi(H) + P2Y12-Inhibitor</td>
<td>1.07 (0.25; 4.66)</td>
<td>1.52 (0.31; 7.69)</td>
<td>0.77 (0.15; 4.06)</td>
<td>1.06 (0.19; 5.93)</td>
<td>1.27 (0.23; 6.96)</td>
<td></td>
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<tr>
<td>1.11 (0.61; 2.03)</td>
<td>VKA + P2Y12-Inhibitor</td>
<td>0.95 (0.36; 2.64)</td>
<td>1.42 (0.47; 4.35)</td>
<td>0.72 (0.22; 2.29)</td>
<td>0.99 (0.21; 4.57)</td>
<td>1.19 (0.26; 5.31)</td>
<td></td>
</tr>
<tr>
<td>1.11 (0.52; 2.41)</td>
<td>Api + DAPT</td>
<td>0.96 (0.32; 2.94)</td>
<td>1.01 (0.46; 2.16)</td>
<td>0.51 (0.15; 1.70)</td>
<td>0.70 (0.13; 3.74)</td>
<td>0.84 (0.16; 4.35)</td>
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<tr>
<td>1.09 (0.51; 2.39)</td>
<td>Api + P2Y12-Inhibitor</td>
<td>0.94 (0.31; 2.89)</td>
<td>0.99 (0.45; 2.12)</td>
<td>0.99 (0.43; 2.25)</td>
<td>0.99 (0.43; 2.25)</td>
<td>1.38 (0.25; 7.54)</td>
<td>1.65 (0.31; 8.85)</td>
</tr>
<tr>
<td>1.01 (0.42; 2.44)</td>
<td>Riva + DAPT</td>
<td>0.88 (0.26; 2.89)</td>
<td>0.92 (0.31; 2.64)</td>
<td>0.91 (0.28; 2.92)</td>
<td>0.98 (0.28; 2.97)</td>
<td>0.98 (0.28; 2.97)</td>
<td>1.20 (0.33; 4.26)</td>
</tr>
</tbody>
</table>
Table B. Rank probability

<table>
<thead>
<tr>
<th>TIMI major bleeding</th>
<th>VKA + DAPT</th>
<th>Dabi(L) + P2Y12-inhibitor</th>
<th>Dabi(H) + P2Y12-inhibitor</th>
<th>VKA + P2Y12-inhibitor</th>
<th>Api + DAPT</th>
<th>Api + P2Y12-inhibitor</th>
<th>Riva + DAPT</th>
<th>Riva + P2Y12-inhibitor</th>
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<td>0.06</td>
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<tr>
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<td>0.17</td>
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<td>0.09</td>
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<tr>
<td>3rd</td>
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<td>0.18</td>
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<tr>
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<td>0.13</td>
<td>0.15</td>
<td>0.14</td>
</tr>
<tr>
<td>5th</td>
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<td>0.06</td>
<td>0.14</td>
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<td>0.09</td>
<td>0.14</td>
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<td>0.12</td>
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<td>0.05</td>
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<tr>
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<td>0.03</td>
<td>0.24</td>
<td>0.02</td>
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Table C. SUCRA values for each treatment regimen and outcomes
The larger the SUCRA value (darker color) the better the treatment regimen performance with respect to the outcome.

<table>
<thead>
<tr>
<th>MACE</th>
<th>VKA + DAPT</th>
<th>Dabi(L) + P2Y12-inhibitor</th>
<th>Dabi(H) + P2Y12-inhibitor</th>
<th>VKA + P2Y12-inhibitor</th>
<th>Api + DAPT</th>
<th>Api + P2Y12-inhibitor</th>
<th>Riva + DAPT</th>
<th>Riva + P2Y12-inhibitor</th>
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<tbody>
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<td>0.16</td>
<td>0.17</td>
<td>0.08</td>
</tr>
<tr>
<td>2nd</td>
<td>0.06</td>
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<td>0.15</td>
<td>0.11</td>
<td>0.08</td>
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<td>0.12</td>
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<td>0.08</td>
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<td>0.11</td>
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<td>0.10</td>
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<td>0.10</td>
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<td>0.18</td>
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<tr>
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<td>0.06</td>
<td>0.05</td>
<td>0.08</td>
<td>0.09</td>
<td>0.13</td>
<td>0.28</td>
</tr>
</tbody>
</table>

Figure B. Forest plot of summary estimates

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Figure C. Odds ratio for bleeding and MACE

- VKA + DAPT
- Dabigatran (Low) + P2Y₁₂-inhibitor
- Dabigatran (High) + P2Y₁₂-inhibitor
- VKA + P2Y₁₂-Inhibitor
- Apixaban + DAPT
- Apixaban + P2Y₁₂-inhibitor
- Rivaroxaban + DAPT
- Rivaroxaban + P2Y₁₂-inhibitor

- 95% CI for TIMI major bleeding
- 95% CI for MACE
eAppendix 3B. Sensitivity analysis 2
This network lumped rivaroxaban and apixaban assuming they had comparable efficacy and safety as they are Xa inhibitor agents. Dabi(H)= dabigatran etexilate 150mg; Dabi(L)=dabigatran etexilate 110mg; DAPT= dual antiplatelet therapy; VKA=vitamin K antagonist

Figure A. Network of treatment strategies

Table A. League table of summary estimates
Odds ratio smaller than 1 means that the odds of having an event for the column treatment regimen is lower than the row treatment regimen. Statistically significant results, where the 95% credible interval does not include 1, are in bold. Upper triangle is for TIMI major bleeding and lower triangle is for MACE. The estimated between-trial effect heterogeneity and its 95% credible interval (in standard deviation of the log odds ratio scale) for the TIMI major bleeding and MACE outcomes is 0.34 (0.01, 0.89) and 0.27 (0.02, 0.51), respectively.

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>Dabi(L) + P2Y12-inhibitor</th>
<th>Dabi(H) + P2Y12-inhibitor</th>
<th>VKA + P2Y12-inhibitor</th>
<th>Xa-inhibitor + DAPT</th>
<th>Xa-inhibitor + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>VKA + DAPT</td>
<td>0.86 (0.43; 1.73)</td>
<td>0.54 (0.18; 1.52)</td>
<td>0.59 (0.28; 1.25)</td>
<td>0.71 (0.33; 1.46)</td>
<td>0.54 (0.25; 1.14)</td>
<td></td>
</tr>
<tr>
<td>Dabi(L) + P2Y12-inhibitor</td>
<td>1.15 (0.57; 2.34)</td>
<td>1.49 (0.48; 4.62)</td>
<td>1.63 (0.44; 6.05)</td>
<td>1.97 (0.53; 7.17)</td>
<td>1.49 (0.40; 5.47)</td>
<td></td>
</tr>
<tr>
<td>Dabi(H) + P2Y12-inhibitor</td>
<td>1.22 (0.53; 2.97)</td>
<td>1.22 (0.39; 2.23)</td>
<td>1.32 (0.36; 4.76)</td>
<td>1.00 (0.27; 3.71)</td>
<td>1.49 (0.40; 5.47)</td>
<td></td>
</tr>
<tr>
<td>VKA + P2Y12-inhibitor</td>
<td>1.06 (0.65; 1.80)</td>
<td>1.22 (0.53; 2.97)</td>
<td>1.21 (0.49; 2.92)</td>
<td>1.21 (0.49; 2.92)</td>
<td>0.91 (0.37; 2.25)</td>
<td></td>
</tr>
<tr>
<td>Xa-inhibitor + DAPT</td>
<td>1.07 (0.64; 1.80)</td>
<td>1.25 (0.53; 2.94)</td>
<td>1.01 (0.55; 1.80)</td>
<td>0.76 (0.35; 1.68)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xa-inhibitor + P2Y12-inhibitor</td>
<td>0.99 (0.59; 1.67)</td>
<td>1.15 (0.49; 2.72)</td>
<td>0.94 (0.51; 1.67)</td>
<td>0.94 (0.51; 1.67)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table B. Rank probability

<table>
<thead>
<tr>
<th>TIMI major bleeding</th>
<th>VKA + DAPT</th>
<th>Dabi(L) + P2Y₁₂-inhibitor</th>
<th>Dabi(H) + P2Y₁₂-inhibitor</th>
<th>VKA + P2Y₁₂-inhibitor</th>
<th>Xa-inhibitor + DAPT</th>
<th>Xa-inhibitor + P2Y₁₂-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>0.00</td>
<td>0.60</td>
<td>0.14</td>
<td>0.09</td>
<td>0.03</td>
<td>0.14</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>0.00</td>
<td>0.19</td>
<td>0.29</td>
<td>0.19</td>
<td>0.07</td>
<td>0.25</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>0.01</td>
<td>0.09</td>
<td>0.19</td>
<td>0.26</td>
<td>0.15</td>
<td>0.29</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>0.06</td>
<td>0.06</td>
<td>0.16</td>
<td>0.25</td>
<td>0.26</td>
<td>0.21</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt;</td>
<td>0.20</td>
<td>0.03</td>
<td>0.15</td>
<td>0.16</td>
<td>0.37</td>
<td>0.09</td>
</tr>
<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt;</td>
<td>0.72</td>
<td>0.02</td>
<td>0.08</td>
<td>0.05</td>
<td>0.12</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Table C. SUCRA values for each treatment regimen and outcomes
The larger the SUCRA value (darker color) the better the treatment regimen performance with respect to the outcome.

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>Dabi(L) + P2Y₁₂-inhibitor</th>
<th>Dabi(H) + P2Y₁₂-inhibitor</th>
<th>VKA + P2Y₁₂-inhibitor</th>
<th>Xa-inhibitor + DAPT</th>
<th>Xa-inhibitor + P2Y₁₂-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIMI (major)</td>
<td>7.0</td>
<td>83.6</td>
<td>58.0</td>
<td>53.0</td>
<td>35.4</td>
<td>61.6</td>
</tr>
<tr>
<td>MACE</td>
<td>46.4</td>
<td>27.4</td>
<td>67.2</td>
<td>55.2</td>
<td>58.2</td>
<td>44.8</td>
</tr>
</tbody>
</table>

Figure B. Forest plot of summary estimates
Figure C. Odds ratio for bleeding and MACE

- VKA + DAPT
- Dabigatran (Low) + P2Y₁₂-Inhibitor
- Dabigatran (High) + P2Y₁₂-Inhibitor
- VKA + P2Y₁₂-inhibitor
- Xa-inhibitor + DAPT
- Xa-Inhibitor + P2Y₁₂-inhibitor

- 95% CI for TIMI major bleeding
- 95% CI for MACE
eAppendix 3C. Sensitivity analysis 3
Given the network used in sensitivity analysis 3, we lumped two dabigatran groups having different doses. Dabi= dabigatran etexilate; DAPT= dual antiplatelet therapy; Riva=rivaroxaban; VKA=vitamin K antagonist

Figure A. Network of treatment strategies

Table A. League table of summary estimates
Odds ratio smaller than 1 means that the odds of having an event for the column treatment regimen is lower than the row treatment regimen. Statistically significant results, where the 95% credible interval does not include 1, are in bold. Upper triangle is for TIMI major bleeding and lower triangle is for MACE. The estimated between-trial effect heterogeneity and its 95% credible interval (in standard deviation of the log odds ratio scale) for the TIMI major bleeding and MACE outcomes is 0.30 (0.01, 0.76) and 0.28 (0.03, 0.51), respectively.

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>Dabi + P2Y12-inhibitor</th>
<th>VKA + DAPT</th>
<th>Dabi + P2Y12-inhibitor</th>
<th>Xa-inhibitor + P2Y12-inhibitor</th>
<th>Xa-inhibitor + DAPT</th>
<th>Xa-inhibitor + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>VKA + DAPT</td>
<td>0.44</td>
<td>1.32</td>
<td>0.59</td>
<td>1.60</td>
<td>1.22</td>
<td>0.90</td>
<td>0.92</td>
</tr>
<tr>
<td></td>
<td>(0.18; 1.12)</td>
<td>(0.42; 4.18)</td>
<td>(0.29; 1.17)</td>
<td>(0.50; 4.95)</td>
<td>(0.53; 2.75)</td>
<td>(0.39; 2.12)</td>
<td>(0.36; 1.58)</td>
</tr>
<tr>
<td>Dabi + P2Y12-inhibitor</td>
<td>0.97</td>
<td>1.09</td>
<td>0.71</td>
<td>1.01</td>
<td>1.01</td>
<td>0.75</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td>(0.49; 1.93)</td>
<td>(0.47; 2.61)</td>
<td>(0.36; 1.38)</td>
<td>(0.54; 1.80)</td>
<td>(0.54; 1.80)</td>
<td>(0.36; 1.58)</td>
<td>(0.36; 1.58)</td>
</tr>
<tr>
<td>Xa-inhibitor + P2Y12-inhibitor</td>
<td>1.05</td>
<td>1.11</td>
<td>0.71</td>
<td>0.93</td>
<td>0.93</td>
<td>0.75</td>
<td>0.93</td>
</tr>
<tr>
<td></td>
<td>(0.65; 1.80)</td>
<td>(0.47; 2.61)</td>
<td>(0.36; 1.38)</td>
<td>(0.50; 1.67)</td>
<td>(0.50; 1.67)</td>
<td>(0.36; 1.58)</td>
<td>(0.50; 1.67)</td>
</tr>
<tr>
<td>Xa-inhibitor + DAPT</td>
<td>1.07</td>
<td>1.02</td>
<td>0.53</td>
<td>0.92</td>
<td>0.92</td>
<td>0.75</td>
<td>0.92</td>
</tr>
<tr>
<td></td>
<td>(0.64; 1.80)</td>
<td>(0.43; 2.41)</td>
<td>(0.36; 1.58)</td>
<td>(0.54; 1.57)</td>
<td>(0.54; 1.57)</td>
<td>(0.36; 1.58)</td>
<td>(0.54; 1.57)</td>
</tr>
</tbody>
</table>

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### Table B. Rank probability

<table>
<thead>
<tr>
<th>TIMI major bleeding</th>
<th>VKA + DAPT</th>
<th>Dabi + P2Y12-inhibitor</th>
<th>VKA + P2Y12-inhibitor</th>
<th>Xa-inhibitor + DAPT</th>
<th>Xa-inhibitor + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>0.00</td>
<td>0.55</td>
<td>0.15</td>
<td>0.04</td>
<td>0.25</td>
</tr>
<tr>
<td>2nd</td>
<td>0.01</td>
<td>0.20</td>
<td>0.30</td>
<td>0.13</td>
<td>0.37</td>
</tr>
<tr>
<td>3rd</td>
<td>0.04</td>
<td>0.13</td>
<td>0.32</td>
<td>0.26</td>
<td>0.26</td>
</tr>
<tr>
<td>4th</td>
<td>0.17</td>
<td>0.09</td>
<td>0.19</td>
<td>0.45</td>
<td>0.10</td>
</tr>
<tr>
<td>5th</td>
<td>0.79</td>
<td>0.03</td>
<td>0.04</td>
<td>0.12</td>
<td>0.02</td>
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</table>

<table>
<thead>
<tr>
<th>MACE</th>
<th>VKA + DAPT</th>
<th>Dabi + P2Y12-inhibitor</th>
<th>VKA + P2Y12-inhibitor</th>
<th>Xa-inhibitor + DAPT</th>
<th>Xa-inhibitor + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>0.09</td>
<td>0.23</td>
<td>0.25</td>
<td>0.28</td>
<td>0.15</td>
</tr>
<tr>
<td>2nd</td>
<td>0.22</td>
<td>0.13</td>
<td>0.22</td>
<td>0.23</td>
<td>0.19</td>
</tr>
<tr>
<td>3rd</td>
<td>0.29</td>
<td>0.12</td>
<td>0.20</td>
<td>0.19</td>
<td>0.20</td>
</tr>
<tr>
<td>4th</td>
<td>0.28</td>
<td>0.15</td>
<td>0.17</td>
<td>0.17</td>
<td>0.22</td>
</tr>
<tr>
<td>5th</td>
<td>0.12</td>
<td>0.36</td>
<td>0.16</td>
<td>0.12</td>
<td>0.23</td>
</tr>
</tbody>
</table>

### Table C. SUCRA values for each treatment regimen and outcomes
The larger the SUCRA value (darker color) the better the treatment regimen performance with respect to the outcome.

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>Dabi + P2Y12-inhibitor</th>
<th>VKA + P2Y12-inhibitor</th>
<th>Xa-inhibitor + DAPT</th>
<th>Xa-inhibitor + P2Y12-inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIMI (major)</td>
<td>7.0</td>
<td>78.8</td>
<td>58.3</td>
<td>38.0</td>
<td>68.3</td>
</tr>
<tr>
<td>MACE</td>
<td>47.0</td>
<td>42.5</td>
<td>55.8</td>
<td>59.0</td>
<td>44.8</td>
</tr>
</tbody>
</table>

### Figure B. Forest plot of summary estimates
Figure C. Odds ratio for bleeding and MACE
eAppendix 3D. Sensitivity analysis 4
This network compares double antithrombotic treatment (DAT) and triple antithrombotic treatment (TAT).

Figure A. Network

Table A. League table of summary estimates
Odds ratio smaller than 1 means that the odds of having an event for the column treatment regimen is lower than the row treatment regimen. Statistically significant results, where the 95% credible interval does not include 1, are in bold. Upper triangle is for TIMI major bleeding and lower triangle is for MACE. The estimated between-trial effect heterogeneity and its 95% credible interval (in standard deviation of the log odds ratio scale) for the TIMI major bleeding and MACE outcomes is 0.28 (0.01,0.73) and 0.23 (0.01, 0.50), respectively.

<table>
<thead>
<tr>
<th></th>
<th>TAT</th>
<th>DAT</th>
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</thead>
<tbody>
<tr>
<td>TAT</td>
<td>0.58</td>
<td>(0.36; 0.92)</td>
</tr>
<tr>
<td></td>
<td>1.01</td>
<td>(0.74; 1.43)</td>
</tr>
<tr>
<td>DAT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table B. Rank probability

<table>
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<tr>
<th>TIMI major bleeding</th>
<th>TAT</th>
<th>DAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>0.01</td>
<td>0.99</td>
</tr>
<tr>
<td>2nd</td>
<td>0.99</td>
<td>0.01</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MACE</th>
<th>TAT</th>
<th>DAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>0.50</td>
<td>0.50</td>
</tr>
<tr>
<td>2nd</td>
<td>0.50</td>
<td>0.50</td>
</tr>
</tbody>
</table>

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Table C. SUCRA values for each treatment regimen and outcomes
The larger the SUCRA value (darker color) the better the treatment regimen performance with respect to the outcome.

<table>
<thead>
<tr>
<th></th>
<th>TAT</th>
<th>DAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIMI (major)</td>
<td>1.0</td>
<td>99.0</td>
</tr>
<tr>
<td>MACE</td>
<td>50.0</td>
<td>50.0</td>
</tr>
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</table>

Figure B. Forest plot of summary estimates

Figure C. Odds ratio for bleeding and MACE
eAppendix 3E. Sensitivity analysis 5
The landmark analysis results of ISAR-TRIPLE were included in the main network analysis. DAPT= dual antiplatelet therapy; NOAC= non-vitamin K oral anticoagulant; VKA=vitamin K antagonist

Figure A. Network of treatment strategies

Table A. League table of summary estimates
Odds ratio smaller than 1 means that the odds of having an event for the column treatment regimen is lower than the row treatment regimen. Statistically significant results, where the 95% credible interval does not include 1, are in bold. Upper triangle is for TIMI major bleeding and lower triangle is for MACE. The estimated between-trial effect heterogeneity and its 95% credible interval (in standard deviation of the log odds ratio scale) for the TIMI major bleeding and MACE outcomes is 0.25 (0.01, 0.71) and 0.27 (0.02, 0.73), respectively.

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y12-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y12-inhibitor</th>
<th>VKA + Aspirin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VKA + DAPT</strong></td>
<td></td>
<td>0.58 (0.30; 1.08)</td>
<td>0.70 (0.38; 1.25)</td>
<td>0.50 (0.30; 0.83)</td>
<td>0.99 (0.29; 3.46)</td>
</tr>
<tr>
<td>1.05 (0.63; 1.86)</td>
<td></td>
<td>1.21 (0.57; 2.56)</td>
<td>0.86 (0.42; 1.80)</td>
<td>1.72 (0.43; 7.10)</td>
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</tr>
<tr>
<td>1.06 (0.63; 1.82)</td>
<td>1.01 (0.52; 1.86)</td>
<td>0.94 (0.50; 1.65)</td>
<td>0.71 (0.38; 1.36)</td>
<td>1.42 (0.36; 5.70)</td>
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<tr>
<td>0.98 (0.63; 1.52)</td>
<td></td>
<td>0.92 (0.54; 1.57)</td>
<td></td>
<td>1.99 (0.53; 7.69)</td>
<td></td>
</tr>
<tr>
<td>2.80 (0.74; 12.3)</td>
<td>2.66 (0.63; 12.68)</td>
<td>2.64 (0.63; 12.68)</td>
<td>2.68 (0.7; 13.33)</td>
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<td></td>
</tr>
</tbody>
</table>
### Table B. Rank probability

<table>
<thead>
<tr>
<th>TIMI major bleeding</th>
<th>VKA + DAPT</th>
<th>VKA + P2Y₁₂-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y₁₂-inhibitor</th>
<th>VKA + Aspirin</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>0.00</td>
<td>0.26</td>
<td>0.07</td>
<td>0.56</td>
<td>0.11</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>0.01</td>
<td>0.38</td>
<td>0.21</td>
<td>0.32</td>
<td>0.09</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>0.06</td>
<td>0.25</td>
<td>0.46</td>
<td>0.10</td>
<td>0.12</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>0.48</td>
<td>0.09</td>
<td>0.21</td>
<td>0.02</td>
<td>0.20</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt;</td>
<td>0.45</td>
<td>0.02</td>
<td>0.05</td>
<td>0.00</td>
<td>0.48</td>
</tr>
</tbody>
</table>

### Table C. SUCRA values for each treatment regimen and outcomes

The larger the SUCRA value (darker color) the better the treatment regimen performance with respect to the outcome.

<table>
<thead>
<tr>
<th></th>
<th>VKA + DAPT</th>
<th>VKA + P2Y₁₂-inhibitor</th>
<th>NOAC + DAPT</th>
<th>NOAC + P2Y₁₂-inhibitor</th>
<th>VKA + Aspirin</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIMI (major)</td>
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<td>69.3</td>
<td>51.0</td>
<td>85.5</td>
<td>28.8</td>
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<td>MACE</td>
<td>36.3</td>
<td>43.3</td>
<td>46.8</td>
<td>32.5</td>
<td>92.5</td>
</tr>
</tbody>
</table>

### Figure B. Forest plot of summary estimates

Odds ratio for TIMI major bleeding

Odds ratio for MACE
Figure C. Odds ratio for bleeding and MACE