Un patient bitronculaire

Biarritz APPAC

7 Juin 2011

Bernard LIVAREK

Histoire de Mr M., 65 ans

- ATCD cardiovasculaires:
  - Janvier 2011 : IDM antérieur (A. Beclère)

    Thrombo-aspiration + angioplastie au ballon seul de IVA moyenne du fait d'une allergie à l'ASPIRINE

  - Désensibilisation secondaire à l'ASPIRINE

Histoire de Mr M.

- <u>FDR cardiovasculaires :</u>
  - Dyslipidémie

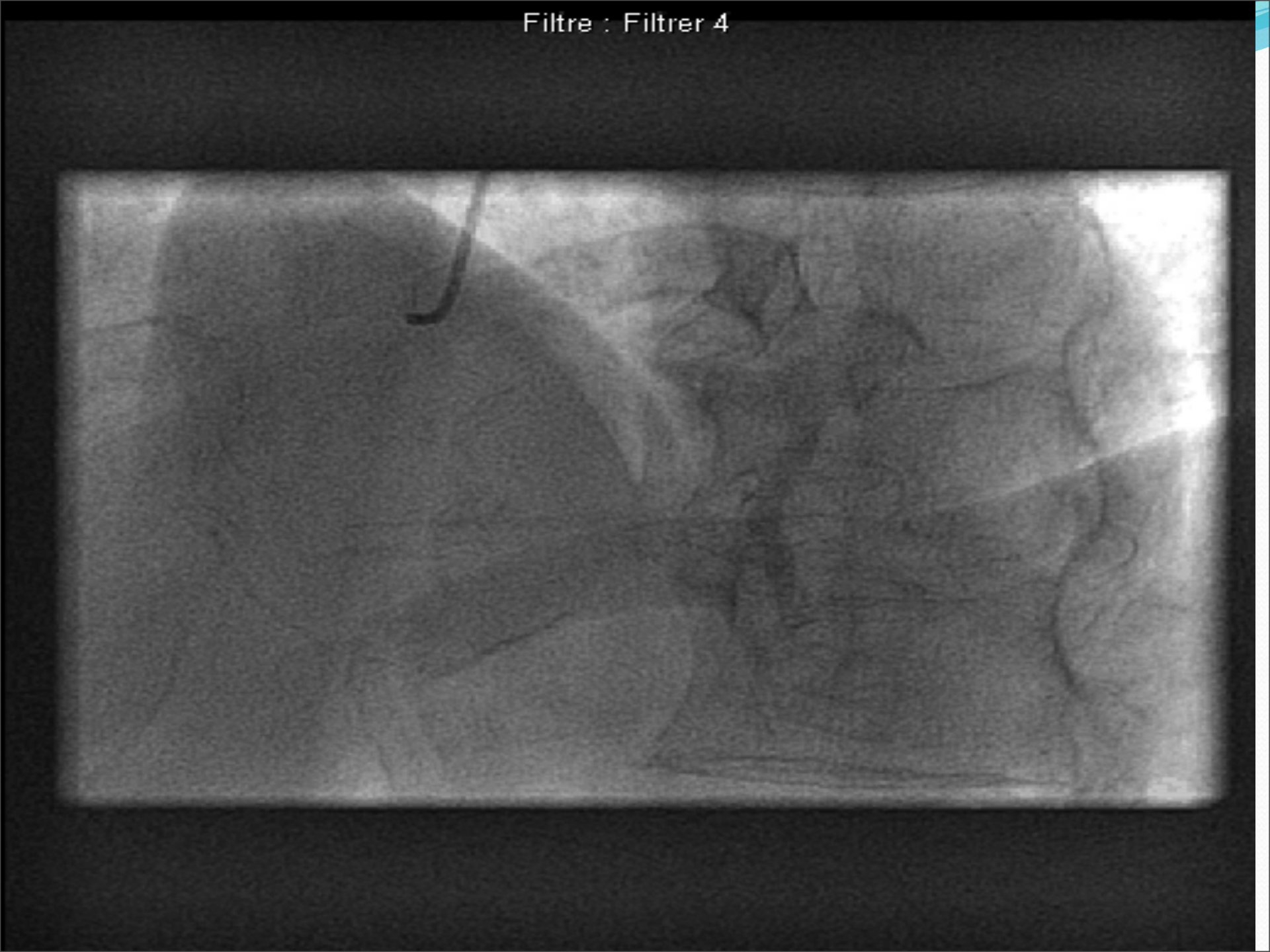
- <u>TTT d'entrée :</u>
  - Kardegic 75 mg / jour
  - Cardensiel 2.5 mg / jour
  - Pravastatine 40 mg/ jour
  - Omacor 1 gel / jour

HDM

- 29/04/2011
  - EE maximale négative
  - Scintigraphie positive avec ischémie ASA 4 segments

- Coronarographie réalisée le 1er Juin 2011

Coronaire droite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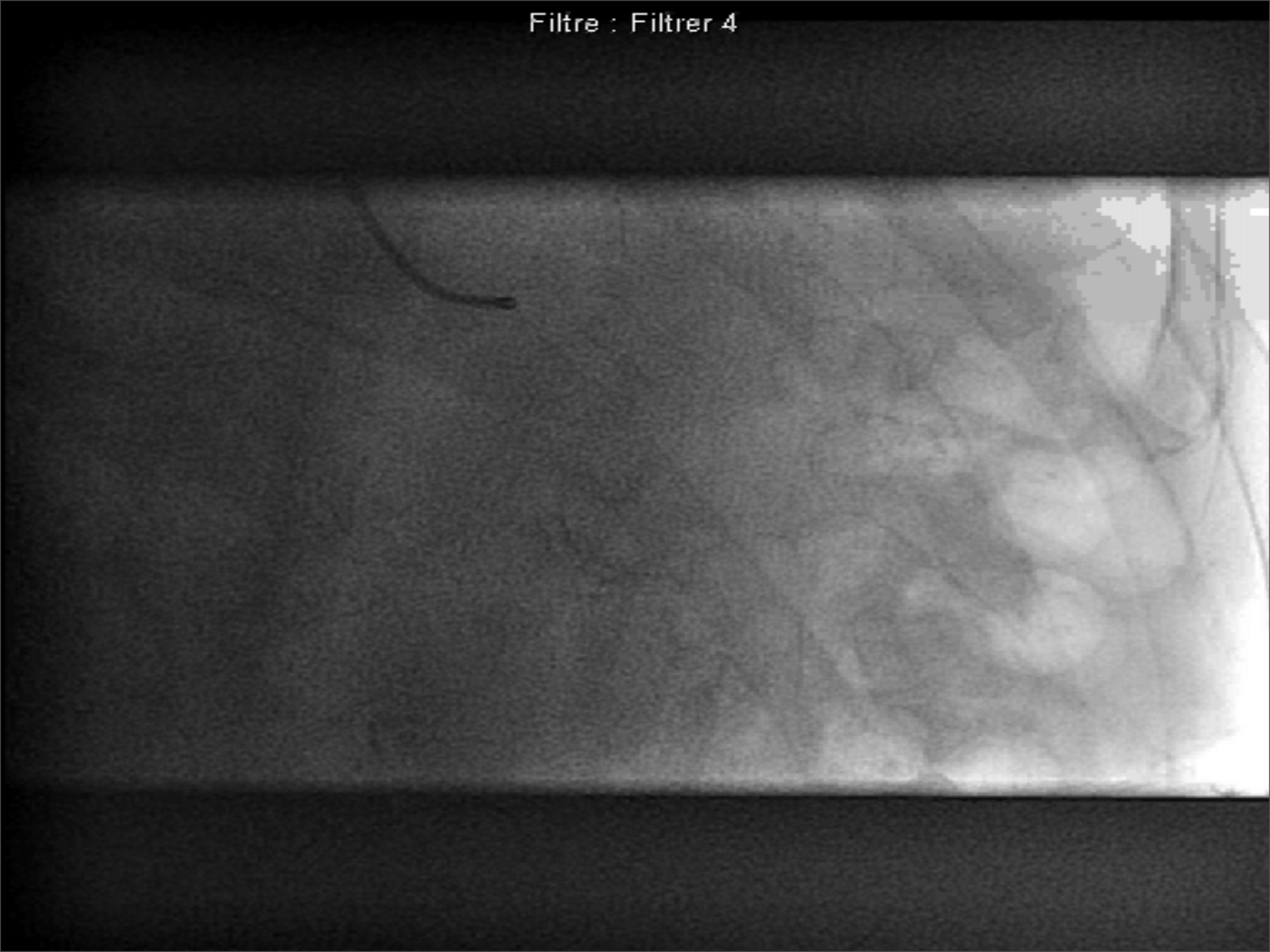
Coronaire droite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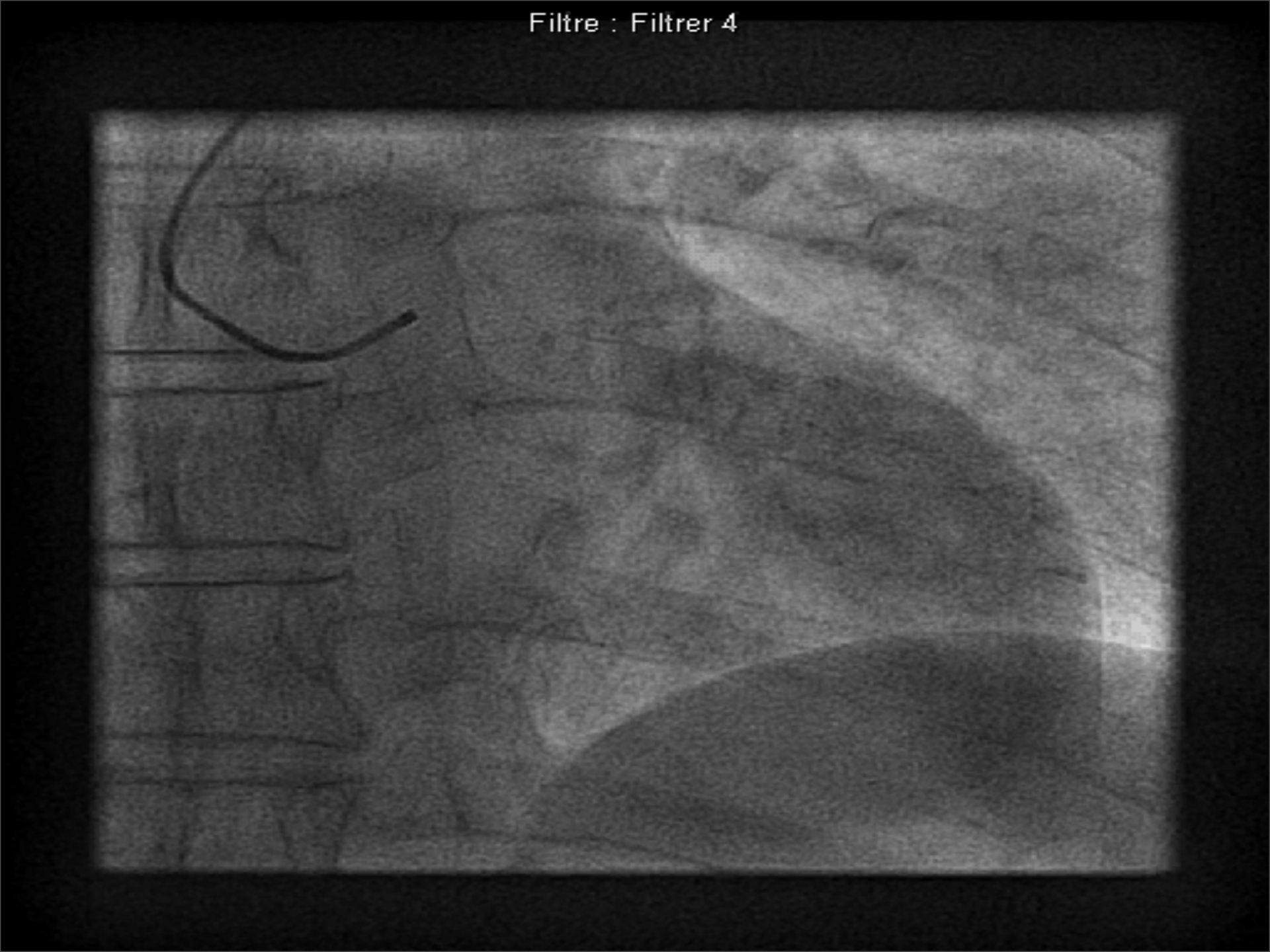
Coronaire Gauche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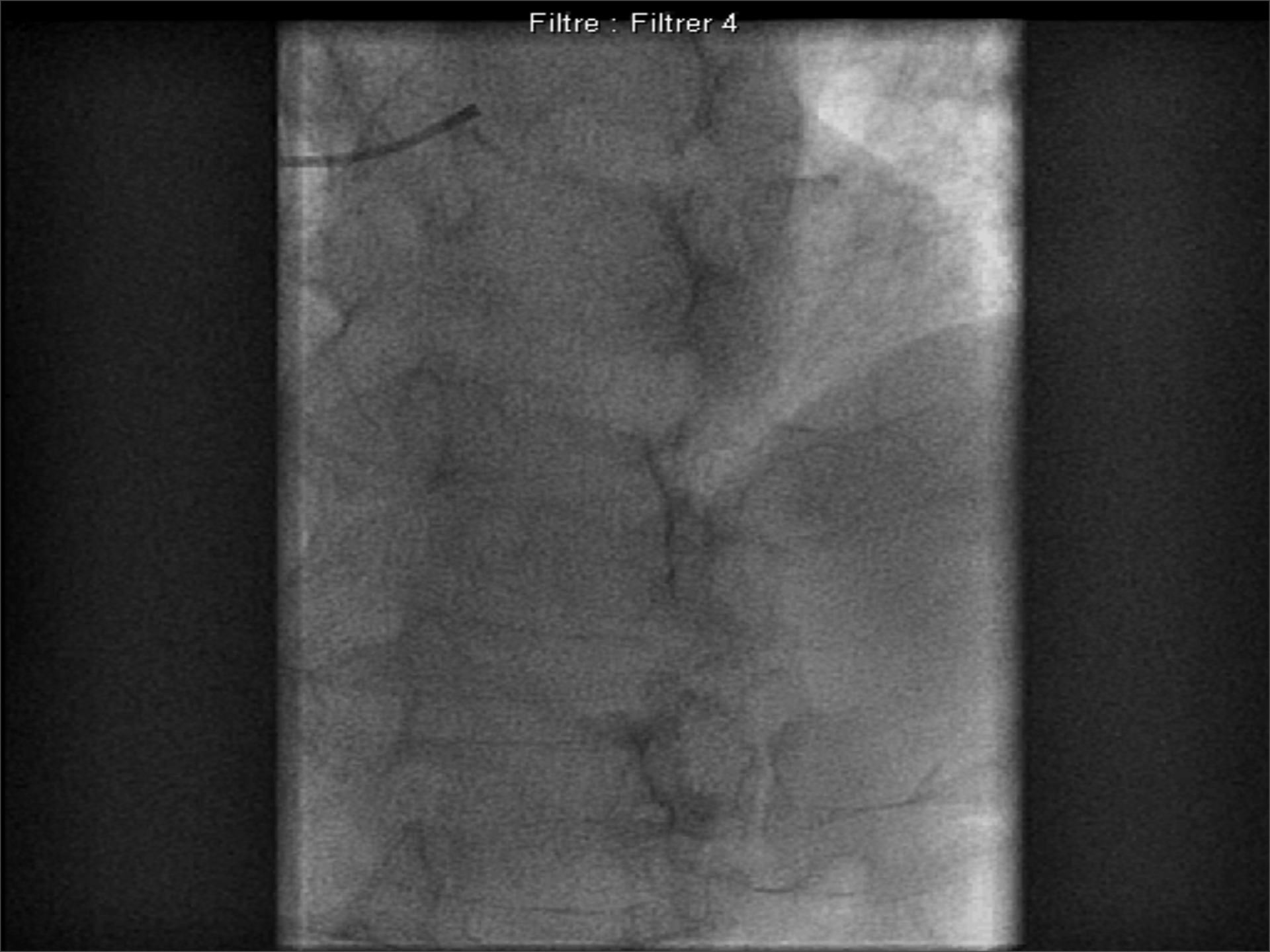
Coronaire Gauche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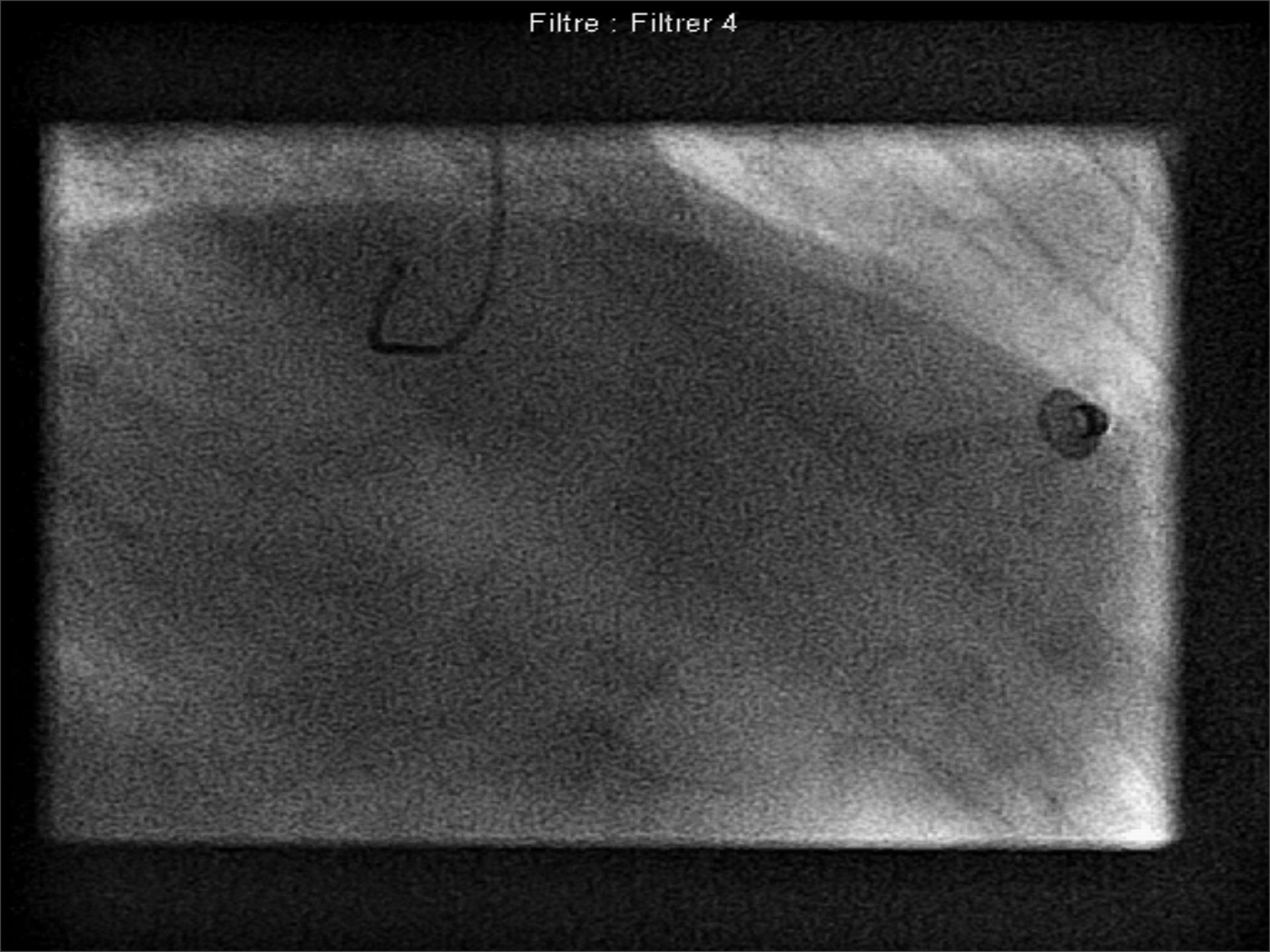
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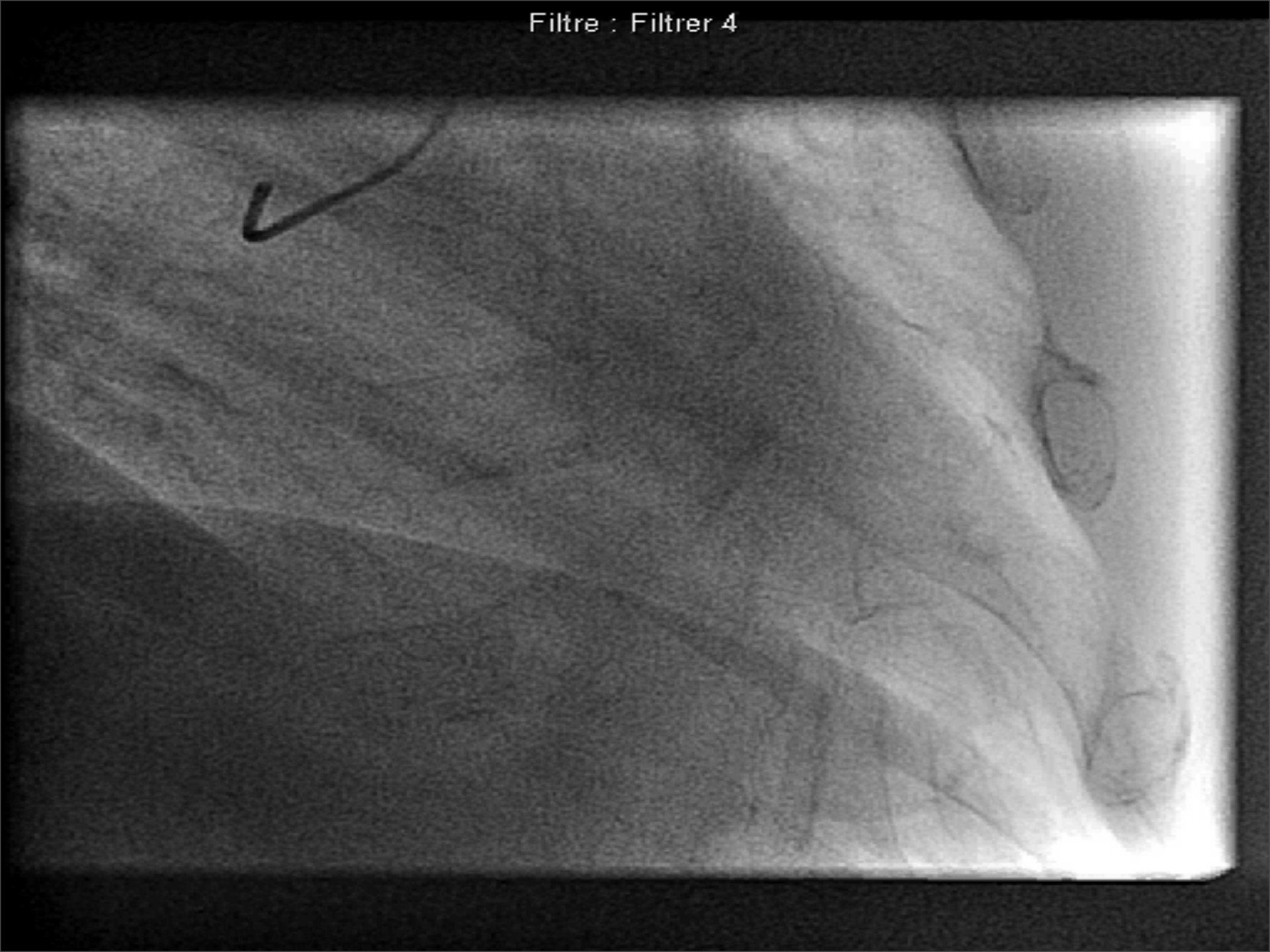
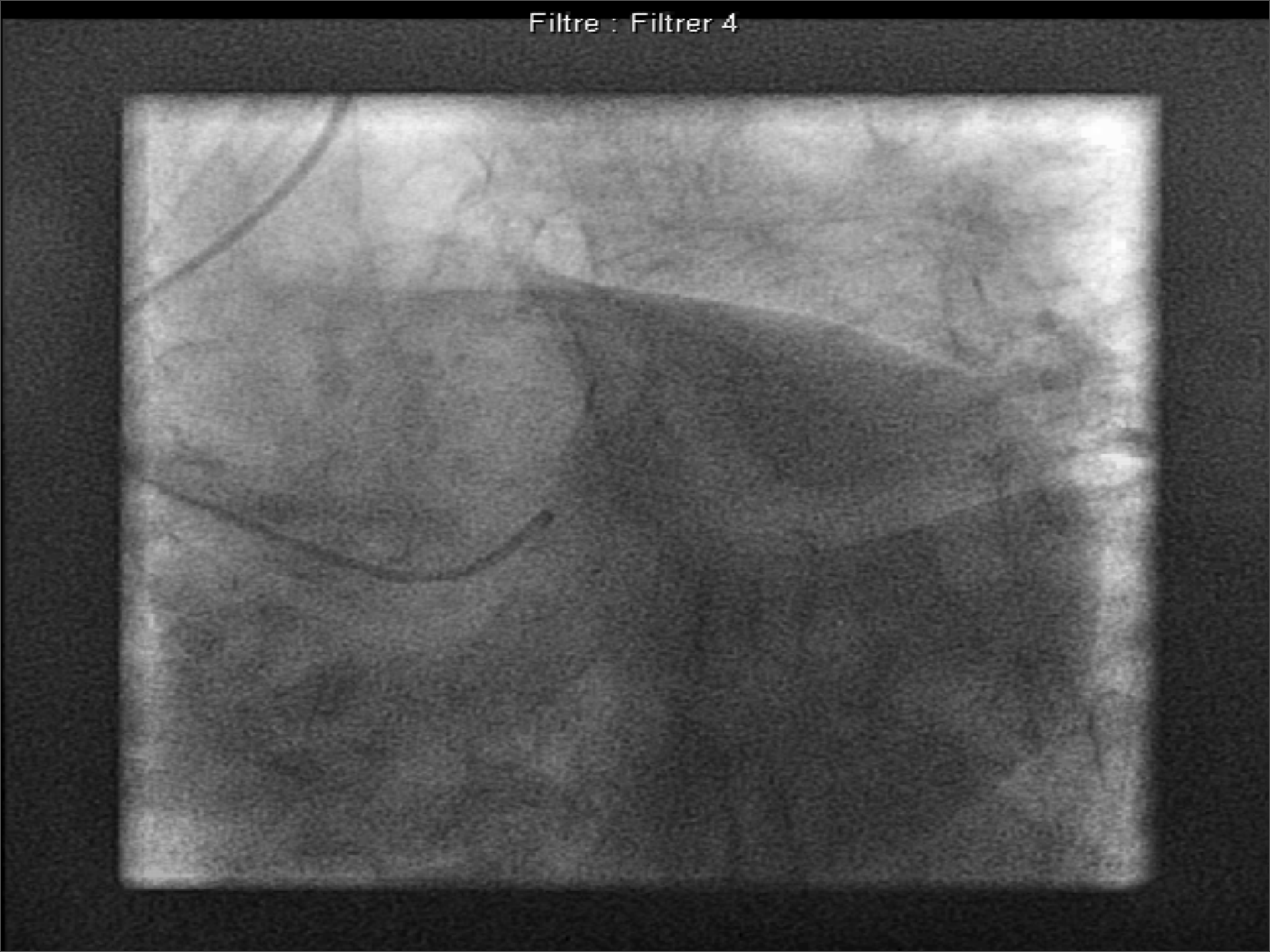

Filtre : Filtrer 4

Coronaire Gauche


Filtre : Filtrer 4

Discussion de revascularisation

- 65 ans, bitronculaire, non diabétique, FE VG 68%
- Score syntax: 19
- Euroscore logistique, Mortalité prédite: 1.3 %
- Revascularisation optimale de 3 lésions accessibles :

  IVA 1-2 / diagonale,

  IVA 3,

Table 8 Indications for revascularization in stable angina or silent ischaemia

	Subset of CAD by anatomy	Class[a]	Level[b]	Ref.[c]
For prognosis	Left main >50%[d]	I	A	30, 31, 54
	Any proximal LAD >50%[d]	I	A	30–37
	2VD or 3VD with impaired LV function[d]	I	B	30–37
	Proven large area of ischaemia (>10% LV)	I	B	13, 14, 38
	Single remaining patent vessel >50% stenosis[d]	I	C	—
	1VD without proximal LAD and without >10% ischaemia	III	A	39, 40, 53
For symptoms	Any stenosis >50% with limiting angina or angina equivalent, unresponsive to OMT	I	A	30, 31, 39–43
	Dyspnoea/CHF and >10% LV ischaemia/viability supplied by >50% stenotic artery	IIa	B	14, 38
	No limiting symptoms with OMT	III	C	—

[a]Class of recommendation.
[b]Level of evidence.
[c]References.
[d]With documented ischaemia or FFR <0.80 for angiographic diameter stenoses 50–90%.
CAD = coronary artery disease; CHF = chronic heart failure; FFR = fractional flow reserve; LAD = left anterior descending; LV = left ventricle; OMT = optimal medical therapy; VD = vessel disease.

Table 4 Multidisciplinary decision pathways, patient informed consent, and timing of intervention

	ACS				Stable MVD	Stable with indication for *ad hoc* PCI[a]
	Shock	STEMI	NSTE - ACS[b]	Other ACS[c]		
Multidisciplinary decision making	Not mandatory.	Not mandatory.	Not required for culprit lesion but required for non-culprit vessel(s).	Required.	Required.	According to predefined protocols.
Informed consent	Oral witnessed informed consent or family consent if possible without delay.	Oral witnessed informed consent may be sufficient unless written consent is legally required.	Written informed consent[d] (if time permits).	Written informed consent[d]	Written informed consent[d]	Written informed consent[d]
Time to revascularization	Emergency: no delay.	Emergency: no delay.	Urgency: within 24 h if possible and no later than 72 h.	Urgency: time constraints apply.	Elective: no time constraints.	Elective: no time constraints.
Procedure	Proceed with intervention based on best evidence/ availability.	Proceed with intervention based on best evidence/ availability.	Proceed with intervention based on best evidence/ availability. Non-culprit lesions treated according to institutional protocol.	Proceed with intervention based on best evidence/ availability. Non-culprit lesions treated according to institutional protocol.	Plan most appropriate intervention allowing enough time from diagnostic catheterization to intervention.	Proceed with intervention according to institutional protocol defined by local Heart Team.

[a]Potential indications for *ad hoc* PCI are listed in *Table 5*.
[b]See also *Table 12*.
[c]Other ACS refers to unstable angina, with the exception of NSTE-ACS.
[d]This may not apply to countries that legally do not ask for written informed consent. ESC and EACTS strongly advocate documentation of patient consent for all revascularization procedures.
ACS = acute coronary syndrome; MVD = multivessel disease; NSTE-ACS = non-ST-segment elevation acute coronary syndrome; PCI = percutaneous coronary intervention; STEMI = ST-segment elevation myocardial infarction.

Table 5 Potential indications for *ad hoc* percutaneous coronary intervention vs. revascularization at an interval

Ad hoc PCI
Haemodynamically unstable patients (including cardiogenic shock).
Culprit lesion in STEMI and NSTE-ACS.
Stable low-risk patients with single or double vessel disease (proximal LAD excluded) and favourable morphology (RCA, non-ostial LCx, mid- or distal LAD).
Non-recurrent restenotic lesions.
Revascularization at an interval
Lesions with high-risk morphology.
Chronic heart failure.
Renal failure (creatinine clearance <60 mL/min), if total contrast volume required >4 mL/kg.
Stable patients with MVD including LAD involvement.
Stable patients with ostial or complex proximal LAD lesion.
Any clinical or angiographic evidence of higher periprocedural risk with *ad hoc* PCI.

LAD = left anterior descending; LCx = left circumflex; MVD = multivessel disease; NSTE-ACS = non-ST-segment elevation acute coronary syndrome; PCI = percutaneous coronary intervention; RCA = right coronary artery; STEMI = ST-segment elevation myocardial infarction.

Table 9 Indications for coronary artery bypass grafting vs. percutaneous coronary intervention in stable patients with lesions suitable for both procedures and low predicted surgical mortality

Subset of CAD by anatomy	Favours CABG	Favours PCI	Ref.
1VD or 2VD - non-proximal LAD	IIb C	I C	—
1VD or 2VD - proximal LAD	I A	IIa B	30, 31, 50, 51
3VD simple lesions, full functional revascularization achievable with PCI, SYNTAX score ≤22	I A	IIa B	4, 30–37, 53
3VD complex lesions, incomplete revascularization achievable with PCI, SYNTAX score >22	I A	III A	4, 30–37, 53
Left main (isolated or 1VD, ostium/shaft)	I A	IIa B	4, 54
Left main (isolated or 1VD, distal bifurcation)	I A	IIb B	4, 54
Left main + 2VD or 3VD, SYNTAX score ≤32	I A	IIb B	4, 54
Left main + 2VD or 3VD, SYNTAX score ≥33	I A	III B	4, 54

Ref. = references.
CABG = coronary artery bypass grafting; CAD = coronary artery disease; LAD = left anterior descending; PCI = percutaneous coronary intervention; VD = vessel disease.

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DES ou BMS ??

- Non diabétique MAIS

- IVA II longue
- IVA III de petit calibre

Donc plutôt DES !!!!

Mesdames, pouvez-vous faire
passer au patient l'épreuve

Questionnaire « stents actifs » – 1

- Avez-vous eu récemment des Pb de saignements anormaux (crachats, vomissements, selles …)?

- Avez-vous eu une anémie récemment ?

- Devez-vous subir dans les 12 prochains mois:

Coloscopie, Fibroscopie gastrique ou des bronches,

Infiltration des articulations ??

Questionnaire « stents actifs » – 2

- Devez-vous subir dans les 12 prochains mois:

  Cataracte, Xie de Hanche, Genou, ORL, Gynéco, Vésicule, Neurochirurgie, Hernie discale, autre..
- Devez-vous avoir prochainement des biopsies?
- Etes vous porteur d'une maladie inflammatoire nécessitant un traitement au long cours ??
- Avez-vous des ATCD de cancer?
- Devez-vous subir prochainement un scanner ??
- Prenez vous des anticoagulants, des AINS ?

Questionnaire « stents actifs » – 3

- Etes-vous capable de prendre un traitement tous les jours sans interruption pendant une durée de un an??

- Si vous prenez des médicaments, combien de jours par mois oubliez vous votre traitement ??

- Le patient est-il capable de prendre son traitement ??

(Pb sociaux, Alcool, Langue, Comportement ..)

Questionnaire « stents actifs » – Résultat

- Patient en attente d'une chirurgie colique (Juillet 2011)
- Diverticulose, avec abcès récent……..

Indication de Revascularisation Chirurgicale !!

Take Home Messages

- Respecter les recommandations !

(Heart Team, pas d'Ad Hoc sauf urgence…)

- Intérêt d'un questionnaire dédié « stents actifs »

(En salle de KT ou préalablement en secteur d'hospitalisation)