Table 1. Guideline recommendations for available glycoprotein IIb/IIIa antagonists in the setting of PCI.

	Abciximab	Tirofiban	Eptifibatide
Dosing	IV bolus of 0.25 mg/kg, followed by 0.125 µg/kg/min (max 10 µg/min) for 12 hours after PCI (no need for renal adjustment)	IV bolus of 25 µg/kg for 30 min followed by maintenance dose of 0.1 µg/kg/min for a minimum of 12 hours and up to 18-24 hours (dose reduction by 50% for IV bolus and maintenance dose if creatinine clearance <30 ml/min)	IV bolus of 180 µg/kg followed 10 min later by a second 180 µg/kg bolus, followed by maintenance dose of 2.0 µg/kg/min for a minimum of 12 hours and up to 18-24 hours (adjustment for maintenance dose to 1 µg/kg/min if creatinine clearance less than 50 ml/min)
2011 ACCF/AHA Focused Update of the Guidelines for the Management of Patients With Unstable Angina/Non–ST Elevation Myocardial Infarction*	***No thienopyridine treatment*** **Class I; Level of Evidence A**	***No thienopyridine treatment*** **Class I; Level of Evidence A**	***No thienopyridine treatment*** **Class I; Level of Evidence A**
	In patients at medium or high risk at the time of PCI (tirofiban or eptifibatide preferred if started before PCI)	In patients at medium or high risk before PCI, or at the time of PCI	In patients at medium or high risk, before PCI or at the time of PCI
	Dual antiplatelet therapy **High-risk patients: Class IIb; Level of Evidence B**	***Dual antiplatelet therapy*** **High-risk patients: Class IIb; Level of Evidence B**	***Dual antiplatelet therapy*** **High-risk patients: Class IIb; Level of Evidence B**
	Upstream use considered in high-risk patients, such as those with elevated troponin levels, diabetes, or significant ST segment depression, and who are not otherwise at high risk for bleeding.	Upstream use considered in high-risk patients, such as those with elevated troponin levels, diabetes, or significant ST segment depression, and who are not otherwise at high risk for bleeding	Upstream use considered in high-risk patients, such as those with elevated troponin levels, diabetes, or significant ST segment depression, and who are not otherwise at high risk for bleeding.
2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention**	***No clopidogrel pretreatment*** **SIHD: Class IIa; Level of Evidence B** **UA/NSTEMI: Class I; Level of Evidence A** **STEMI: Class IIa; Level of Evidence A**	***No clopidogrel pretreatment*** **SIHD: Class IIa; Level of Evidence B** **UA/NSTEMI: Class I; Level of Evidence A** **STEMI: Class IIa; Level of Evidence A**	***No clopidogrel pretreatment*** **SIHD: Class IIa; Level of Evidence B** **UA/NSTEMI: Class I; Level of Evidence A** **STEMI: Class IIa; Level of Evidence A**
	• UA/NSTEMI: In patients with high-risk features (e.g., elevated troponin level) treated with UFH and not with bivalirudin • STEMI: In patients undergoing primary PCI treated with UFH Intracoronary abciximab. Class IIb; Level of Evidence B Routine or upstream use is not beneficial: Class III; Level of Evidence B	• UA/NSTEMI: In patients with high-risk features (e.g., elevated troponin level) treated with UFH and not with bivalirudin • STEMI: In patients undergoing primary PCI treated with UFH Routine or upstream use is not beneficial: Class III; Level of Evidence B	• UA/NSTEMI: In patients with high-risk features (e.g., elevated troponin level) treated with UFH and not with bivalirudin • STEMI: In patients undergoing primary PCI treated with UFH Routine or upstream use is not beneficial: Class III; Level of Evidence B
	Clopidogrel pretreatment **SIHD: Class IIb; Level of Evidence B** **UA/NSTEMI: Class IIa; Level of Evidence B** **STEMI: Class IIa; Level of Evidence C**	***Clopidogrel pretreatment*** **SIHD: Class IIb; Level of Evidence B** **UA/NSTEMI: Class IIa; Level of Evidence B** **STEMI: Class IIa; Level of Evidence C**	***Clopidogrel pretreatment*** **SIHD: Class IIb; Level of Evidence B** **UA/NSTEMI: Class IIa; Level of Evidence B** **STEMI: Class IIa; Level of Evidence C**

	• UA/NSTEMI: In patients with high-risk features (e.g., elevated troponin level) treated with UFH and not with bivalirudin • STEMI: In patients undergoing primary PCI treated with UFH Intracoronary abciximab. Class IIb; Level of Evidence B Routine or upstream use is not beneficial: Class III; Level of Evidence B	• UA/NSTEMI: In patients with high-risk features (e.g., elevated troponin level) treated with UFH and not with bivalirudin • STEMI: In patients undergoing primary PCI treated with UFH Intracoronary abciximab. Class IIb; Level of Evidence B Routine or upstream use is not beneficial: Class III; Level of Evidence B	• UA/NSTEMI: In patients with high-risk features (e.g., elevated troponin level) treated with UFH and not with bivalirudin • STEMI: In patients undergoing primary PCI treated with UFH Intracoronary abciximab. Class IIb; Level of Evidence B Routine or upstream use is not beneficial: Class III; Level of Evidence B
2011 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation* **	**High-risk patients: Class I; Level of Evidence B** Among patients who are already treated with DAPT, the addition of a GP IIb/IIIa receptor inhibitor for high-risk PCI (elevated troponin, visible thrombus) is recommended if the risk of bleeding is low	**High-risk patients: Class I; Level of Evidence B** Among patients who are already treated with DAPT, the addition of a GP IIb/IIIa receptor inhibitor for high-risk PCI (elevated troponin, visible thrombus) is recommended if the risk of bleeding is low. Tirofiban added to aspirin should be considered prior to angiography in high-risk patients not preloaded with $P2Y_{12}$ inhibitors: Class IIa; Level of Evidence C. In high-risk patients, tirofiban may be considered prior to early angiography in addition to DAPT, if there is ongoing ischemia and the risk of bleeding is low: Class IIb; Level of Evidence C.	**High-risk patients: Class I; Level of Evidence B** Among patients who are already treated with DAPT, the addition of a GP IIb/IIIa receptor inhibitor for high-risk PCI (elevated troponin, visible thrombus) is recommended if the risk of bleeding is low. Eptifibatide added to aspirin should be considered prior to angiography in high-risk patients not preloaded with $P2Y_{12}$ inhibitors: Class IIa; Level of Evidence C. In high-risk patients, eptifibatide may be considered prior to early angiography in addition to DAPT, if there is ongoing ischemia and the risk of bleeding is low: Class IIb; Level of Evidence C.
2010 ESC/EACTS/EAPCI Guidelines on myocardial revascularization******	**Elective PCI: Class IIa; Level of Evidence C** **NSTE-ACS: Class I; Level of Evidence B** **STEMI: Class IIa; Level of Evidence A** • Elective PCI: Bail-out situations only (thrombus, slow flow, vessel closure, very complex lesions) • NSTE-ACS: In patients with evidence of high intracoronary thrombus burden Upstream: Class III; Level of Evidence B • STEMI: In patients with evidence of high intracoronary thrombus burden Upstream: Class III; Level of Evidence B	**Elective PCI: Class IIa; Level of Evidence C** **NSTE-ACS: Class IIa; Level of Evidence B** **STEMI: Class IIb; Level of Evidence B** • Elective PCI: Bail-out situations only (thrombus, slow flow, vessel closure, very complex lesions) • NSTE-ACS: In patients with evidence of high intracoronary thrombus burden Upstream: Class III; Level of Evidence B • STEMI: In patients with evidence of high intracoronary thrombus burden Upstream: Class III; Level of Evidence B	**Elective PCI: Class IIa; Level of Evidence C** **NSTE-ACS: Class IIa; Level of Evidence B** **STEMI: Class IIa; Level of Evidence B** • Elective PCI: Bail-out situations only (thrombus, slow flow, vessel closure, very complex lesions) • NSTE-ACS: In patients with evidence of high intracoronary thrombus burden Upstream: Class III; Level of Evidence B • STEMI: In patients with evidence of high intracoronary thrombus burden Upstream: Class III; Level of Evidence B

DAPT: dual antiplatelet therapy; IV: intravenous; NSTE-ACS: non-ST elevation acute coronary syndrome; PCI: percutaneous coronary intervention; SIHD: stable ischemic heart disease; STEMI: ST elevation myocardial infarction; UA/NSTEMI: unstable angina / non-ST-elevation myocardial infarction; UFH: unfractionated heparin.

* General recommendations:

1. For patients in whom an initial conservative strategy is selected, if recurrent symptoms/ischemia, heart failure (HF), or serious arrhythmias subsequently appear, then diagnostic angiography should be performed (Level of Evidence: A). Either an IV GP IIb/IIIa inhibitor (eptifibatide or tirofiban [Level of Evidence: A]) or clopidogrel (loading dose followed by daily maintenance dose [Level of Evidence: B]) should be added to ASA and anticoagulant therapy before diagnostic angiography (upstream) (Level of Evidence: C). Class I.
2. In patients in whom an initial conservative strategy is selected and who have recurrent ischemic discomfort with clopidogrel, ASA, and anticoagulant therapy, it is reasonable to add a GP IIb/IIIa inhibitor before diagnostic angiography. Class IIa; Level of Evidence C.
3, Abciximab should not be administered to patients in whom PCI is not planned. Class III; Level of Evidence A.
4. In patients at low risk for ischemic events (e.g., TIMI risk score <2) or at high risk of bleeding and who are already receiving ASA and clopidogrel, upstream GP IIb/IIIa inhibitors are not recommended. Class III; Level of Evidence B.

** General recommendations:

1. GPI use in STEMI may be most appropriate in those with large anterior MI and/or large thrombus burden

2. Recommendations apply to those patients not at high risk for bleeding complications.

*** General recommendations:

1. The choice of combination of oral antiplatelet agents, a GP IIb/IIIa receptor inhibitor, and anticoagulants should be made in relation to the risk of ischemic and bleeding events: Class I; Level of Evidence C.
2. GP IIb/IIIa receptor inhibitors are not recommended routinely before angiography in an invasive treatment strategy: Class III; Level of Evidence A.
3. GP IIb/IIIa receptor inhibitors are not recommended for patients on DAPT who are treated conservatively. Class III; Level of Evidence A.
4. Upstream use of GP IIb/IIIa receptor inhibitors may be considered if there is active ongoing ischemia among high-risk patients or where DAPT is not feasible. Patients who receive initial treatment with eptifibatide or tirofiban before angiography should be maintained on the same drug during and after PCI.

****General recommendations:

1. Adopt selective downstream use of GPIIb–IIIa inhibitors, as required in the catheterization laboratory, in preference to unselective upstream use.