



APAC Community Call

April 17, 2025



Agenda

- OHDSI APAC News
- OHDSI Global News
- OHDSI Global's Guideline-Driven Evidence Generation Initiative



OHDSI APAC News

Congratulations!
The Book of OHDSI Japan has been published!!



<https://ohdsi.github.io/TheBookOfOhdsiInJapanese/>



OHDSI

OBSERVATIONAL HEALTH DATA SCIENCES AND INFORMATICS

Who We Are ▾

Community Calls ▾

CBER Best Seminars

Updates & News ▾

Past Events ▾

2024 Global Symposium ▾

Standards

Workgroups ▾

Guideline Opportunities

Software Tools ▾

2024 'Our Journey' Annual Report

Github

Network Studies ▾

Current OHDSI Events

YouTube

Community Forums ▾

Past Presentations (2015-2021)

Twitter

Education ▾

EHDEN Academy

ATLAS Tutorials

New To OHDSI? ▾

Book of OHDSI

2023 SOS Challenge (Network Studies)

Book of OHDSI (English Version)

Book of OHDSI (Korean Version)

Book of OHDSI (Chinese Version)

Book of OHDSI (Japanese Version)

Order The Book of OHDSI (Amazon)

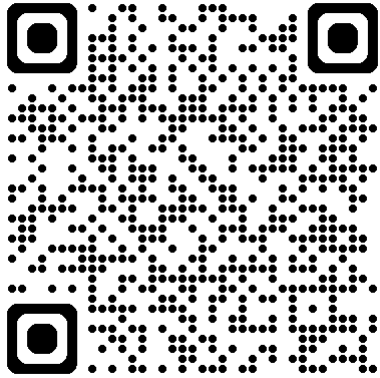
2024 OHDSI APAC Symposium

December 4-8 • Marina Bay Sands & National University of Singapore (NUS)



OHDSI APAC News

- First APAC newsletter of 2025 has been released
- Entirely prepared by Keiko Asao from Japan – thank you for your contribution!



<https://mailchi.mp/ohdsi/apac-2025-q1-newsletter>

► Spotlight on Japan: ATLAS Training Workshop Held in Tokyo

- On February 25, 2025, a hands-on ATLAS training workshop was successfully held at the Tokyo Metropolitan Industrial Trade Center.
- Sixteen participants joined the 4-hour session to learn about OMOP-CDM fundamentals and gain practical experience in cohort creation and data analysis using ATLAS.
- The event was hosted by FedAna and OHDSI Japan, with operations led by Kappa Medical. The training aimed to cultivate future ATLAS users in Japan and expand local capacity for real-world evidence generation.

OHDSI ATLASトレーニング
OMOP CDM形式のデータの解析スキルを習得するためのトレーニング

日程 2025年2月25日(火)
時間 13:30～17:30 (受付13:00～)
場所 東京都立産業貿易センター浜松町館

参加費 4,000円 / 定員16名 定員になり次第締め切ります





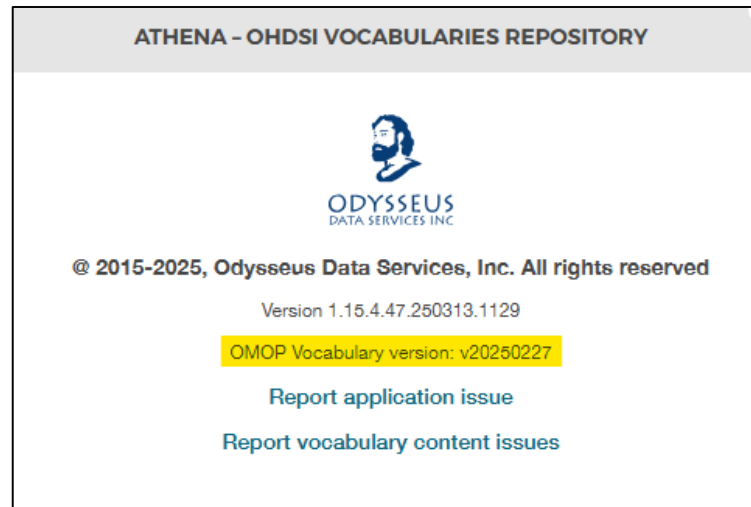
OHDSI APAC News

- Thank you to all OHDSI China collaborators who presented their study proposals at the March community call!
- The following studies have been selected by the APAC community to focus on as a community effort:
 - **Safety Outcomes of Semaglutide in Type 2 Diabetes Using Regional Health Data: A Target Trial Emulation** by Yonggi Zheng
 - **Association Between Fasting Plasma Glucose Levels and Annual Hospitalization Days: A Multicenter Study Using the OHDSI Framework** by Jiaqi Liu
 - **Studying the Disease Trajectory of Type 2 Diabetes with Transformer-based Model** by Sihui Luo



OHDSI Global News

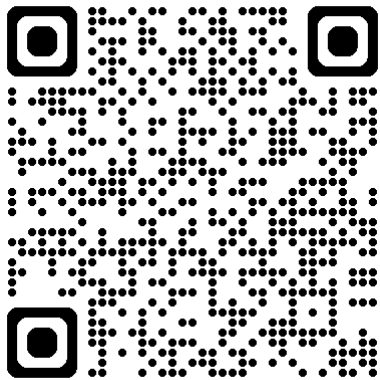
- Latest update of OMOP Standardized Vocabularies has been released
- Adds new drugs, procedures and lab tests, improved mappings for conditions, and expanded hierarchies
- Full release notes available at https://github.com/OHDSI/Vocabulary-v5.0/releases/tag/v20250227_1740652703.000000





OHDSI Global News

- DevCon 2025 will be held on April 25, 9 a.m. to 2 p.m. ET
- More details and link to the event are available at <https://ohdsi.org/devcon2025/>



Agenda

9:00 – 9:15am ET • Welcome & Introduction

- Paul Nagy, Johns Hopkins University

9:15 – 11:30am ET • OHDSI Projects Lightning Talks

- Stabilizing Gaia Core – Robert Miller, Miller Data Solutions
- CustomVocabularyBuilder – Jared Houghtaling, Tufts University
- CohortConstructor – Núria Mercadé-Besora, University of Oxford
- Updates on Strategus – Anthony Sena, Johnson & Johnson
- Experiences with SQLMesh/CICD integration with Databricks – Vishnu Chandrabalan, Lancashire Teaching Hospitals NHS Foundation Trust
- Updates from the Technical Advisory Board – Frank Defalco, Johnson & Johnson

11:30 – 12:30pm ET • Developer dialogue: Dev ops, DBT and, of course, LLMs

Moderator: Katy Sadowski, Boehringer Ingelheim

- Eduard Korchmar, EPAM Systems
- Egill Fríðgeirsson, Erasmus MC
- Martin Lavalley, Boehringer Ingelheim
- Lawrence Adams, Artificial Intelligence Centre for Value Based Healthcare

12:30 – 1:00pm ET • Break

1:00 – 2:00pm ET • Sustainable Open-Source Ecosystems Panel

Moderator: Paul Nagy, Sean O'Reilly

- Data4Life – Peter Hoffmann
- The Hyve – Jan Blom/Wouter Franke
- Cognome – James Green



OHDSI Global News

**OHDSI Global Symposium Set for October 7-9
at Hyatt Regency Hotel in NJ, USA**

SAVE THE DATE: Collaborator Showcase
Submissions will be due July 1!

Agenda and registration will be shared when
available





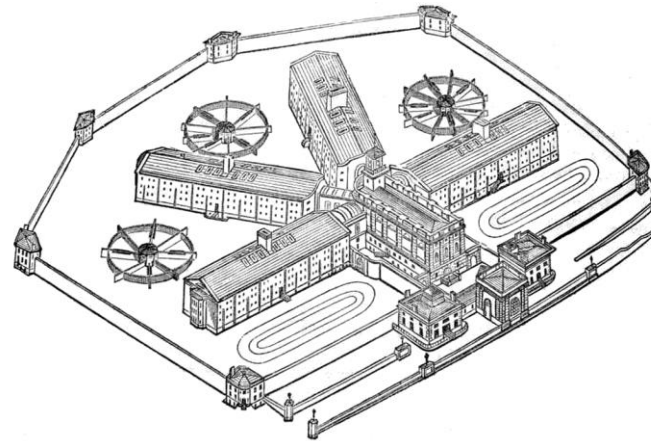
OHDSI Global News

Europe Symposium registration is open!
July 5-7 at “Old Prison” in Hasselt, Belgium

Registrations will close after June 16

Event landing page: <https://www.ohdsi-europe.org/symposium-event>

Registration page: <https://forms.gle/STSJZ7KH6hAJKv9H9>



OHDSI EUROPE SYMPOSIUM 2025

**Join the Network: Advancing Federated
Real-World Evidence in Europe**

Symposium Agenda – July 7, 2025

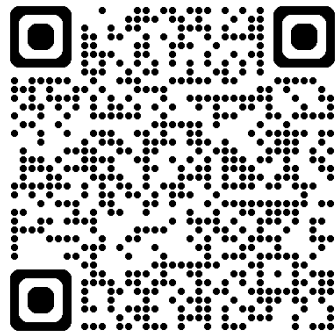
Time	Topic	
8:00 – 9:00	Registration & Coffee	
9:00 – 9:10	Welcome to the European OHDSI Journey	
9:10 – 9:30	Journey of OHDSI: Where have we been and where can we go together?	
9:30 – 11:00	Impact of Leveraging OMOP CDM for Scalable and Reliable Evidence Generation Showcased by the National Nodes	
11:00 – 11:30	Coffee Break	
11:30 – 12:45	Collaborator Showcase: Rapid Fire Presentations	
12:45 – 13:45	Lunch	
13:45 – 16:00	OHDSI Collaborator Showcase	Early Investigator Mentor Meeting (14:00 – 15:00)
16:00 – 17:10	Bridging Policy and Practice: OHDSI's Role in Implementing the European Health Data Space (Panel debate)	
17:10 – 17:30	Closing remarks	



OHDSI Global News

Join OHDSI Global's Guideline-driven Evidence Generation Initiative!

For more information on the initiative and selected studies, please visit:



<https://ohdsi.org/clinical-guideline-evidence-opportunities-2025/>

Community Presents Clinical Guideline Evidence Opportunities for 2025; Learn More and Share Your Potential Interest in Collaboration

Clinical guidelines not only offer treatment recommendations for healthcare providers but also highlight evidence gaps that could shape critical questions for both clinicians and patients. The OHDSI community aimed to identify these gaps and explore how they could be addressed through network studies across the OHDSI Evidence Network.

Throughout January, collaborators around the world [highlighted such gaps in a forum thread](#) and joined a community call to provide a brief description of the gap and why OHDSI is positioned to generate reliable and informative real-world evidence. Please check out the videos below or [read about these evidence opportunities](#), and then fill out the brief form below to share your interest in joining one or multiple studies.

[Join a Guideline Evidence Generation Network Study](#)

Video Presentations

Obesity Management

Presenter: Chungsoo Kim

Anesthesia Post-Operative Care

Presenter: Oleg Zhuk



OHDSI Global News

OHDSI 2025 Guideline-driven evidence collaboration opportunities

In 2025, the OHDSI community is engaged in a community-wide effort to identify guideline-driven evidence opportunities that we can meaningfully contribute to by designing and executing network studies together. Throughout Jan 2025, leaders in our community offered research opportunities on the forums (<https://forums.ohdsi.org/t/guideline-driven-evidence-generation-opportunities/23029>) and during Community Calls (<https://ohdsi.org/community-calls-2025/>). We seek your input on which of these opportunities you are interested in engaging with, so we can prioritize the community's efforts together.

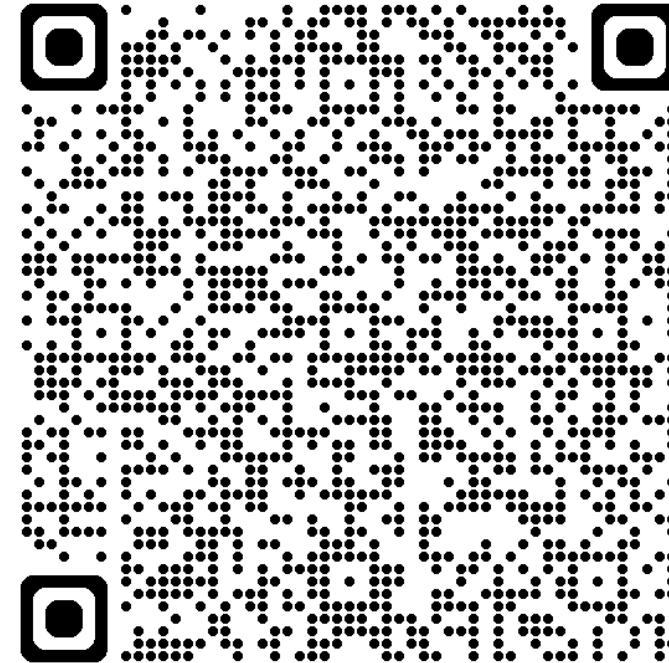
* Required

1. Name *

2. Email (to be used to connect with study leads) *

3. Which guideline-driven evidence opportunities would you like to contribute to (check all that apply) *

- ☐ Obesity management - Chungsoo Kim
- ☐ Anesthesia post-operative care - Oleg Zhuk



<https://forms.office.com/pages/responsepage.aspx?id=IAAPoyCRq0q6TOVQkCOy1dASOXn2aCVJpwpY4vxZsSdURVhXMk1LTzRFMUMzM1czMUNWV0xXQzA5MyQlQCN0PWcu>



Guideline-Driven Evidence 2025: Ticagrelor Vs. Prasugrel

OHDSI APAC Community Call

Apr. 17, 2025

Chang Hoon Han



About Myself

Chang Hoon Han

- ✓ Pediatrician & Data scientist in training
- ✓ Dr. Chan's Lab, Yonsei University
- ✓ Interested in ...
 - Common data model & network studies
 - Pediatric pulmonology & intensive care
- ✓ One of study leads in GDE 2025





Guideline-Driven Evidence 2025

Today's Goal

- ✓ Share the context and current progress of **GDE 2025**
- ✓ Promote the study,
antiplatelet use in ACS undergoing PCI:
Ticagrelor vs. Prasugrel



Guideline-Driven Evidence 2025

Table of Contents

1. Why Guideline-Driven Evidence?
2. Why Ticagrelor vs. Prasugrel?
3. Current Progress in GDE 2025



Guideline-Driven Evidence 2025

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Guideline-Driven Evidence 2025

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1. Why Guideline-Driven Evidence?

- What are Clinical Guidelines?
- Evidence Gap in Guidelines
- Opportunity

2. Why Ticagrelor vs. Prasugrel?

3. Current Progress in GDE 2025

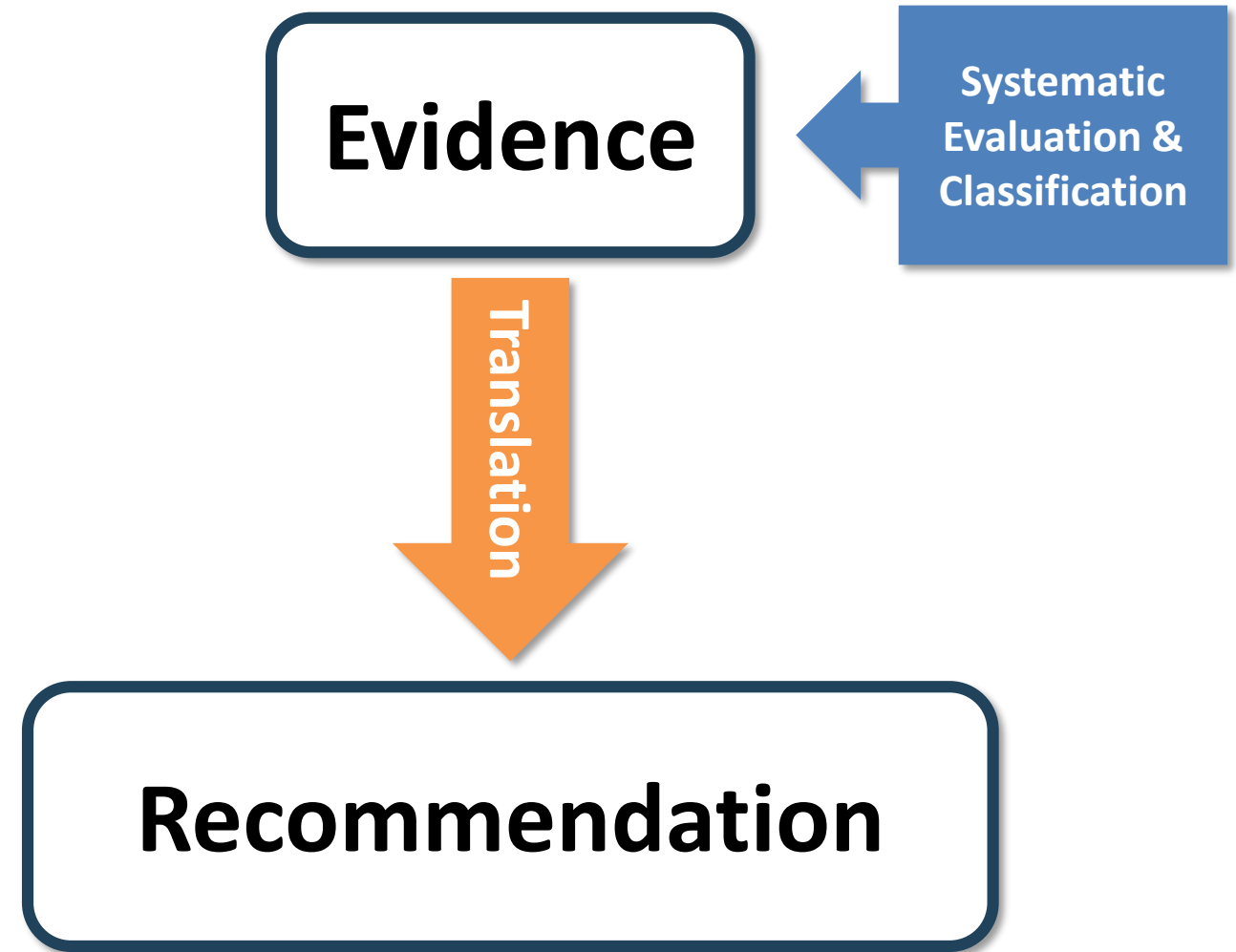


What are Clinical Guidelines?

PREAMBLE

Since 1980, the American College of Cardiology (ACC) and American Heart Association (AHA) have translated scientific evidence into clinical practice guidelines with recommendations to improve cardiovascular health. These guidelines, which are based on systematic methods to evaluate and classify evidence, provide a foundation for the delivery of quality cardiovascular care. The ACC and AHA sponsor the development and publication of clinical practice guidelines without commercial support, and members volunteer their time to the writing and review efforts. Guidelines are official policy of the ACC and AHA. For some guidelines, the ACC and AHA collaborate with other organizations.

From 2025 ACC/AHA guideline (ACS)





What are Clinical Guidelines?

Structure of Clinical Guidelines

Class (Strength) of Recommendations

CLASS 1 (STRONG)	Benefit >>> Risk	CLASS 2b (WEAK)	Benefit ≥ Risk
Suggested phrases for writing recommendations: • Is recommended • Is indicated/useful/effective/beneficial • Should be performed/administered/other • Comparative-Effectiveness Phrases†: – Treatment/strategy A is recommended/indicated in preference to treatment B – Treatment A should be chosen over treatment B		Suggested phrases for writing recommendations: • May/might be reasonable • May/might be considered • Usefulness/effectiveness is unknown/unclear/uncertain or not well-established	
CLASS 2a (MODERATE)	Benefit >> Risk	CLASS 3: No Benefit (MODERATE) (Generally, LOE A or B use only)	Benefit = Risk
Suggested phrases for writing recommendations: • Is reasonable • Can be useful/effective/beneficial • Comparative-Effectiveness Phrases†: – Treatment/strategy A is probably recommended/indicated in preference to treatment B – It is reasonable to choose treatment A over treatment B		Suggested phrases for writing recommendations: • Is not recommended • Is not indicated/useful/effective/beneficial • Should not be performed/administered/other	
		Class 3: Harm (STRONG)	Risk > Benefit
		Suggested phrases for writing recommendations: • Potentially harmful • Causes harm • Associated with excess morbidity/mortality • Should not be performed/administered/other	

Level of Evidence

LEVEL A
• High-quality evidence‡ from more than 1 RCT • Meta-analyses of high-quality RCTs • One or more RCTs corroborated by high-quality registry studies
LEVEL B-R (Randomized)
• Moderate-quality evidence‡ from 1 or more RCTs • Meta-analyses of moderate-quality RCTs
LEVEL B-NR (Nonrandomized)
• Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies • Meta-analyses of such studies
LEVEL C-LD (Limited Data)
• Randomized or nonrandomized observational or registry studies with limitations of design or execution • Meta-analyses of such studies • Physiological or mechanistic studies in human subjects
LEVEL C-EO (Expert Opinion)
• Consensus of expert opinion based on clinical experience



Evidence Gap in Guidelines

1. Recommendations with multiple options

Recommendations	Class ^a	Level ^b
Among all BP-lowering drugs, <u>ACE inhibitors</u> , <u>ARBs</u> , <u>dihydropyridine CCBs</u> , and <u>diuretics</u> (thiazides and thiazide-like drugs such as chlorthalidone and indapamide) have demonstrated the most effective reduction of BP and CVD events, and are therefore recommended as first-line treatments to lower BP. ^{122,446}	I	A
It is recommended that beta-blockers are combined with any of the other major BP-lowering drug classes when there are other compelling indications for their use, e.g. angina, post-myocardial infarction, heart failure with reduced ejection fraction, or for heart rate control. ^{122,448–450}	I	A

From 2024 ESC guidelines (Hypertension)

In-Hospital Management in Patients With NSTEMI-ACS		
1	B-R	3. In patients with NSTEMI-ACS undergoing PCI, <u>prasugrel</u> or <u>ticagrelor</u> is recommended to reduce MACE and stent thrombosis. ^{4–6}
1	B-R	4. In patients with NSTEMI-ACS who are managed without planned invasive evaluation, ticagrelor is recommended to reduce MACE. ^{5,7}
1	B-R	5. In patients with NSTEMI-ACS, clopidogrel is recommended to reduce MACE when prasugrel or ticagrelor are unavailable, cannot be tolerated, or are contraindicated. ¹

From 2025 ACC/AHA guideline (ACS)



Evidence Gap in Guidelines

2. Recommendations with insufficient evidence

	National Comprehensive Cancer Network®	NCCN Guidelines Version 1.2025 Melanoma: Cutaneous	NCCN Guidelines Index Table of Contents Discussion
SYSTEMIC THERAPY CONSIDERATIONS			
<u>When to Stop or Switch Therapies</u> • Definition of maximal clinical benefit ▸ Patients who achieve a clinical response following combination immunotherapy and who have experienced IrAEs (grade 3 or higher) and receive no further treatment do similarly well compared to patients who continue on to maintenance anti-PD-1 treatment. ▸ <u>The optimal duration of anti-PD-1 therapy remains unknown.</u> ▸ Most patients who achieve a complete or partial response and discontinue anti-PD-1 monotherapy after 2 years of therapy maintain the response with 2 years of follow-up. • Defining response and pseudoprogression ▸ Radiographic or clinically evident increase in tumor size may precede regression early in the course of immune-based therapy (pseudoprogression). ▸ Since average time to response ranges from 6 to 12 weeks in most patients who are asymptomatic, depending on the clinical situation, it is reasonable to continue immunotherapy beyond progression for an additional interval of 6 to 10 weeks, with short-interval imaging. Some patients may have true progression at 16 weeks or sooner, and this judgment is based on the volume or size of tumor progression, number of new lesions, organ involvement, and/or tumor-related symptoms. ▸ Continued growth 16 weeks after starting immunotherapy should be considered true progression.			



Evidence Gap in Guidelines

3. Discordance between guidelines

Guideline Differences	 2017 AHA/ACC	 2023 ESH
Hypertension Definition (mmHg)	≥130/80	≥140/90
Hypertension Ranges (mmHg)	Stage 1: 130-139/80-89 Stage 2: ≥140/90	Grade 1: 140-159/90-99 Grade 2: 160-179/100-109 Grade 3: ≥180/110
Nocturnal Hypertension (mmHg)	≥ 110/65	≥ 120/70
Treatment Target Thresholds (mmHg)	Treat most to <130/80 (May target higher BP for patients with advanced age or high comorbidity burden)	<i>Age Based Thresholds</i> 18-64  <130/80 65-79  < 140/80 ≥80  140-150/< 80
Use of Beta Blockers	First line for ischemic heart disease and heart failure	First line for broad range of clinical conditions
Guideline Similarities	2017 AHA/ACC	2023 ESH
Focus on BP measurement technique	Use of validated devices for accurate BP measurements	
Pharmacotherapy	Use of combination therapy as initial treatment strategy	
CVD Risk Assessment	Calculation of CVD Risk to guide treatment decisions	



Opportunity

For clinical areas with evidence gaps

1. Recommendations with multiple options
2. Recommendations with insufficient/inconsistent evidence
3. Discordance between guidelines



Opportunity

To generate evidence with clinical impact

1. Clarify optimal treatment options
2. Strengthen evidence
3. Contribute to achieve consensus



Guideline-Driven Evidence 2025

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1. Why Guideline-Driven Evidence?

2. Why Ticagrelor vs. Prasugrel?

3. Current Progress in GDE 2025



Guideline-Driven Evidence 2025

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1. Why Guideline-Driven Evidence?

2. Why Ticagrelor vs. Prasugrel?

- Clinical Background
- Evidence & Guidelines
- Opportunity

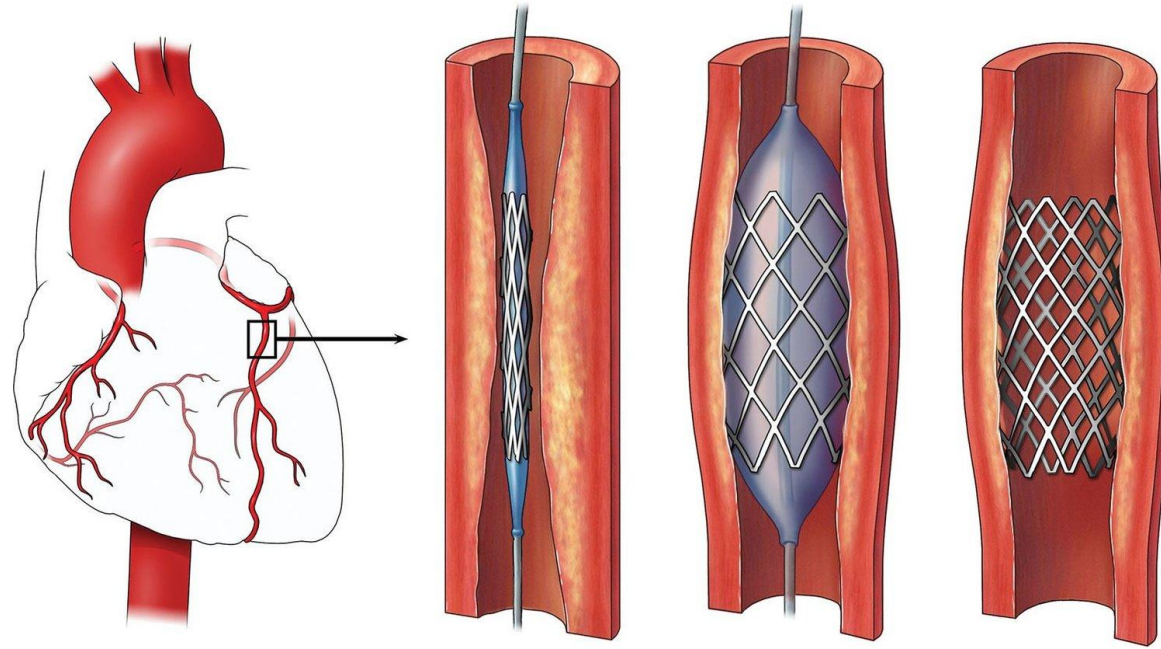
3. Current Progress in GDE 2025



Clinical Background

Acute Coronary Syndrome (ACS)

➤ Percutaneous Coronary Intervention (PCI)

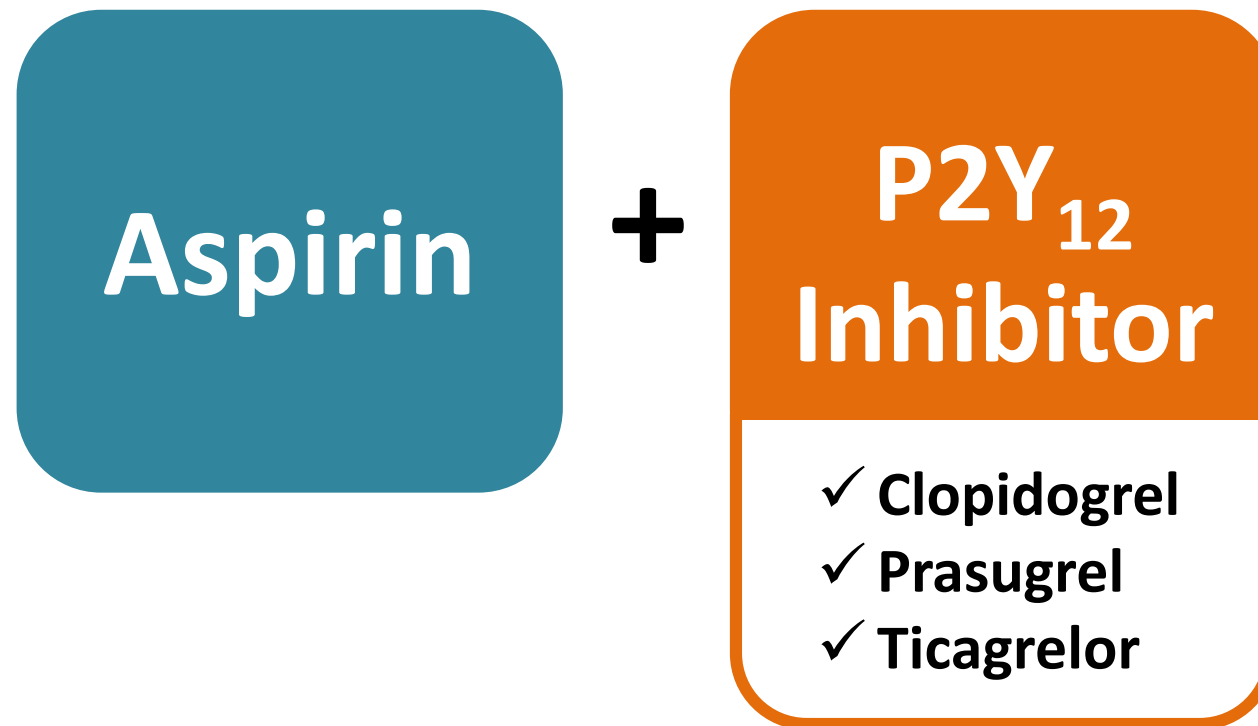




Clinical Background

Dual Antiplatelet Therapy (DAPT)

- Cornerstone of medical treatment in ACS undergoing PCI





Clinical Background

P2Y₁₂ Inhibitors

Clopidogrel

Prasugrel

Ticagrelor



Clinical Background

P2Y₁₂ Inhibitors

Clopidogrel

- ✓ Slower
- ✓ Less potent
- ✓ Irreversible
- ✓ Once daily

Prasugrel

- ✓ Faster
- ✓ More potent
- ✓ Irreversible
- ✓ Once daily

Ticagrelor

- ✓ Faster
- ✓ More potent
- ✓ Reversible
- ✓ Twice daily
- ✓ Dyspnea



Clinical Background

P2Y₁₂ Inhibitors

Clopidogrel

Prasugrel

Ticagrelor

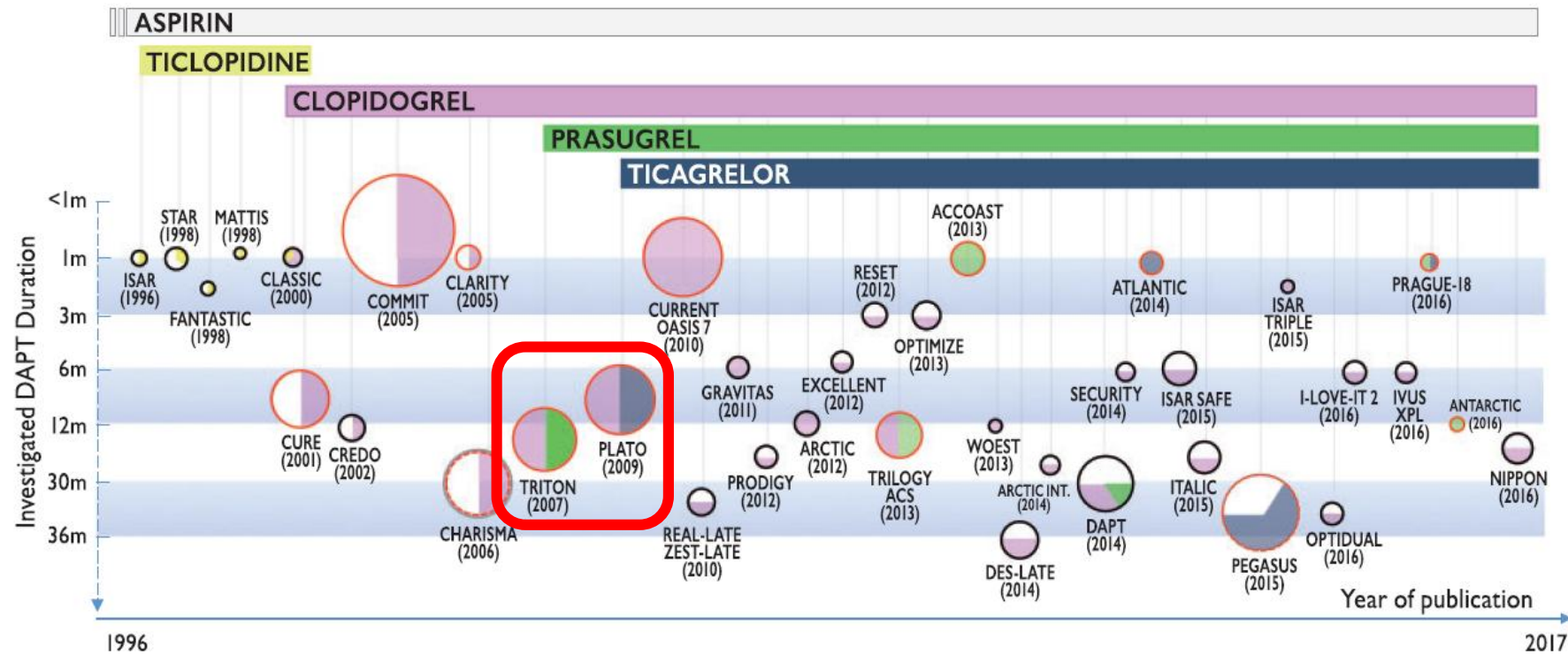
Efficacy : Preventing ischemic events

Safety : Minimizing bleeding risks

Composite of both

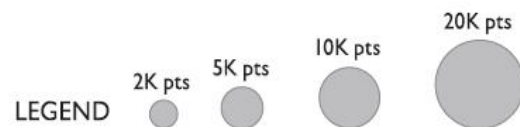


Evidence & Guidelines



Size of the circles denotes sample size

Perimeter of the circles denotes type of investigated population



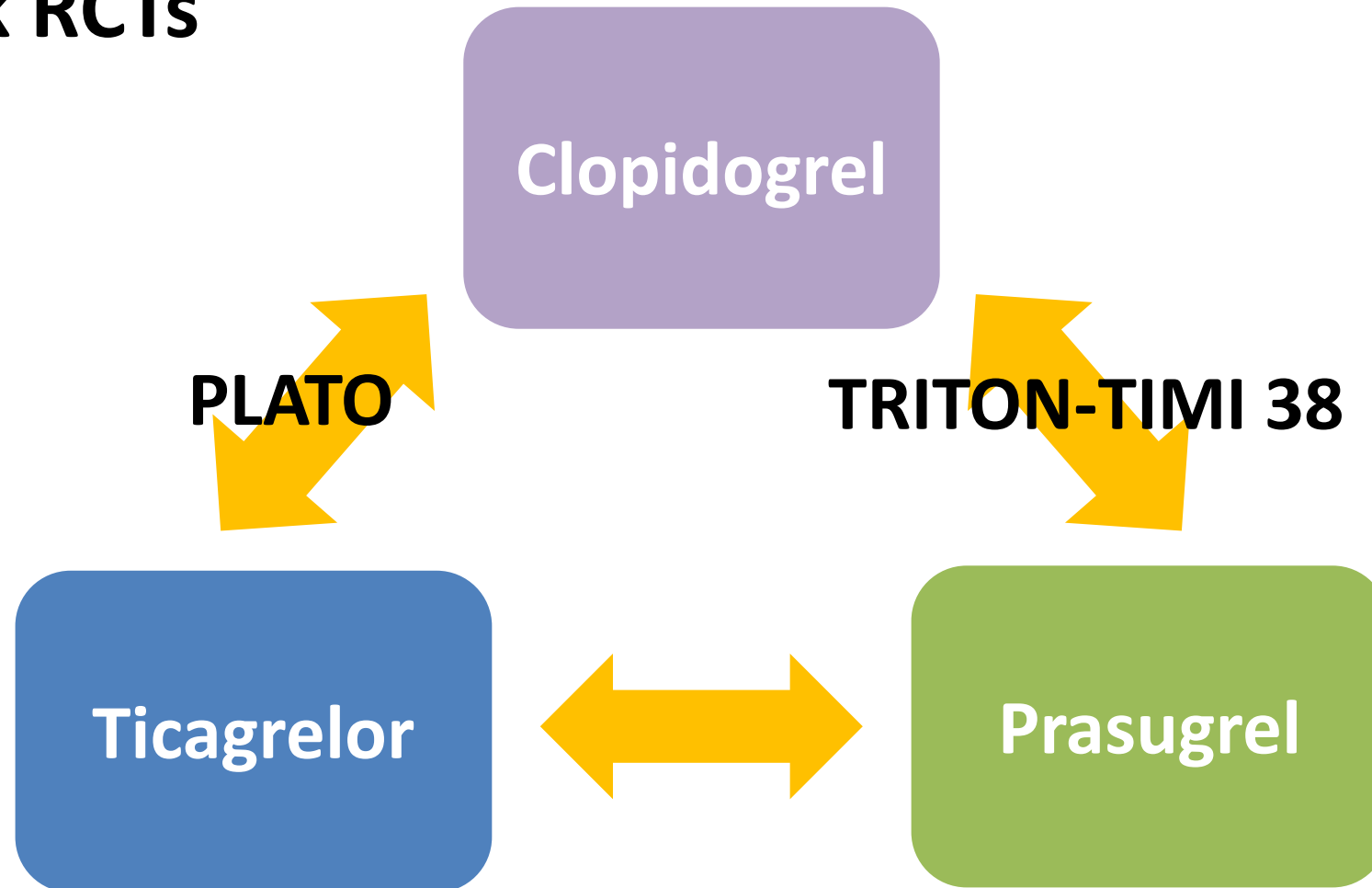
- Mixed clinical presentation at the time of stent implantation
- Acute coronary syndrome at presentation
- DAPT initiated in patients with prior myocardial infarction
- DAPT for primary prevention

©ESC 2017



Evidence & Guidelines

Landmark RCTs





Evidence & Guidelines

2007

Landmark RCTs

- **TRITON-TIMI 38 (2007): Clopidogrel vs. Prasugrel**
 - ✓ Phase III, double-blind
 - ✓ ACS with scheduled PCI (N = 13608)
 - ✓ **Efficacy:** Composite (cardiovascular death + MI + stroke)
 - ✓ **Safety:** TIMI Major bleeding

Prasugrel

Clopidogrel



Evidence & Guidelines

2009

Landmark RCTs

- **PLATO (2009): Clopidogrel vs. Ticagrelor**
 - ✓ Phase III, double-blind
 - ✓ Patients admitted with ACS (N = 18624)
 - ✓ **Efficacy:** Composite (cardiovascular death + MI + stroke)
 - ✓ **Safety:** PLATO Major bleeding

Comparable

Ticagrelor



Evidence & Guidelines

2011 ESC Guideline for NSTEMI-ACS

2011
2012

Ticagrelor (180-mg loading dose, 90 mg twice daily) is recommended for all patients at moderate-to-high risk of ischaemic events (e.g. elevated troponins), regardless of initial treatment strategy and including those pre-treated with clopidogrel (which should be discontinued when ticagrelor is commenced).	I	B
Prasugrel (60-mg loading dose, 10-mg daily dose) is recommended for P2Y ₁₂ -inhibitor-naïve patients (especially diabetics) in whom coronary anatomy is known and who are proceeding to PCI <u>unless there is a high risk of life-threatening bleeding or other contraindications.</u> ^d	I	B
Clopidogrel (300-mg loading dose, 75-mg daily dose) is recommended for patients who cannot receive ticagrelor or prasugrel.	I	A

2012 ESC Guideline for STEMI

An ADP-receptor blocker is recommended in addition to aspirin. Options are:	I	A
• Prasugrel in clopidogrel-naïve patients, <u>if no history of prior stroke/TIA, age <75 years.</u>	I	B
• Ticagrelor.	I	B
• Clopidogrel, preferably when prasugrel or ticagrelor are either not available or contraindicated.	I	C



Evidence & Guidelines

2013 ACCF/AHA Guideline for STEMI

2011
2012

3. A loading dose of a P2Y₁₂ receptor inhibitor should be given as early as possible or at time of primary PCI to patients with STEMI. Options include
- a. Clopidogrel 600 mg^{253,258,259} (*Level of Evidence: B*);
or
 - b. Prasugrel 60 mg²⁶⁰ (*Level of Evidence: B*); or
 - c. Ticagrelor 180 mg.²⁶¹ (*Level of Evidence: B*)

2014 AHA/ACC Guideline for NSTEMI-ACS

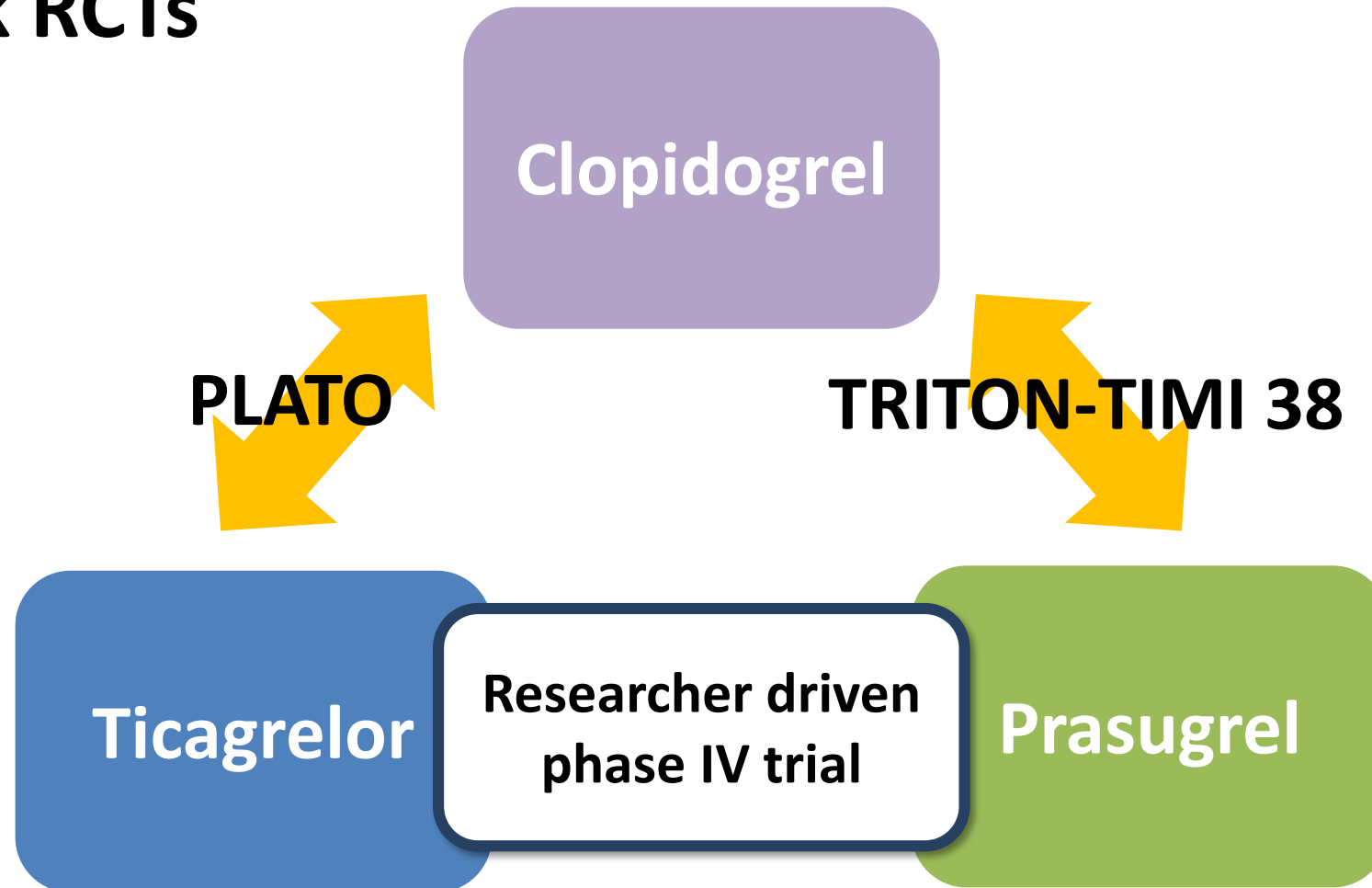
4. A loading dose of a P2Y₁₂ receptor inhibitor should be given before the procedure in patients undergoing PCI with stenting.^{26,293,302,331,372-375} (*Level of Evidence: A*)
Options include:
- a. Clopidogrel: 600 mg^{331,372-374,376-378} (*Level of Evidence: B*) or
 - b. Prasugrel#: 60 mg³⁰² (*Level of Evidence: B*) or
 - c. Ticagrelor||: 180 mg²⁹³ (*Level of Evidence: B*)

Results of PLATO &
TRITON-TIMI 38
Introduced



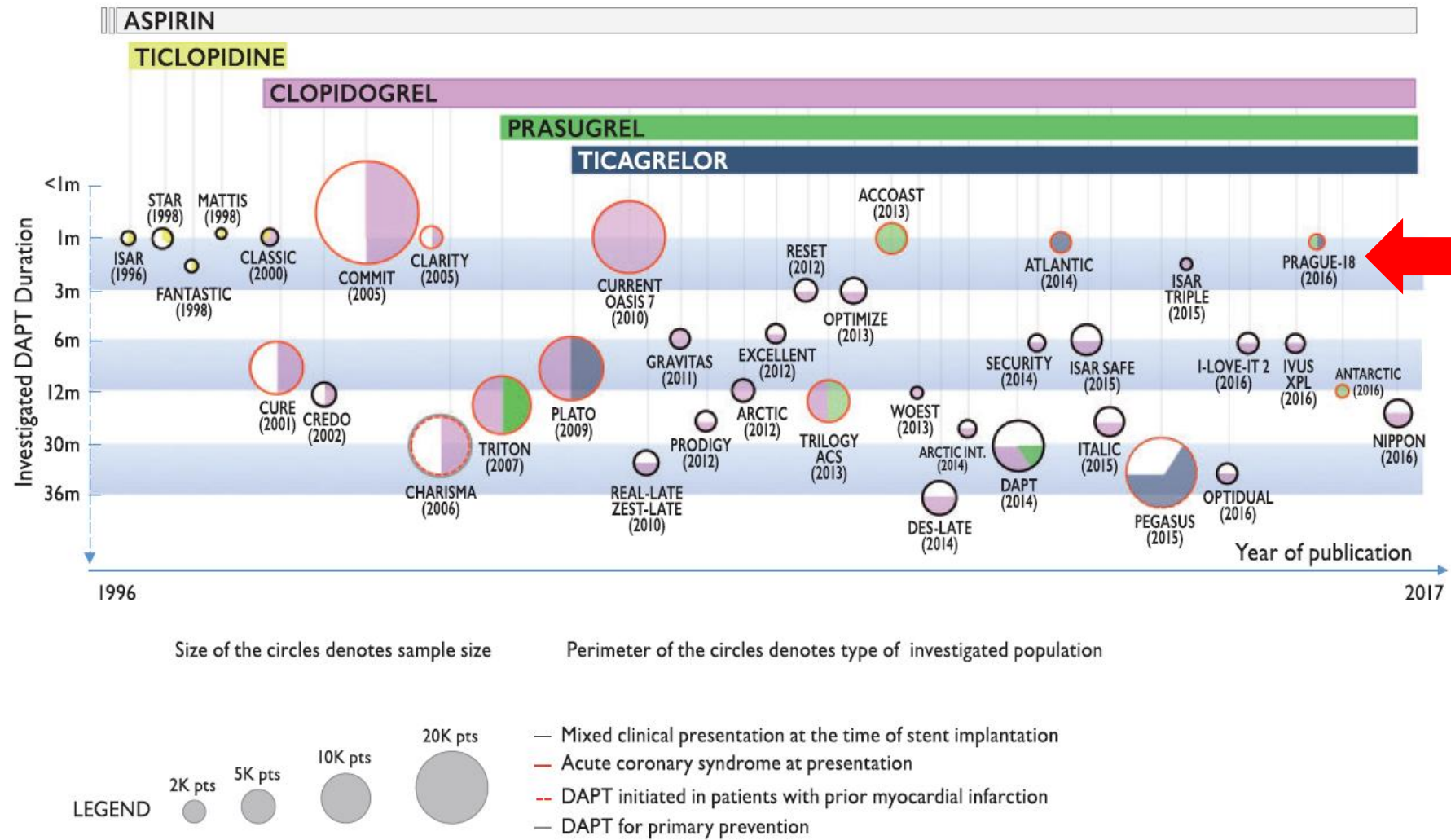
Evidence & Guidelines

Landmark RCTs





Evidence & Guidelines





Evidence & Guidelines

2016

Ticagrelor vs. Prasugrel

➤ PRAGUE-18 (2016)

- ✓ Phase IV, open-label
- ✓ Prematurely terminated for futility (underpowered)
- ✓ **Composite** (death + reinfarction + stroke + serious bleeding)

Comparable



Evidence & Guidelines

2017 ESC Focused Update on DAPT

2017

Recommendations	Class ^a	Level ^b
In patients with ACS, ticagrelor (180 mg loading dose, 90 mg twice daily) on top of aspirin ^c is recommended, regardless of initial treatment strategy, including patients pre-treated with clopidogrel (which should be discontinued when ticagrelor is commenced) unless there are contraindications. ²⁰	I	B
In patients with ACS undergoing PCI, prasugrel (60 mg loading dose, 10 mg daily dose) on top of aspirin is recommended for P2Y ₁₂ inhibitor-naïve patients with NSTEMI-ACS or initially conservatively managed STEMI if indication for PCI is established, or in STEMI patients undergoing immediate coronary catheterization ^c unless there is a high risk of life-threatening bleeding or other contraindications. ²³	I	B

PRAGUE-18 not mentioned



Evidence & Guidelines

2019

Ticagrelor vs. Prasugrel

➤ ISAR-REACT 5 (2019)

- ✓ Phase IV, open-label
- ✓ ACS with planned invasive evaluation (N = 4018)

- ✓ **Efficacy:** Composite (death + MI + stroke)

Prasugrel

- ✓ **Safety:** Major bleeding

Comparable

Controversial



Evidence & Guidelines

2021 ACC/AHA guideline

2021

COR	LOE	Recommendations
1	B-R	1. In patients undergoing PCI, a loading dose of aspirin, followed by daily dosing, is recommended to reduce ischemic events. ^{1-4*}
1	B-R	2. In patients with ACS undergoing PCI, a loading dose of P2Y12 inhibitor, followed by daily dosing, is recommended to reduce ischemic events. ⁵⁻¹⁵
1	C-LD	3. In patients with SIHD undergoing PCI, a loading dose of clopidogrel, followed by daily dosing, is recommended to reduce ischemic events. ^{8,12,15-19}
1	C-LD	4. In patients undergoing PCI within 24 hours after fibrinolytic therapy, a loading dose of 300 mg of clopidogrel, followed by daily dosing, is recommended to reduce ischemic events. ⁵

COR	LOE	Recommendations
2a	B-R	5. In patients with ACS undergoing PCI, it is reasonable to use ticagrelor or prasugrel in preference to clopidogrel to reduce ischemic events, including stent thrombosis. ^{6,14,20}
2b	B-R	6. In patients <75 years of age undergoing PCI within 24 hours after fibrinolytic therapy, ticagrelor may be a reasonable alternative to clopidogrel to reduce ischemic events. ²¹
3: Harm	B-R	7. In patients undergoing PCI who have a history of stroke or transient ischemic attack, prasugrel should not be administered. ⁶

ISAR-REACT 5
not mentioned

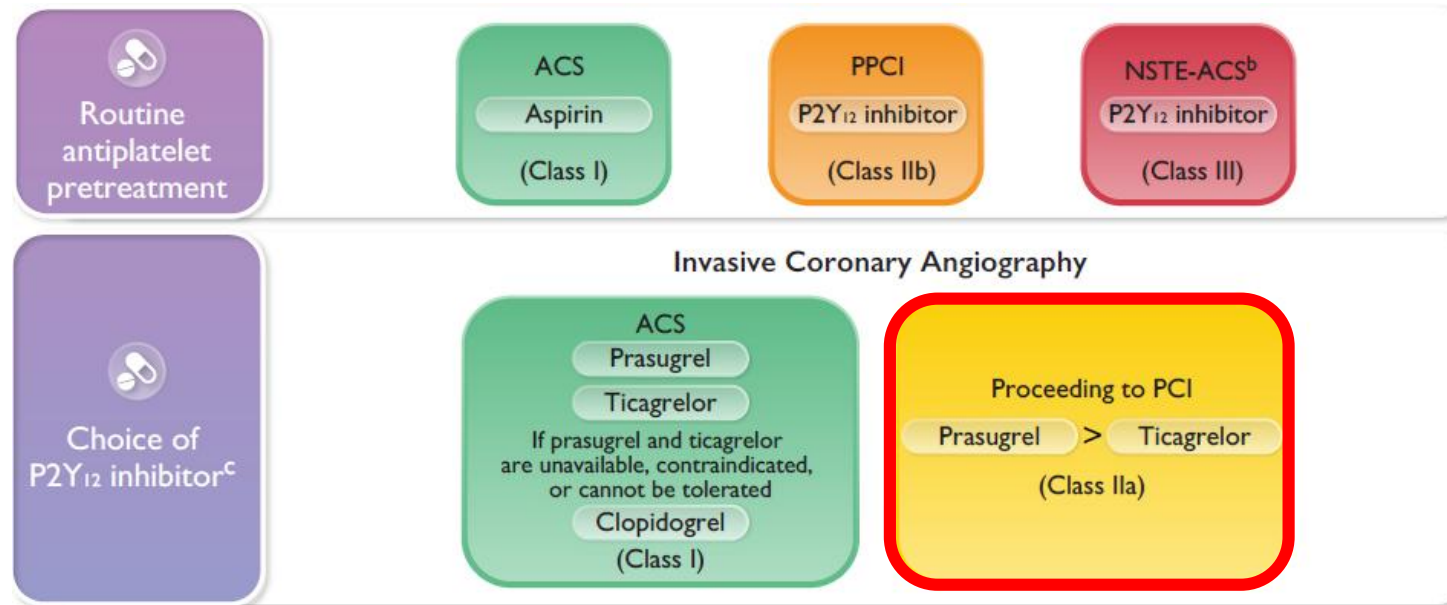


Evidence & Guidelines

2023

2023 ESC guideline

➤ Antiplatelet therapy in the acute phase



Prasugrel should be considered in preference to ticagrelor for ACS patients who proceed to PCI.^{244,290}

IIa

B



Evidence & Guidelines

2025 ACC/AHA guideline

2025

COR	LOE	Recommendations
All Patients With ACS (STEMI and NSTEMI-ACS)		
1	A	1. In patients with ACS, an oral P2Y12 inhibitor should be administered in addition to aspirin to reduce MACE. ¹⁻⁵
3: Harm	B-R	2. In patients with a history of stroke or transient ischemic attack, prasugrel should not be administered because of worse net clinical outcomes.*† ⁴
In-Hospital Management in Patients With NSTEMI-ACS		
1	B-R	3. In patients with NSTEMI-ACS undergoing PCI, prasugrel or ticagrelor is recommended to reduce MACE and stent thrombosis. ⁴⁻⁶
1	B-R	4. In patients with NSTEMI-ACS who are managed without planned invasive evaluation, ticagrelor is recommended to reduce MACE. ^{5,7}
1	B-R	5. In patients with NSTEMI-ACS, clopidogrel is recommended to reduce MACE when prasugrel or ticagrelor are unavailable, cannot be tolerated, or are contraindicated. ¹

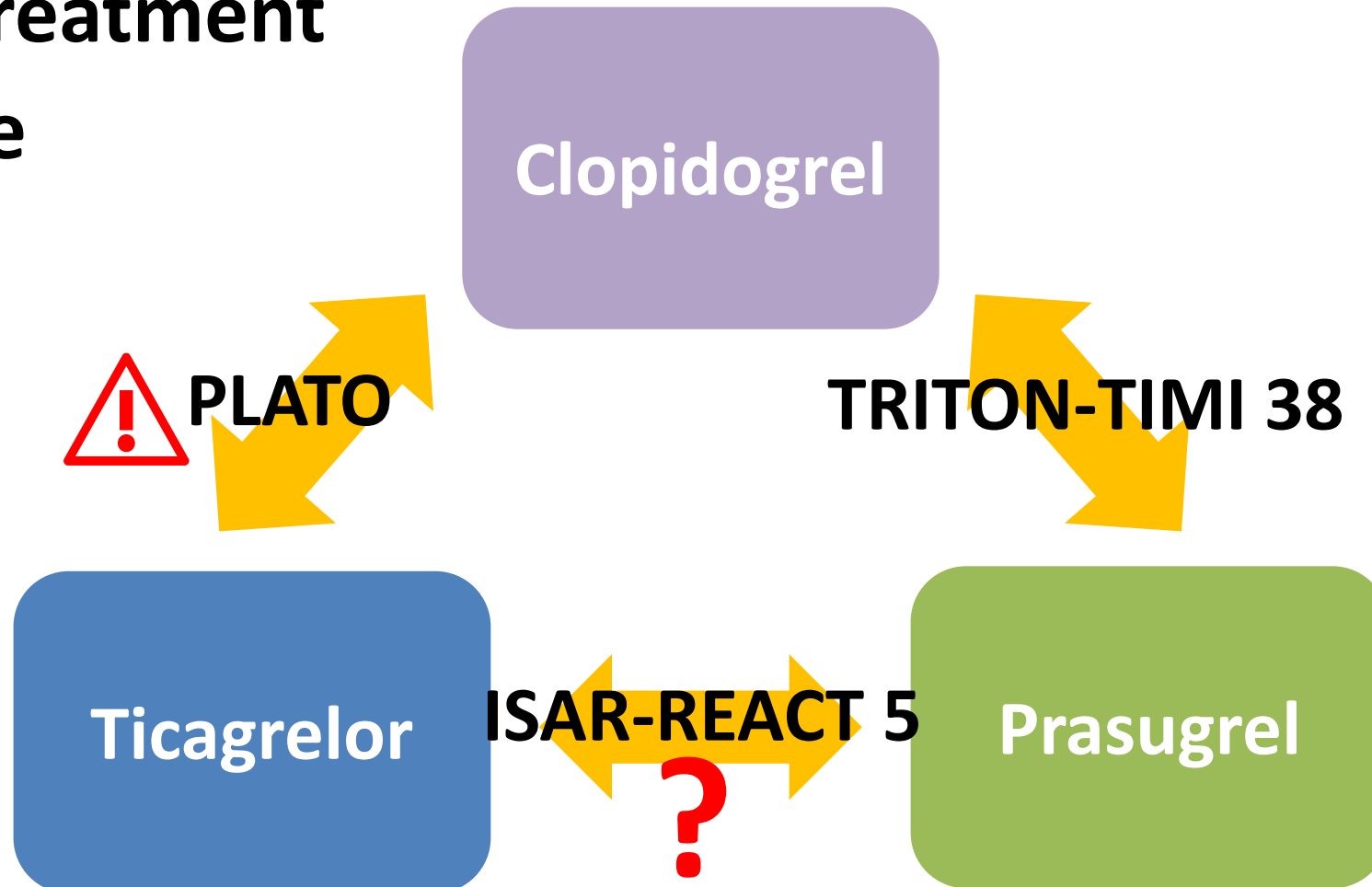
Limited data exist to compare the efficacy and safety of prasugrel versus ticagrelor head-to-head. One open-label randomized trial reported a lower rate of MACE with similar bleeding with prasugrel administered at the time of PCI compared with ticagrelor used as upstream therapy in patients with ACS undergoing invasive evaluation.²²

**ISAR-REACT 5
only introduced**



Opportunity

Shifting Treatment Landscape





Opportunity

Shifting Treatment Landscape

➤ Results of PLATO called into question

The BMJ (2024)

INVESTIGATION

Doubts over landmark heart drug trial: ticagrelor PLATO study

A top selling antiplatelet drug has never quite shaken off doubts about its advantage over cheaper rivals. With generic versions of ticagrelor about to launch, **Peter Doshi** takes a fresh look at the evidence

Peter Doshi senior editor

Ticagrelor's approval provoked a steady stream of criticism from those who maintained that the published PLATO trial results could not be trusted.^{25 26} Critics said it was noteworthy that ticagrelor failed in the US, the only high enrolling country where sites were not monitored by the sponsor itself.



Opportunity

Shifting Treatment Landscape

- Results of PLATO called into question

JAMA | Original Investigation

JAMA (2020)

Association of Ticagrelor vs Clopidogrel With Net Adverse Clinical Events in Patients With Acute Coronary Syndrome Undergoing Percutaneous Coronary Intervention

Seng Chan You, MD, MS; Yeunsook Rho, PhD; Behnood Bikdeli, MD, MS; Jiwoo Kim, MS; Anastasios Siapos, MSc; James Weaver, MSc; Ajit Londhe, MPH; Jaehyeong Cho, BS; Jimyung Park, BS; Martijn Schuemie, PhD; Marc A. Suchard, MD, PhD; David Madigan, PhD; George Hripcsak, MD, MS; Aakriti Gupta, MD, MS; Christian G. Reich, MD; Patrick B. Ryan, PhD; Rae Woong Park, MD, PhD; Harlan M. Krumholz, MD, SM

RESULTS After propensity score matching among 31 290 propensity-matched pairs (median age group, 60-64 years; 29.3% women), 95.5% of patients took aspirin together with ticagrelor or clopidogrel. The 1-year risk of NACE was not significantly different between ticagrelor and clopidogrel (15.1% [3484/23 116 person-years] vs 14.6% [3290/22 587 person-years]; summary HR, 1.05 [95% CI, 1.00-1.10]; $P = .06$).



Opportunity

To generate meaningful evidence,
comparing the effectiveness & safety of **ticagrelor** vs. **prasugrel**
in ACS patients undergoing PCI using **real-world data**





Guideline-Driven Evidence 2025

Table of Contents

1. Why Guideline-Driven Evidence?

2. Why Ticagrelor vs. Prasugrel?

3. Current Progress in GDE 2025



Guideline-Driven Evidence 2025

Table of Contents

1. Why Guideline-Driven Evidence?

2. Why Ticagrelor vs. Prasugrel?

3. Current Progress in GDE 2025

- Steps Toward Evidence Generation
- My Experience in GDE 2025



Steps Toward Evidence Generation

Dry January

Review guidelines
Determine evidence needs

Phenotype Phebruary

Specify cohorts in need
Develop & evaluate cohorts

March to Data Fitness

Utilize Evidence Network
Data partner matchmaking

Analysis April

Prepare protocol
Specify & initiate analysis

Meta-Analysis May

Collaborative interpretation
across network

Journey to June

Mid-year reflection

Spread-the-Word Second Half

Focus on evidence dissemination (OHDSI symposiums)



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Dry January

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We're here!

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Steps Toward Evidence Generation

Dry January

- Reviewing guidelines & brainstorming
- OHDSI Forum posts & community calls

Video Presentations

Obesity Management

Guideline-Driven Evidence Opportunity...

Evidence gap

AACE/ACE Guidelines (2016)

80% failure to the control of currently available weight loss medications have demonstrated differences in efficacy regarding mean weight loss and the proportion of patients who achieved 5% and 10% weight loss.

In terms of pharmacotherapies

- Limited head-to-head study (pharm. and AOMs vs non-pharm)
- No evidence on related outcomes (e.g., CV outcomes)
- Limited long-term follow-up data
- Limited data for underserved population (e.g., older adults)

(Stevens / Atlas et al (2020).

80% evidence demonstrated that currently available weight loss medications have demonstrated differences in efficacy regarding mean weight loss and the proportion of patients who achieved 5% and 10% weight loss.

with obesity (1714 (3), 4, 561).

80% evidence demonstrated that currently available weight loss medications have demonstrated differences in efficacy regarding mean weight loss and the proportion of patients who achieved 5% and 10% weight loss.

Presenter: Chungsoo Kim

Anesthesia Post-Operative Care

Guideline-Driven Evidence Opportunity...

Postoperative AKI is strongly associated with increased mortality, cost of care, and cardiovascular and kidney disease.

Presenter: Oleg Zhuk

<https://forums.ohdsi.org/>

OHDSI

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Researchers
CDM Builders
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patientprediction
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Guideline-driven evidence generation opportunities

General

Patrick_Ryan Jan 8

Clinical guidelines are extremely helpful, not only for providing guidance not only for providers on how to best treat their patients, but also for highlighting to the research community where there are open questions and evidence gaps. Some of these evidence gaps can be filled reliably through proper analysis of real-world data, as we aim to conduct across the OHDSI Evidence Network.

To help stimulate discussion and prioritize our community's collaborative activities in 2025, I'm opening up this thread with a specific ask for anyone who is interested in leading or participating in an OHDSI network study, or simply are interested in seeing an OHDSI study conducted by the community on a topic that's of interest to you:

Post a link to a current clinical guideline about a disease/topic of interest.
Review the guideline and share what evidence gaps you see that could be potentially filled with real-world evidence.

We'll use the input and interest from the community on this thread to guide us toward collaborative evidence generation activities this year.

7 ❤️ 🔗 ... ➡ Reply

Weekly OHDSI Digest - January 27, 2025
Weekly OHDSI Digest - January 20, 2025

995 views 28 likes 18 links 28 users P A

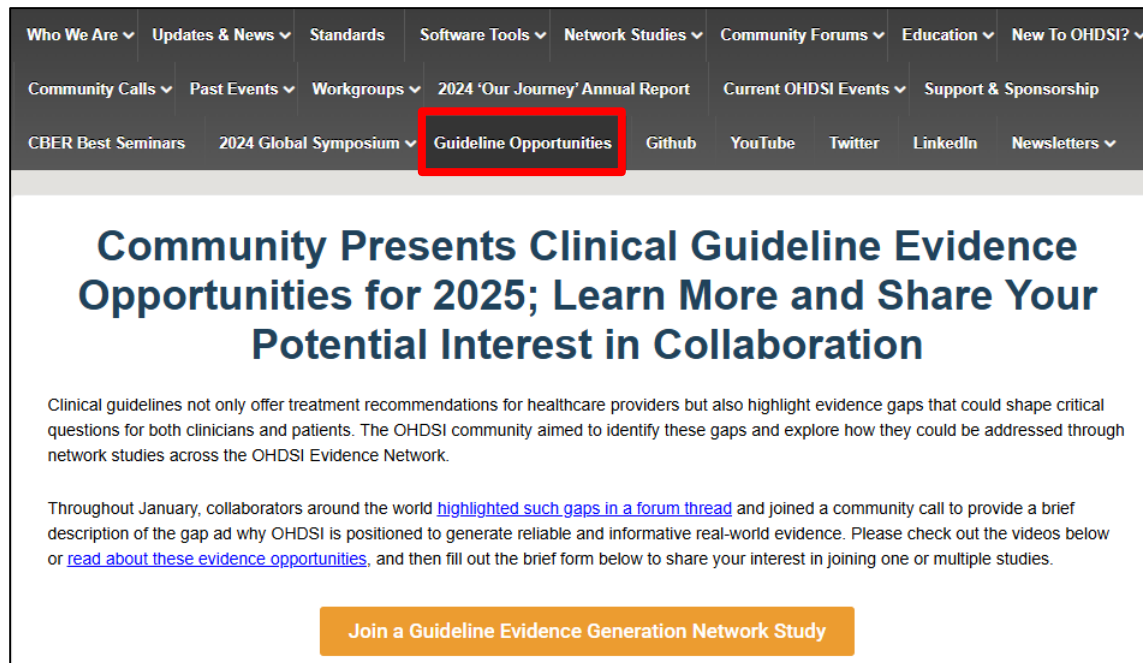
25 min read Top replies



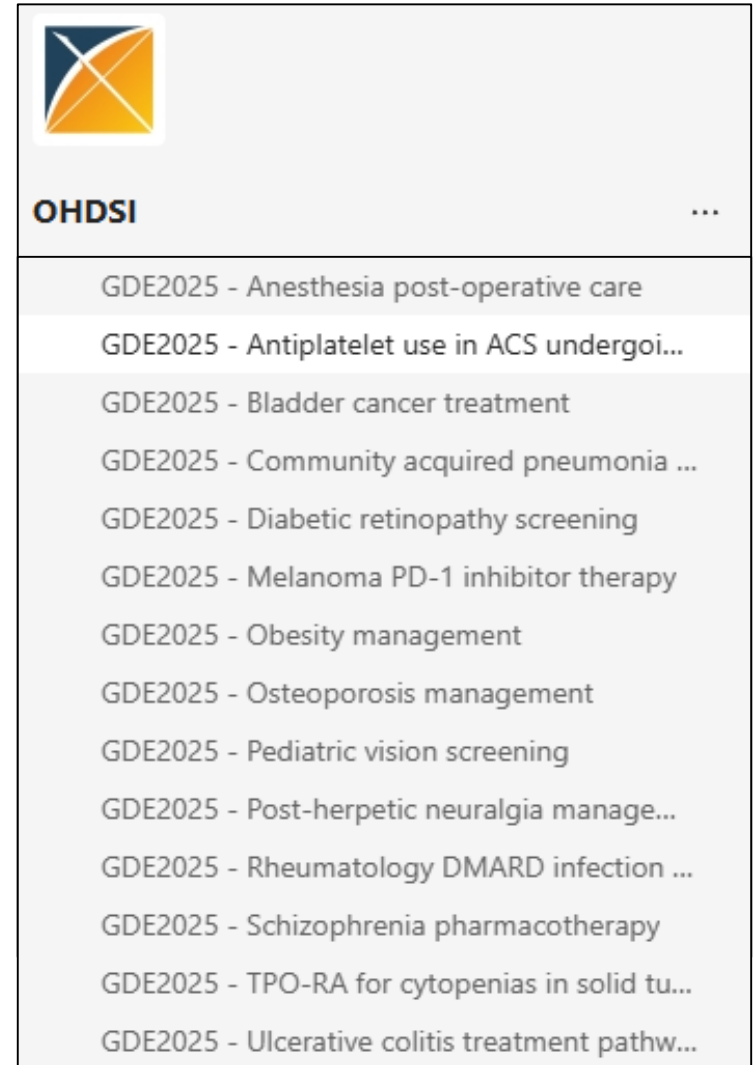
Steps Toward Evidence Generation

Dry January

➤ 14 Guideline-Driven Evidence 2025 studies



The screenshot shows the OHDSI website navigation bar with the following items: Who We Are, Updates & News, Standards, Software Tools, Network Studies, Community Forums, Education, New To OHDSI, Community Calls, Past Events, Workgroups, 2024 'Our Journey' Annual Report, Current OHDSI Events, Support & Sponsorship, CBER Best Seminars, 2024 Global Symposium, **Guideline Opportunities** (highlighted with a red box), Github, YouTube, Twitter, LinkedIn, and Newsletters. Below the navigation bar, the main content area features the heading "Community Presents Clinical Guideline Evidence Opportunities for 2025; Learn More and Share Your Potential Interest in Collaboration". The text below the heading states: "Clinical guidelines not only offer treatment recommendations for healthcare providers but also highlight evidence gaps that could shape critical questions for both clinicians and patients. The OHDSI community aimed to identify these gaps and explore how they could be addressed through network studies across the OHDSI Evidence Network." It continues: "Throughout January, collaborators around the world [highlighted such gaps in a forum thread](#) and joined a community call to provide a brief description of the gap and why OHDSI is positioned to generate reliable and informative real-world evidence. Please check out the videos below or [read about these evidence opportunities](#), and then fill out the brief form below to share your interest in joining one or multiple studies." At the bottom of the section is a button that says "Join a Guideline Evidence Generation Network Study".



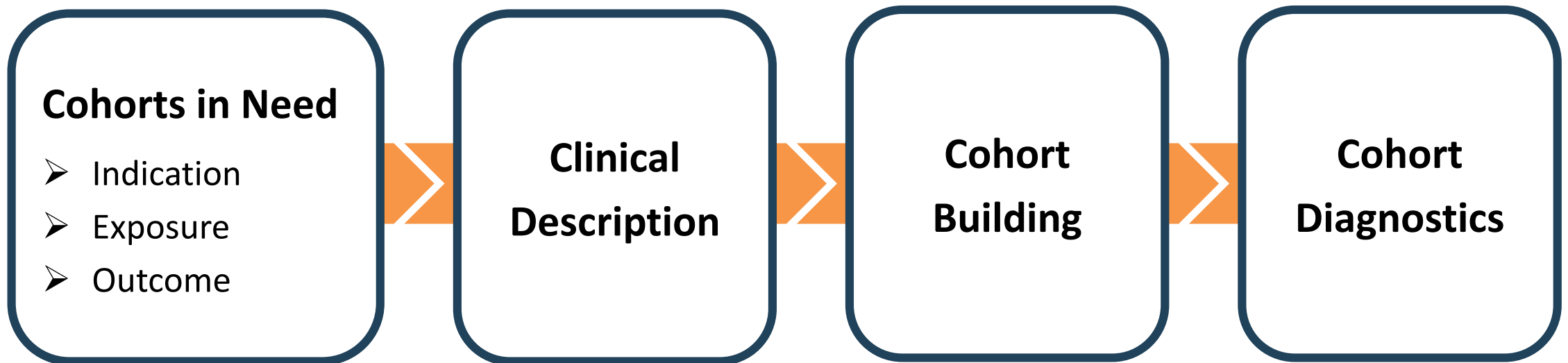
The screenshot shows the OHDSI website with the "Guideline Opportunities" section highlighted in red. Below the navigation bar, the main content area features the heading "Community Presents Clinical Guideline Evidence Opportunities for 2025; Learn More and Share Your Potential Interest in Collaboration". The text below the heading states: "Clinical guidelines not only offer treatment recommendations for healthcare providers but also highlight evidence gaps that could shape critical questions for both clinicians and patients. The OHDSI community aimed to identify these gaps and explore how they could be addressed through network studies across the OHDSI Evidence Network." It continues: "Throughout January, collaborators around the world [highlighted such gaps in a forum thread](#) and joined a community call to provide a brief description of the gap and why OHDSI is positioned to generate reliable and informative real-world evidence. Please check out the videos below or [read about these evidence opportunities](#), and then fill out the brief form below to share your interest in joining one or multiple studies." At the bottom of the section is a button that says "Join a Guideline Evidence Generation Network Study".



Steps Toward Evidence Generation

Phenotype Phebruary

- Developing phenotypes for cohorts needed for GDE 2025 studies





PhenotypeLibrary 3.36.0 Reference Articles Changelog HADES

Cohort Definitions in OHDSI Phenotype Library

Gowtham A. Rao

2025-04-02

Source: vignettes/CohortDefinitionsInOhdsiPhenotypeLibrary.Rmd

Download Cohorts.csv

Search

Cohort Id	Cohort Name	Cohort Name Atlas	Cohort Name
3	Cough or Sputum	[P] Cough or Sputum	Cough or S
4	Diarrhea	[P] Diarrhea	Diarrhea

Cohorts in Need

- Indication
- Exposure
- Outcome

Clinical
Description

Cohort
Building

Cohort
Diagnostics



PhenotypeLibrary 3.36.0

Reference

Articles ▾

Changelog

HADES

Guidance on writing clinical description for Condition Phenotypes

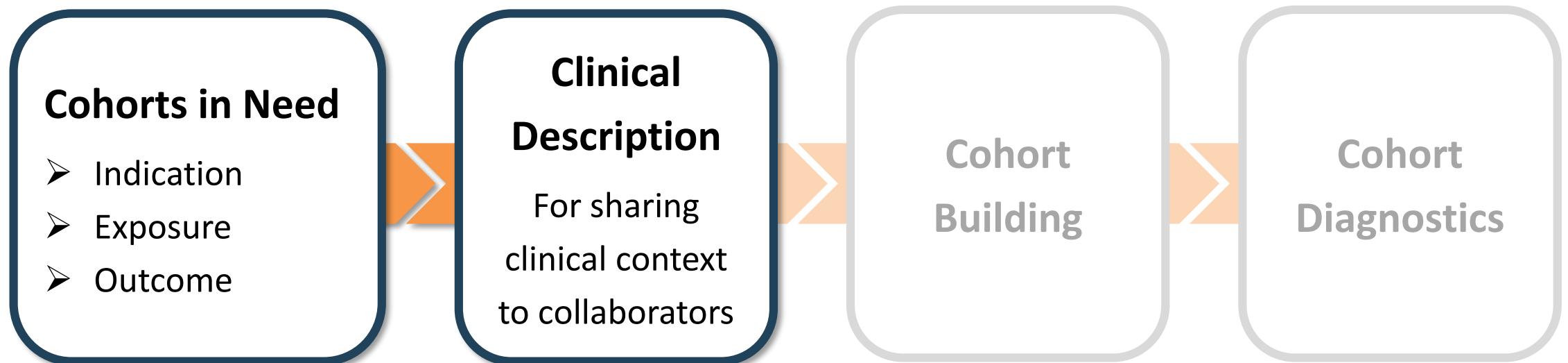
Gowtham A. Rao

2025-04-02

Source: vignettes/GuidanceOnClinicalDescriptionForConditionPhenotypes.Rmd

PhenotypeLibrary is part of [HADES](#).

Note: This document is a DRAFT guidance. We request a succinct clinical description, tailored for individuals with a background in medical terminology, informatics, or clinical practice, to enable a shared comprehension of the clinical concept being modeled in the phenotype. While the following structure is recommended, all fields are OPTIONAL.





ATLAS

English

Home

Data Sources

Search

Concept Sets

Cohort Definitions

Characterizations

Cohort Pathways

Incidence Rates

Profiles

Estimation

Cohort Definitions

New Cohort

Showing 1 to 50 of 18,934 entries

Show columns

Copy

CSV

Show 50 entries

Filter: Search...

Previous

1

2

3

4

5

...

379

Next

	Id	Name	Created	Updated	Author	Prod_Group
Prod_Group	1792758	Adult women with newly diagnosed breast cancer	04/08/2025 10:25 AM	04/08/2025 10:46 AM	anonymous	
Untagged (18913)	1792728	cs	04/04/2025 12:36 AM	04/08/2025 4:15 AM	anonymous	
test (6)	1792736	CCC Htn Cohort	04/04/2025 10:57 PM	04/08/2025 3:09 AM	anonymous	
testing (3)	1792753	non hodgkin ttc	04/07/2025 11:46 PM	04/08/2025 12:13 AM	anonymous	
Ready for Review (2)	1792757	PhePhe25[DR] autonomous AI screening (earliest event)	04/08/2025 12:04 AM	04/08/2025 12:04 AM	anonymous	
Created	1792755	PhePhe25[DR] office DR screening combo-NO specialty (earliest event)	04/08/2025 12:03 AM	04/08/2025 12:04 AM	anonymous	
2+ Weeks Ago (18768)	1792756	PhePhe25[DR] telemedicine screening (earliest event)	04/08/2025 12:03 AM	04/08/2025 12:04 AM	anonymous	
This Week (80)	1792754	PhePhe25[DR] office DR screening combo (earliest event)	04/08/2025 12:02 AM	04/08/2025 12:02 AM	anonymous	
Last Week (75)	1792114	PhePhe25[DR] office DR screening combo	02/14/2025 11:01 AM	04/08/2025 12:02 AM	anonymous	
Within 24 Hours (11)						
Updated						
2+ Weeks Ago (18740)						
This Week (101)						

Cohorts in Need

- Indication
- Exposure
- Outcome

Clinical Description

For sharing
clinical context
to collaborators

Cohort Building

Using ATLAS

- Concept set
- Cohort

Cohort Diagnostics



CohortDiagnostics 3.3.1 Reference Articles Changelog

CohortDiagnostics

R-CMD-check passing codecov 89%

CohortDiagnostics is part of [HADES](#).

Introduction

CohortDiagnostics is an R utility package for the development and evaluation of phenotype algorithms for OMOP CDM compliant data sets. This package provides a standard, end to end, set of analytics for understanding patient capture including data generation and result exploration through an R Shiny interface. Analytics computed include cohort characteristics, record counts, index event misclassification, captured observation windows and basic incidence proportions for age, gender and calendar year. Through the identification of errors, CohortDiagnostics enables the comparison of multiple candidate cohort definitions across one or more data sources, facilitating reproducible research.

OHDSI Evidence Sharing

Cohort Dagnostics

Cohort Definition

Concepts in Data Source
Orphan Concepts
Cohort Counts
Incidence Rate
Time Distributions
Index Event Breakdown
Visit Context
Cohort Overlap
Cohort Characterization
Compare Characterization
Meta data

Cohort Definition

	Cohort Id	Cohort Name
☐	1791885	[PP25 HowOftenSgx] AKI (condn or dialysis), no ESKD or dialysis in 365
☐	1791887	[PP25 SgxHowOften] AKI with no dialysis, no ESKD, no prior dialysis 365
☐	1791888	[PP25 SgxHowOften] AKI with dialysis (no ESKD or prior dialysis)
☐	1791901	[PP25 Community acquired pneumonia management] CAP
☐	1791902	[PP25 Community acquired pneumonia management] CAP-associated hospitalization
☐	1791938	[PP25 Rheumatology_Infection_Malignancy] Incident systemic sclerosis
☐	1791939	[PP25 Rheumatology_Infection_Malignancy] Incident systemic sclerosis with RP
☐	1791944	[PP25 Rheumatology_Infection_Malignancy] Incident_Shingles_Sensitive
☐	1791945	[PP25 Rheumatology_Infection_Malignancy] Incident_Shingles_Specific
☐	1791964	[PP25 Rheumatology_Infection_Malignancy] squamous and basal cell carcinoma of skin
☐	1791968	PhePhe25 [Diabetic Retinopathy] Type 2 Diabetes including Insulins (aim1,2,3)
☐	1791985	[PP25 Rheumatology_Infection_Malignancy] [DMARD] Pneumocystis Pneumonia

Cohorts in Need

- Indication
- Exposure
- Outcome

Clinical Description

For sharing
clinical context
to collaborators

Cohort Building

Using ATLAS

- Concept set
- Cohort

Cohort Dagnostics

Evaluate &
revise cohorts

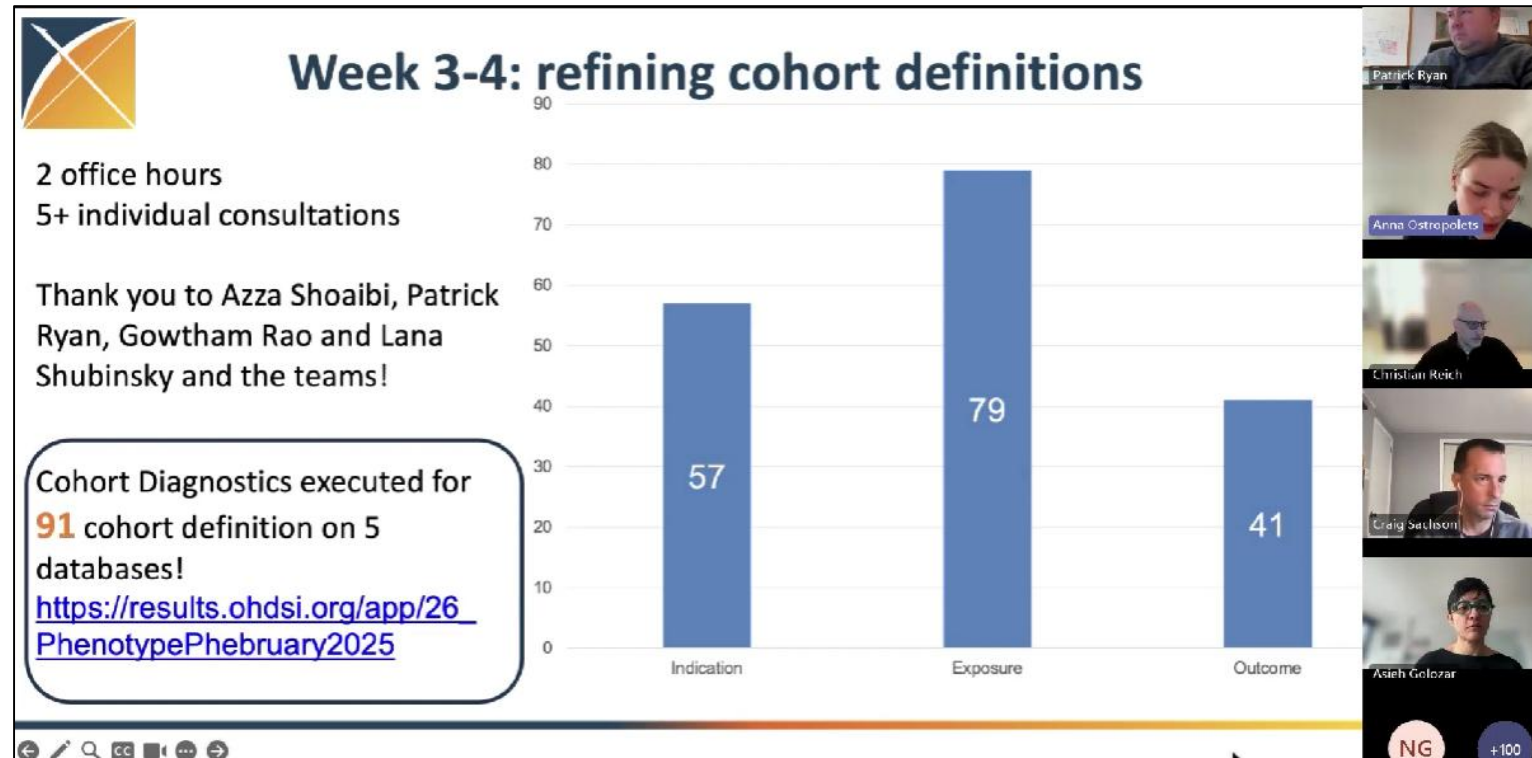


Steps Toward Evidence Generation

Phenotype Phebruary

<https://youtu.be/3KmJpVABjbo?si=Q5LMCMMM2SDhh8y5>

https://results.ohdsi.org/app/26_PhenotypePhebruary2025





Steps Toward Evidence Generation

March to Fitness

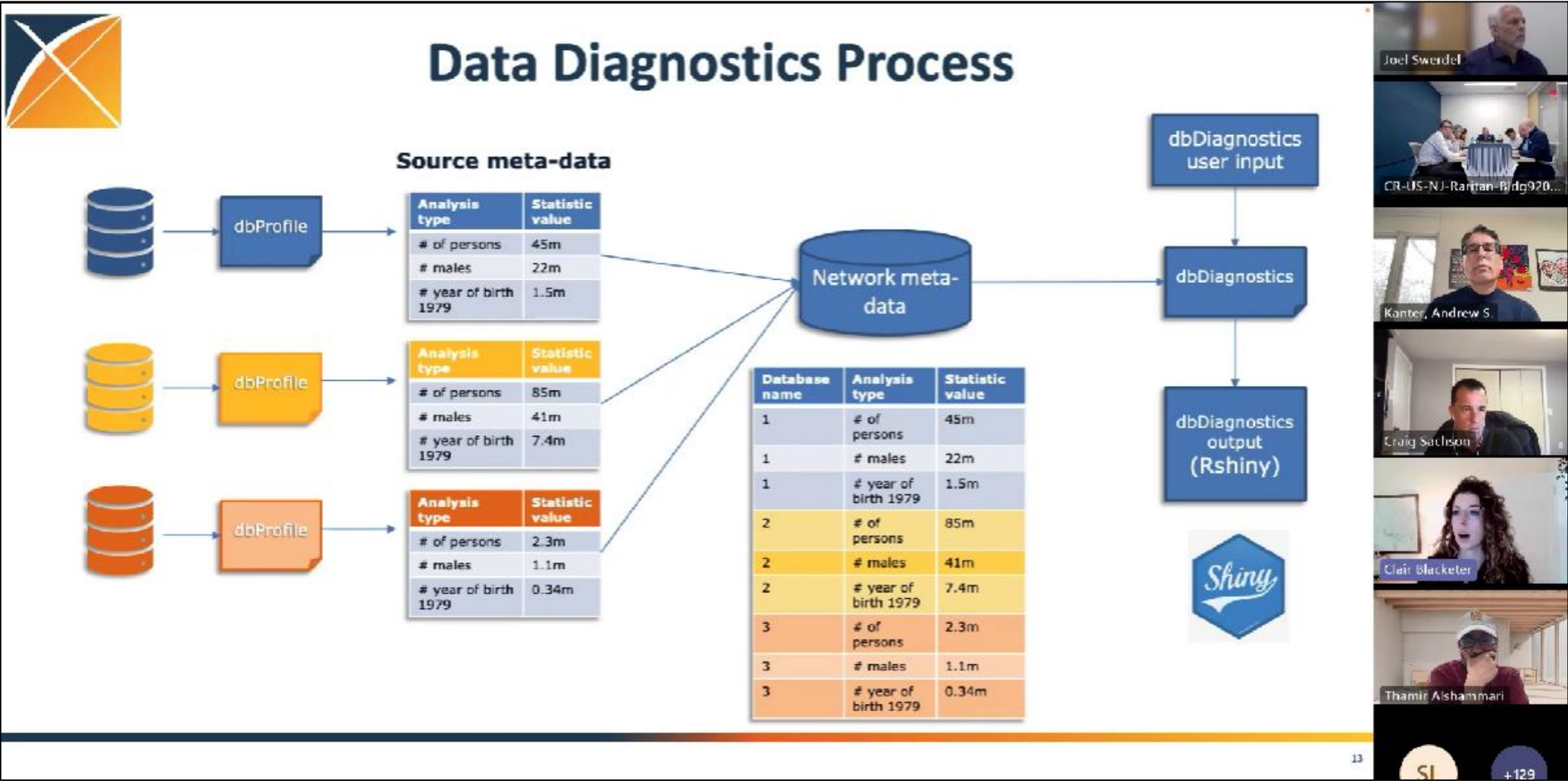
- Matching suitable databases within Evidence Network for GDE 2025 studies





Steps Toward Evidence Generation

<https://youtu.be/Rv1arONKd9o>





My Experience in GDE 2025

Dry January

Review guidelines
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Phenotype February

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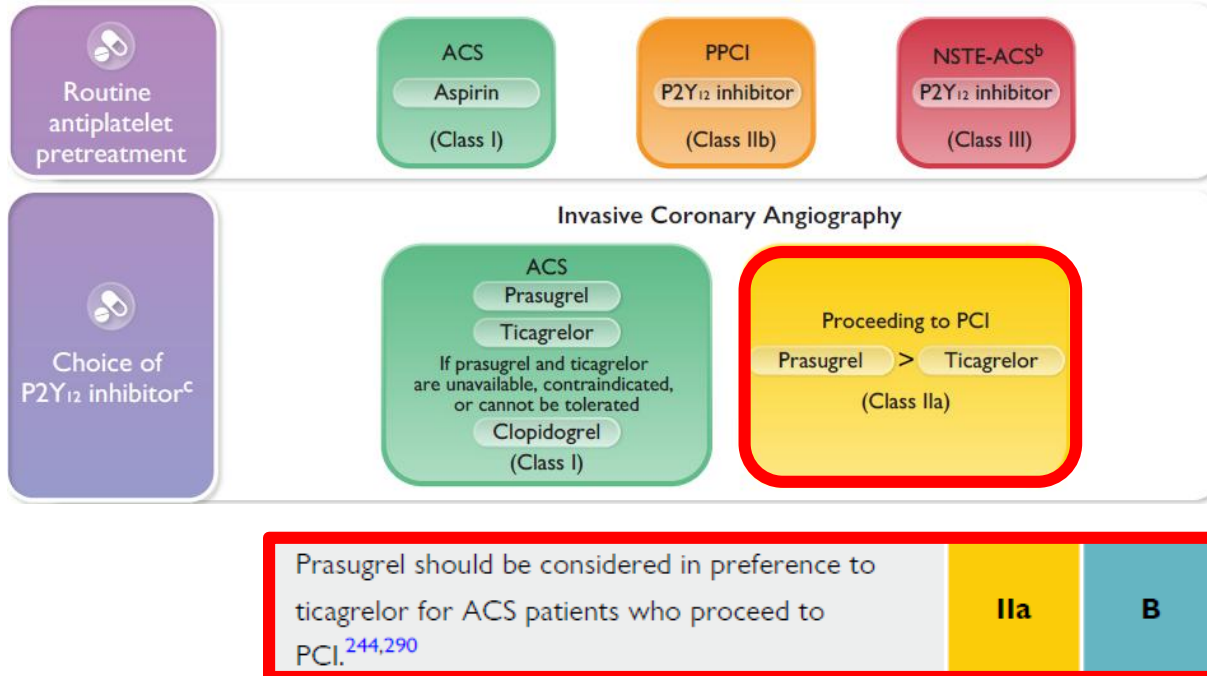
Focus on evidence dissemination (OHDSI symposiums)



My Experience in GDE 2025

Dry January

2023 ESC guideline



2025 ACC/AHA guideline

COR	LOE	Recommendations
All Patients With ACS (STEMI and NSTEMI-ACS)		
1	A	1. In patients with ACS, an oral P2Y ₁₂ inhibitor should be administered in addition to aspirin to reduce MACE. ¹⁻⁵
3: Harm	B-R	2. In patients with a history of stroke or transient ischemic attack, prasugrel should not be administered because of worse net clinical outcomes.*† ⁴
In-Hospital Management in Patients With NSTEMI-ACS		
1	B-R	3. In patients with NSTEMI-ACS undergoing PCI, prasugrel or ticagrelor is recommended to reduce MACE and stent thrombosis. ⁴⁻⁶
1	B-R	4. In patients with NSTEMI-ACS who are managed without planned invasive evaluation, ticagrelor is recommended to reduce MACE. ^{5,7}
1	B-R	5. In patients with NSTEMI-ACS, clopidogrel is recommended to reduce MACE when prasugrel or ticagrelor are unavailable, cannot be tolerated, or are contraindicated. ¹



My Experience in GDE 2025

Phenotype Phebruary

Clinical Description

GDE2025 - Antiplatelet use in ACS undergoing PCI > Clinical Descriptions

 Clinical description_ACS.docx	2월 17일	Thamir Alshammari
 Clinical description_composite outcomes.docx	2월 18일	Chang Hoon Han
 Clinical description_DAPT.docx	2월 16일	Chang Hoon Han
 Clinical description_outcome_Bleeding.docx	2월 18일	Chang Hoon Han
 Clinical description_outcome_SCD.docx	2월 18일	Chang Hoon Han
 Clinical description_PCI.docx	2월 18일	Chang Hoon Han
 Clinical_description_outcome_HF.docx	2월 18일	Chang Hoon Han
 Clinical_description_outcome_MI.docx	2월 18일	Chang Hoon Han
 Clinical_description_outcome_Sroke.docx	2월 18일	Chang Hoon Han



My Experience in GDE 2025

Phenotype Phebruary

Cohort Building

ATLAS		Cohort Definitions		
Home				
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Cohort Definitions				
Characterizations				
Cohort Pathways				
Incidence Rates				
Profiles				
Estimation				
Prediction				
Reusables				
Jobs				

Show columns▼CopyCSVShow 50▼entries

Showing 1 to 13 of 13 entries (filtered from 18,934 total entries)

	Id	Name	Created
Prod_Group			
Untagged (18913)	1792374	[GDE2025 Antiplatelet] Outcome - GI bleeding	03/04/2025 11:09 AM
test (6)	1792373	[GDE2025 Antiplatelet] Outcome - Stroke(ischemic)	03/04/2025 11:09 AM
testing (3)	1792372	[GDE2025 Antiplatelet] Outcome - Stroke(hemorrhagic)	03/04/2025 11:06 AM
Ready for Review (2)	1792371	[GDE2025 Antiplatelet] Outcome - Stroke(both)	03/04/2025 11:03 AM
Created			
2+ Weeks Ago (18769)	1792370	[GDE2025 Antiplatelet] Outcome - AMI	03/04/2025 11:01 AM
This Week (80)	1792365	[GDE2025 Antiplatelet] Outcome - Cardiovascular mortality	03/04/2025 10:37 AM
Last Week (74)	1792364	[GDE2025 Antiplatelet] Outcome - All cause mortality	03/04/2025 10:37 AM
Within 24 Hours (11)	1792366	[GDE2025 Antiplatelet] Outcome - NACE	03/04/2025 10:42 AM
Updated			
2+ Weeks Ago (18741)	1792367	[GDE2025 Antiplatelet] Outcome - MACE	03/04/2025 10:48 AM
This Week (101)	1792369	[GDE2025 Antiplatelet] Outcome - Ischemic event	03/04/2025 10:54 AM
Last Week (78)	1792368	[GDE2025 Antiplatelet] Outcome - Hemorrhagic event	03/04/2025 10:51 AM
Within 24 Hours (14)	1792363	[GDE2025 Antiplatelet] Prasugrel cohort	03/04/2025 10:33 AM
Author			
anonymous (18846)	1792362	[GDE2025 Antiplatelet] Ticagrelor cohort	03/04/2025 10:33 AM
demo (88)			
Designs			



My Experience in GDE 2025

Phenotype Phebruary

Cohort Building

[GDE2025_Antiplatelet] Prasugrel cohort

Cohort Entry Events

People with continuous observation of 90 days before event may enter the cohort when observing any of the following:

1. procedure occurrences of '[GDE2025_Antiplatelet] PCI', who are ≥ 18 years old.

Limit cohort entry events to the earliest event per person.

Restrict entry events to with all of the following criteria:

1. having at least 1 drug exposure of '[GDE2025_Antiplatelet] Prasugrel', starting between 7 days before and 0 days after cohort entry start date.
2. having at least 1 condition occurrence of '[GDE2025_Antiplatelet] ACS', starting between 7 days before and 0 days after cohort entry start date.

Inclusion Criteria

1. Exclude Ticagrelor

Entry events having at most 0 drug exposures of '[GDE2025_Antiplatelet] Ticagrelor', starting between 30 days before and 0 days after cohort entry start date.

2. Exclude Hx of Stroke

Entry events with all of the following criteria:

1. having at most 0 condition occurrences of '[GDE2025_Antiplatelet] Ischemic stroke', starting anytime on or before cohort entry start date.
2. having at most 0 condition occurrences of '[GDE2025_Antiplatelet] Hemorrhagic stroke', starting anytime on or before cohort entry start date.

3. Exclude Hx of GI Bleeding

Entry events having at most 0 condition occurrences of '[GDE2025_Antiplatelet] GI bleeding', starting anytime on or before cohort entry start date.

Cohort Exit

The cohort end date will be based on a continuous exposure to '[GDE2025_Antiplatelet] Prasugrel': allowing 14 days between exposures, adding 0 days after exposure ends, and using days supply and exposure end date for exposure duration. The person exits the cohort when encountering any of the following events:

1. drug exposures of '[GDE2025_Antiplatelet] Ticagrelor'.
2. drug exposures of '[GDE2025_Antiplatelet] Clopidogrel'.
3. drug exposures of '[GDE2025_Antiplatelet] Cangrelor'.



My Experience in GDE 2025

Phenotype Phebruary

Cohort Diagnostics

Selected cohorts :

C1792362: [GDE2025_Antiplatelet] Ticagrelor cohort
C1792363: [GDE2025_Antiplatelet] Prasugrel cohort
C1792364: [GDE2025_Antiplatelet] Outcome - All cause mortality
C1792365: [GDE2025_Antiplatelet] Outcome - Cardiovascular mortality
C1792366: [GDE2025_Antiplatelet] Outcome - NACE
C1792367: [GDE2025_Antiplatelet] Outcome - MACE
C1792368: [GDE2025_Antiplatelet] Outcome - Hemorrhagic event
C1792369: [GDE2025_Antiplatelet] Outcome - Ischemic event
C1792370: [GDE2025_Antiplatelet] Outcome - AMI
C1792371: [GDE2025_Antiplatelet] Outcome - Stroke(both)
C1792372: [GDE2025_Antiplatelet] Outcome - Stroke(hemorrhagic)
C1792373: [GDE2025_Antiplatelet] Outcome - Stroke(ischemic)
C1792374: [GDE2025_Antiplatelet] Outcome - GI bleeding

Selected databases :

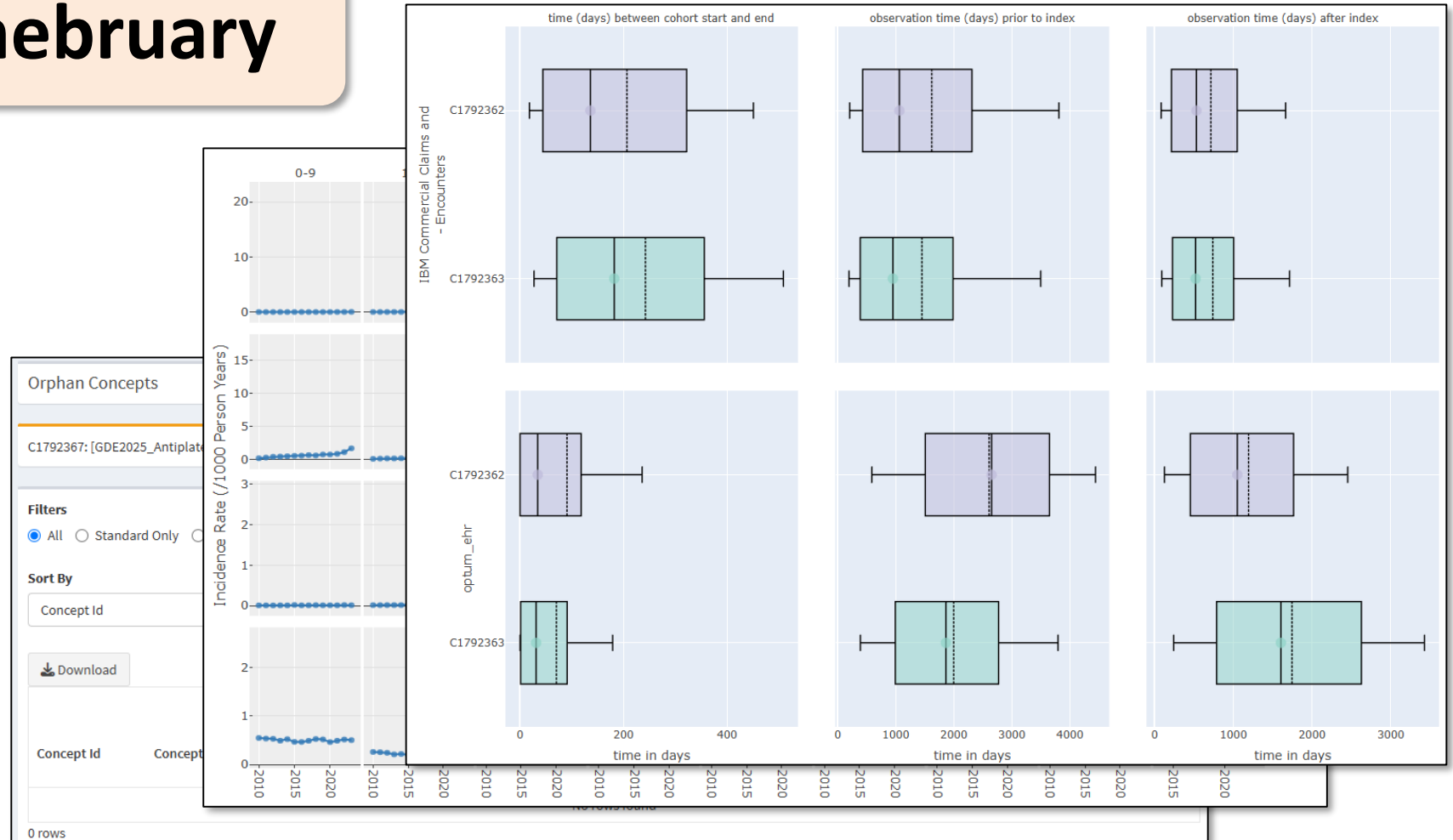
IBM Commercial Claims and Encounters
optum_ehr



My Experience in GDE 2025

Phenotype Phebruary

Cohort Diagnostics





My Experience in GDE 2025

March to Fitness

DB
Diagnostics

databaseId	↑ 1 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_NACE	2 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_MACE	3 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_All_cause_mortality	4 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Cardiovascular_mortality	5 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Ischemic_event	6 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Hemorrhagic_event	7 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Stroke	8 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_AMI	9 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_GI_bleeding	10 - [TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Hemorrhagic_stroke
1001-1001	0	0	0	0	0	0	0	0	0	0
1002-1002	0	0	0	0	0	0	0	0	0	0
1003-1007	0	0	0	0	0	0	0	0	0	0
1004-1029	0	0	0	0	0	0	0	0	0	0
1004-1030	0	0	1	1	0	0	0	0	0	0
1004-1031	0	0	2	2	0	0	0	0	0	0
1005-1017	0	0	0	0	0	0	0	0	0	0
1006-1008	0	0	0	0	0	0	0	0	0	0



My Experience in GDE 2025

March to Fitness

DB
Diagnostics

CDM Source Name	Number of Viable Analyses	Data Source Name
hdc_uchealth_kratos	11	University of Colorado
Tufts_Research_Data_Warehouse	11	Tufts Research Data Warehouse
optum_extended_ses_v2883	11	Optum Extended SES
JHM_OMOP_Nold	11	Johns Hopkins University
CUIMC_OMOP	11	CUIMC OMOP
truven_mdcr_v2886	11	Merative MDCR
optum_ehr_v2885	11	Optum EHR
STARR_OMOP_2024_08_25	11	Stanford
US Hospital	11	IQVIA OMOP US Hospital Data Master
optum_extended_dod_v2882	11	Optum Extended DOD
yuhs	11	Severance Hospital South Korea
omopcdm_trinetx	11	UMass Chan
PSH_OMOPCDM	11	Penn State Health
WUSM_Datalake	11	Washington University
VA-OMOP	11	VA OMOP
truven_mdcd_v2888	11	Merative MDCCD
UTSW	11	UT Southwestern
truven_ccae_v2887	11	Merative CCAE
UNM_MDCR_2003_2022	11	Merative MDCR
US PharMetrics Plus	9	IQVIA OMOP US PharMetrics Plus
UNM_CCAE_2003_2022	9	Merative CCAE
HealthPartners_RIOMOP	9	HealthPartners Institute
US OPEN CLAIMS	9	IQVIA OMOP US Open Claims

Analysis Name	Number Available Databases
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_AMI	23
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Hemorrhagic_event	23
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Ischemic_event	23
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_All_cause_mortality	20
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Stroke	23
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Ischemic_stroke	23
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_NACE	23
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Cardiovascular_mortality	20
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_GI_bleeding	23
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_MACE	23
[TicaPra] Ticagrelor_cohort_[TicaPra] Prasugrel_cohort_[TicaPra] Outcome_Hemorrhagic_stroke	23



Take Home Messages

- ✓ **Evidence gaps in guidelines** are golden opportunities for OHDSI to generate impactful evidence.
- ✓ Conflicting guidelines on **Ticagrelor vs Prasugrel** highlight the need for **Guideline-Driven Evidence** studies.
- ✓ OHDSI supports network studies with **powerful tools** and **structured workflows**.



Thank you for listening!

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