Tratamiento antiagregante en el pre, intra y post IAM

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Conflictos de interés: AstraZeneca

Pre-tratamiento antiagregante en STEMI
¿Sí o no?

ESC European Society of Cardiology
European Heart Journal (2017) 00, 1–66
doi:10.1093/eurheartj/ehx393
ESC GUIDELINES

2017 ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation

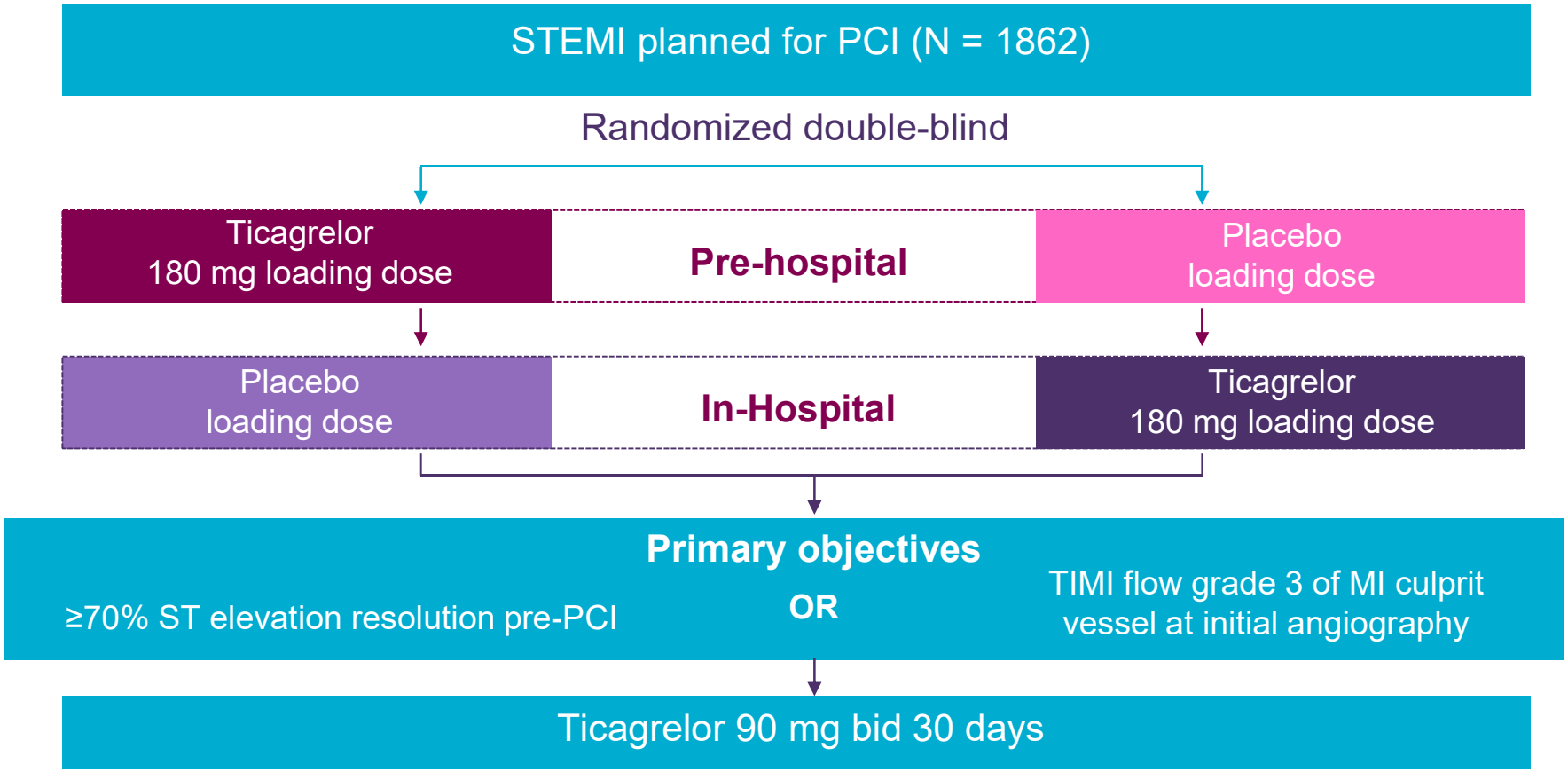
The Task Force for the management of acute myocardial infarction in patients presenting with ST-segment elevation of the European Society of Cardiology (ESC)

minor bleeding events were identical in both treatment arms. While the evidence of a clinical benefit of $P2Y_{12}$ inhibitor pre-treatment in this setting is lacking, early initiation of a $P2Y_{12}$ inhibitor while the patient is being transported to a primary PCI centre is common practice in Europe and is consistent with the pharmacokinetic data. Furthermore, early treatment with high-dose clopidogrel was superior to in-catheterization laboratory treatment in observational studies and one small randomized trial.[183–185] In all, the data suggest that the earliest administration may be preferable to achieve early efficacy, particularly for long delays. However, in cases in which the STEMI diagnosis is not clear, delaying $P2Y_{12}$ inhibitor loading until the anatomy is known should be considered.

Ibanez B et al. European Heart Journal (2017) 00, 1–66 - doi:10.1093/eurheartj/ehx393

ATLANTIC

Administration of Ticagrelor in the cath Lab or in the Ambulance for New ST-elevation MI to open the coronary artery

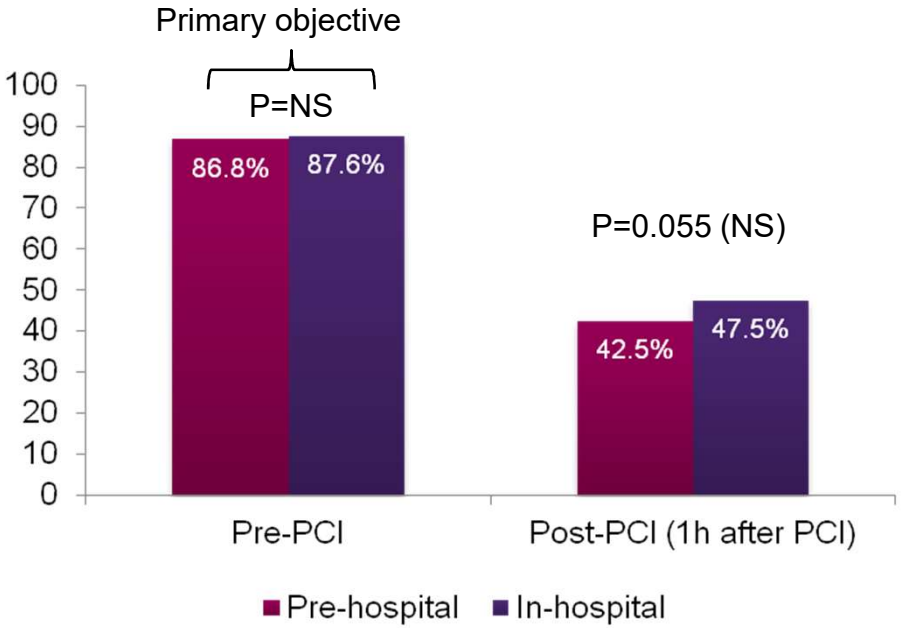


Montalescot G et al. N Engl J Med 2014;371:1016-27.

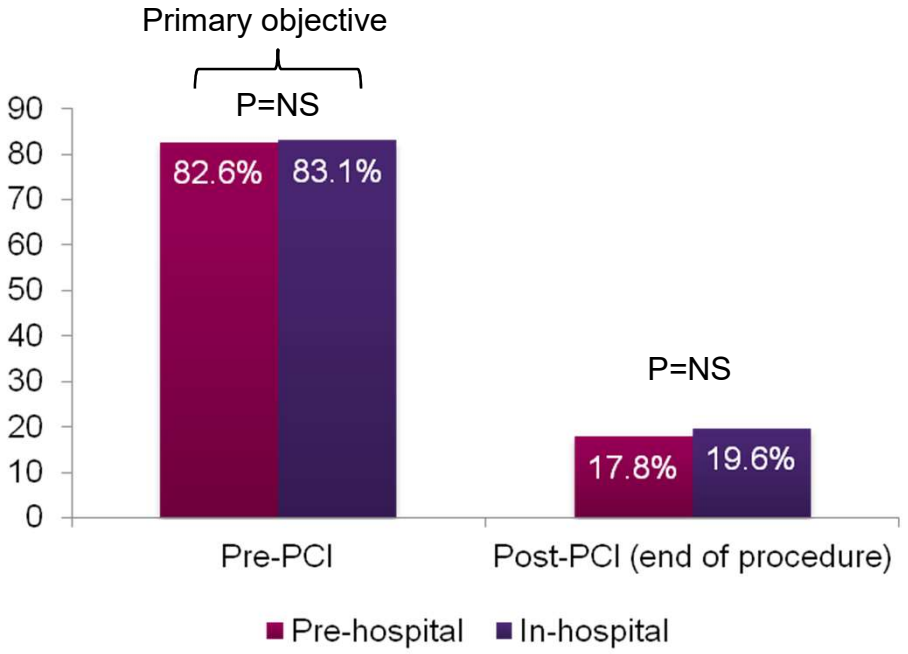
ATLANTIC

Results – coprimary endpoints:

Absence of ST-segment elevation resolution (%)



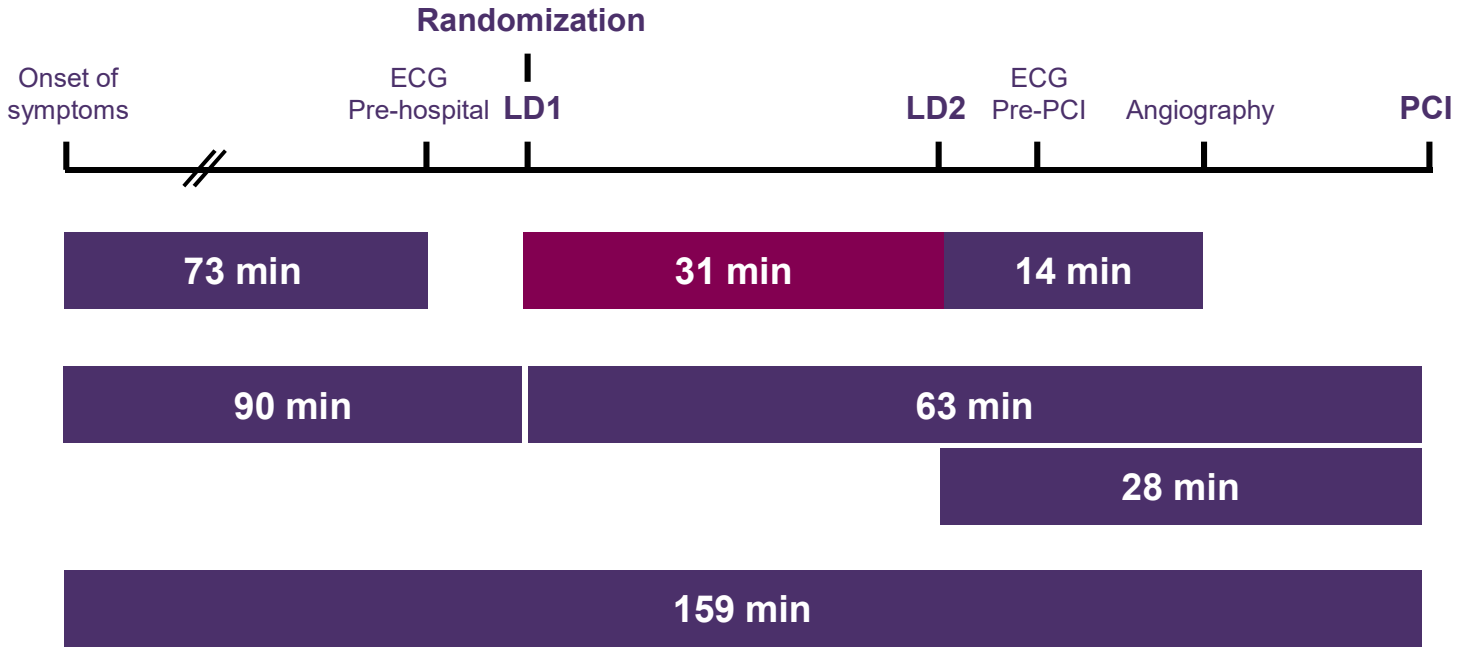
Absence of TIMI-flow grade 3 in IRA (%)



Montalescot G et al. N Engl J Med 2014;371:1016-27.

ATLANTIC

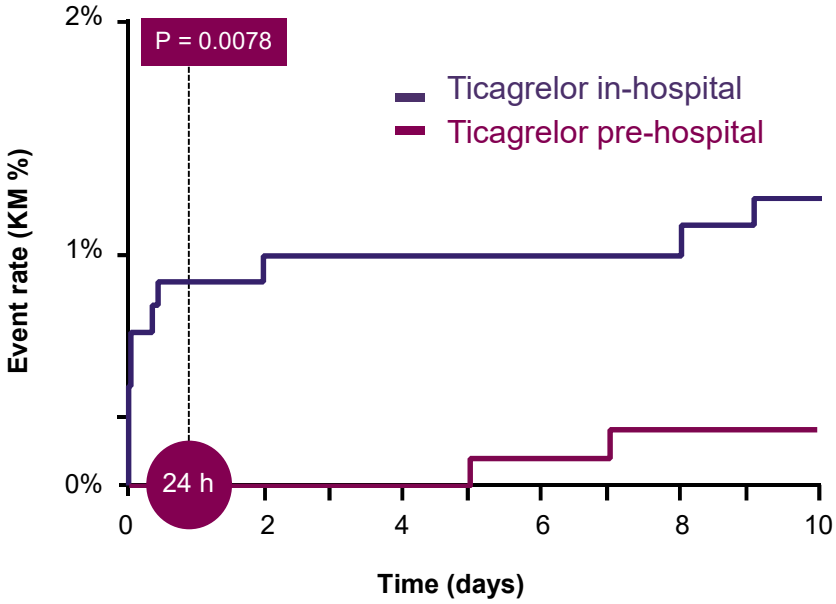
Median times to pre- and in-hospital steps

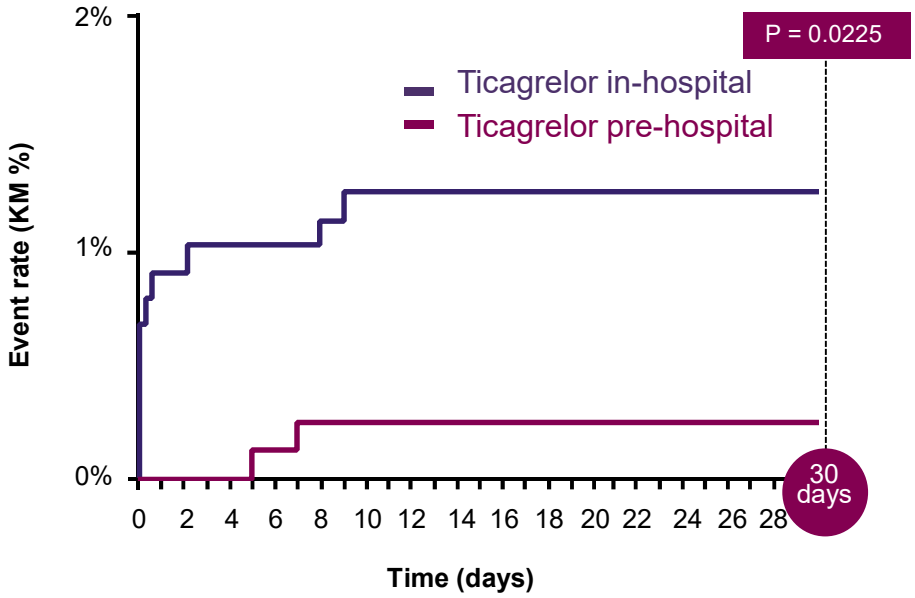


Montalescot G et al. N Engl J Med 2014;371:1016-27.

ATLANTIC

Secondary endpoint: Stent thrombosis





Ticagrelor pre-hospital 0.2% vs in-hospital 1.2%

OR 0.19 (0.04-0.86) p=0.0225

Montalescot G et al. N Engl J Med 2014;371:1016-27.

ACCF/AHA Guideline

2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction

A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines

Developed in Collaboration With the American College of Emergency Physicians and Society for Cardiovascular Angiography and Interventions

Circulation 2013 Jan 29;127(4):529-55.

3.4. Antiplatelet Therapy to Support Primary PCI for STEMI

See Table 3 for a summary of recommendations from this section.

Class I

1. Aspirin 162 to 325 mg should be given before primary PCI.[74–76] (*Level of Evidence: B*)
2. After PCI, aspirin should be continued indefinitely.[77,78,80] (*Level of Evidence: A*)
3. A loading dose of a $P2Y_{12}$ 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[76,81,82] (*Level of Evidence: B*); or
   b. Prasugrel 60 mg[83] (*Level of Evidence: B*); or
   c. Ticagrelor 180 mg.[84] (*Level of Evidence: B*)

Circulation 2013 Jan 29;127(4):529-55.

ACCF/AHA Guideline

2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction

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Table 3. Adjunctive Antithrombotic Therapy to Support Reperfusion With Primary PCI

	COR	LOE
Antiplatelet therapy		
Aspirin		
• 162- to 325-mg load before procedure	I	B
• 81- to 325-mg daily maintenance dose (indefinite)*	I	A
• 81 mg daily is the preferred maintenance dose*	IIa	B
$P2Y_{12}$ inhibitors		
Loading doses		
• Clopidogrel: 600 mg as early as possible or at time of PCI	I	B
• Prasugrel: 60 mg as early as possible or at time of PCI	I	B
• Ticagrelor: 180 mg as early as possible or at time of PCI	I	B

Circulation 2013 Jan 29;127(4):529-55.

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4.4.2 Emergency medical system

An EMS with an easily recalled and well publicized unique medical dispatching number (112 for most medical emergencies across Europe) is important to speed up activation. Parallel circuits for referral and transport of patients with a STEMI that bypass the EMS should be avoided. The ambulance system has a critical role in the early management of STEMI patients and it is not only a mode of transport but also a system to enhance early initial diagnosis, triage, and treatment.[87,94]

Ibanez B et al. European Heart Journal (2017) 00, 1–66 - doi:10.1093/eurheartj/ehx393

ESC European Society of Cardiology
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It is recommended that ambulance teams are trained and equipped to identify STEMI (with use of ECG recorders and telemetry as necessary) and administer initial therapy, including fibrinolysis when applicable.[95]	I	C

Ibanez B et al. European Heart Journal (2017) 00, 1–66 - doi:10.1093/eurheartj/ehx393

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Periprocedural and post-procedural antithrombotic therapy[a] in patients undergoing primary percutaneous coronary intervention

Recommendations	Class[b]	Level[c]
Antiplatelet therapy		
A potent $P2Y_{12}$ inhibitor (prasugrel or ticagrelor), or clopidogrel if these are not available or are contraindicated, is recommended before (or at latest at the time of) PCI and maintained over 12 months, unless there are contraindications such as excessive risk of bleeding.[186,187]	I	A
Aspirin (oral or i.v. if unable to swallow) is recommended as soon as possible for all patients without contraindications.[213,214]	I	B

Ibanez B et al. European Heart Journal (2017) 00, 1–66 - doi:10.1093/eurheartj/ehx393

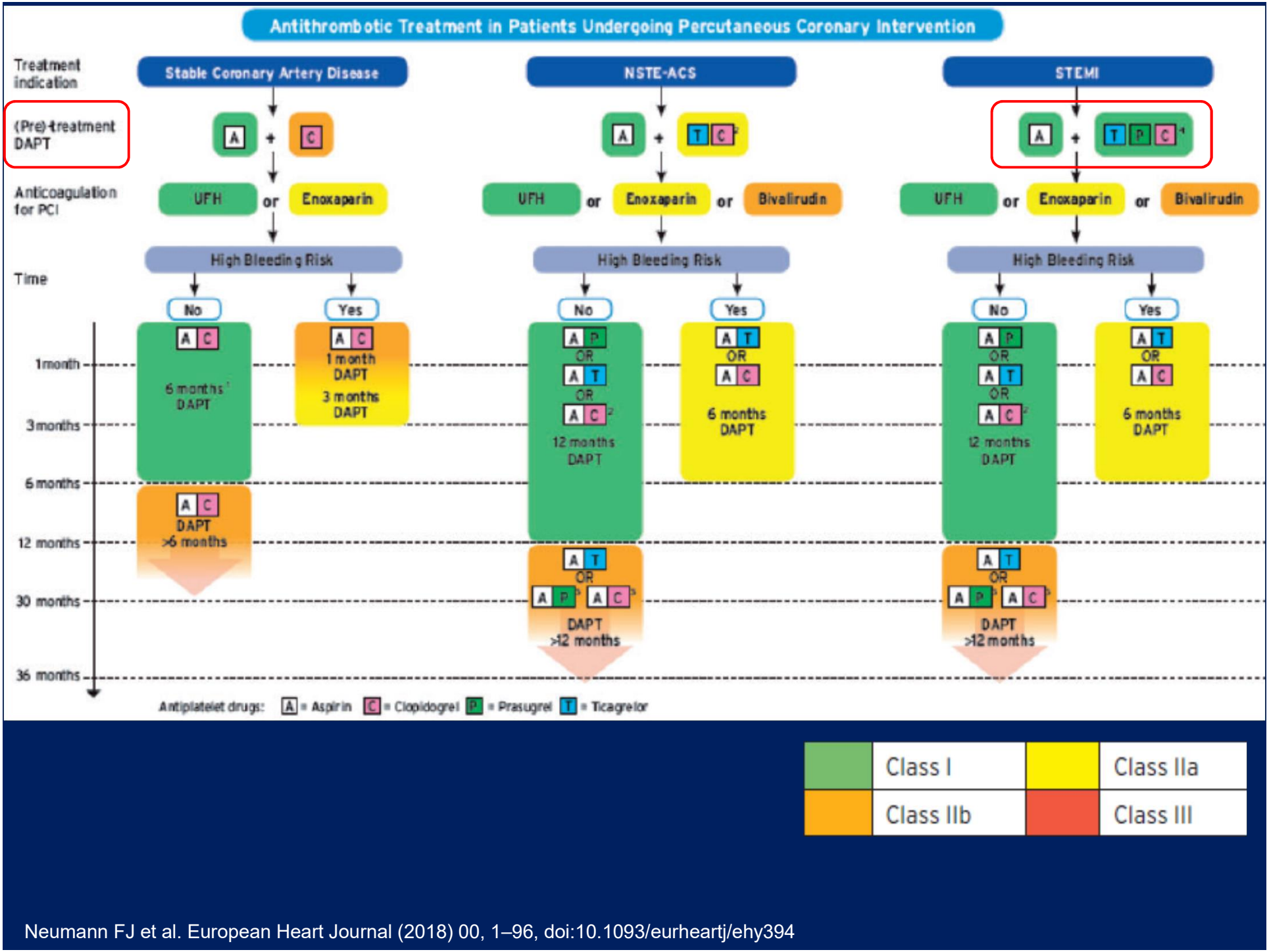
ESC
European Society of Cardiology
European Heart Journal (2018) **00**, 1–96
doi:10.1093/eurheartj/ehy394

ESC/EACTS GUIDELINES

2018 ESC/EACTS Guidelines on myocardial revascularization

The Task Force on myocardial revascularization of the European Society of Cardiology (ESC) and European Association for Cardio-Thoracic Surgery (EACTS)

Neumann FJ et al. European Heart Journal (2018) 00, 1–96, doi:10.1093/eurheartj/ehy394



Neumann FJ et al. European Heart Journal (2018) 00, 1–96, doi:10.1093/eurheartj/ehy394

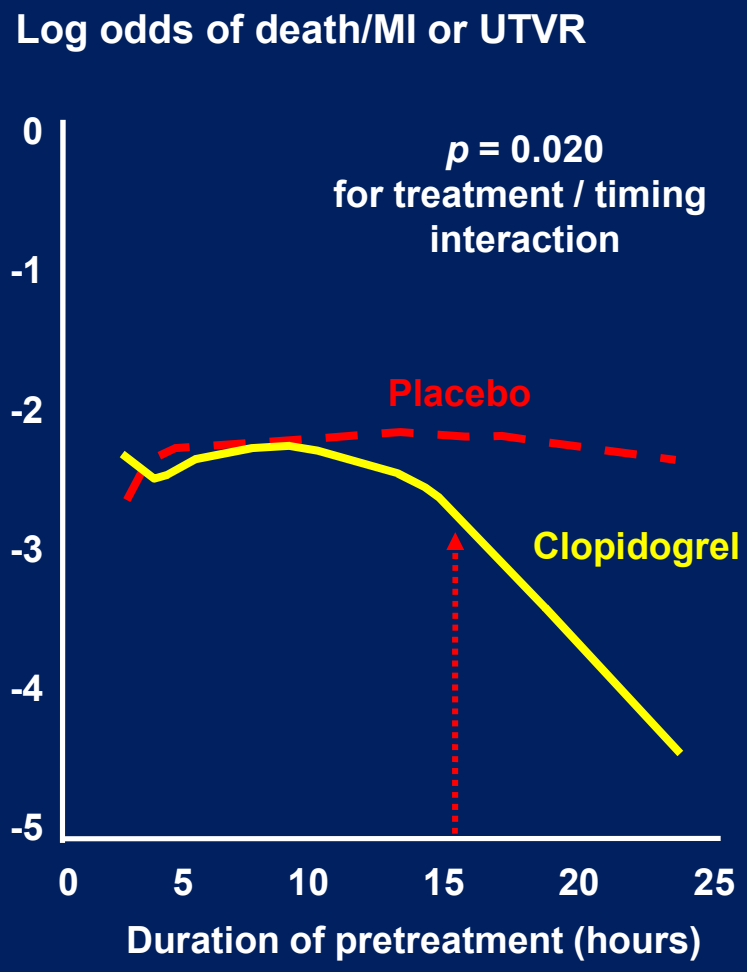
Pre-tratamiento antiagregante en STEMI
¿Sí o no?

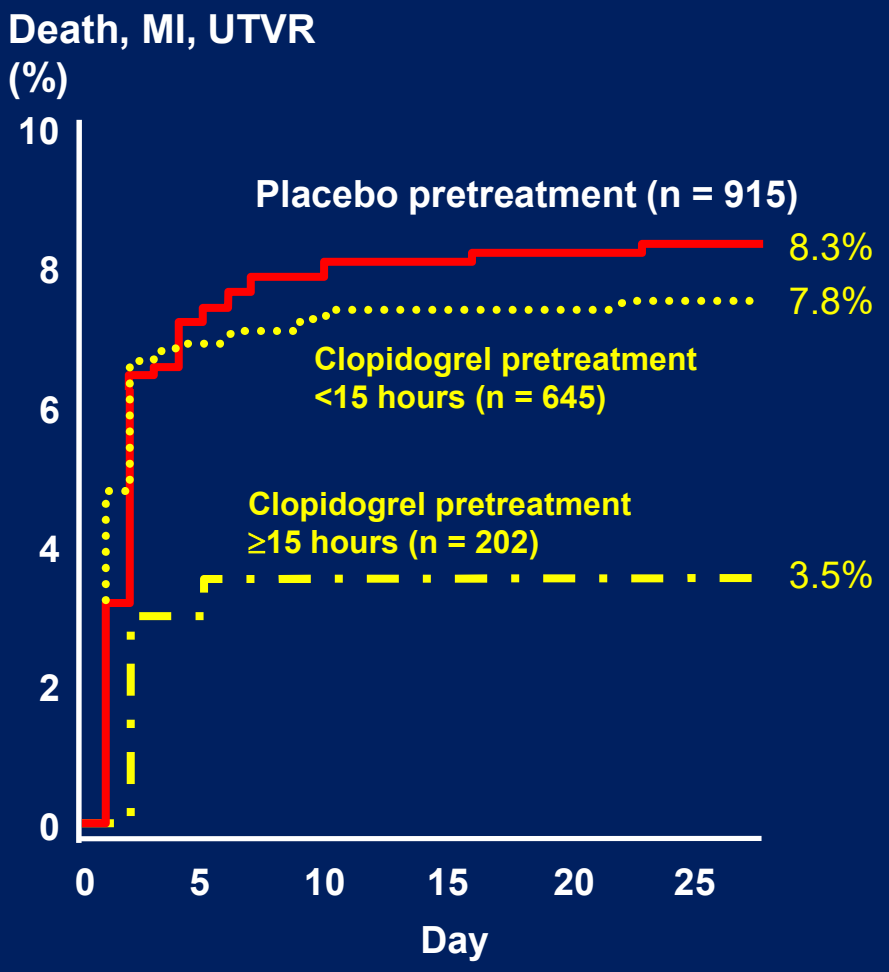
STEMI: Sí

SCA no ST: Aún hay debate.

¿Qué droga usar?

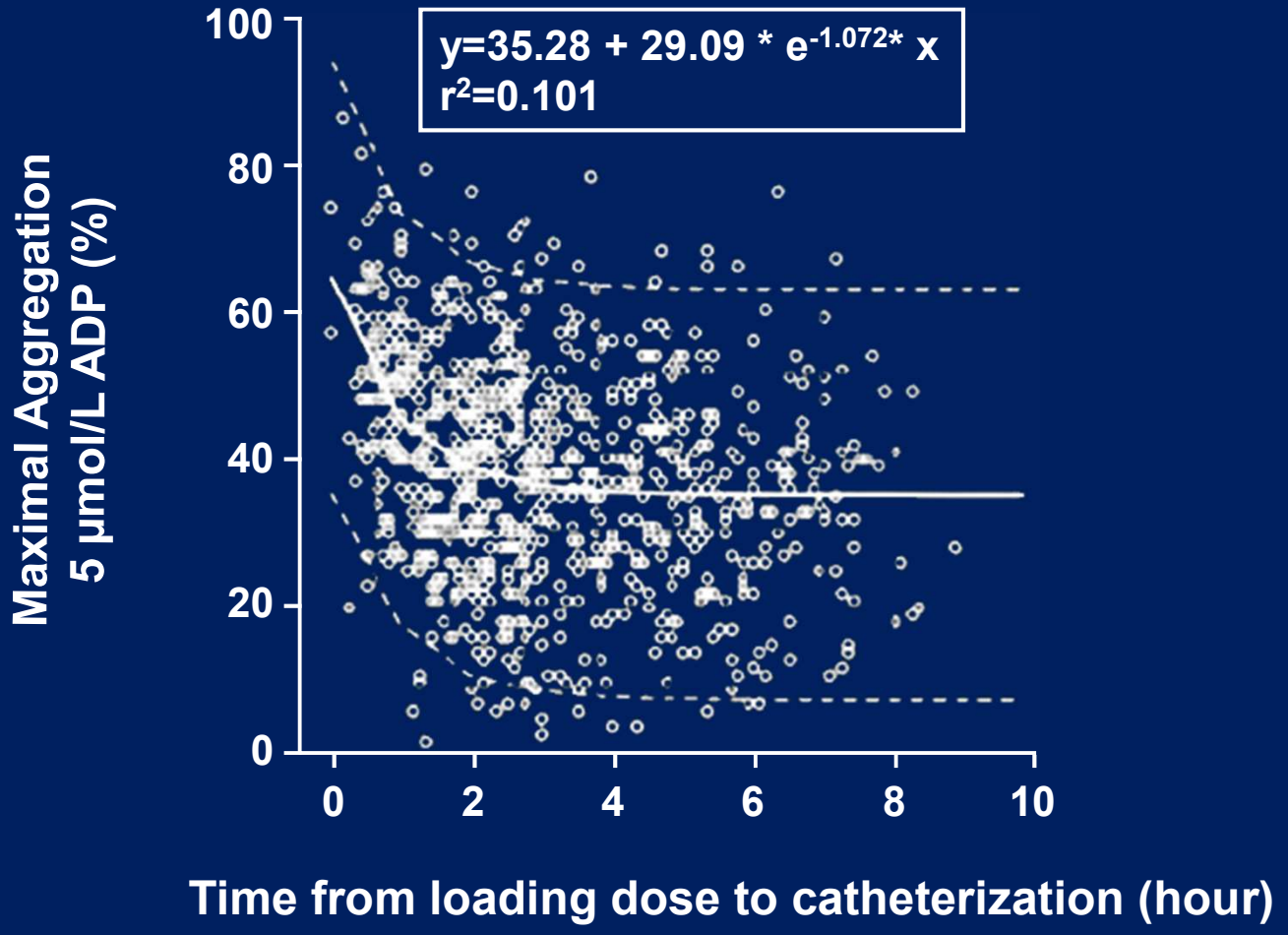
CREDO: Optimal timing for initiation of pretreatment with 300 mg clopidogrel before PCI





Steinhubl S et al. *J Am Coll Cardiol* 2006; 47: 939-943.

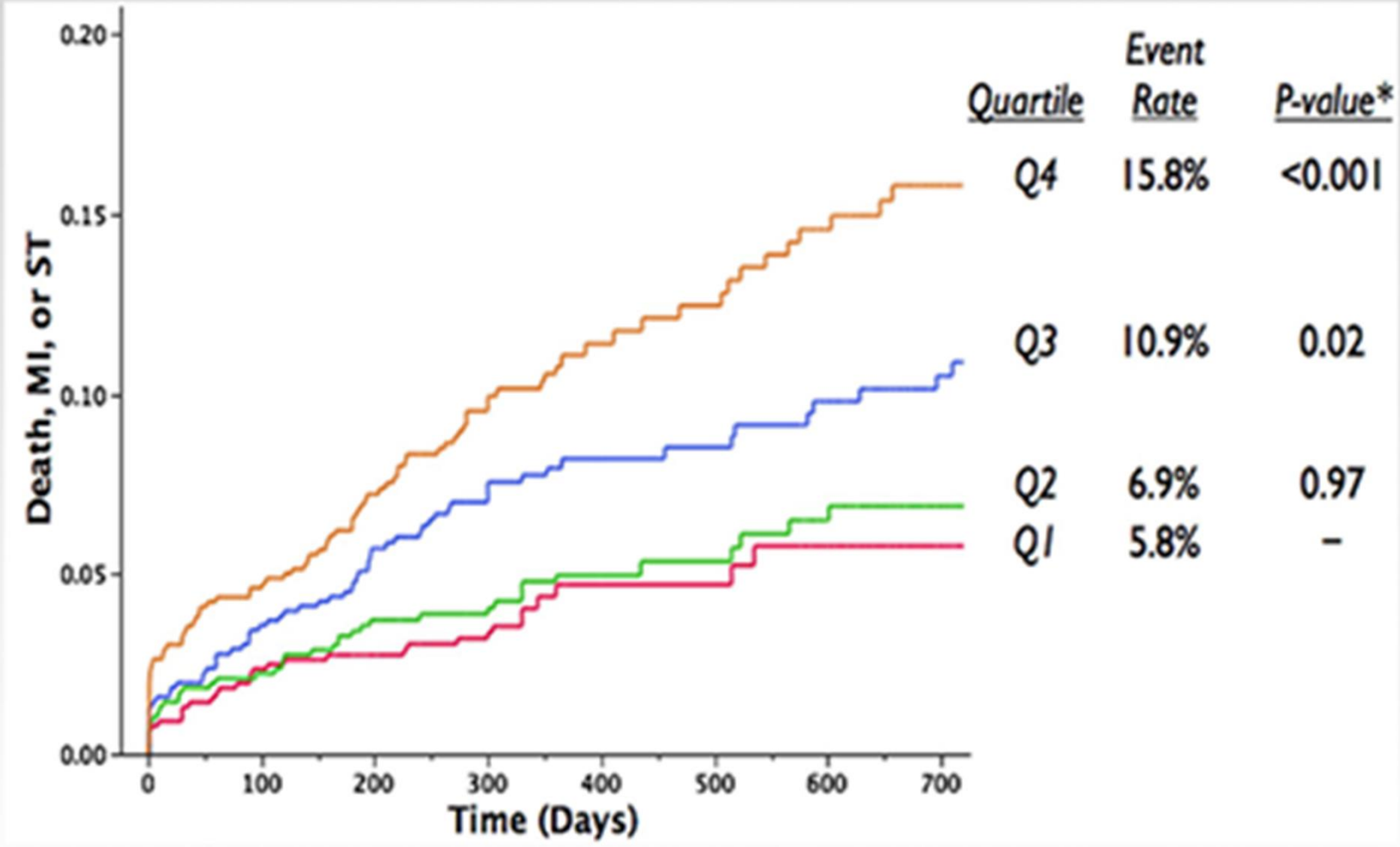
Inter-individual variability: Clopidogrel 600 mg



Hochholzer W et al. *Circulation.* 2005; 111: 2560-4.

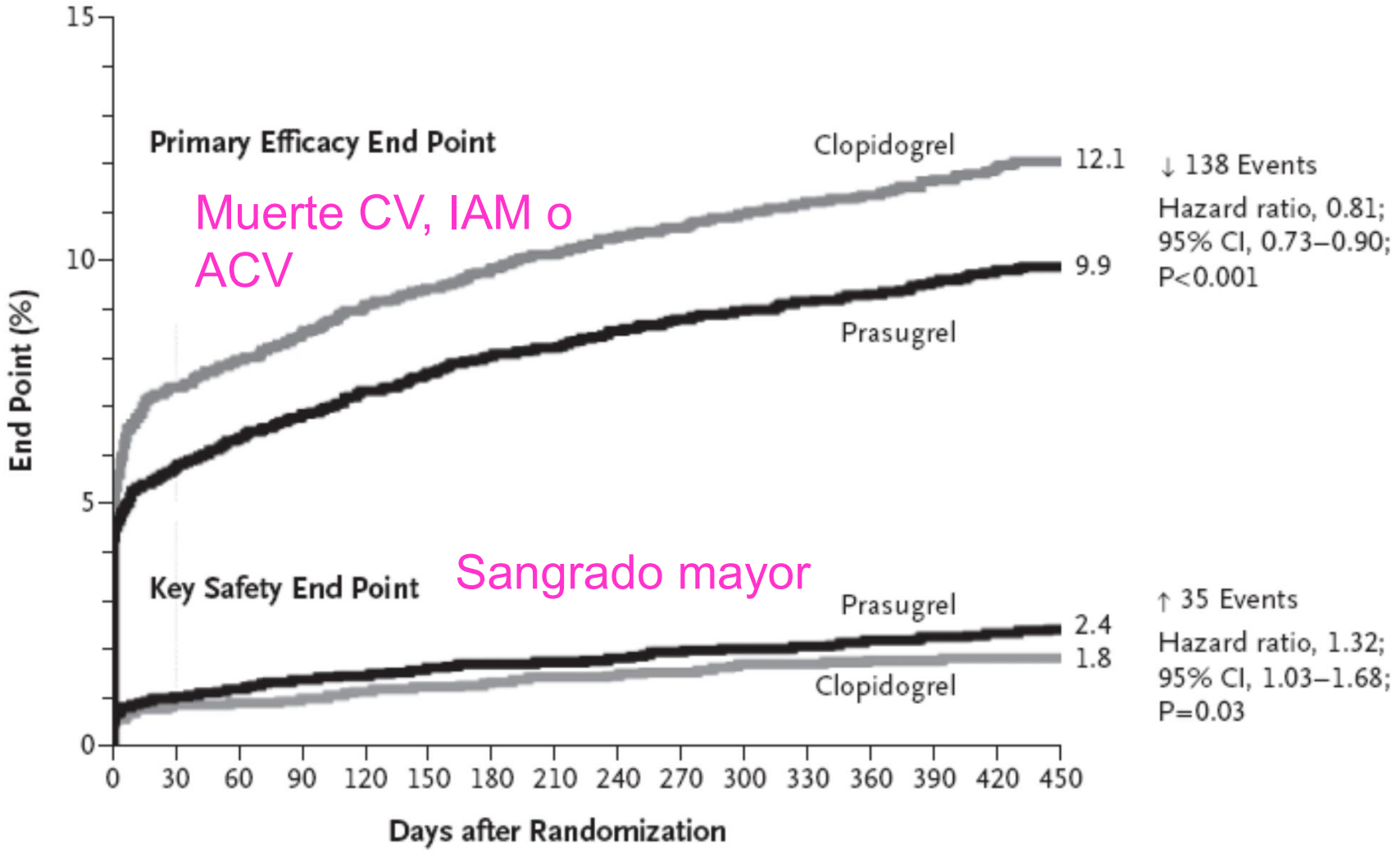
Platelet Reactivity and Outcomes

Meta-analysis of 3059 Patients



Brar SS et al. J Am Coll Cardiol 2011; 58: 1945-54.

TRITON TIMI 38 – Puntos finales de eficacia y seguridad



TRITON TIMI 38 - N Engl J Med 2007; 357: 2001-2015.

TRITON TIMI 38 – Puntos finales de eficacia

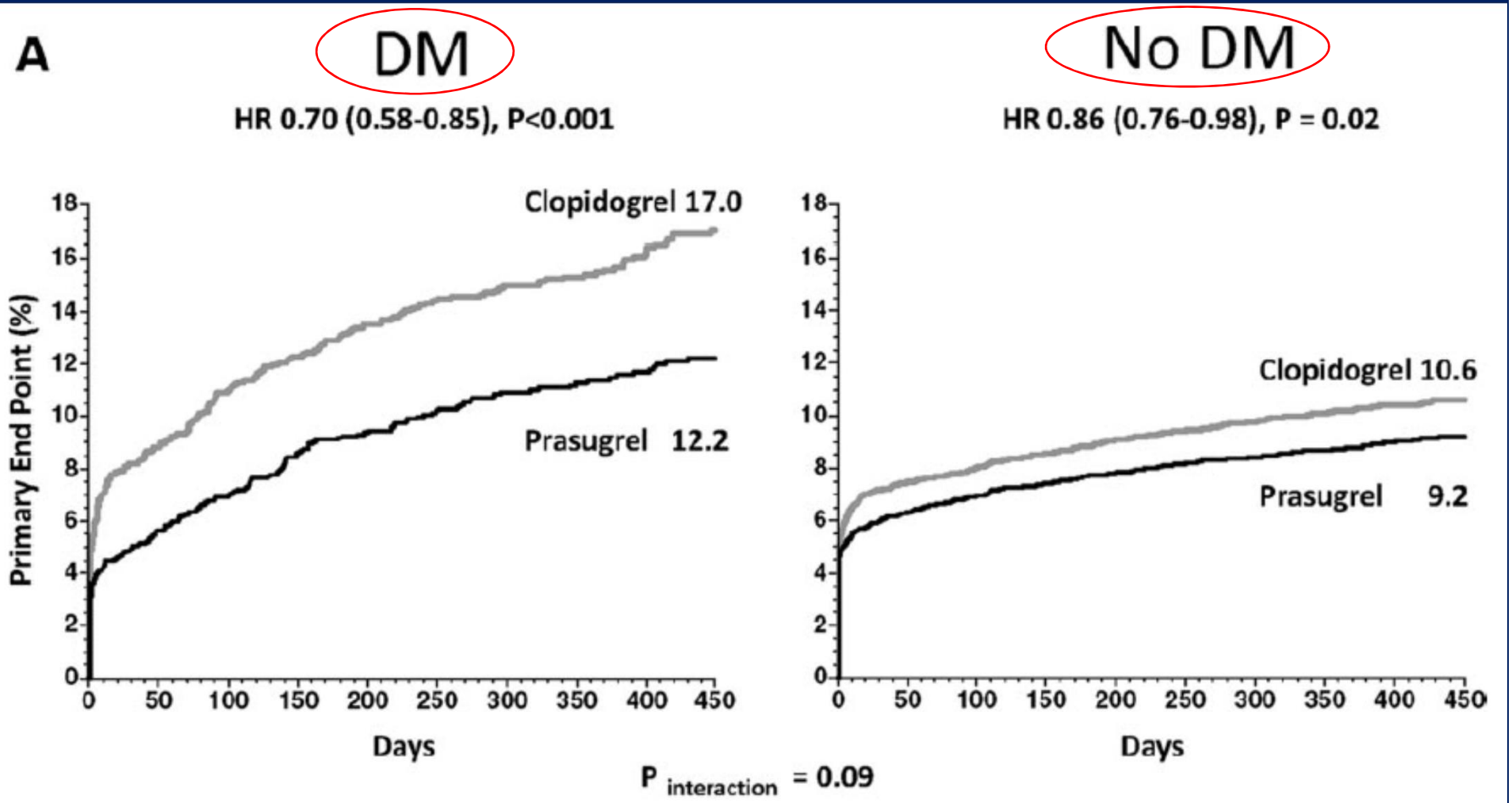
Table 2. Major Efficacy End Points in the Overall Cohort at 15 Months.*

End Point	Prasugrel (N=6813)	Clopidogrel (N=6795)	Hazard Ratio for Prasugrel (95% CI)	P Value†
	no. of patients (%)			
Death from cardiovascular causes, nonfatal MI, or nonfatal stroke (primary end point)	643 (9.9)	781 (12.1)	0.81 (0.73–0.90)	<0.001
Death from cardiovascular causes	133 (2.1)	150 (2.4)	0.89 (0.70–1.12)	0.31
Nonfatal MI	475 (7.3)	620 (9.5)	0.76 (0.67–0.85)	<0.001
Nonfatal stroke	61 (1.0)	60 (1.0)	1.02 (0.71–1.45)	0.93
Death from any cause	188 (3.0)	197 (3.2)	0.95 (0.78–1.16)	0.64

El beneficio clínico neto (muerte CV, IAM, ACV o sangrado mayor) benefició a prasugrel: HR 0,87 (0,79-0,95), p=0,004
excepto en ancianos (>75 años), bajo peso (<60 kg) o antec ACV/AIT.

TRITON TIMI 38 - N Engl J Med 2007; 357: 2001-2015.

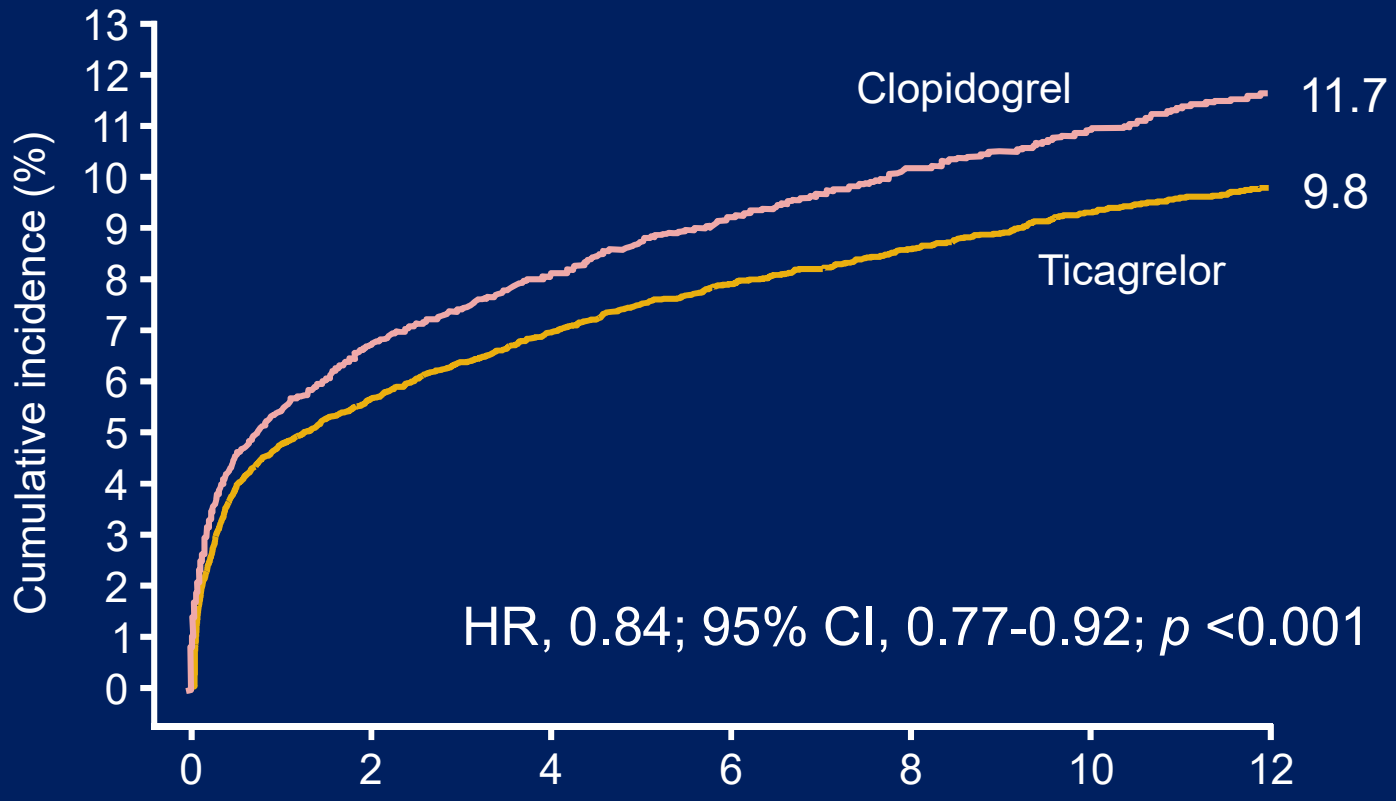
TRITON TIMI 38 – Subestudio diabetes



Wiviott S et al (TRITON-TIMI 38) - Circulation 2008;118:1626-1636.

PLATO: primary endpoint

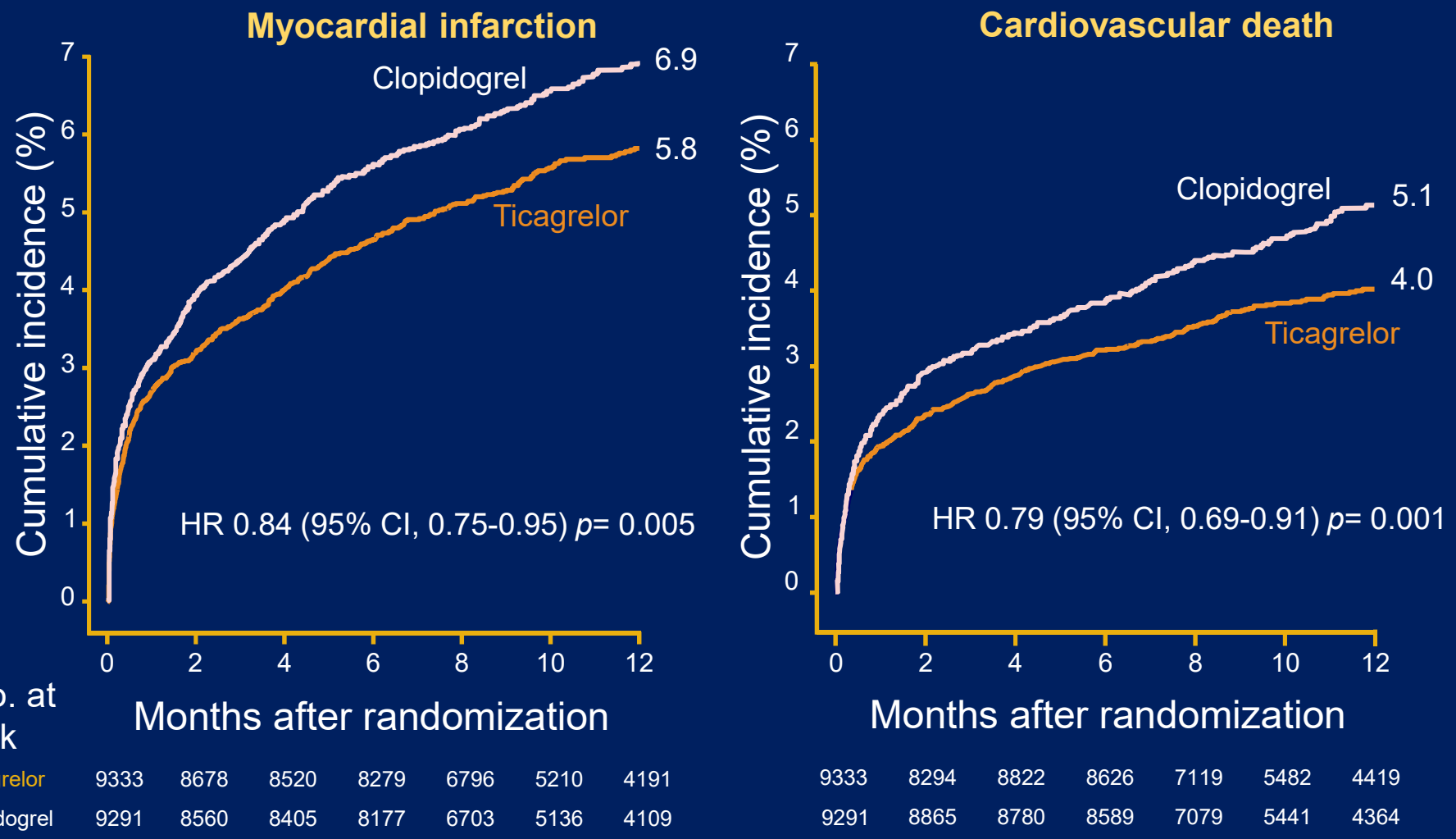
K-M estimate of time to major CV event (composite of CV death, MI or stroke)



No. at risk							
Ticagrelor	9333	8628	8460	8219	6743	5161	4147
Clopidogrel	9291	8521	8362	8124	6650	5096	4047

Wallentin L, et al. *N Engl J Med*. 2009;361:1045-1057

PLATO: K-M estimates of time to secondary efficacy endpoints*



No. at risk

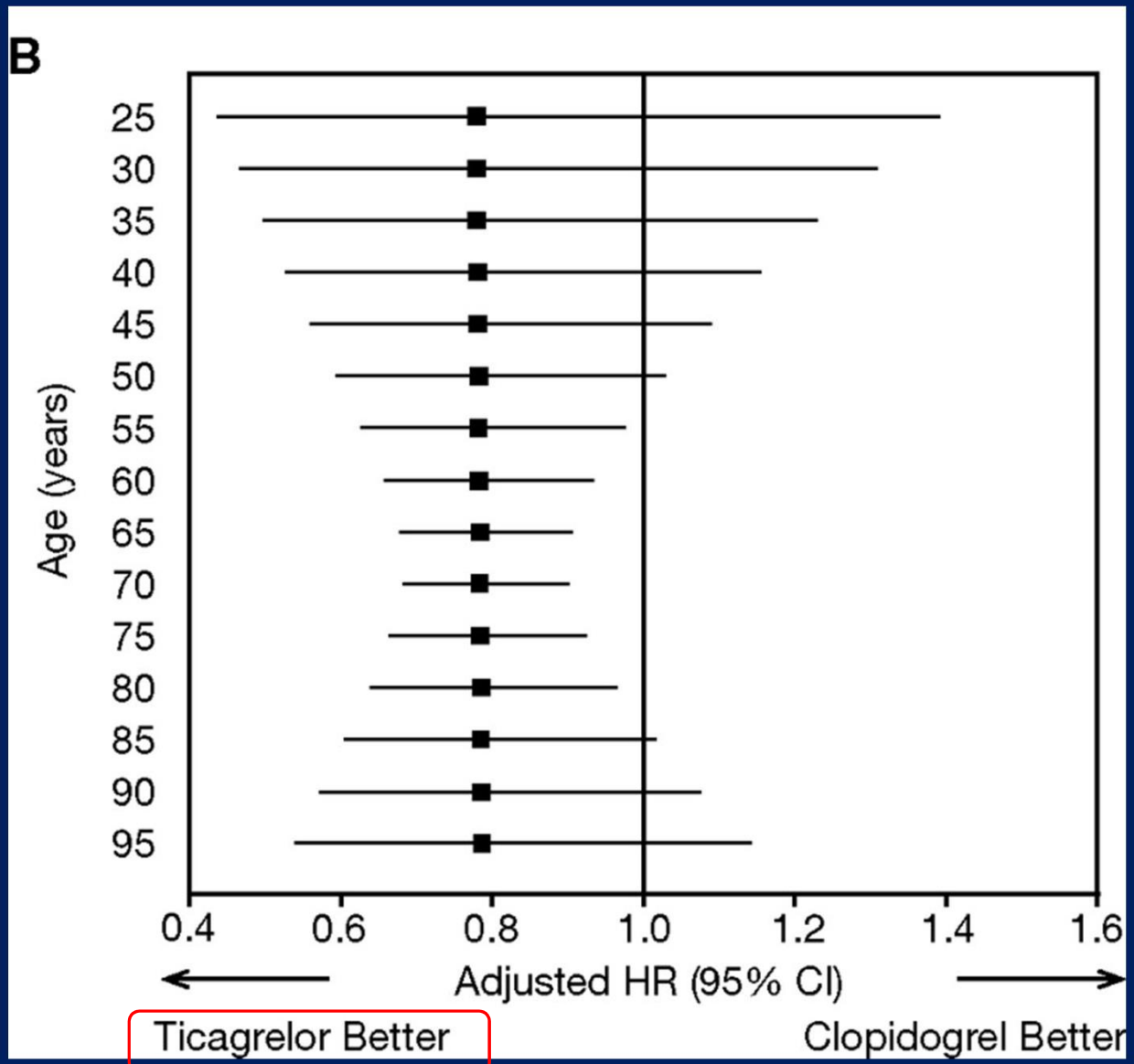
Ticagrelor	9333	8678	8520	8279	6796	5210	4191
Clopidogrel	9291	8560	8405	8177	6703	5136	4109

9333	8294	8822	8626	7119	5482	4419
9291	8865	8780	8589	7079	5441	4364

*The rate of stroke did not differ significantly between the 2 treatment groups

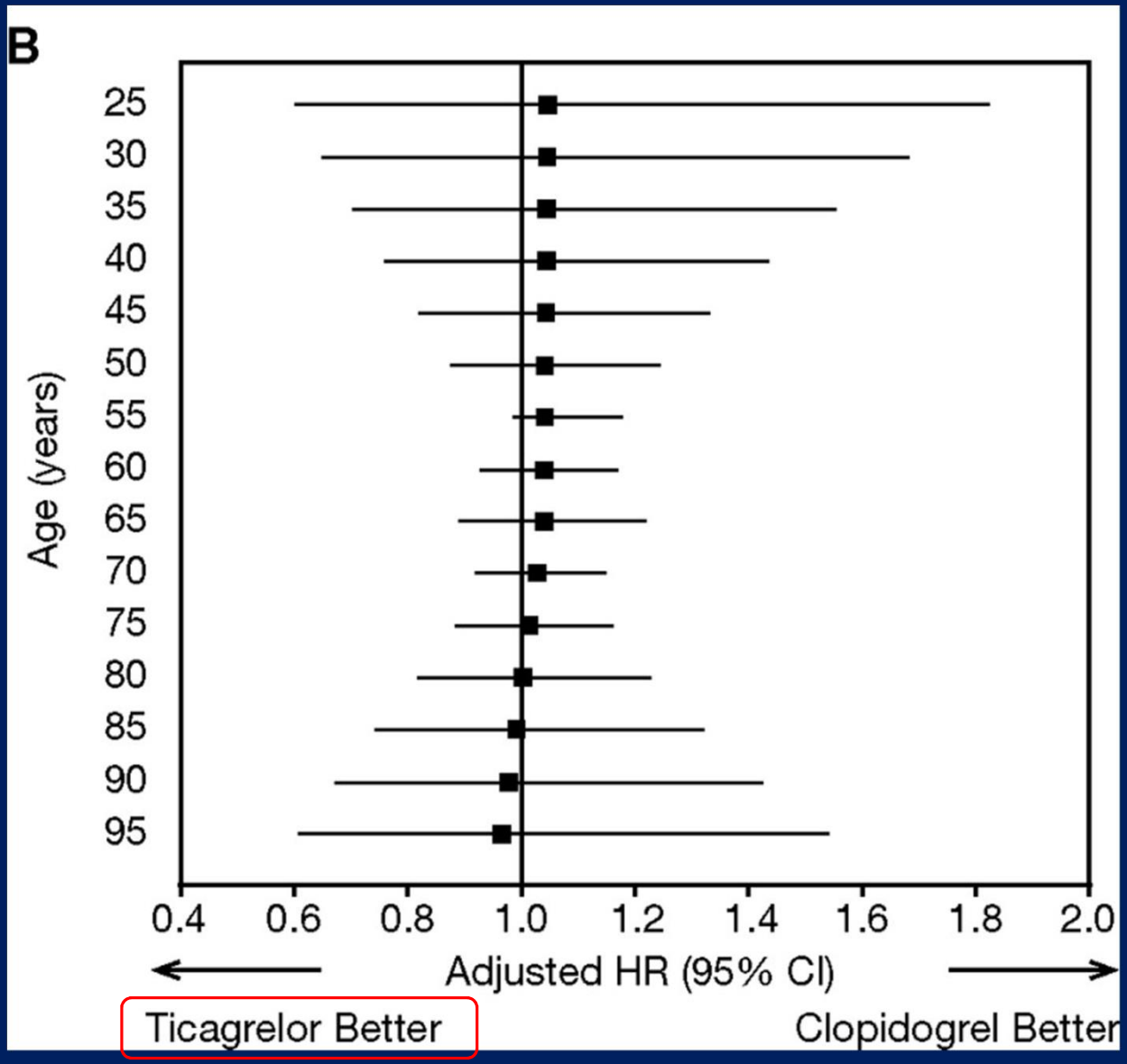
Wallentin L, et al. *N Engl J Med*. 2009;361:1045-1057.

PLATO - All-cause mortality according to age.



Husted S et al. Circ Cardiovasc Qual Outcomes 2012;5:680-688.

PLATO – Overall Plato major bleeding according to age



Husted S et al. Circ Cardiovasc Qual Outcomes 2012;5:680-688.

¿Qué droga usar?

¡Antiagregantes potentes!

European Heart Journal
doi:10.1093/eurheartj/ehr236

ESC GUIDELINES

ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

The Task Force for the management of acute coronary syndromes (ACS) in patients presenting without persistent ST-segment elevation of the European Society of Cardiology (ESC)

Authors/Task Force Members: Christian W. Hamm (Chairperson) (Germany)*, Jean-Pierre Bassand (Co-Chairperson)*, (France), Stefan Agewall (Norway), Jeroen Bax (The Netherlands), Eric Boersma (The Netherlands), Hector Bueno (Spain), Pio Caso (Italy), Dariusz Dudek (Poland), Stephan Gielen (Germany), Kurt Huber (Austria), Magnus Ohman (USA), Mark C. Petrie (UK), Frank Sonntag (Germany), Miguel Sousa Uva (Portugal), Robert F. Storey (UK), William Wijns (Belgium), Doron Zahger (Israel).

European Heart Journal 2011; 32: 2999-3054.

Guías ESC - SCA sin elevación del segmento ST

Debiera administrarse aspirina a todos los pacientes sin contraindicaciones, a una dosis de carga inicial de150–300 mg, y una dosis de mantenimiento a largo plazo de 75–100 mg por día, independientemente de la estrategia de tratamiento.	I	A
Se recomienda ticagrelor (dosis de carga de 180 mg, mantenimiento 90 mg dos veces/día) para todos los pacientes de moderado a alto riesgo de eventos isquémicos (ej. troponinas elevadas), independientemente de la estrategia de tratamiento inicial e incluyendo aquellos pretratados con clopidogrel (el cual debe ser discontinuado cuando se inicie ticagrelor).	I	B
Se recomienda prasugrel (dosis de carga de 60 mg, mantenimiento 10 mg/día) para los pacientes vírgenes de inhibidores $P2Y_{12}$ (especialmente diabéticos) en los que su anatomía coronaria sea conocida y que esten procediendo a una angioplastia, excepto que exista un alto riesgo de sangrado amenazante para la vida u otra contraindicación.	I	B
Se recomienda clopidogrel (dosis de carga de 300 mg, mantenimiento 75 mg/día) para pacientes que no puedan recibir ticagrelor o prasugrel.	I	A

European Heart Journal 2011; 32: 2999-3054.

European Heart Journal
doi:10.1093/eurheartj/ehs215

ESC GUIDELINES

ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation

The Task Force on the management of ST-segment elevation acute myocardial infarction of the European Society of Cardiology (ESC)

Table 12 Periprocedural antithrombotic medication in primary percutaneous coronary intervention

Recommendations	Class[a]	Level[b]	Ref[c]
Antiplatelet therapy			
Aspirin oral or i.v. (if unable to swallow) is recommended	I	B	133, 134
An ADP-receptor blocker is recommended in addition to aspirin. Options are:	I	A	135, 136
• Prasugrel in clopidogrel-naive patients, if no history of prior stroke/TIA, age <75 years.	I	B	109
• Ticagrelor.	I	B	110
• Clopidogrel, preferably when prasugrel or ticagrelor are either not available or contraindicated.	I	C	-

Eur Heart J 2012; DOI:10.1093/eurheartj/ehs215

Canadian Journal of Cardiology 29 (2013) 1334–1345

Society Guidelines

Focused 2012 Update of the Canadian Cardiovascular Society Guidelines for the Use of Antiplatelet Therapy

Jean-François Tanguay, MD, CSPQ, FRCPC, FACC, FAHA, FESC,[a] Alan D. Bell, MD, CCFP,[b] Margaret L. Ackman, BSc(Pharm), PharmD, ACPR, FCSHP,[c] Robert D.C. Bauer, MD, FRCPC, FACC,[d] Raymond Cartier, MD, FRCPC,[e] Wee-Shian Chan, MD, FRCPC,[f] James Douketis, MD, FRCPC,[g] André Roussin, MD, FRCPC,[h] Gregory Schnell, BSP, MD, FRCPC,[i] Subodh Verma, MD, PhD, FRCSC,[j] Graham Wong, MD, MPH, FRCPC, FACC,[k] and Shamir R. Mehta, MD, MSc, FRCPC, FACC, FESC[l]

Can J Cardiol 2013; 29:1334-1345 (noviembre 2013)

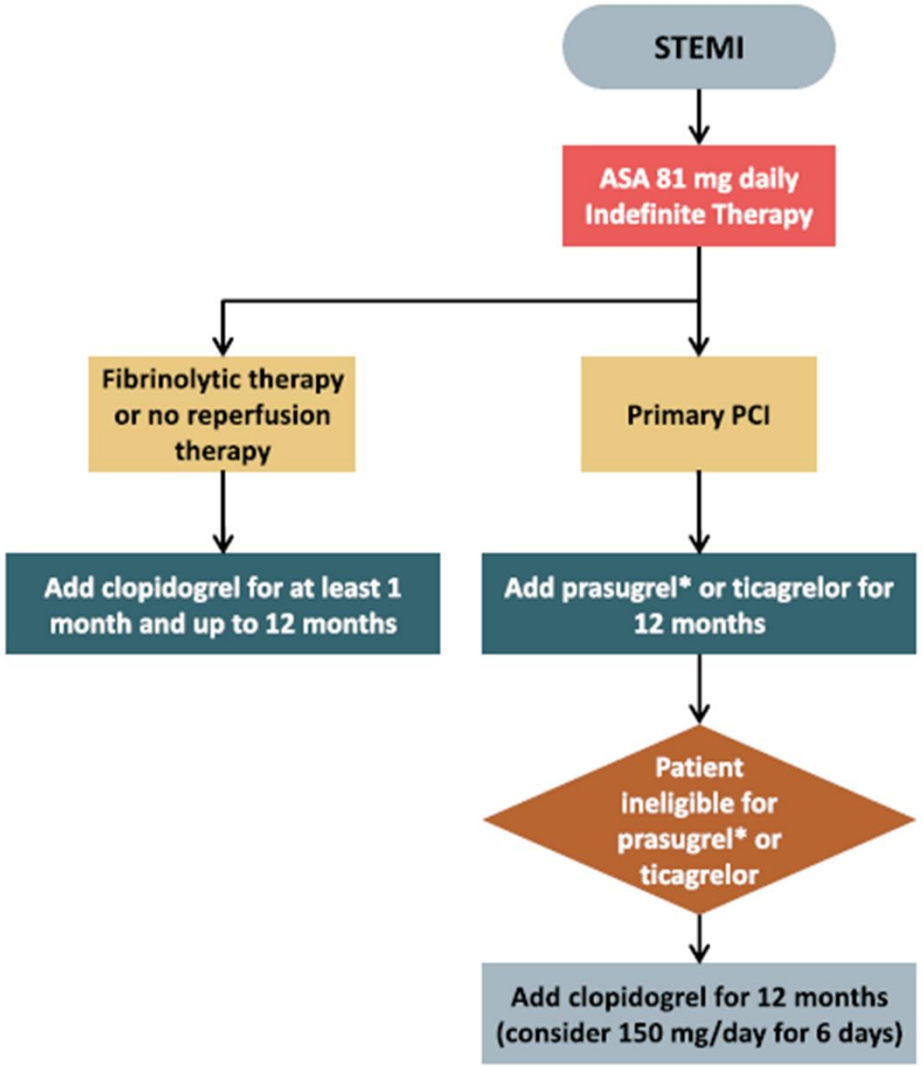


Figure 3. Recommendations for ST-elevation myocardial infarction (STEMI). ASA, acetylsalicylic acid; PCI, percutaneous coronary intervention; TIA, transient ischemic attack. * Prasugrel should be avoided in patients with previous TIA or stroke. In patients aged 75 years and older, or body weight $\leq$ 60 kg, prasugrel should be used with caution and a 5-mg dose considered.

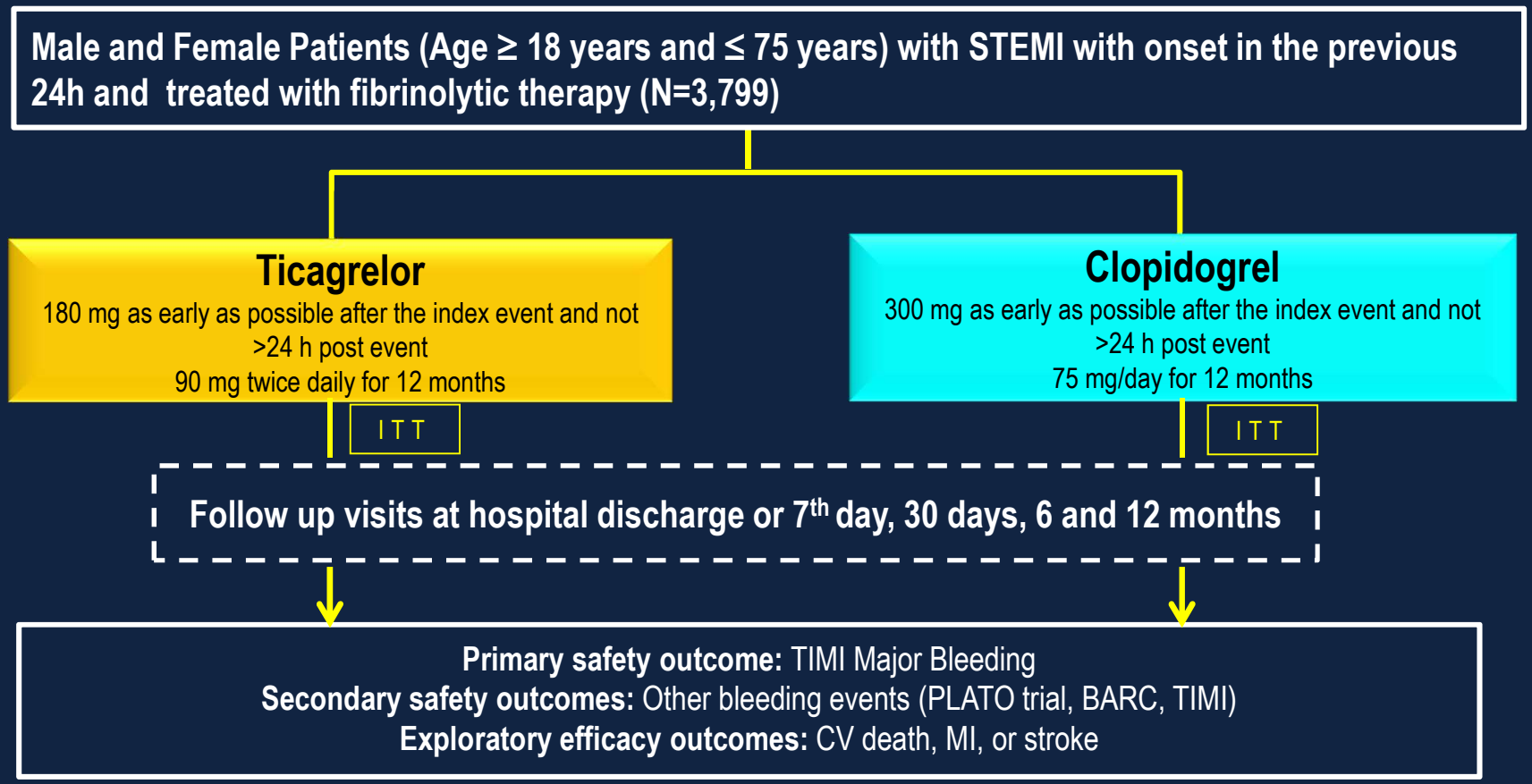
Can J Cardiol 2013; 29:1334-1345.

TICAGRELOR VERSUS CLOPIDOGREL AFTER THROMBOLYTIC THERAPY IN PATIENTS WITH ST-ELEVATION MYOCARDIAL INFARCTION: A RANDOMIZED CLINICAL TRIAL

Otavio Berwanger, MD, PhD - On behalf of the TREAT Trial Steering Committee and Investigators


BREATHE CHANGE
AMERICAN COLLEGE OF CARDIOLOGY
ACC.18
67th Annual Scientific Session & Expo
FEEL THE PULSE

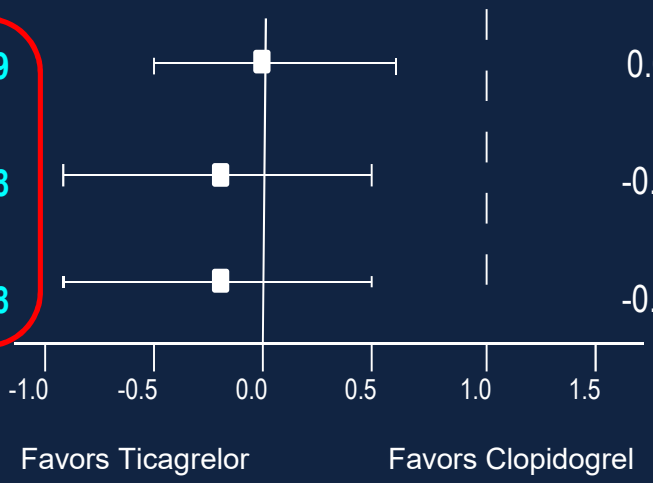
Study Design



Berwanger O et al for the Treat Study Group. JAMA Cardiol 2018 May 1;3(5):391-399.

Major Bleeding at 30 Days

	Ticagrelor (n=1913)	Clopidogrel (n=1886)	Difference , 95% CI	P no ninf.
TIMI Major Bleeding (Primary Endpoint)	0.73	0.69	0.04 [-0.49; 0.58]	<0.001
PLATO Major Bleeding	1.20	1.38	-0.18 [-0.89; 0.54]	0.001
BARC Type 3 - 5 Bleeding	1.20	1.38	-0.18 [-0.89; 0.54]	0.001



Data presented as no. (%)

* Absolute difference (in percentage) presented as bilateral 95% confidence interval.

† 1% absolute difference margin non inferiority test. Non-inferiority test was done considering an one sided test.

Berwanger O et al for the Treat Study Group. JAMA Cardiol 2018 May 1;3(5):391-399.

ESC
European Society of Cardiology
European Heart Journal (2017) **00**, 1–66
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Ibanez B et al. European Heart Journal (2017) 00, 1–66 - doi:10.1093/eurheartj/ehx393

Periprocedural and post-procedural antithrombotic therapy[a] in patients undergoing primary percutaneous coronary intervention

Recommendations	Class[b]	Level[c]
Antiplatelet therapy		
A potent $P2Y_{12}$ inhibitor (prasugrel or ticagrelor), or clopidogrel if these are not available or are contraindicated, is recommended before (or at latest at the time of) PCI and maintained over 12 months, unless there are contraindications such as excessive risk of bleeding.[186,187]	I	A
Aspirin (oral or i.v. if unable to swallow) is recommended as soon as possible for all patients without contraindications.[213,214]	I	B

Ibanez B et al. European Heart Journal (2017) 00, 1–66 – doi:10.1093/eurheartj/ehx393

Switching between oral $P2Y_{12}$ inhibitors

Recommendations	Class[a]	Level[b]
In patients with ACS who were previously exposed to clopidogrel, switching from clopidogrel to ticagrelor is recommended early after hospital admission at a loading dose of 180 mg irrespective of timing and loading dose[c] of clopidogrel, unless contraindications to ticagrelor exist.[20]	I	B
Additional switching between oral $P2Y_{12}$ inhibitors may be considered in cases of side effects/drug intolerance according to the proposed algorithms.	IIb	C

Valgimigli M et al. 2017 ESC focused update on dual antiplatelet therapy in coronary artery disease. Eur Heart J 2018 Jan 14;39(3):213-260.

¿Qué droga usar?

¡Antiagregantes potentes!

¿Cuánto tiempo debe mantenerse la doble antiagregación post IAM?

¿Cuánto tiempo debe mantenerse la doble antiagregación en SCA?

PCI	**ACC/AHA/SCAI 2009 Update**	**I**	**BMS or DES – at least 12 months**
		IIb	**ADP blockade beyond 15 months may be considered in patients with DES**
NSTE-ACS	**ACC/AHA 2007 Update**	**I**	**Conservative – at least 1 month and up to 12 [see 2009 PCI Update]**
	ESC 2007	**Ia**	**Clopidogrel should be maintained for 12 mos unless there is an excessive risk of bleeding**
STEMI	**ACC/AHA 2007 Update**	**I**	**Clopidogrel for at least 14 days (Class I)**
		IIa	**Maintenance with clopidogrel (eg, 1 year) is reasonable**
	ESC 2008	**IIa**	**Clopidogrel for 12 months in all patients irrespective of acute treatment**

Hasta ahora, las guías y consensos recomendaban 12 meses de DAPT.

¿Un año para todos?
¿O existe beneficio más allá del año?

Estudio CHARISMA – La cohorte “CAPRIE-like”

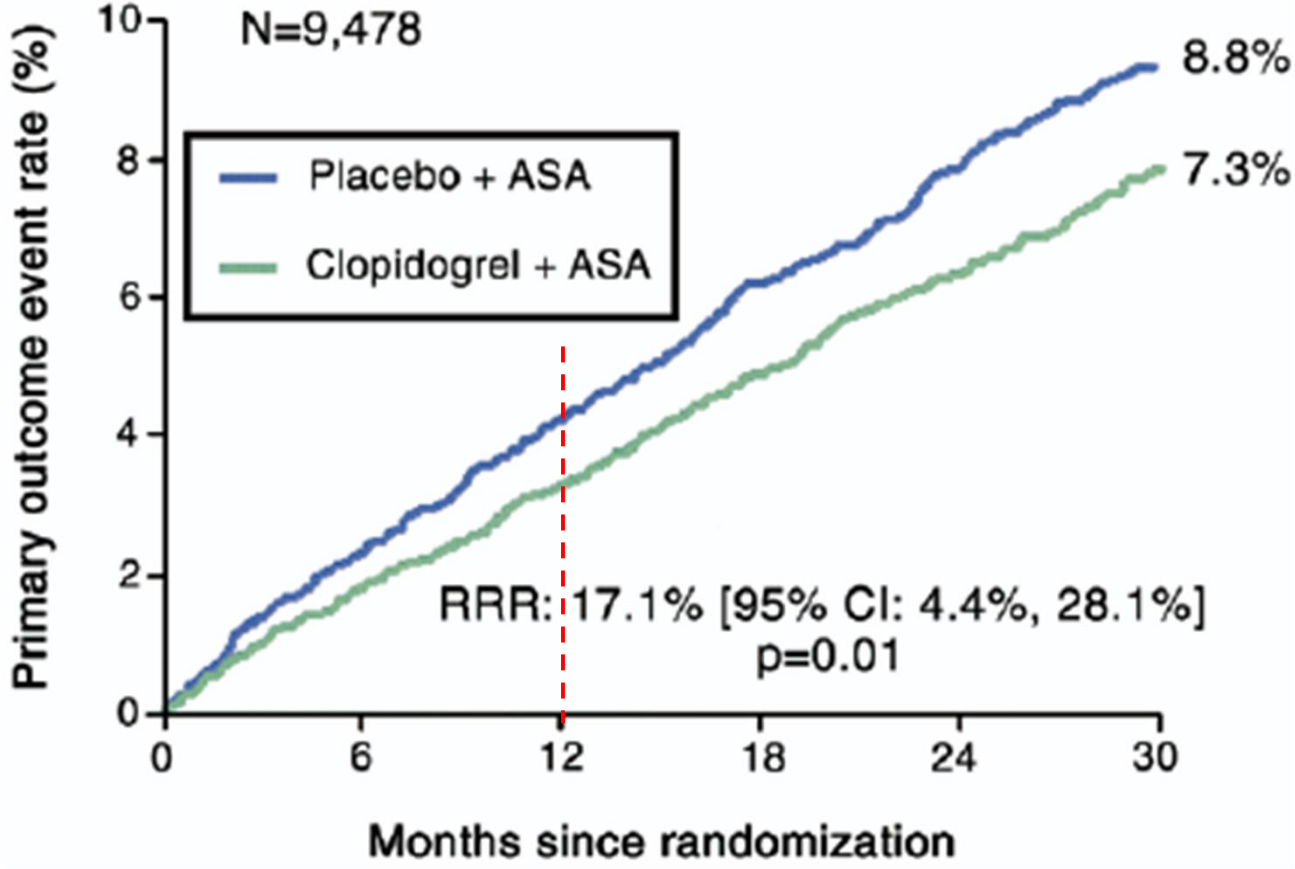
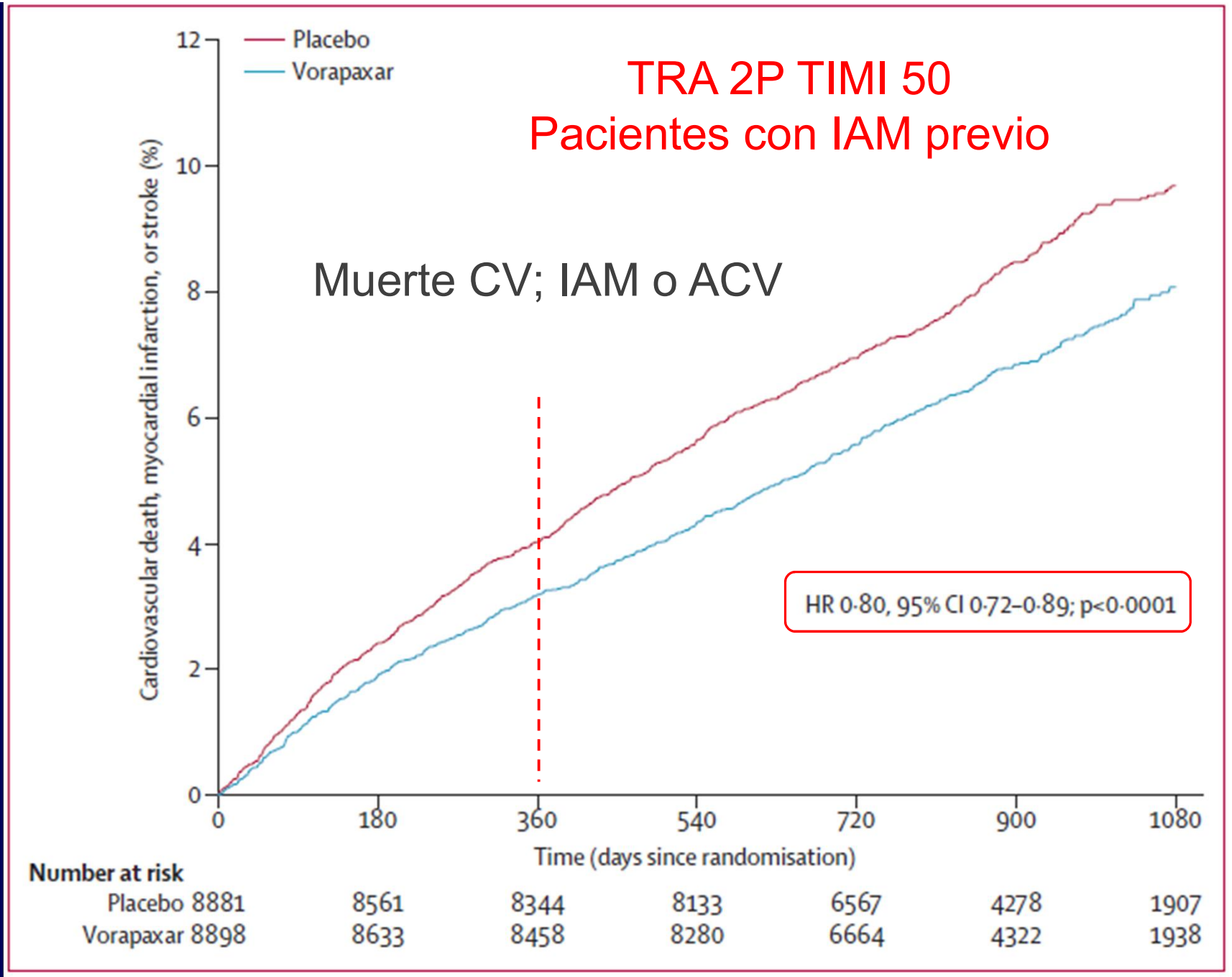


Figure 1 Kaplan-Meier Curves for Cardiovascular Death, MI, or Stroke for Clopidogrel + ASA Versus Placebo + ASA

Bhatt DL, et al. *J Am Coll Cardiol* 2007;49:1982–1988

TRA 2P TIMI 50
Pacientes con IAM previo



Scirica B et al. *Lancet* 2012; DOI:10.1016/S0140- 6736(12)61269-0 (26 agosto)

Estudio DAPT

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Twelve or 30 Months of Dual Antiplatelet Therapy after Drug-Eluting Stents

Laura Mauri, M.D., Dean J. Kereiakes, M.D., Robert W. Yeh, M.D., Priscilla Driscoll-Shempp, M.B.A., Donald E. Cutlip, M.D., P. Gabriel Steg, M.D., Sharon-Lise T. Normand, Ph.D., Eugene Braunwald, M.D., Stephen D. Wiviott, M.D., David J. Cohen, M.D., David R. Holmes, Jr., M.D., Mitchell W. Krucoff, M.D., James Hermiller, M.D., Harold L. Dauerman, M.D., Daniel I. Simon, M.D., David E. Kandzari, M.D., Kirk N. Garratt, M.D., David P. Lee, M.D., Thomas K. Pow, M.D., Peter Ver Lee, M.D., Michael J. Rinaldi, M.D., and Joseph M. Massaro, Ph.D., for the DAPT Study Investigators*

Mauri L et al for the DAPT Study Investigators. NEJM 2014 (nov 16), DOI: 10.1056/NEJMoa1409312

DAPT Study

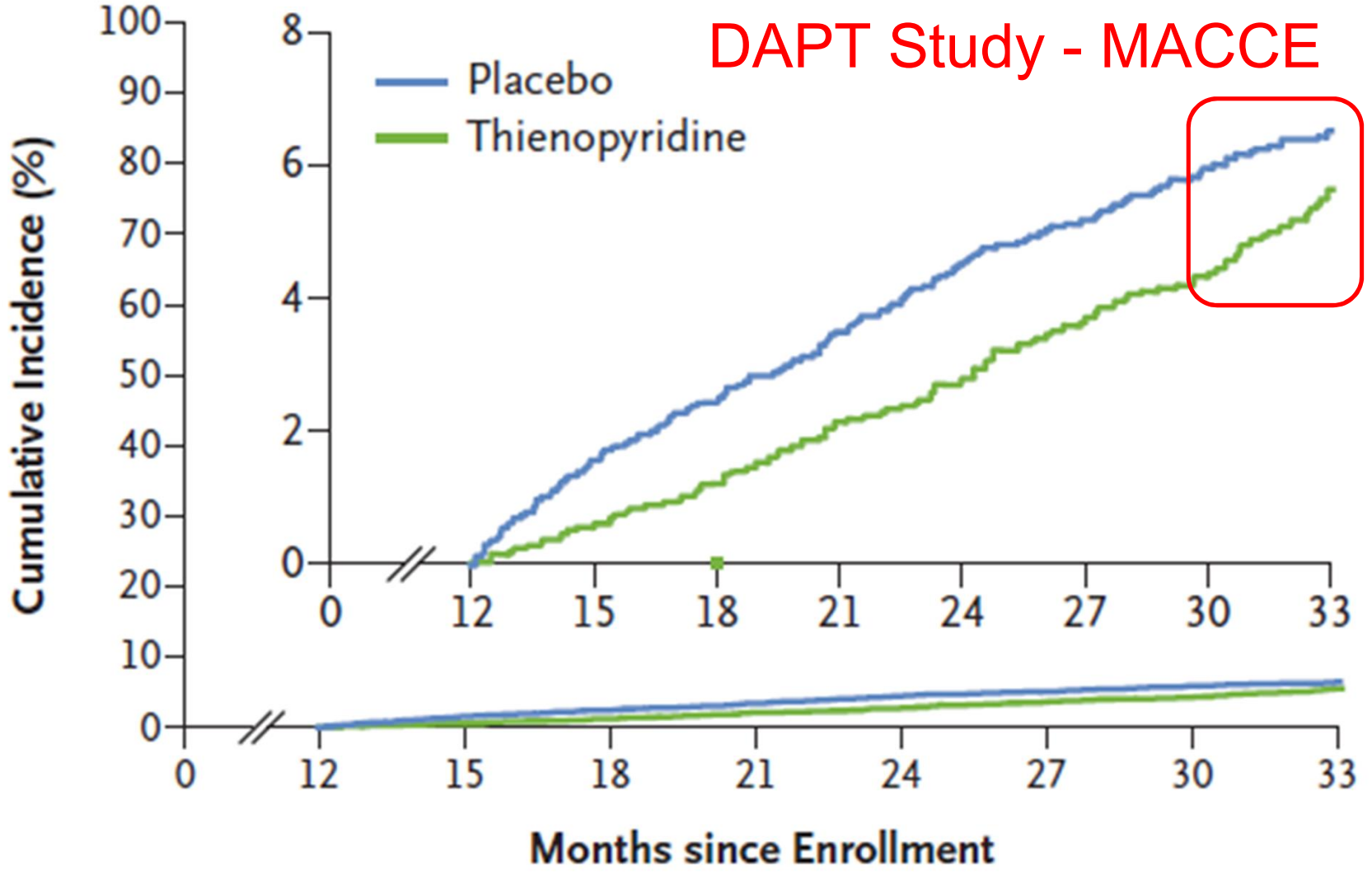
Co-primary efficacy endpoint	30 months of thienopyridine [N=5020], n (%)	12 months of thienopyridine [N=4941], n (%)	HR (95% CI)	*P* Value
Stent thrombosis	19 (0.4)	65 (1.4)	0.29 (0.17–0.48)	<0.001
MACCE	211 (4.3)	285 (5.9)	0.71 (0.59–0.85)	<0.001

Primary safety endpoint	30 months of thienopyridine [N=4710], n (%)	12 months of thienopyridine [N=4649], n (%)	HR (95% CI)	*P* Value
GUSTO severe or moderate	119 (2.5)	73 (1.6)	1.61 (1.21–2.16)	0.001

GUSTO severe bleeding was not significantly different between the two arms (difference of 0.2%; P=0.15).

Mauri L et al for the DAPT Study Investigators. NEJM 2014 (nov 16), DOI: 10.1056/NEJMoa1409312

DAPT Study - MACCE



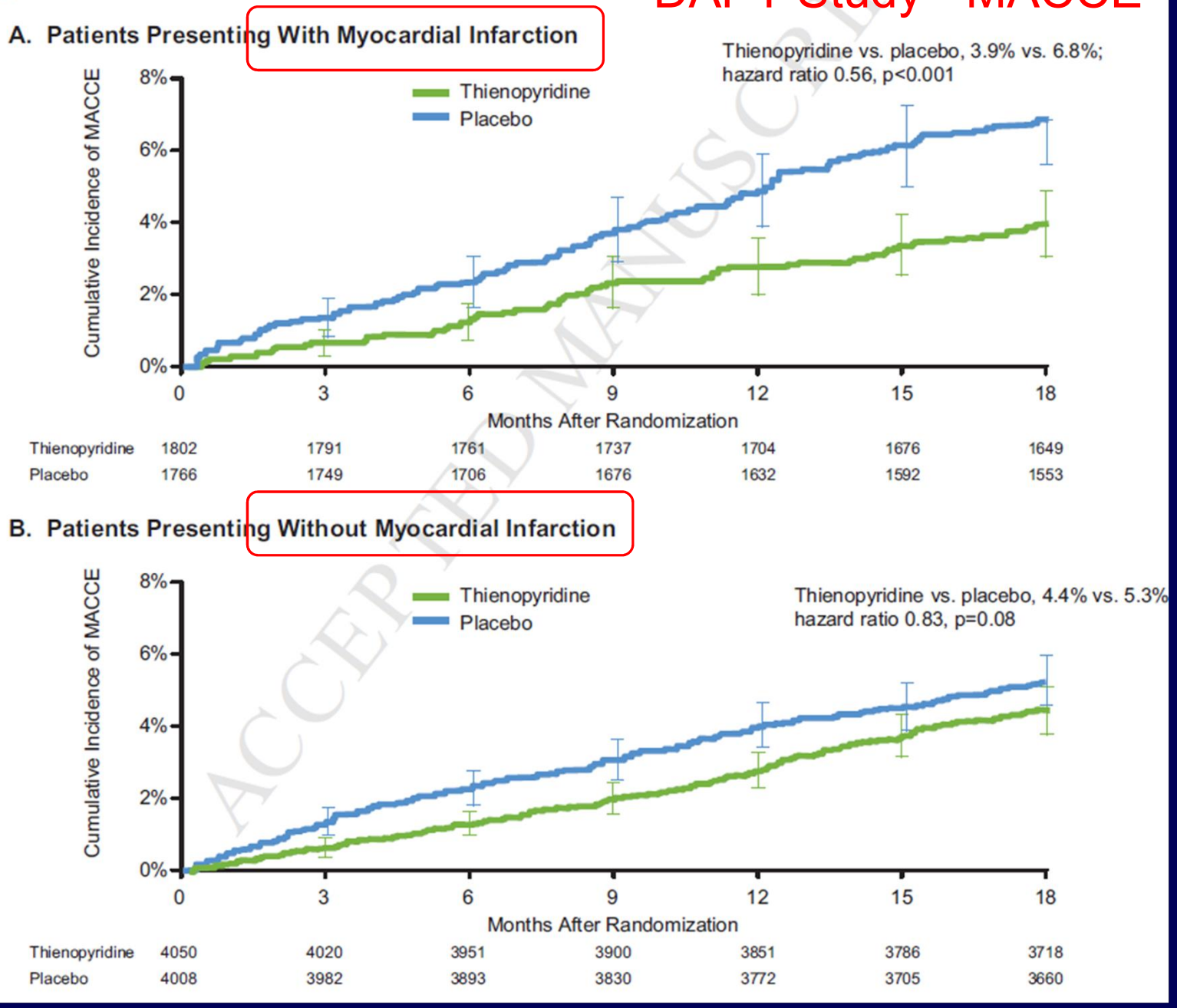
No. at Risk

Thienopyridine	5020	4917	4840	4778	4702	4611	4554	3029
Placebo	4941	4799	4715	4635	4542	4476	4412	2997

Mauri L et al for the DAPT Study Investigators. NEJM 2014 (nov 16), DOI: 10.1056/NEJMoa1409312

DAPT Study - MACCE

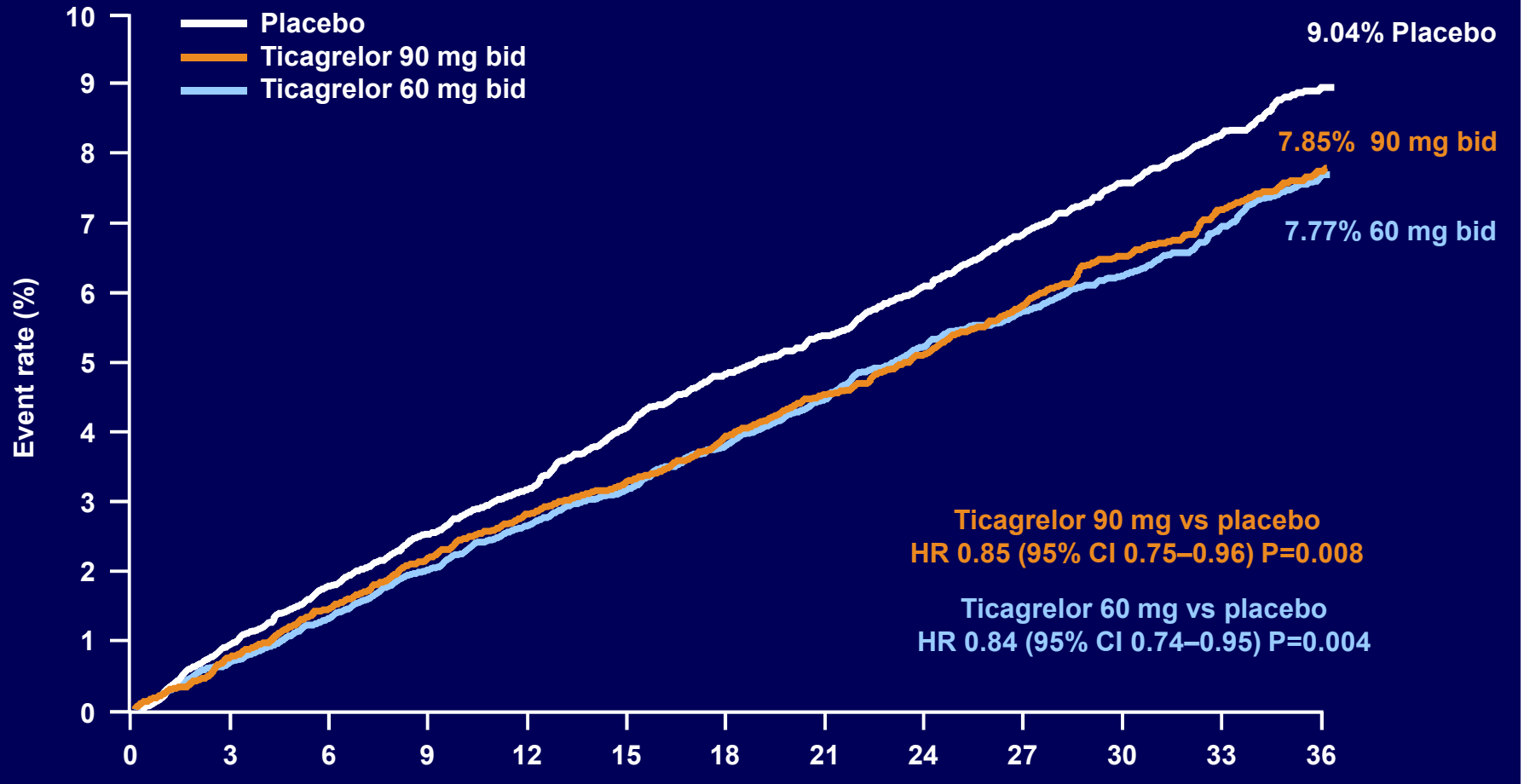
Figure 3



Yeh R et al. JACC online (march 2015) - DOI 10.1016/j.jacc.2015.03.003

PEGASUS-TIMI 54 - Muerte CV, IAM, ACV

Pacientes que han tenido un IAM entre 1 y 3 años previos a la randomización (n=21,162)

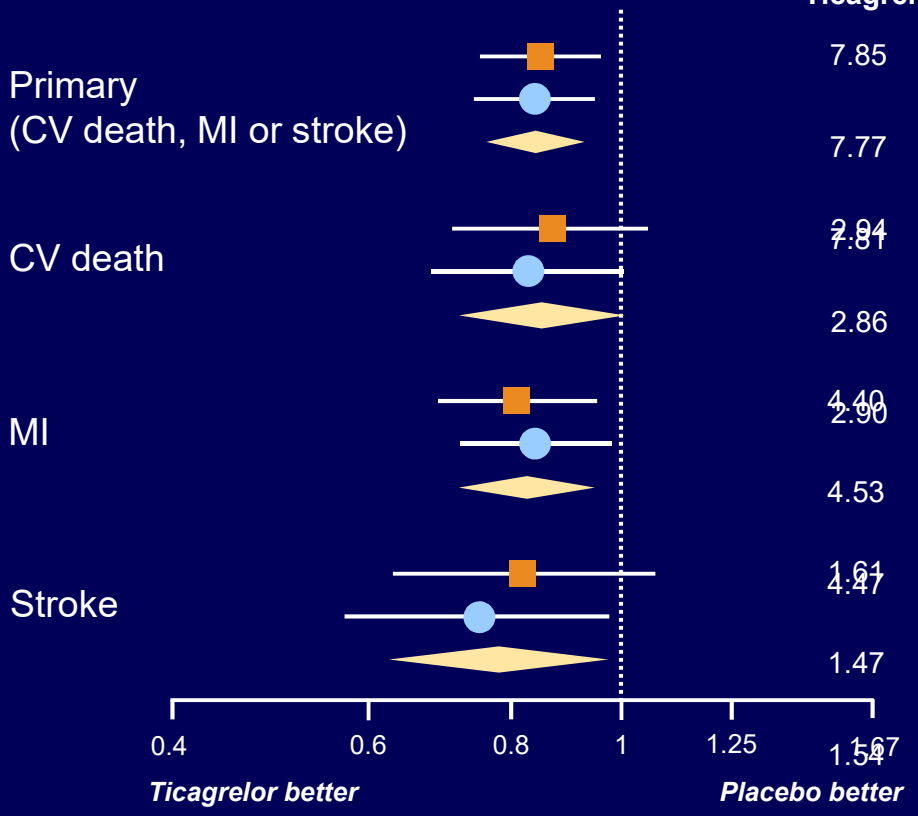


No. at risk													
Placebo	7067	6979	6892	6823	6761	6681	6508	6236	5876	5157	4343	3360	2028
90 mg bid	7050	6973	6899	6827	6769	6719	6550	6272	5921	5243	4401	3368	2038
60 mg bid	7045	6969	6905	6842	6784	6733	6557	6270	5904	5222	4424	3392	2055

CI, confidence interval; HR, hazard ratio

Bonaca MP *et al*. *N Engl J Med* 2015 [Epub ahead of print]

PEGASUS-TIMI 54: Efficacy Endpoints



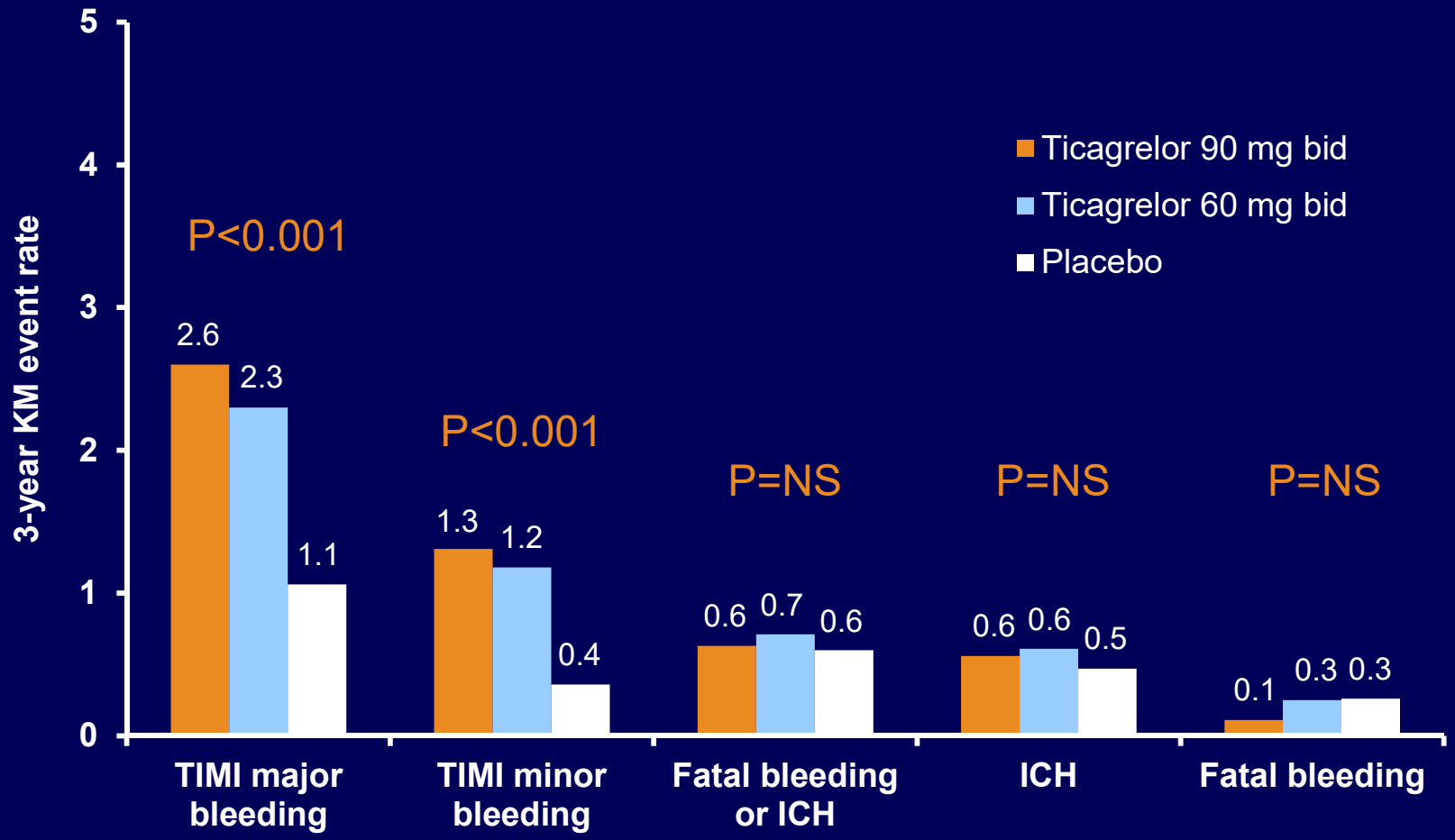
Endpoint	3-year KM event rates (%) Ticagrelor	Placebo	HR (95% CI)	P value
Primary (CV death, MI or stroke)	7.85	9.04	0.85 (0.75–0.96)	0.008
	7.77	9.04	0.84 (0.74–0.95)	0.004
CV death	2.84	3.39	0.87 (0.71–1.06)	0.15
	7.81	9.04	0.84 (0.76–0.94)	0.001
	2.86	3.39	0.83 (0.68–1.01)	0.07
MI	4.40	5.25	0.81 (0.69–0.95)	0.01*
	2.90	3.39	0.85 (0.71–1.00)	0.06
	4.53	5.25	0.84 (0.72–0.98)	0.03*
Stroke	1.61	1.94	0.82 (0.63–1.07)	0.14*
	4.47	5.25	0.83 (0.72–0.95)	0.005*
	1.47	1.94	0.75 (0.57–0.98)	0.03*
	1.54	1.94	0.78 (0.62–0.98)	0.03*

Ticagrelor 90 mg bid
Ticagrelor 60 mg bid
Ticagrelor pooled

*Indicates nominal P value; P<0.026 indicates statistical significance

Bonaca MP *et al*. *N Engl J Med* 2015 [Epub ahead of print]

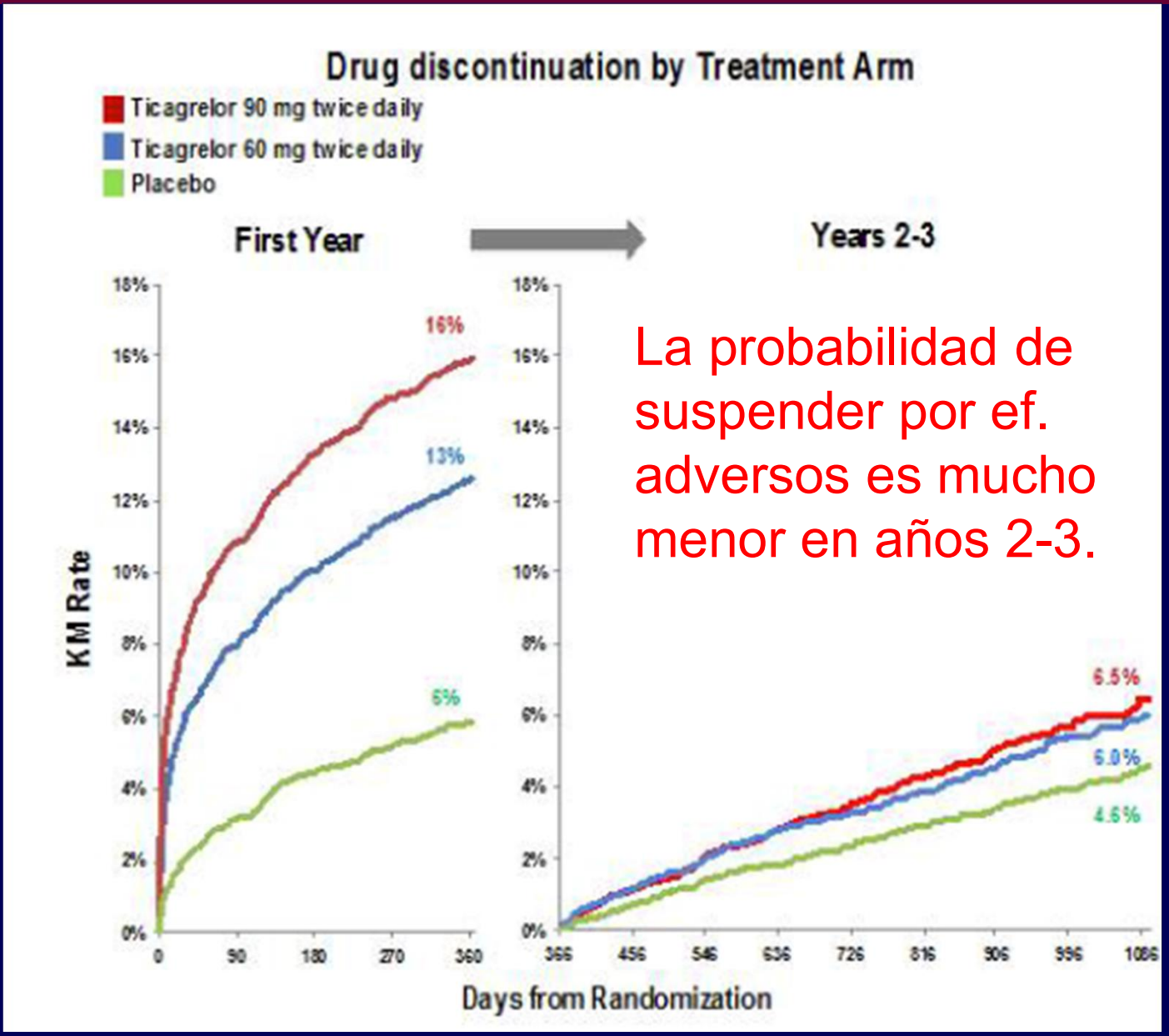
PEGASUS-TIMI 54: Bleeding



Rates are presented as 3-year Kaplan-Meier estimates
P<0.026 indicates statistical significance

Bonaca MP *et al*. *N Engl J Med* 2015 [Epub ahead of print]

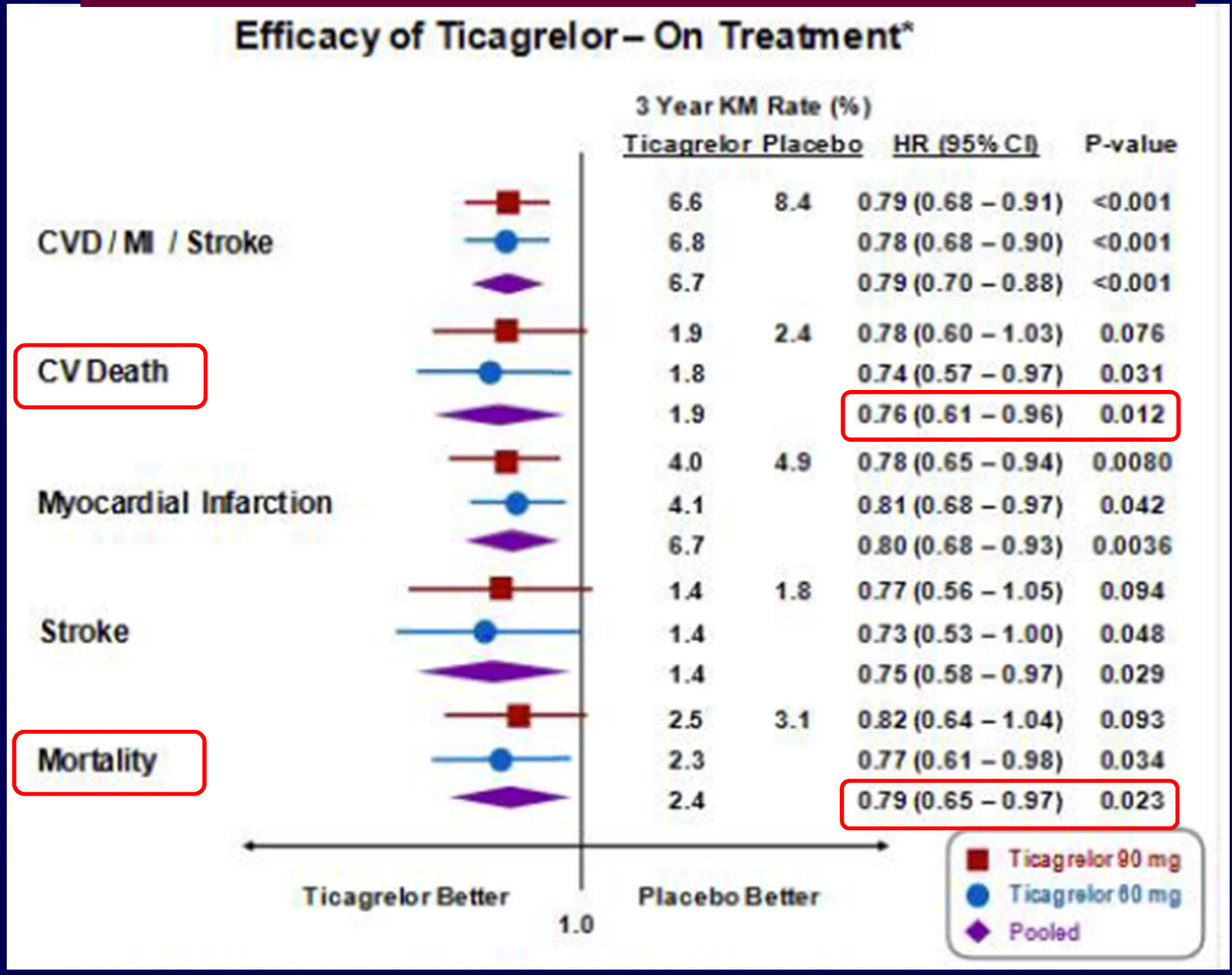
PEGASUS-TIMI 54 trial



La probabilidad de suspender por ef. adversos es mucho menor en años 2-3.

Bonaca M et al. AHA 2015, abstract.

PEGASUS-TIMI 54 trial



Bonaca M et al. AHA 2015, abstract.

Metaanálisis de DAPT en pacientes con IAM previo

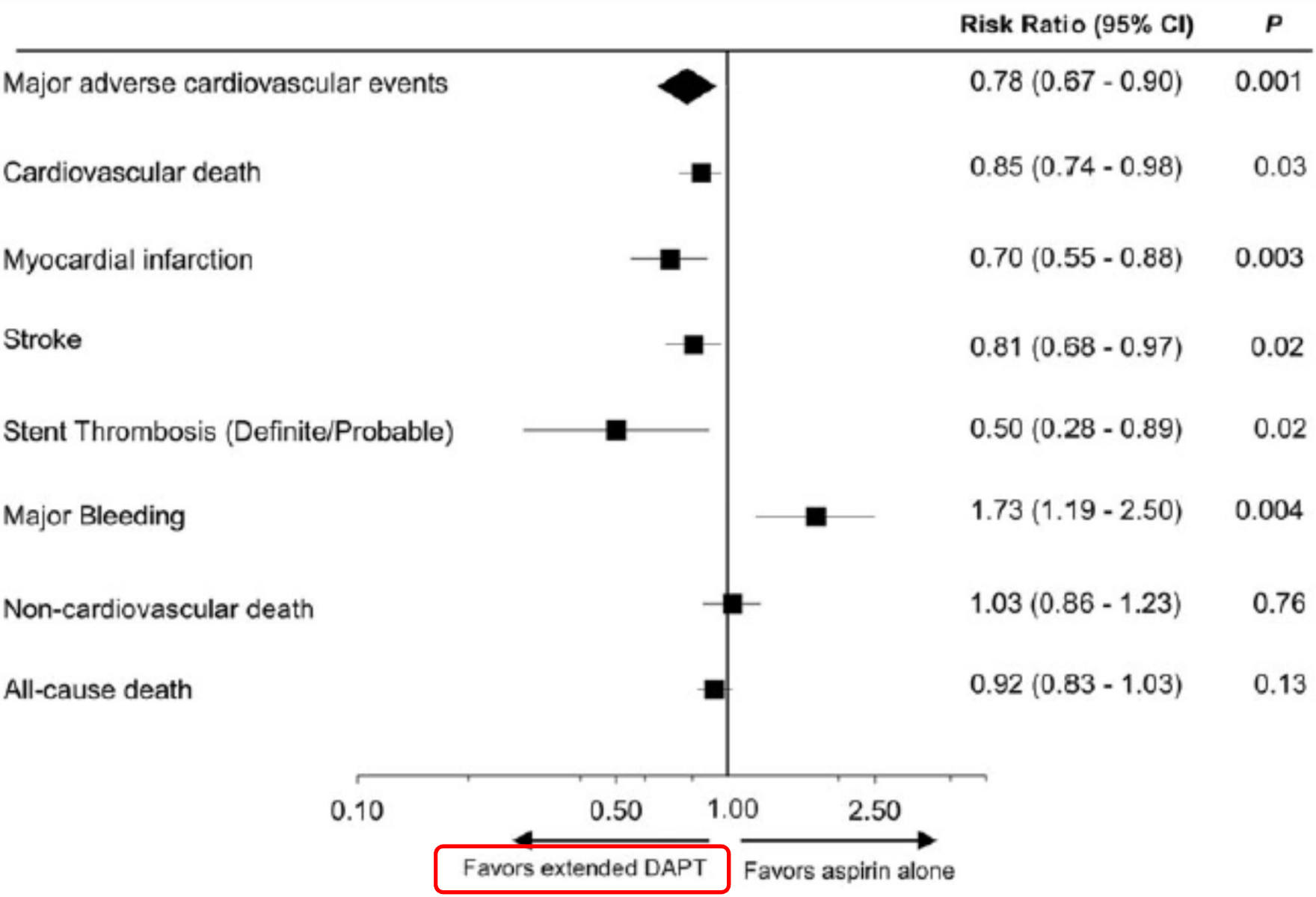
European Heart Journal
doi:10.1093/eurheartj/ehv443

FASTTRACK
ESC Clinical Trial Update

Long-term dual antiplatelet therapy for secondary prevention of cardiovascular events in the subgroup of patients with previous myocardial infarction: a collaborative meta-analysis of randomized trials

Jacob A. Udell[1,2*], Marc P. Bonaca[3], Jean-Philippe Collet[4], A. Michael Lincoff[5], Dean J. Kereiakes[6], Francesco Costa[7], Cheol Whan Lee[8], Laura Mauri[9], Marco Valgimigli[7,10], Seung-Jung Park[8], Gilles Montalescot[4], Marc S. Sabatine[3], Eugene Braunwald[3], and Deepak L. Bhatt[3*]

Udell J. et al. European Heart Journal 2015 (Advance Access, 31 aug); doi:10.1093/eurheartj/ehv443.

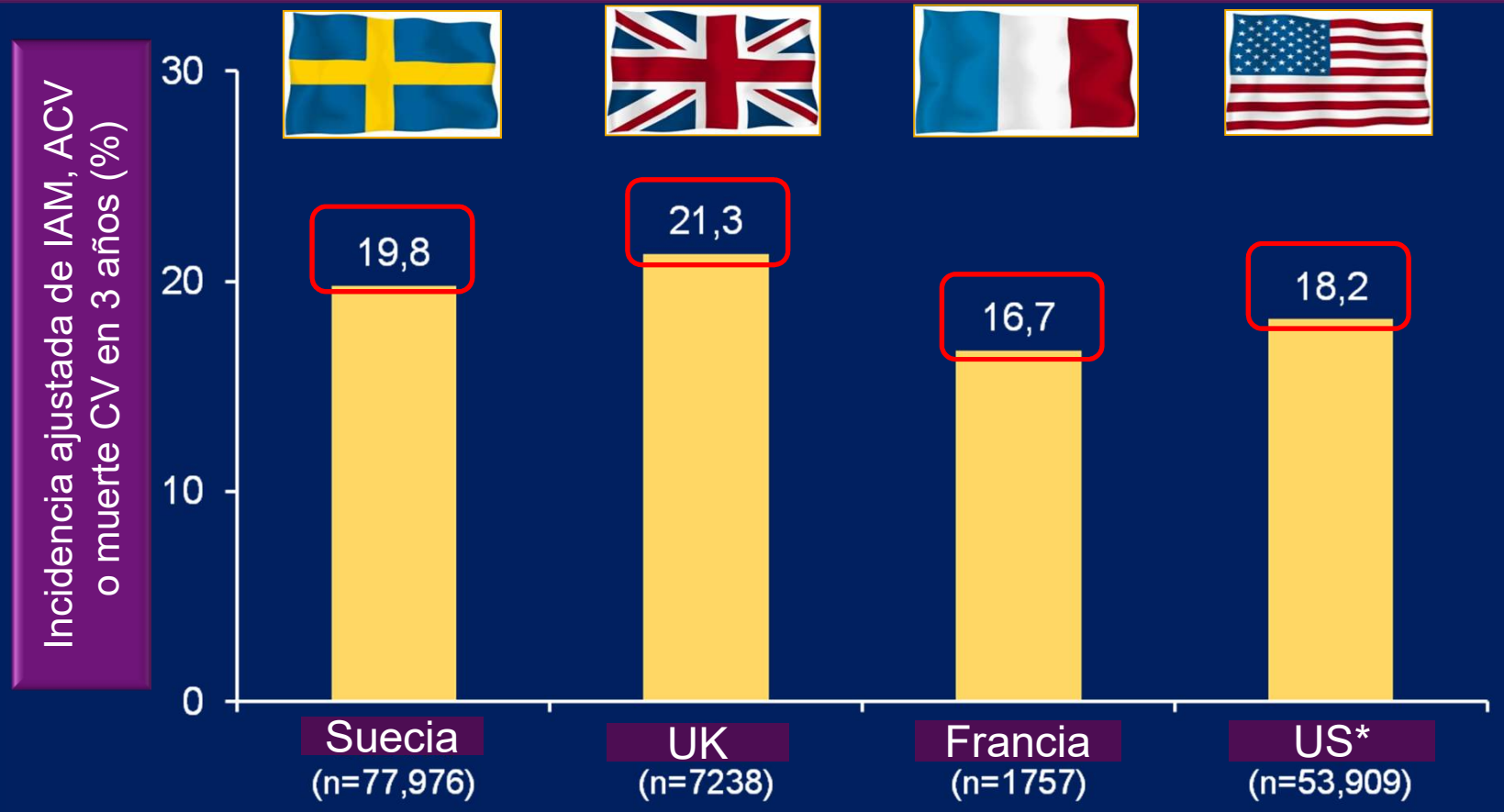


Udell J. et al. European Heart Journal 2015 (Advance Access, 31 aug); doi:10.1093/eurheartj/ehv443.

Long DAPT: ¿por qué salva vidas?
Porque los pacientes con SCA *se mueren de eventos aterotrombóticos*

APOLLO: Registro en 4 países con >150,000 pacientes con IAM

1 cada 5 pacientes *libre de eventos dentro del primer año* post IAM sufrió un IAM, ACV o muerte dentro de los 3 años.

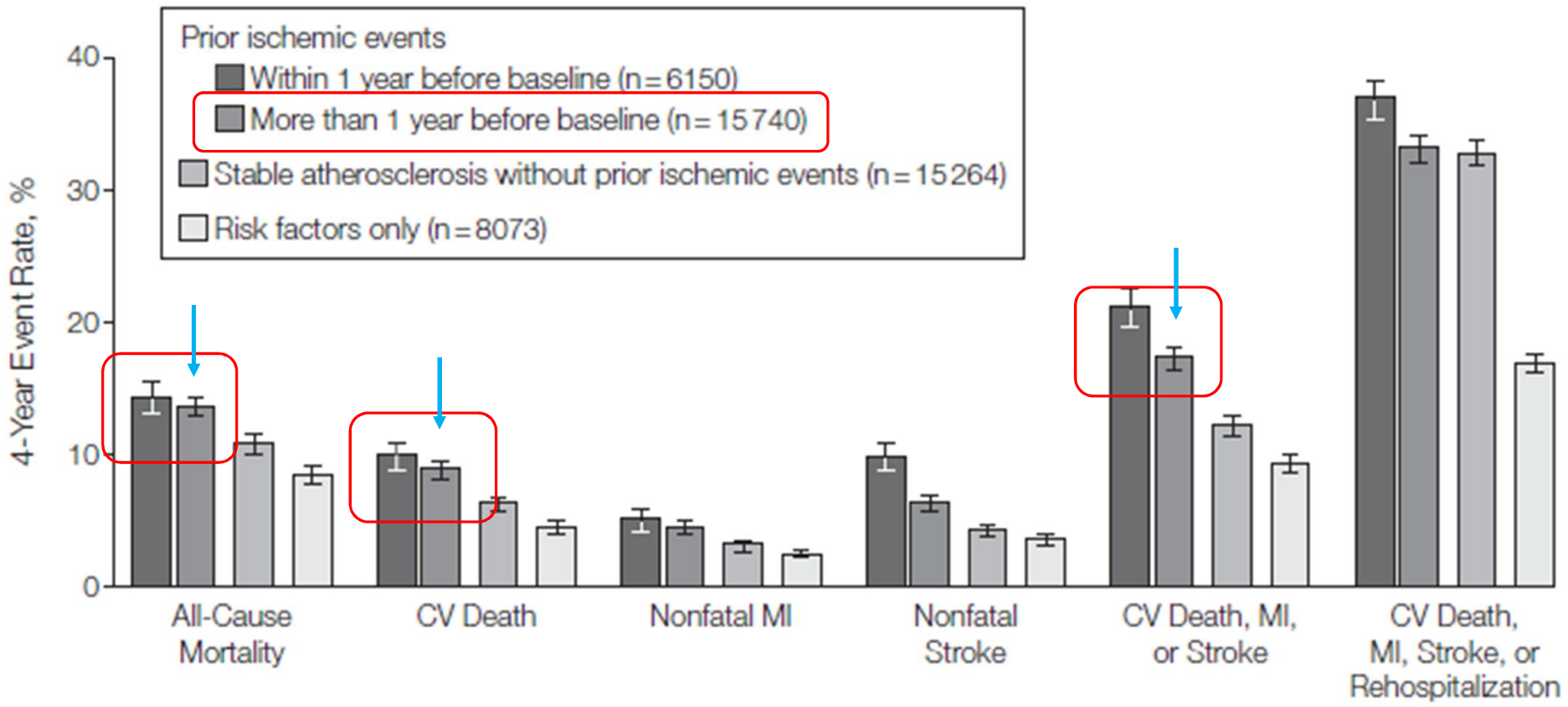


*Adjusted for differences in study populations; MI, myocardial infarction.

Rapsomaniki E, et al. ESC Late Breaking Registry presentation 2014: In press.

Registro REACH

Figure 4. Risk of Ischemic Events in the Subsequent 4 Years of Follow-up in Patients With History at Enrollment of Prior Ischemic Events, Either Within Year Prior to Enrollment or More Remotely



Bhatt D et al, for the REACH Registry Investigators. JAMA 2010; 304:1350-1357.

Culprit and Non-Culprit Recurrent Ischaemic Events in Post-Myocardial Infarction Patients: Data From SWEDEHEART

Christoph Varenhorst, Saga Johansson, Pål Hasvold, Magnus Janzon, Per Albertsson, Margret Leosdottir, Kristina Hambraeus, Stefan James, Tomas Jernberg, Bodil Svennblad, Bo Lagerqvist

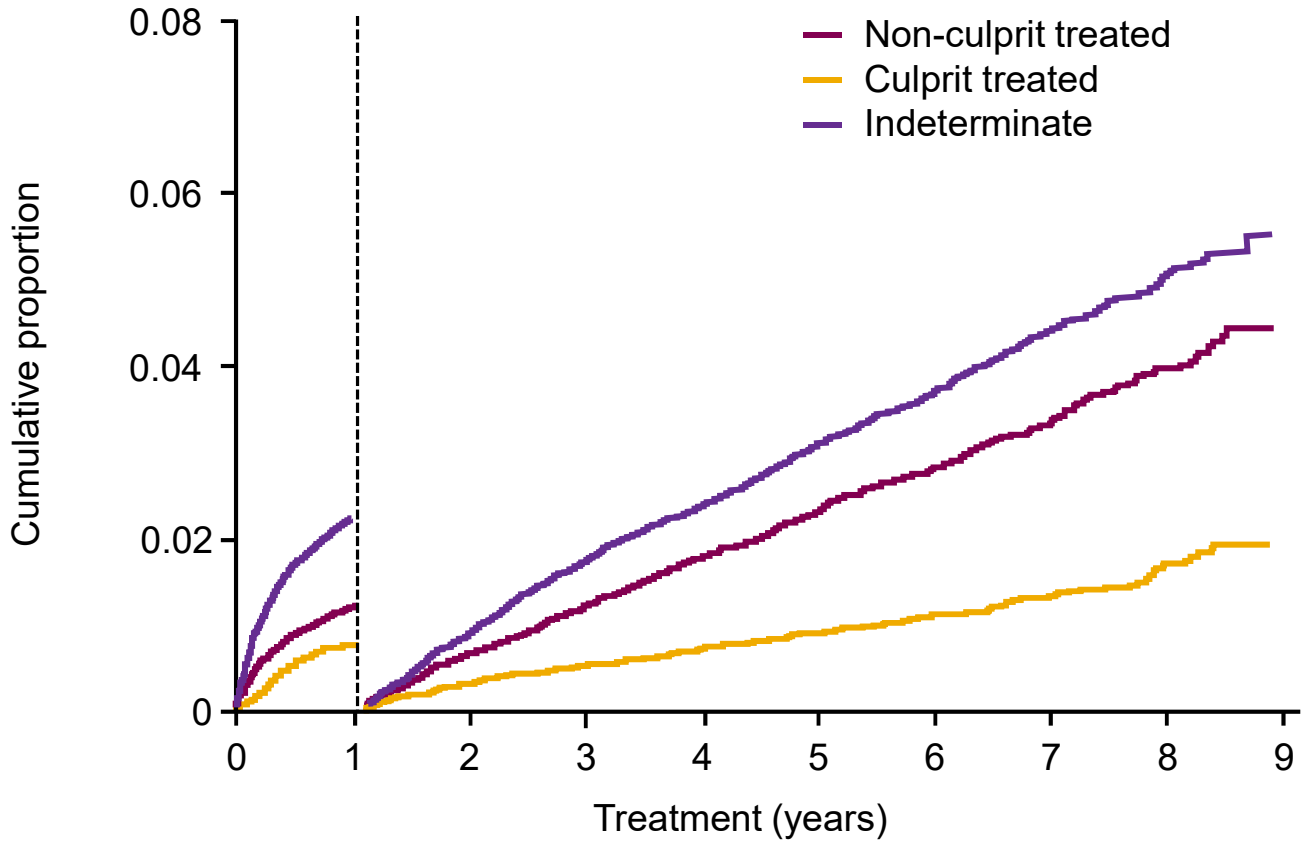
- Large real-world patient population (n=99,546) with long-term (8 years') follow up from a high-quality registry data (SWEDEHEART registry, Sweden)
- Among patients with a defined culprit lesion at the index MI (n=41,789) there was a total of 3603 *recurrent MIs* of which:

  1193 were non-culprit, 597 were culprit and 1813 were indeterminate.

AHA Scientific Sessions, November 2016; Abstract: *Circulation* 2016;134:A13206

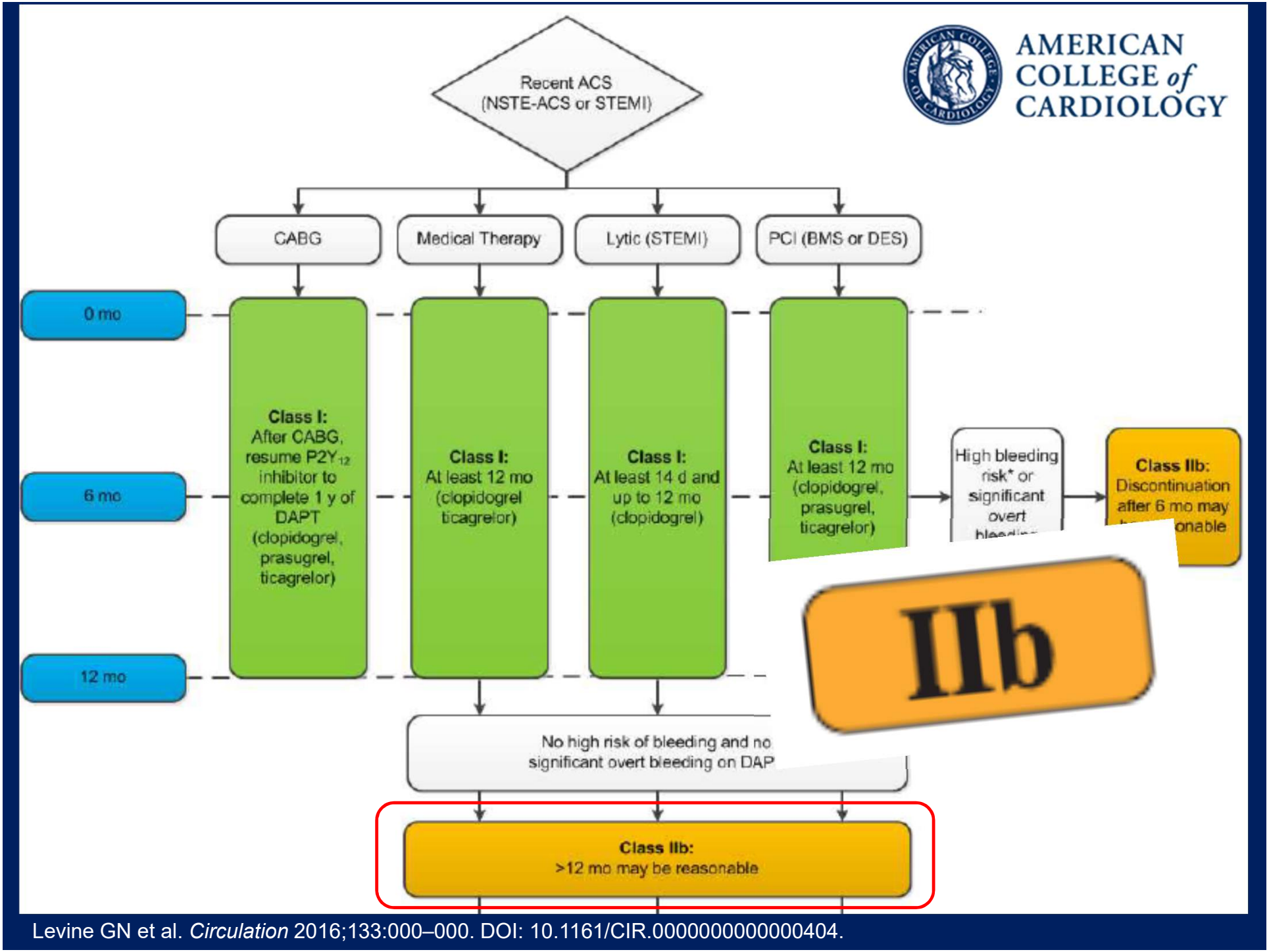
The risk for non-culprit related recurrent MIs was *twice* than for culprit-related recurrent MIs

Cumulative event probability at 8 years for first recurrent MI



The 1-year land mark analysis was included to show the acute (within 1 year post-MI) vs the long term (beyond 1-year post-MI) probability of recurrent MI

¿Qué dicen las guías?



Levine GN et al. *Circulation* 2016;133:000–000. DOI: 10.1161/CIR.0000000000000404.

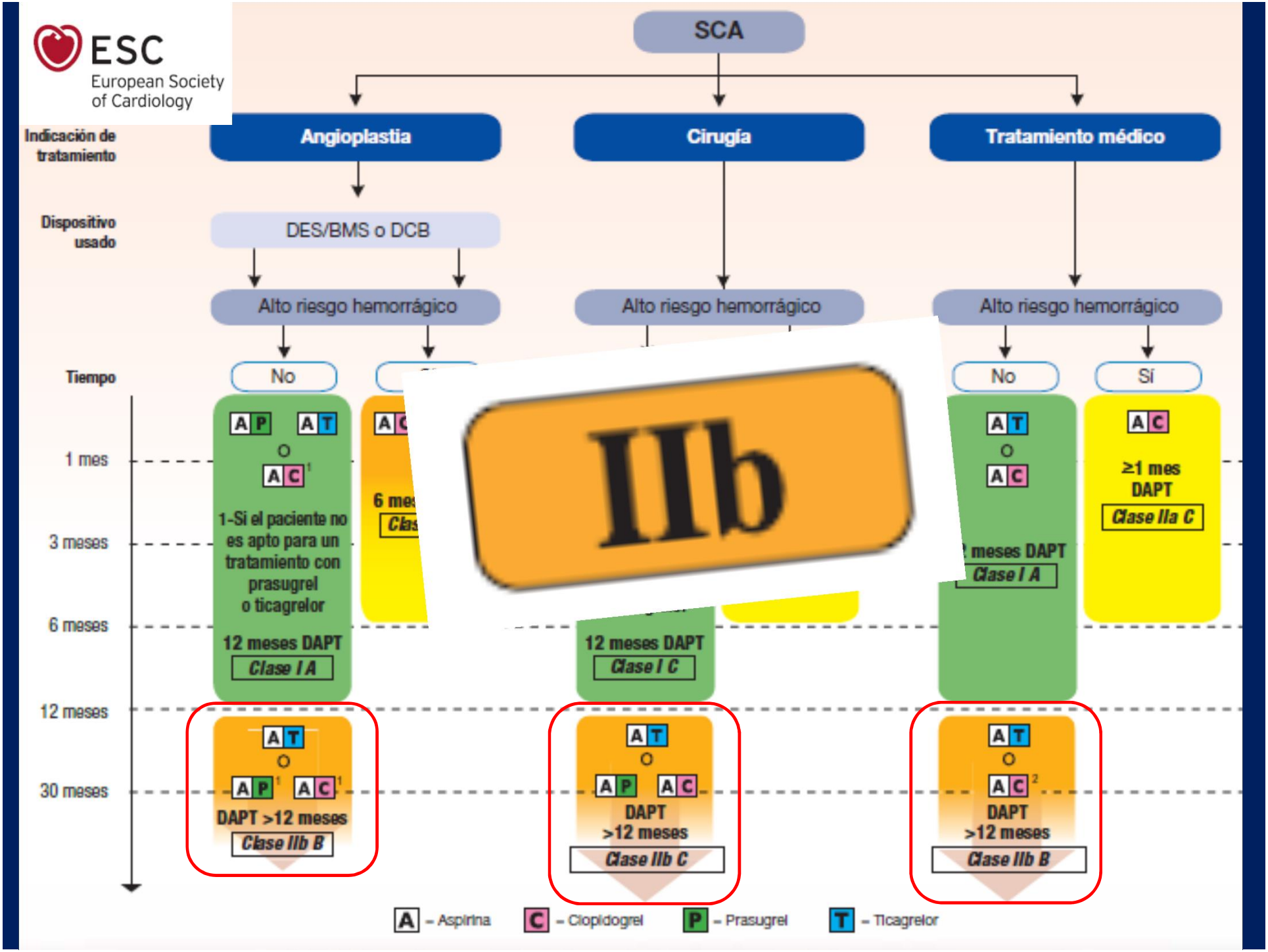
ESC
European Society of Cardiology
European Heart Journal (2017) **00**, 1–66
doi:10.1093/eurheartj/ehx393

ESC GUIDELINES

2017 ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation

The Task Force for the management of acute myocardial infarction in patients presenting with ST-segment elevation of the European Society of Cardiology (ESC)

Ibanez B et al. European Heart Journal (2017) 00, 1–66 - doi:10.1093/eurheartj/ehx393


ESC
European Society of Cardiology
SCA
Indicación de tratamiento
Angioplastia
Cirugía
Tratamiento médico
Dispositivo usado
DES/BMS o DCB
Alto riesgo hemorrágico
Alto riesgo hemorrágico
Alto riesgo hemorrágico
Tiempo
No
No
Sí
1 mes
3 meses
6 meses
12 meses
30 meses
A P
A T
O
A C 1
1-Si el paciente no es apto para un tratamiento con prasugrel o ticagrelor
12 meses DAPT
Clase I A
A C
6 mes
Clas
12 meses DAPT
Clase I C
A T
O
A C
meses DAPT
Clase I A
A C
≥1 mes DAPT
Clase IIa C
IIb
A T
O
A P 1
A C 1
DAPT >12 meses
Clase IIb B
A T
O
A P
A C
DAPT >12 meses
Clase IIb C
A T
O
A C 2
DAPT >12 meses
Clase IIb B
A – Aspirina
C – Clopidogrel
P – Prasugrel
T – Ticagrelor

Rev Argent Cardiol 2015; 83 (supl 4): s1-s57 (oct 2015).

REVISTA ARGENTINA DE CARDIOLOGIA

ISSN 0034-7000 www.sac.org.ar VOL 83 SUPLEMENTO 4 OCTUBRE 2015

Consenso de Infarto Agudo de Miocardio con Elevación del segmento ST

Consenso de la Sociedad Argentina de Cardiología

Uso prolongado		
• Doble antiagregación con aspirina más ticagrelor 60 mg cada 12 horas luego de los 12 meses y hasta por 3 años en pacientes con IAMCEST seleccionados en base al análisis de riesgo-beneficio.	IIb	B
• Doble antiagregación con aspirina más ticagrelor 60 mg c/12 horas, clopidogrel 75 mg/día o prasugrel 10 mg/día, luego de los 12 meses y hasta por 3 años, en pacientes con IAMCEST sel… en base al análisis de riesgo-beneficio y tratados con …	IIb	B
• Prasugrel y ticagrelor están contrai… al crónica.	III	B

Rev Argent Cardiol 2015; 83 (supl 4): s1-s57 (oct 2015).

¿Por qué el bajo uso de la estrategia “Long DAPT”?

No por falta de beneficio, sino por miedo al sangrado

REVISTA ARGENTINA DE CARDIOLOGIA

ISSN 0034-7000 www.sac.org.ar VOL 85 SUPLEMENTO 1 MARZO 2017

Consenso para la Prevención y Manejo del Sangrado en Enfermedades Cardiovasculares

Consenso de la Sociedad Argentina de Cardiología

Rev Argent Cardiol 2017; 85 (Supl 1):1-53.

European Heart Journal Advance Access published August 6, 2015

European Heart Journal
doi:10.1093/eurheartj/ehv377

REVIEW

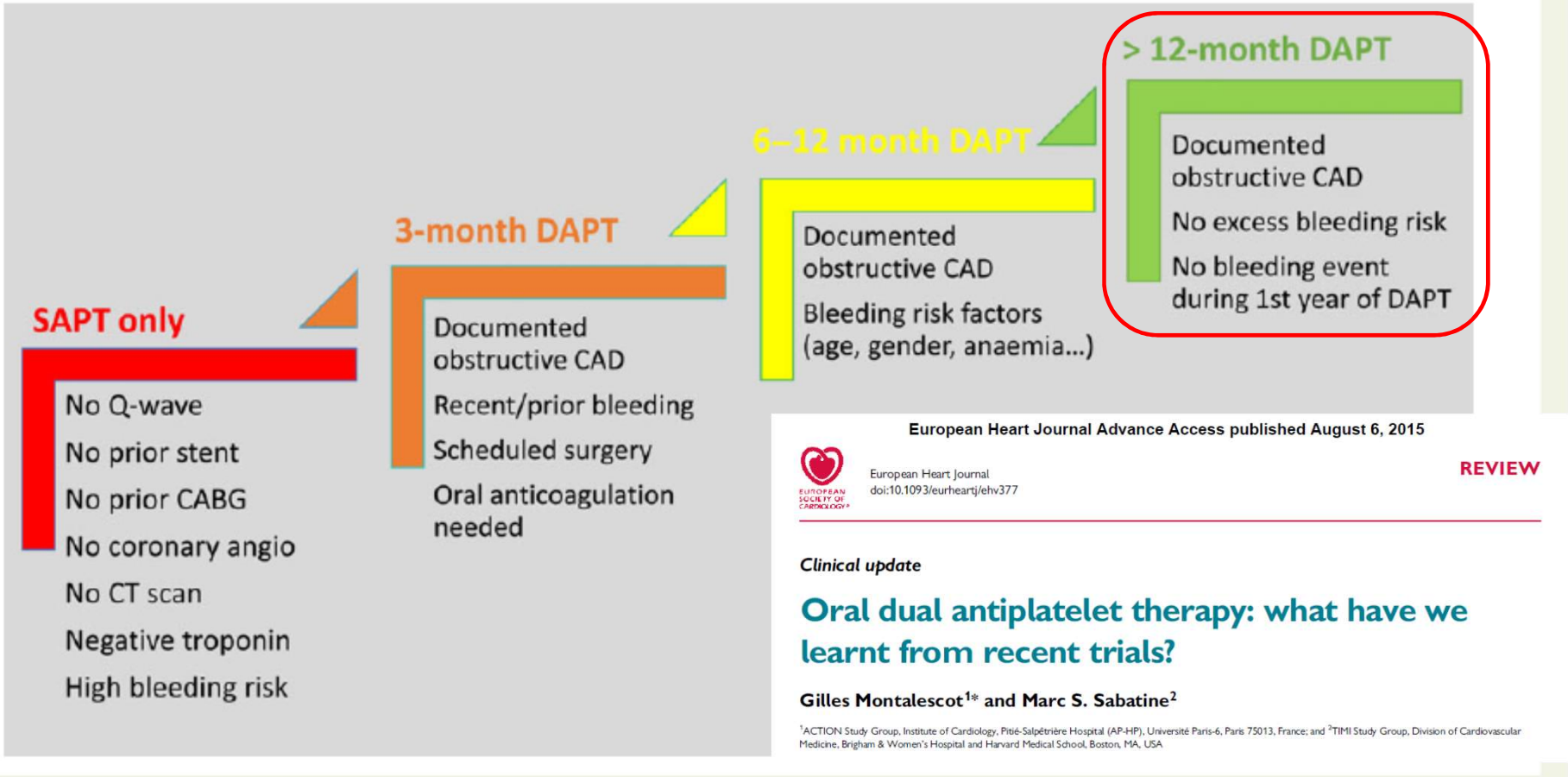
Clinical update

Oral dual antiplatelet therapy: what have we learnt from recent trials?

Gilles Montalescot[1]* and Marc S. Sabatine[2]

[1]ACTION Study Group, Institute of Cardiology, Pitié-Salpêtrière Hospital (AP-HP), Université Paris-6, Paris 75013, France; and [2]TIMI Study Group, Division of Cardiovascular Medicine, Brigham & Women's Hospital and Harvard Medical School, Boston, MA, USA

European Heart Journal 2015 (Advance Access, 6 aug); doi:10.1093/eurheartj/ehv377.



European Heart Journal Advance Access published August 6, 2015

European Heart Journal
doi:10.1093/eurheartj/ehv377

REVIEW

Clinical update

Oral dual antiplatelet therapy: what have we learnt from recent trials?

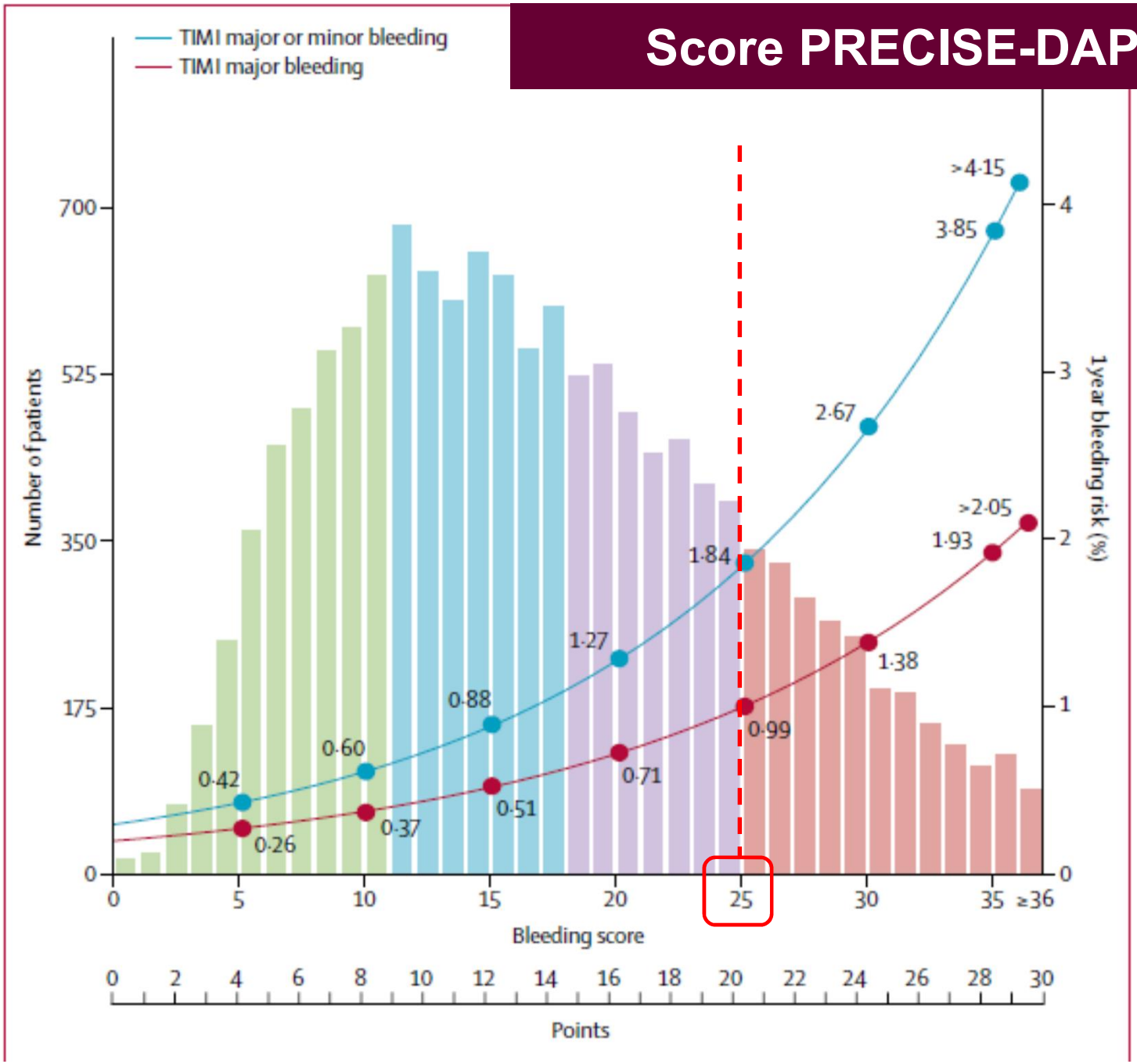
Gilles Montalescot[1]* and Marc S. Sabatine[2]

[1]ACTION Study Group, Institute of Cardiology, Pitié-Salpêtrière Hospital (AP-HP), Université Paris-6, Paris 75013, France; and [2]TIMI Study Group, Division of Cardiovascular Medicine, Brigham & Women's Hospital and Harvard Medical School, Boston, MA, USA

Figure 4 The proposed algorithm for the decisions concerning the use and duration of dual antiplatelet therapy in acute coronary syndrome patients, irrespective of the use of stents. Patients with a diagnosis of acute coronary syndrome which remains uncertain or with a low ischaemic/high bleeding risk acute coronary syndrome, single anti-platelet therapy may be the optimal antiplatelet strategy. In acute coronary syndrome patients with documented coronary artery disease, the strength, and duration of dual antiplatelet therapy may be driven by the risk of bleeding.[1,22,24–26,31,36]

European Heart Journal 2015 (Advance Access, 6 aug); doi:10.1093/eurheartj/ehv377.

Score PRECISE-DAPT



Costa F et al. for the PRECISE-DAPT Study Investigators. *Lancet* 2017; 389: 1025–34.

Las guías están cambiando

Canadian Journal of Cardiology 34 (2018) 214–233

Society Guidelines

2018 Canadian Cardiovascular Society/Canadian Association of Interventional Cardiology Focused Update of the Guidelines for the Use of Antiplatelet Therapy

Shamir R. Mehta, MD, MSc (co-chair),[a] Kevin R. Bainey, MD,[b] Warren J. Cantor, MD,[c] Marie Lordkipanidzé, BPharm, PhD,[d] Guillaume Marquis-Gravel, MD,[d] Simon D. Robinson, MBChB, MD,[e] Matthew Sibbald, MD, PhD,[a] Derek Y. So, MD,[f] Graham C. Wong, MD, MPH,[g] Joseph G. Abunassar, MD,[f] Margaret L. Ackman, PharmD,[b] Alan D. Bell, MD,[h] Raymond Cartier, MD,[d] James D. Douketis, MD,[i] Patrick R. Lawler, MD, MPH,[j] Michael S. McMurtry, MD,[b] Jacob A. Udell, MD,[j] Sean van Diepen, MD,[b] Subodh Verma, MD,[k] G.B. John Mancini, MD,[g] John A. Cairns, MD,[g] and Jean-François Tanguay, MD (co-chair);[d] and members of the Secondary Panel

Mehta S et al. Canadian Journal of Cardiology 2018;34:214e233 (Epub March 2018).

Mehta S et al. Canadian Journal of Cardiology 2018;34:214e233 (Epub March 2018).

Recommendations

In patients with ACS (STEMI or NSTEMI) who receive PCI:

1. We recommend DAPT with ASA 81 mg daily with either ticagrelor 90 mg BID or prasugrel 10 mg once daily over clopidogrel 75 mg once daily for 1 year (Strong Recommendation; High-Quality Evidence).
2. We recommend that, in patients who tolerate 1 year of DAPT without a major bleeding event and who are not at high risk of bleeding, DAPT should be extended beyond 1 year (Strong Recommendation; High-Quality Evidence for up to 3 years of treatment). After 1 year, we recommend a DAPT regimen of ASA 81 mg daily plus either ticagrelor 60 mg BID or clopidogrel 75 mg once daily (Strong Recommendation; High-Quality Evidence) or prasugrel 10 mg once daily (Weak Recommendation; Moderate-Quality Evidence).

Values and preferences. These recommendations place greater emphasis on reduction of major CV events and stent thrombosis vs an increase in bleeding complications.

Conclusiones

- ✓ Usar pre-tratamiento antiagregante en STEMI.
- ✓ Usar antiagregantes potentes.
- ✓ Si el paciente no sangró durante el primer año, y no tiene alto riesgo hemorrágico (PRECISE-DAPT <25) continuar con DAPT más allá del año.


THANK
YOU
GRACIAS
ARIGATO
SHUKURIA
DANKSCHEEN
BÏYAN
SHUKRIA
TINGKI
YAQHANYELAY
TASHAKKUR ATU
SUKSAMA
EKHMET
MEHRBANI
GRAZIE
MAAKE
KOMAPSUMNIDA
PALDIES
GOZAIMASHITA
EFCHARISTO
JUSPAXAR
BOLZÏN
MERCI