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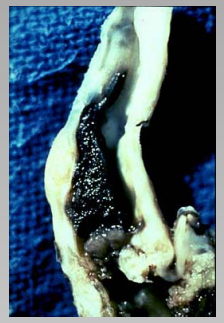
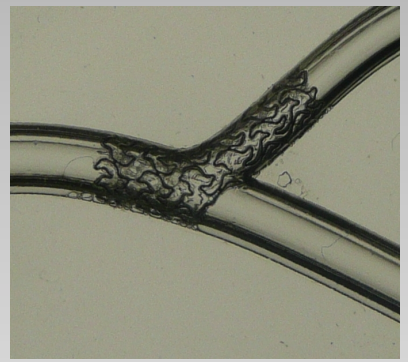
Prise en charge du SCA ST+ : Données actuelles



Philippe BRUNEL Nantes



APPAC
Actualisations et Perspectives en PAthologie Cardiovasculaire
www.appac.fr
BIARRITZ
9-10 et 11 JUIN 2010

Session organisée avec le GACI JEUDI 10 JUIN 14h30-16h00

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SCA ST+ : données actuelles

- ✓ VOIE RADIALE
- ✓ THROMBOASPIRATION
- ✓ NOUVEAUX ANTIPLAQUETTAIRES
- ✓ STENT ACTIFS
- ✓ STENT FOR LIFE
- ✓ DIVERS…..

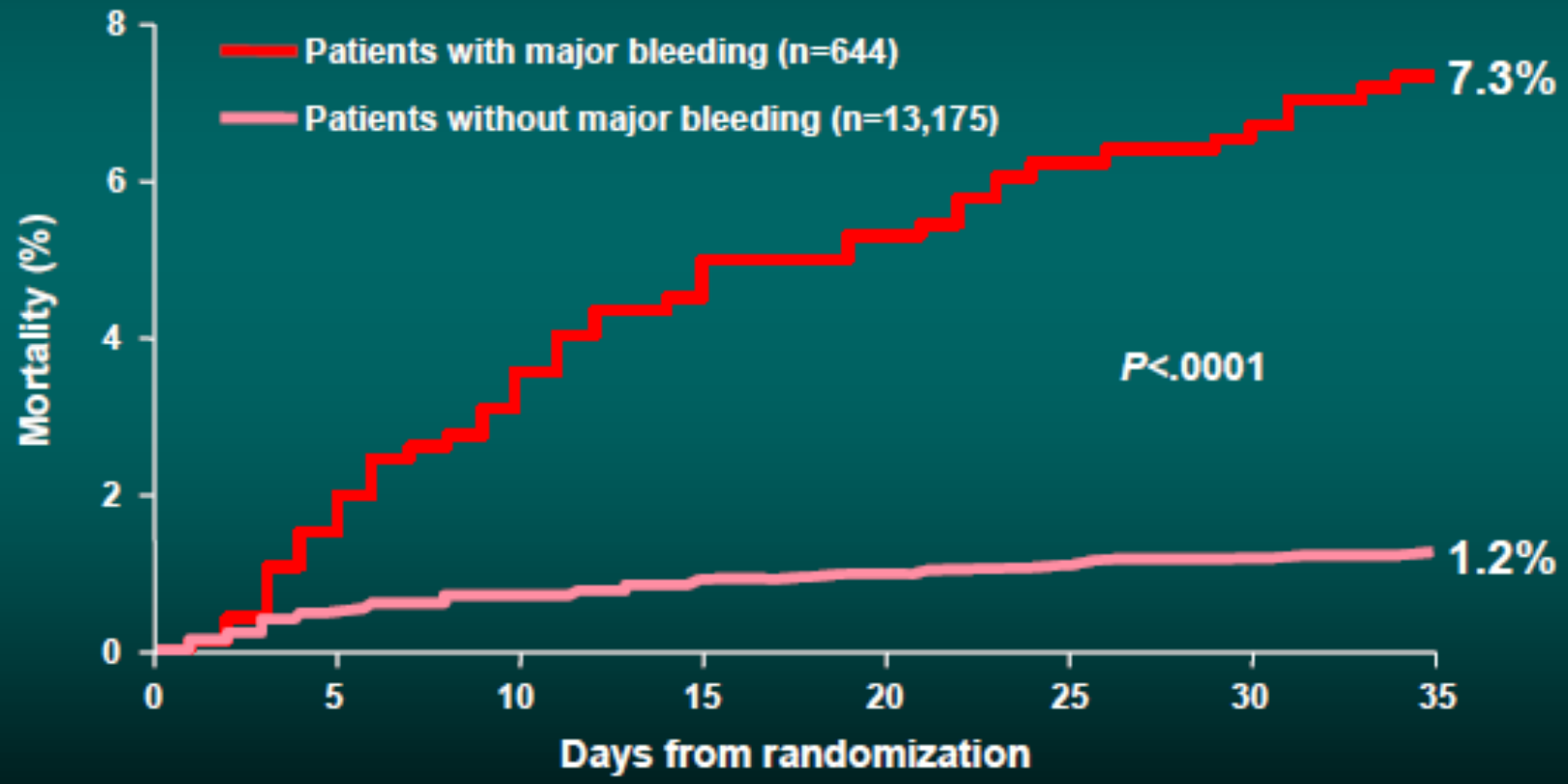
SCA ST+


NOUVELLES CLINIQUES NANTAISES
UNITE-SOINS
CARDIOLOGIE
INTERVENTIONNELLE

Major Bleeding Is a Predictor of 30-Day Mortality: Results From the ACUITY Trial

ACUITY TRIAL

Logistic regression analysis of 13,819 patients from ACUITY evaluated predictors of major bleeding and its impact on 30-day mortality



Reproduced with permission from Manoukian SV et al. *J Am Coll Cardiol.* 2007;49:1362-1368.

UNITE-SOINS --CARDIOLOGIE INTERVENTIONNELLE

Radial versus femoral access for coronary angiography or intervention and the impact on major bleeding and ischemic events: a systematic review and meta-analysis of randomized trials.

Jolly SS, Amlani S, Hamon M, Yusuf S, Metha SR. Am Heart J. 2009 Jan;157(1):132-40. Epub 2008 Nov 1

✓*Reduced major bleeding* by 73% compared to femoral access P < .001).

✓*trend for reductions in the composite of death, myocardial infarction, or stroke* (2.5% vs 3.8%, P = .058)

as well as death (1.2% vs 1.8% P = .29).

✓*trend for higher rate of inability to the cross lesion* with wire, balloon, or stent during percutaneous coronary intervention with radial access (P = .21).

✓*reduced hospital stay* by 0.4 days (95% CI 0.2-0.5, P = .0001)

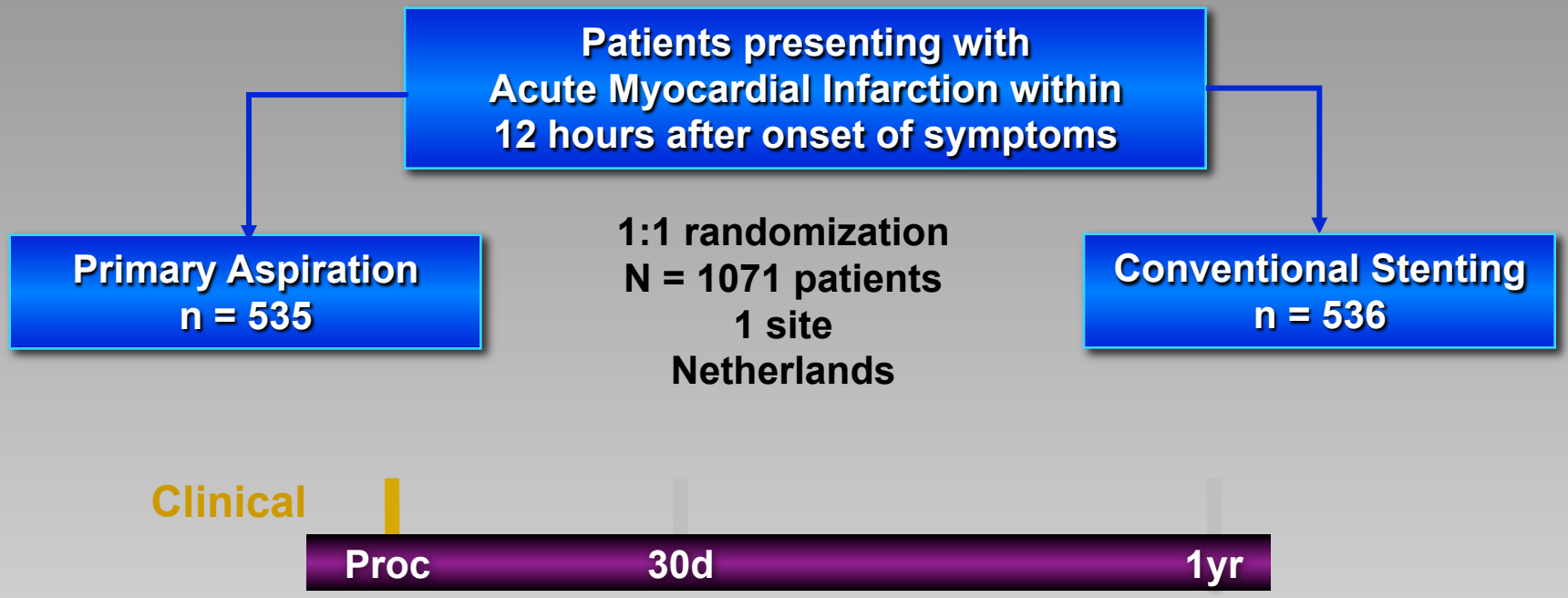
Facteurs prédictifs de décès en cas d'angioplastie primaire

	OR	IC 95%	P
Age Q1 vs Q2	1,37	0,241 – 7,772	0,72
Q1 vs Q3	3,43	0,71 – 16,71	0,13
Q1 vs Q4	11,86	2,72 – 51,76	0,001
Pression artérielle systolique	0,99	0,97 – 0,99	0,039
Drogues inotropes	2.13	0.90 – 5.09	0.09
Support respiratoire	14.73	6.41 – 33.83	< 0.0001
GUSTO sévère & modéré	2.00	0.89 – 4.48	0.09
Evènements ischémiques	0.93	0.30 – 2.84	0.90
Accès radial	0.34	0.17 – 0.70	0.003
Atteinte multitronculaire	3.05	1.37 – 6.80	0.006
HNF	2.16	1.11 – 4.18	0.02

O. Barthélémy et al - JESFC 2010

TAPAS Study

Randomized, Open Label, Single Center Trial

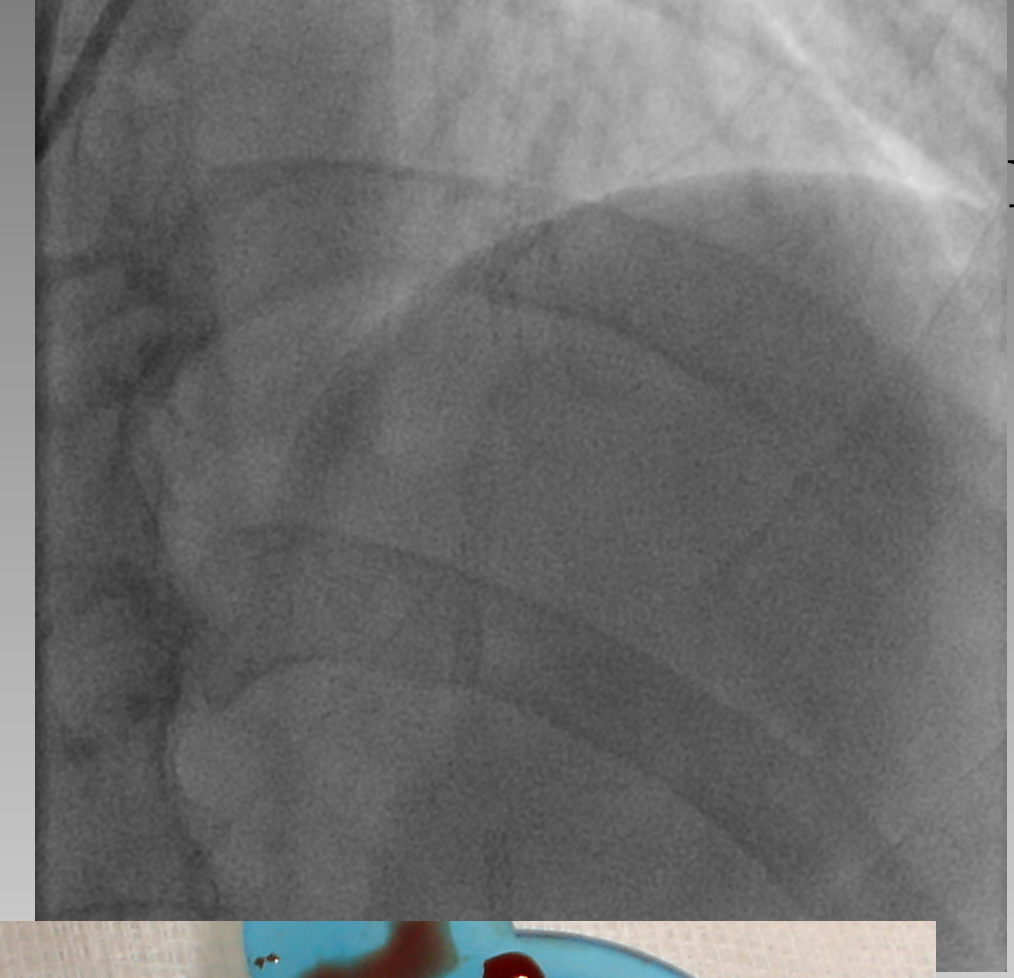


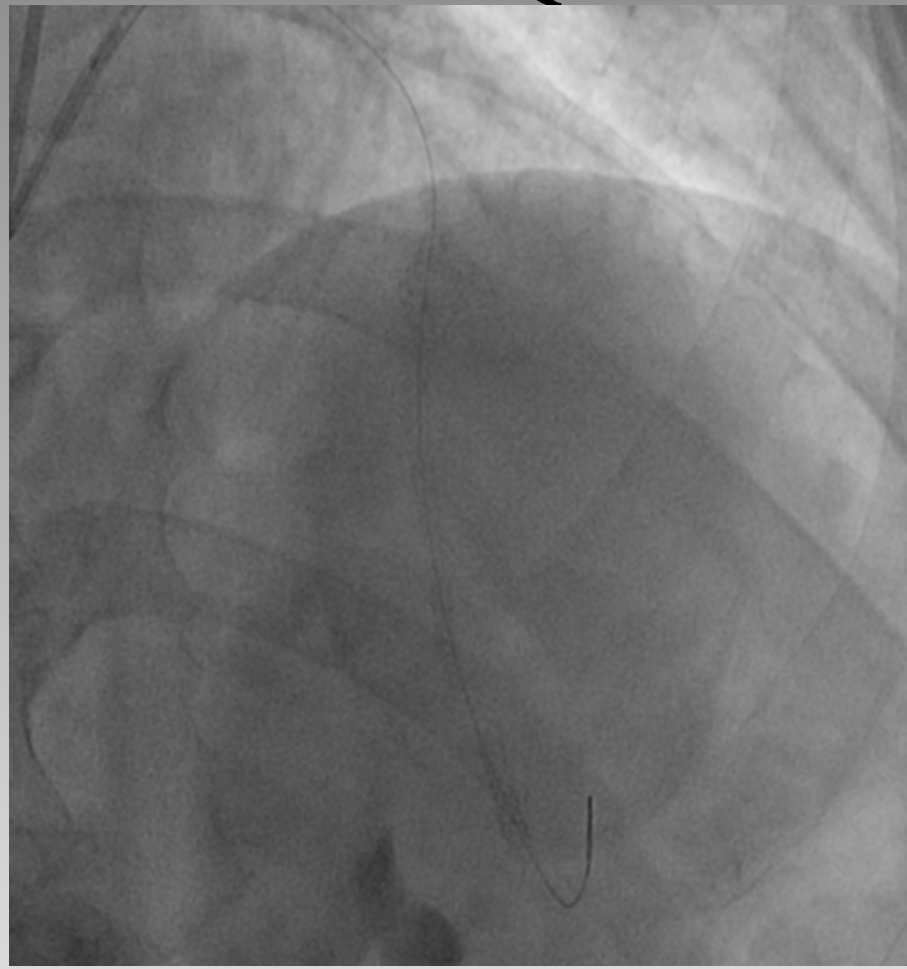
Primary Endpoint: Myocardial Blush Grade of 0 or 1 (defined as absent or minimal myocardial reperfusion)

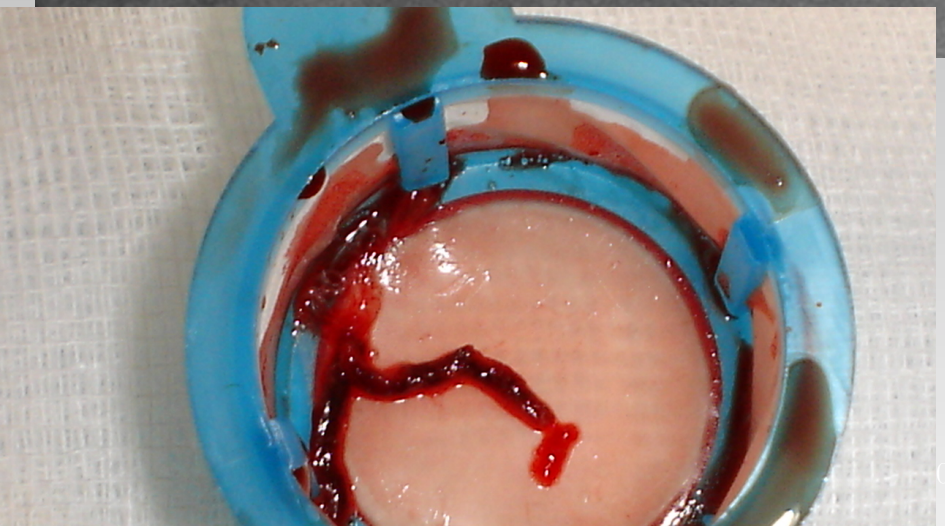
Secondary Endpoints: TIMI 3 flow, complete resolution of ST-segment elevation, absence of persistent ST-segment deviation, target-vessel revascularization, reinfarction, death, and MACE at 30 days.

Svilaas T. et al., NEJM, February 7, 2008, Vol. 358, No. 6

N SYSTEMATIQUE?

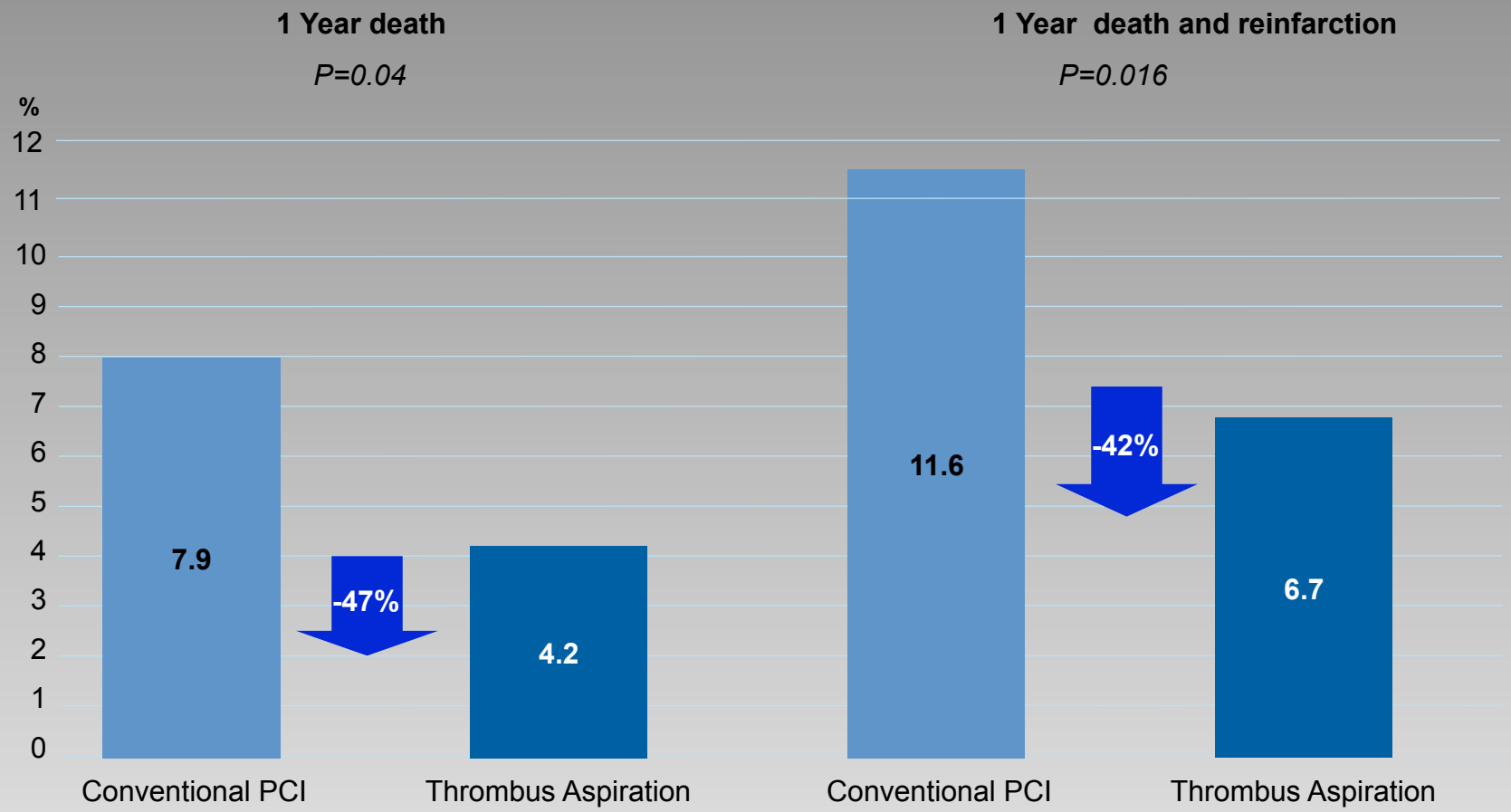






TAPAS Study – 1 Year

Death and MACE at 1 Year



Statistically Significant Reduction in Death and Reinfarction in Favor of the Export Group

Vlaar P. et al., Lancet, June 7, 2008, Vol. 371:1915-20

ETUDE TAPAS : CONCLUSIONS

La thromboaspiration au cathéter Export des Infarctus ST+ conduit à :

- ✓ **amélioration de la reperfusion coronaire et de l'évolution clinique comparée avec l'angioplastie conventionelle quelle que soit la présentation clinique ou angiographique (ex. thrombus visible en angio)**

- ✓ **réduit la mortalité et le taux de mortalité et réinfarctus non-fatal à 1 an**

- ✓ **L' analyse histopathologique des produits d'aspiration souligne l'importance du traitement antiplaquettaire pour l'amélioration de l'évolution après angioplastie primaire**

Vlaar P. et al., Lancet, June 7, 2008, Vol. 371:1915-20

METAANALYSE BURZOTA

European Heart Journal (2009) **30**, 2193–2203
doi:10.1093/eurheartj/ehp348

EUROPEAN SOCIETY OF CARDIOLOGY®

FASTTRACK
ESC CLINICAL TRIAL UPDATE

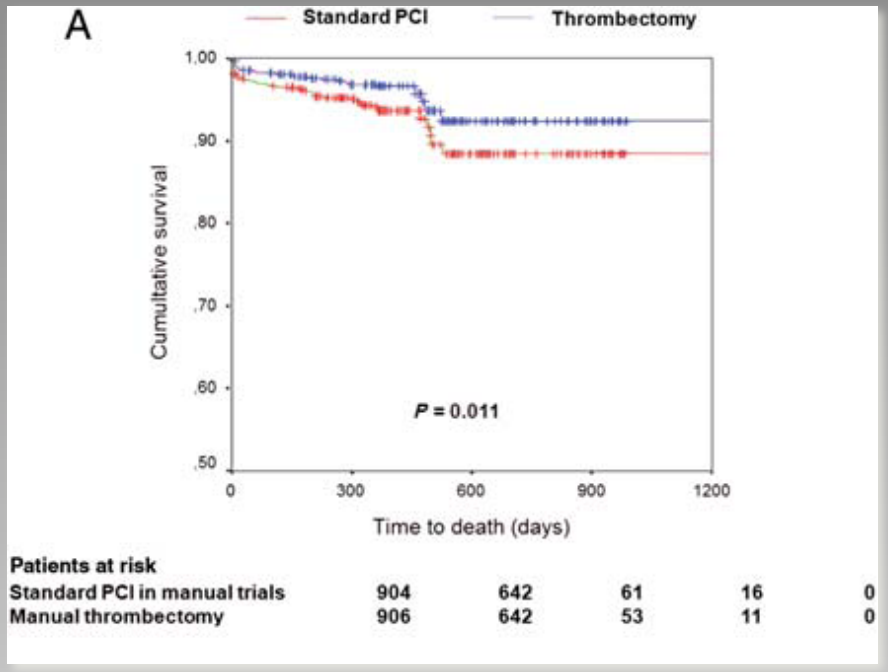
Clinical impact of thrombectomy in acute ST-elevation myocardial infarction: an individual patient-data pooled analysis of 11 trials

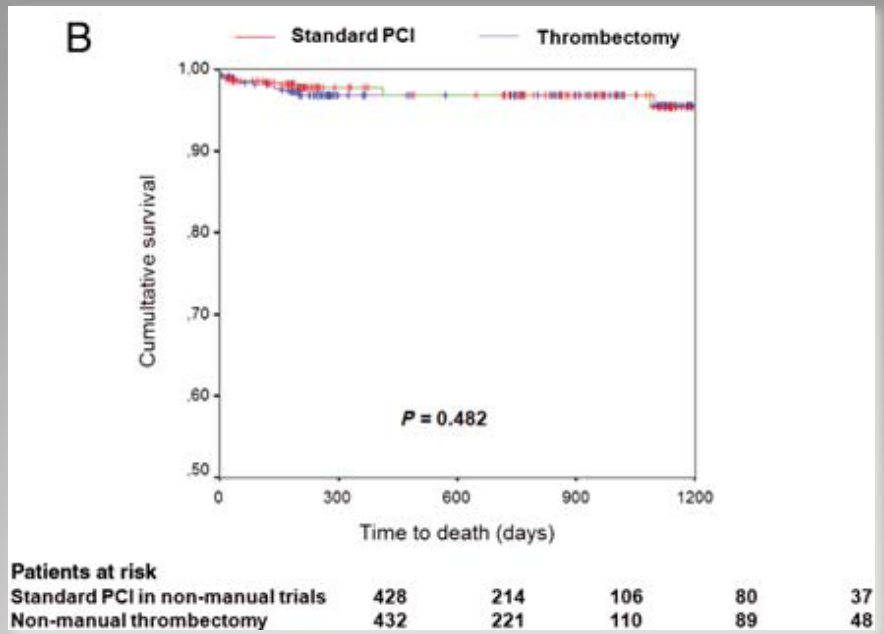
Francesco Burzotta[1]*†, Maria De Vita[1]†, Youlan L. Gu[2], Takaaki Isshiki[3], Thierry Lefèvre[4], Anne Kaltoft[5], Dariusz Dudek[6], Gennaro Sardella[7], Pedro Silva Orrego[8], David Antoniucci[9], Leonardo De Luca[10], Giuseppe G.L. Biondi-Zoccai[11], Filippo Crea[1], and Felix Zijlstra[2]

[1]Cardiology Institute, Catholic University of Sacred Heart, Rome, Italy, [2]University Medical Center Groningen, University of Groningen, Groningen, The Netherlands, [3]Department of Cardiology, Teykio University School of Medicine, Tokyo, Japan, [4]Institut Cardiovasculaire Paris Sud, Massy, France, [5]Department of Cardiology, Aarhus University Hospital, Skejby, Denmark, [6]Department of Cardiology, Jagiellonian University, Kracow, Poland, [7]Department of Cardiovascular and Respiratory Sciences, La Sapienza University, Rome, Italy, [8]Interventional Cardiology, A. De Gasperis Department, Niguarda Hospital, Milan, Italy, [9]Division of Cardiology, Careggi Hospital, Florence, Italy, [10]Department of Cardiovascular Sciences, European Hospital, Rome, Italy, [11]Division of Cardiology, University of Turin, Turin, Italy

Received 30 June 2009; revised 3 August 2009; accepted 7 August 2009

METAANALYSE BURZOTA





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TAPAS-II ACC, Pieter Vlaar

- ✓ Thrombus removal : 83%
- ✓ One Year Follow-up of Thrombus Aspiration during Primary Percutaneous Coronary Intervention in Acute Non-ST-elevation Myocardial Infarction Study

- ✓ in most NSTEMI patients is feasible and safe, is associated with a high rate of retrieval of thrombotic material, and results in excellent clinical outcomes

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et Cardio
de la Soc

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 NOVEMBER 15, 2007 VOL. 357 NO. 20

Prasugrel versus Clopidogrel in Patients with Acute Coronary Syndromes

Stephen D. Wiviott, M.D., Eugene Braunwald, M.D., Carolyn H. McCabe, B.S., Gilles Montalescot, M.D., Ph.D., Witold Ruzyllo, M.D., Shmuel Gottlieb, M.D., Franz-Joseph Neumann, M.D., Diego Ardissino, M.D., Stefano De Servi, M.D., Sabina A. Murphy, M.P.H., Jeffrey Riesmeyer, M.D., Govinda Weerakkody, Ph.D., C. Michael Gibson, M.D., and Elliott M. Antman, M.D., for the TRITON–TIMI 38 Investigators*

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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
Death from cardiovascular causes, nonfatal MI, or urgent target-vessel revascularization	652 (10.0)	798 (12.3)	0.81 (0.73–0.89)	<0.001
Death from any cause, nonfatal MI, or nonfatal stroke	692 (10.7)	822 (12.7)	0.83 (0.75–0.92)	<0.001
Urgent target-vessel revascularization	156 (2.5)	233 (3.7)	0.66 (0.54–0.81)	<0.001
Death from cardiovascular causes, nonfatal MI, nonfatal stroke, or rehospitalization for ischemia	797 (12.3)	938 (14.6)	0.84 (0.76–0.92)	<0.001
Stent thrombosis‡	68 (1.1)	142 (2.4)	0.48 (0.36–0.64)	<0.001

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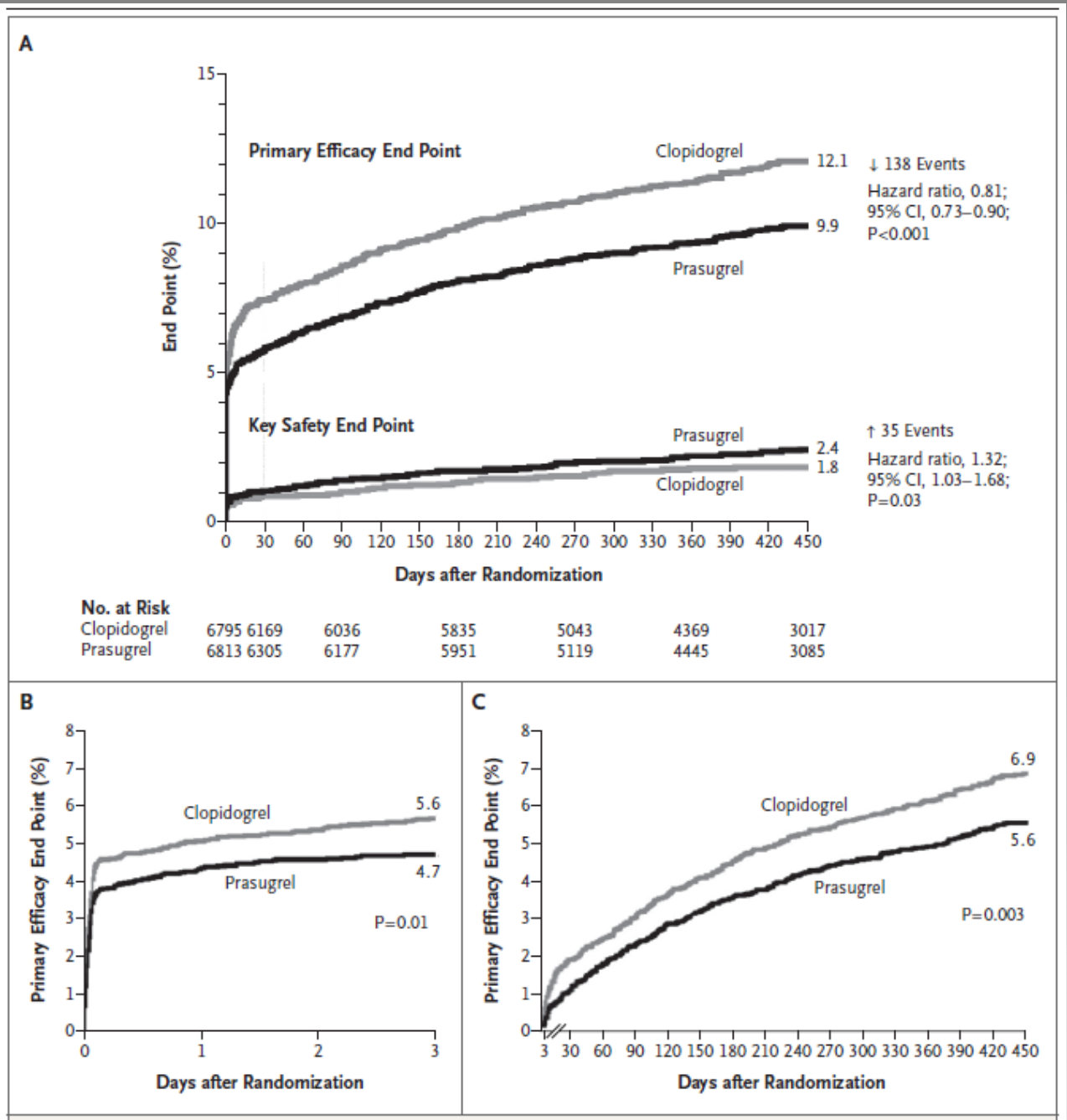

Figure 1. Cumulative Kaplan–Meier Estimates of the Rates of Key Study End Points during the Follow-up Period.

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Figure 1. Cumulative Kaplan–Meier Estimates of the Rates of Key Study End Points during the Follow-up Period.

Panel A shows data for the primary efficacy end point (death from cardiovascular causes, nonfatal myocardial infarction [MI], or nonfatal stroke) (top) and for the key safety end point (Thrombolysis in Myocardial Infarction [TIMI] major bleeding not related to coronary-artery bypass grafting) (bottom) during the full follow-up period. The hazard ratio for prasugrel, as compared with clopidogrel, for the primary efficacy end point at 30 days was 0.77 (95% confidence interval [CI], 0.67 to 0.88; P<0.001) and at 90 days was 0.80 (95% CI, 0.71 to 0.90; P<0.001). Data for the primary efficacy end point are also shown from the time of randomization to day 3 (Panel B) and from 3 days to 15 months, with all end points occurring before day 3 censored (Panel C). In Panel C, the number at risk includes all patients who were alive (regardless of whether a nonfatal event had occurred during the first 3 days after randomization) and had not withdrawn consent for follow-up. The P values in Panel A for the primary efficacy end point were calculated with the use of the Gehan–Wilcoxon test; all other P values were calculated with the use of the log-rank test.

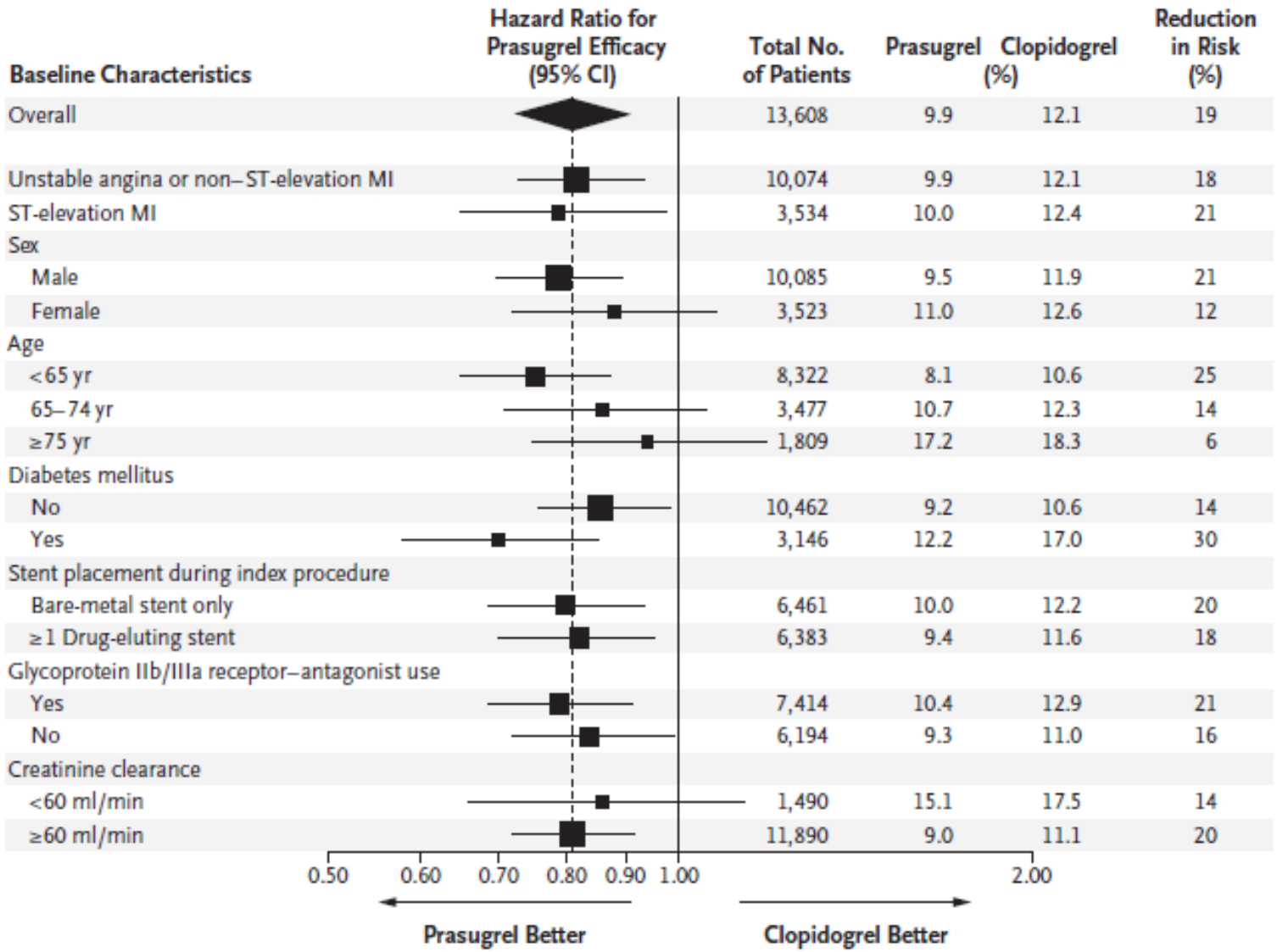

Figure 2. Hazard Ratios and Rates of the Primary End Point, According to Selected Subgroups of Study Patients.

The primary end point was defined as death from cardiovascular causes, nonfatal myocardial infarction (MI), or nonfatal stroke. The percentages are Kaplan–Meier estimates of the rate of the end point at 15 months. For each subgroup, the size of the square is proportional to the number of patients in the subgroups and represents the point estimate of the treatment effect. The overall treatment effect of prasugrel as compared with clopidogrel is represented by the diamond, and the dashed vertical line represents the corresponding overall point estimate. None of

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SCA ST + de TRITON TIMI 38

	PRASU =1769	*CLOPI =1765*	
✓J30	6.5%	9.5%	0.0017
✓M15	10%	12.4%	0.0221

Groupe Athérome et Cardiologie Inter de la Société Franç

Reduction in recurrent cardiovascular events with prasugrel compared with clopidogrel in patients with acute coronary syndromes from the TRITON-TIMI 38 trial

Sabina A. Murphy[1], Elliott M. Antman[1]*, Stephen D. Wiviott[1], Govinda Weerakkody[2], Giorgio Morocutti[3], Kurt Huber[4], Jose Lopez-Sendon[5], Carolyn H. McCabe[1], and Eugene Braunwald[1], for the TRITON-TIMI 38 Investigators

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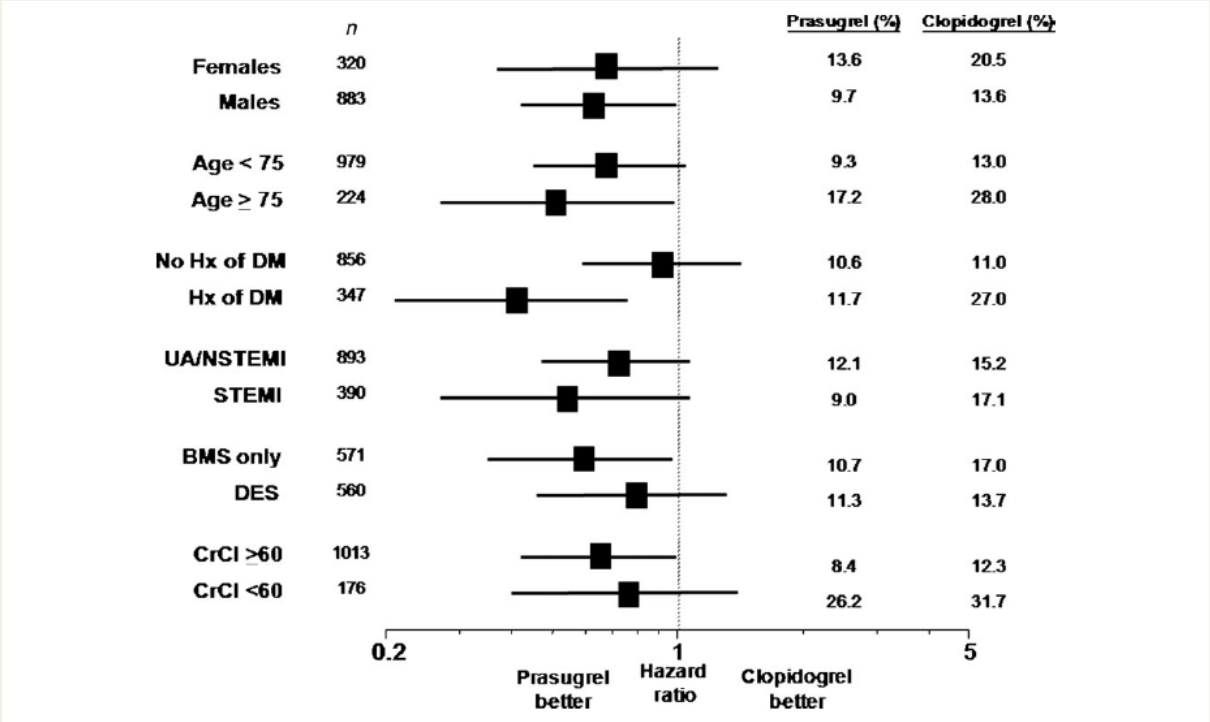


Figure 3 Subsequent primary events during follow-up by randomized therapy among subgroups. Among patients with a first, non-fatal ischaemic event, second events were directionally lower with prasugrel in all subgroups (i.e. point estimate falls to the left of the line of unity). With the exception of history of diabetes (interaction $P = 0.036$), there were no other significant interactions by subgroup. Rates are Kaplan–Meier failure rates at 15 months.

Syndrome Coronaire Aigu avec sus-décalage du segment ST
Patients de MOINS de 75 ans

Douleur thoracique *et* Sus-décalage ST persistants après 2 bouffées de trinitrine
> 0,1 mV dans au moins 2 dérivations périphériques concordantes anatomiquement
ou > 0,2 mV dans au moins 2 dérivations précordiales concordantes anatomiquement
ou Bloc de branche gauche récent

Dans quel délai mon patient peut être dans une salle de cathétérisme ?

- **Transfert < 60 minutes** → **ANGIOPLASTIE PRIMAIRE**
- **Transfert en 60 à 90 minutes** → **Est-ce que mon patient présente sa douleur depuis moins de 2 heures ?**
  - **Douleur > 2 h** → **ANGIOPLASTIE PRIMAIRE**
  - **Douleur < 2 h** → **THROMBOLYSE***
- **Transfert > 90 minutes** → **THROMBOLYSE***

Admission directe en salle

(Eviter VVP au bras droit – poser EMLA en radial droit)

Transfert en CCI

- ☐ **Acide acétylsalicylique (ASPIRINE®) : 250 mg per os ou IV (sauf allergie)**
- ☐ **Clopidogrel (PLAVIX®) : 8 cp = 600 mg**
- ⚠ **Prasugrel (EFIENT®) : Protocole local impératif non si < 60 kg, non si ATCD d'AVC ou d'AIT, non si thrombolyse, non si > 75 ans.**
- ☐ **Enoxaparine (LOVENOX®) : 0,3 ml IVD puis 0,1 ml/10kg/12h SC**
  - ☞ Si Cl Créat < 30 ml/mn : pas de bolus, faire 0,1 ml/10kg/24h SC
- *ou* **HEPARINE® : bolus IVD 4 000 UI** (qlq soit le poids) puis PSE de 25 000 UI dans 50 ml de NaCl 9‰ à la dose de 12 UI/kg/h (vitesse = (12 x poids) / 500) sans dépasser 1 000 UI/h (vitesse 2)

- ☐ **Acide acétylsalicylique (ASPIRINE®) : 250 mg per os ou IV (sauf allergie)**
- ☐ **Clopidogrel (PLAVIX®) : 4 cp = 300 mg**
- ☐ **Enoxaparine (LOVENOX®) : 0,3 ml IVD puis 0,1 ml/10kg/12h SC**
  - ☞ Si Cl Créat < 30 ml/mn : pas de bolus, faire 0,1 ml/10kg/24h SC
- *ou* **HEPARINE® : bolus IVD 4 000 UI** (qlq soit le poids) puis PSE de 25 000 UI dans 50 ml de NaCl 9‰ à la dose de 12 UI/kg/h (vitesse = (12 x poids) / 500) sans dépasser 1 000 UI/h (vitesse 2)
- ☐ **Ténectéplase (METALYSE®)** : bolus IV adapté au poids *** sauf contre-indication**

Favoriser Transfert USIC avec angioplastie 24/24

Accord téléphonique impératif et prévenir de l'heure d'arrivée

H. Cardio (Unité 51) : 04 7235 7076 -- **H. Croix Rousse** (USIC) : 04 7207 1680 -- **I. Protestante** (USIC) : 06 4515 1515
H. St Luc St Joseph (USIC) : 04 7861 8221 -- **Cl. Sauvegarde** (USIC) : 04 7217 1718 -- **Cl. Tonkin** (USIC) : 04 7282 6868
H. Valence (USIC) : 04 7575 7256 – **Cl. Convert** (Réa) : 04 7424 2024

Transport SMUR : considérer primaire si PEC dans un CH avec SMUR pour angioplastie primaire ou de sauvetage

Coordinateurs : Dr Capel (SAMU 69), Dr Jacob (Lyon Sud)
Version : 2.2 du 17/02/10 SCA ST+ (patients de MOINS de 75 ans) : I21.9

TYPE DE STENT

European Heart Journal (2007) 28, 2706–2713
doi:10.1093/eurheartj/ehm402

Clinical researc
Interventional cardiolog

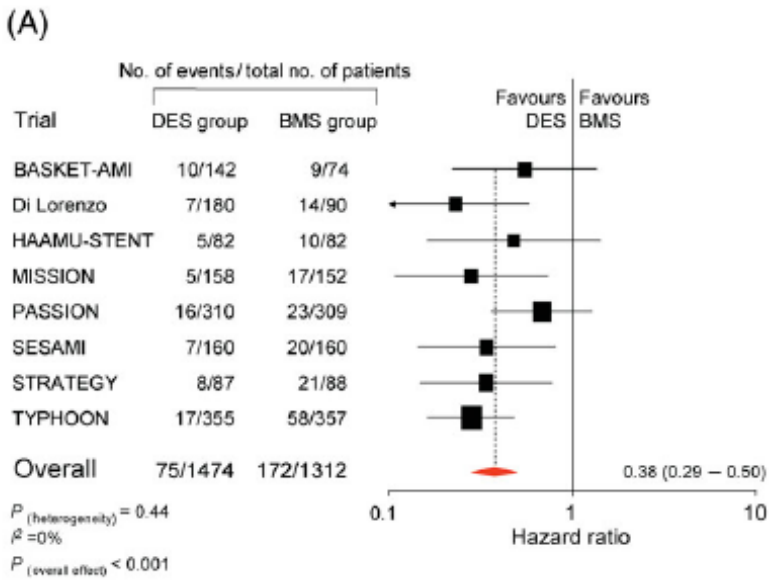
Meta-analysis of randomized trials on drug-eluting stents vs. bare-metal stents in patients with acute myocardial infarction

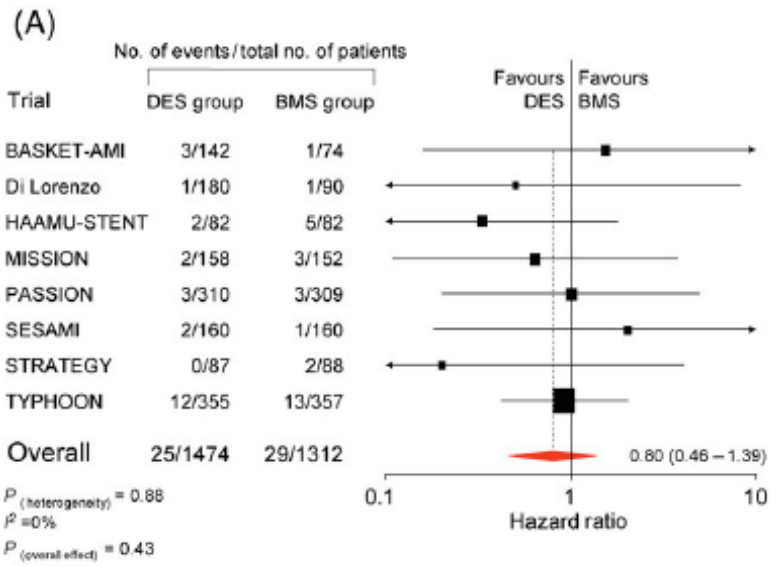
Adnan Kastrati[1]*, Alban Dibra[1], Christian Spaulding[2], Gerrit J. Laarman[3], Maurizio Menichelli[4], Marco Valgimigli[5], Emilio Di Lorenzo[6], Christoph Kaiser[7], Ilkka Tierala[8], Julinda Mehilli[1], Melchior Seyfarth[1], Olivier Varenne[2], Maurits T. Dirksen[3], Gianfranco Percoco[5], Attilio Varricchio[6], Undine Pittl[7], Mikko Syvänne[8], Maarten J. Suttorp[9], Roberto Violini[4], and Albert Schömig[1]

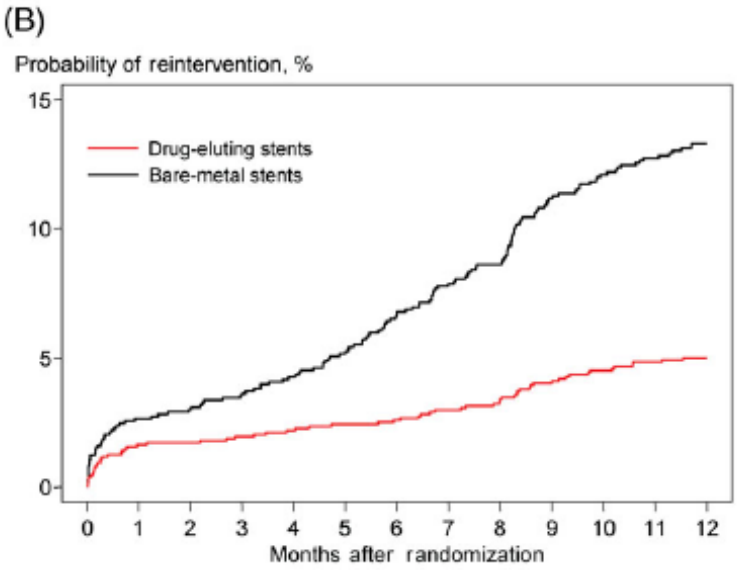
UNITE-SOINS CARDIOLOGIE INTERVENTIONNELLE

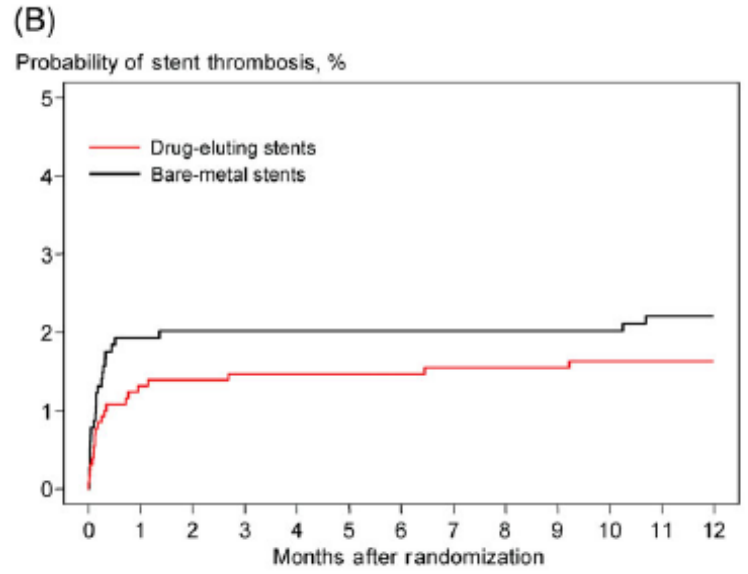
Nouvelles Cliniques Nantaises

TYPE DE STENT

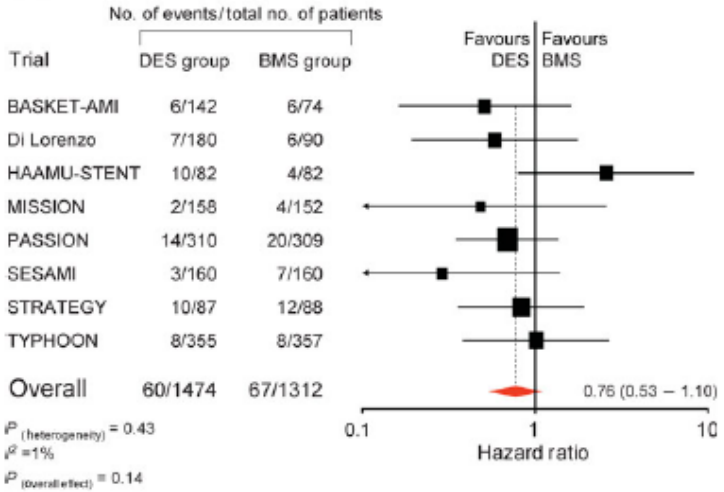




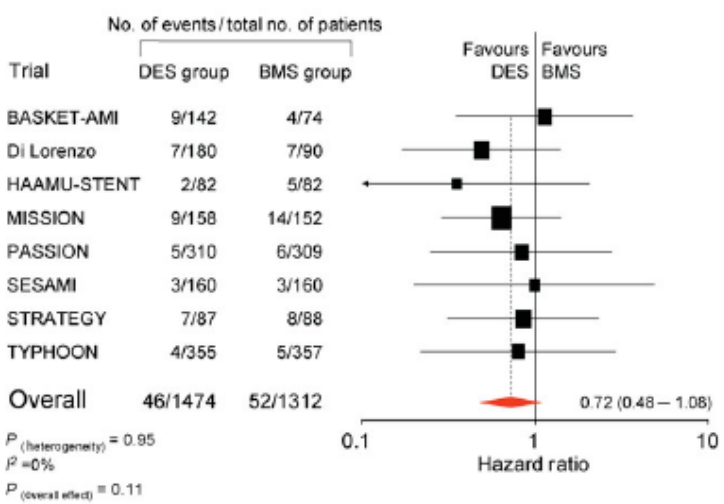




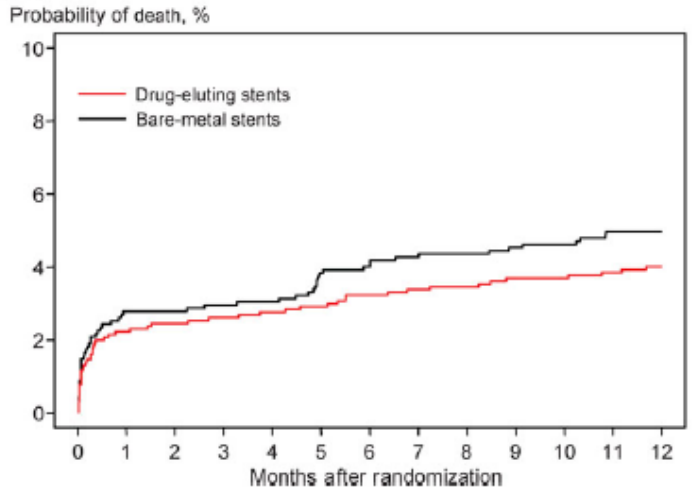
(A)


No. of events / total no. of patients
Trial
DES group
BMS group
Favours DES
Favours BMS
BASKET-AMI 6/142 6/74
Di Lorenzo 7/180 6/90
HAAMU-STENT 10/82 4/82
MISSION 2/158 4/152
PASSION 14/310 20/309
SESAMI 3/160 7/160
STRATEGY 10/87 12/88
TYPHOON 8/355 8/357
Overall 60/1474 67/1312
0.76 (0.53 – 1.10)
P (heterogeneity) = 0.43
I² =1%
P (overall effect) = 0.14
0.1
1
10
Hazard ratio

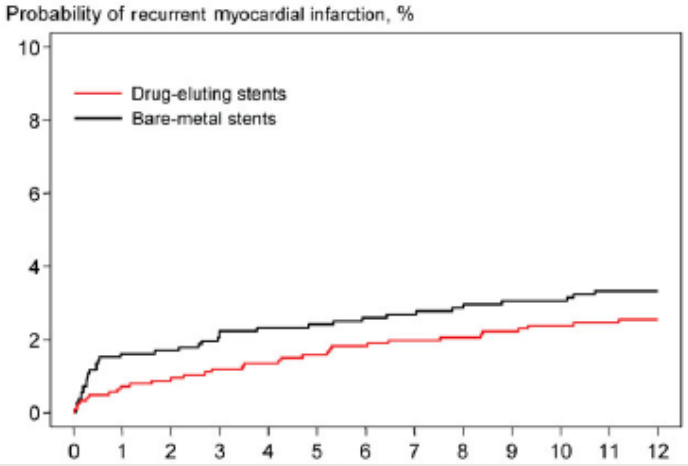
(A)


No. of events / total no. of patients
Trial
DES group
BMS group
Favours DES
Favours BMS
BASKET-AMI 9/142 4/74
Di Lorenzo 7/180 7/90
HAAMU-STENT 2/82 5/82
MISSION 9/158 14/152
PASSION 5/310 6/309
SESAMI 3/160 3/160
STRATEGY 7/87 8/88
TYPHOON 4/355 5/357
Overall 46/1474 52/1312
0.72 (0.48 – 1.08)
P (heterogeneity) = 0.95
I² =0%
P (overall effect) = 0.11
0.1
1
10
Hazard ratio

(B)


Probability of death, %
Drug-eluting stents
Bare-metal stents
0
2
4
6
8
10
0 1 2 3 4 5 6 7 8 9 10 11 12
Months after randomization

(B)


Probability of recurrent myocardial infarction, %
Drug-eluting stents
Bare-metal stents
0
2
4
6
8
10
0 1 2 3 4 5 6 7 8 9 10 11 12

DEDICATION

- ✓ n=626, dans les 12 h
- ✓ Suivi 3 ans
- ✓ Mortalité totale, récidive IDM, incidence des SCA et AVC : idem

- ✓ BMS: revascularisation

artère cible	19.8% (vs 8.9%)	< 0.001
lésion cible	16.3% (vs 6.1%)	<0.024
mortalité	1.9% (vs 6.1%)	0.013

ACC2010

PASSION

- ✓ n=619 ST+
- ✓ Suivi 5 ans
- ✓ Décès CV, récidive IDM, re-revascularisation idem
- ✓ Thrombose de stent identique

TYPE DE STENT

- ✓ **Un stent actif peut etre utilisé**
- ✓ **Bénéfice sur le taux de réinterventions**
- ✓ **Pas de bénéfice sur décès IDM**

- ✓ **La supériorité de l'un ou l'autre type de stent n'est actuellement pas démontré**

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European Heart Journal Advance Access published November 19, 2009

European Heart Journal
doi:10.1093/eurheartj/ehp492

CLINICAL RESEARCH

Reperfusion therapy for ST elevation acute myocardial infarction in Europe: description of the current situation in 30 countries

Petr Widimsky*, William Wijns, Jean Fajadet, Mark de Belder, Jiri Knot, Lars Aaberge, George Andrikopoulos, Jose Antonio Baz, Amadeo Betriu, Marc Claeys, Nicholas Danchin, Slaveyko Djambazov, Paul Erne, Juha Hartikainen, Kurt Huber, Petr Kala, Milka Klinčeva, Steen Dalby Kristensen, Peter Ludman, Josephina Mauri Ferre, Bela Merkely, Davor Miličić, Joao Morais, Marko Noč, Grzegorz Opolski, Miodrag Ostojić, Dragana Radovanovič, Stefano De Servi, Ulf Stenestrand, Martin Studenčan, Marco Tubaro, Zorana Vasiljević, Franz Weidinger, Adam Witkowski, and Uwe Zeymer on behalf of the European Association for Percutaneous Cardiovascular Interventions†

Cardiocenter, 3rd Faculty of Medicine, Charles University Prague, Czech Republic

Received 15 March 2009; revised 20 August 2009; accepted 5 October 2009

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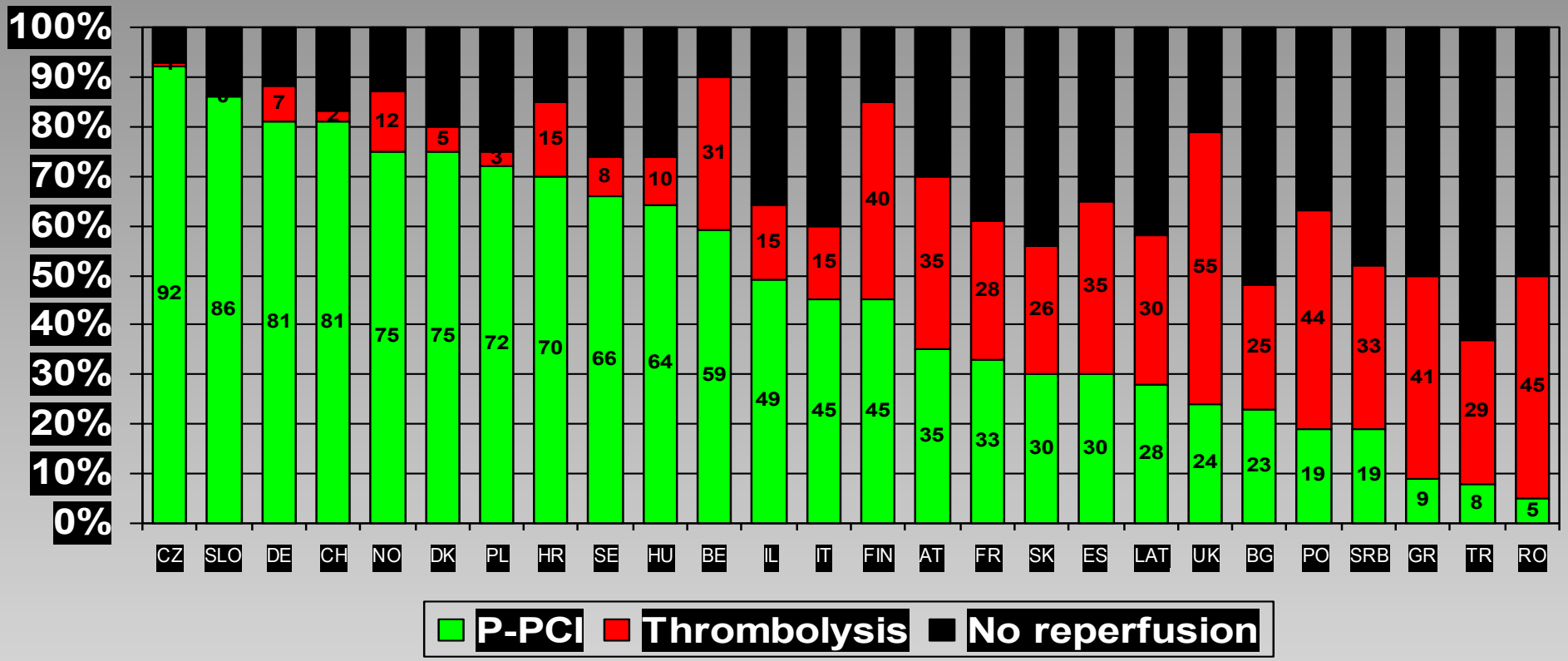
Mode de traitement



P.Widimsky et al.. Eur. Heart.J.doi:10.1093/eurheartj/ehp492

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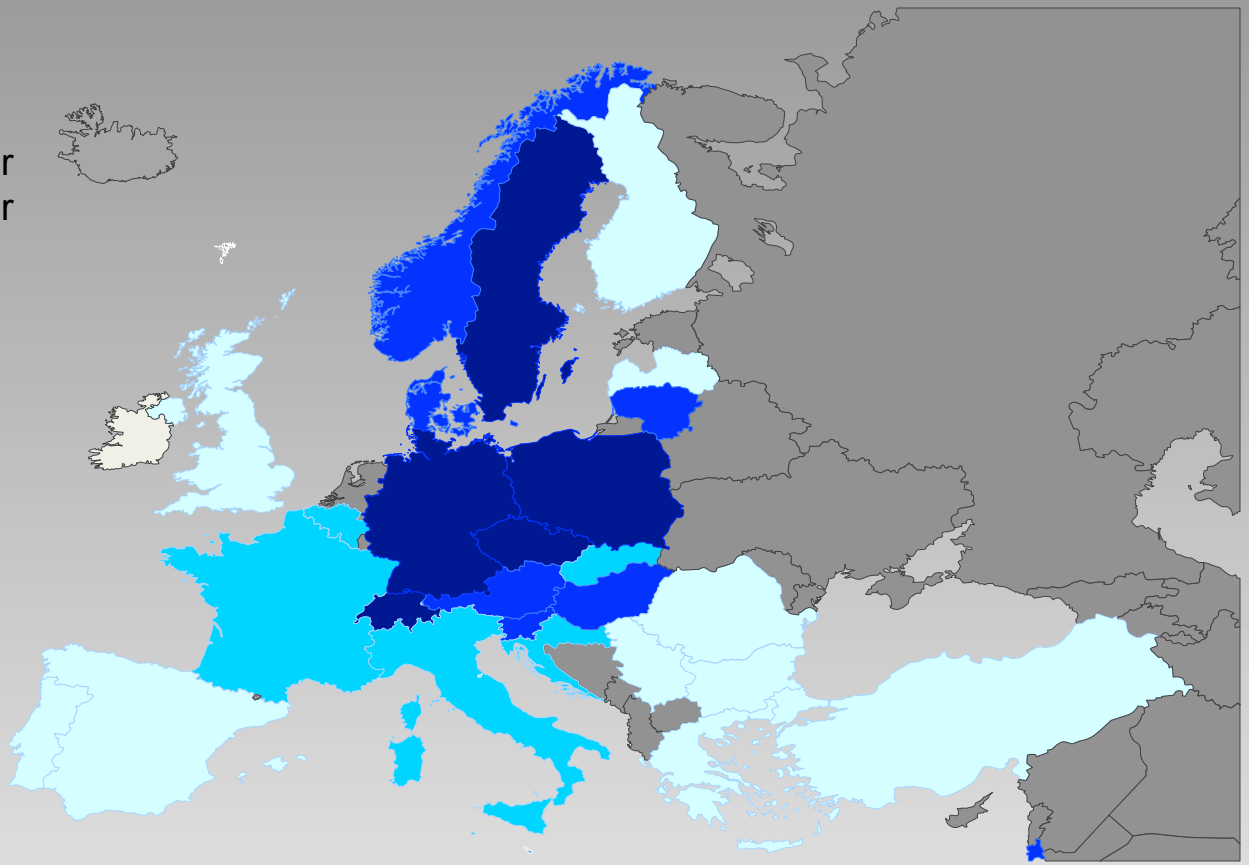
Incidence annuelle de l'ATC primaire

- ≥600 p-PCI / million / year
- 400-599 p-PCI / million / year
- 200-399 p-PCI / million / year
- <200 p-PCI / million / year
- Data not known



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Stent for Life
Pays participants

- Turkie (78 p-PCI / mil. / an)
- Grèce (95 p-PCI / mil. / an)
- Bulgarie (130 p-PCI / mil. / an)
- Serbie (157 p-PCI / mil. / an)
- France (231 p-PCI / mil. / an)
- Espagne (251 p-PCI / mil. /an)

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Comparison of Thrombolysis Followed by Broad Use of Percutaneous Coronary Intervention With Primary Percutaneous Coronary Intervention for ST-Segment–Elevation Acute Myocardial Infarction

Data From the French Registry on Acute ST-Elevation Myocardial Infarction (FAST-MI)

Nicolas Danchin, MD; Pierre Coste, MD; Jean Ferrières, MD; Philippe-Gabriel Steg, MD; Yves Cottin, MD; Didier Blanchard, MD; Loïc Belle, MD; Bernard Ritz, MD; Gilbert Kirkorian, MD; Michael Angioi, MD; Philippe Sans, MD; Bernard Charbonnier, MD; Hélène Eltchaninoff, MD; Pascal Guéret, MD; Khalife Khalife, MD; Philippe Asseman, MD; Jacques Puel, MD; Patrick Goldstein, MD; Jean-Pierre Cambou, MD; Tabassome Simon, MD; for the FAST-MI Investigators*

Circulation 2008, 118:268-76

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223 centres et 1714 patients: période de 1 mois(2005)

60% de patients traités:

33% ATC primaires

29% thrombolyse (18% pré- hospitalière)

Danchin et al Circulation 2008, 118:268-76

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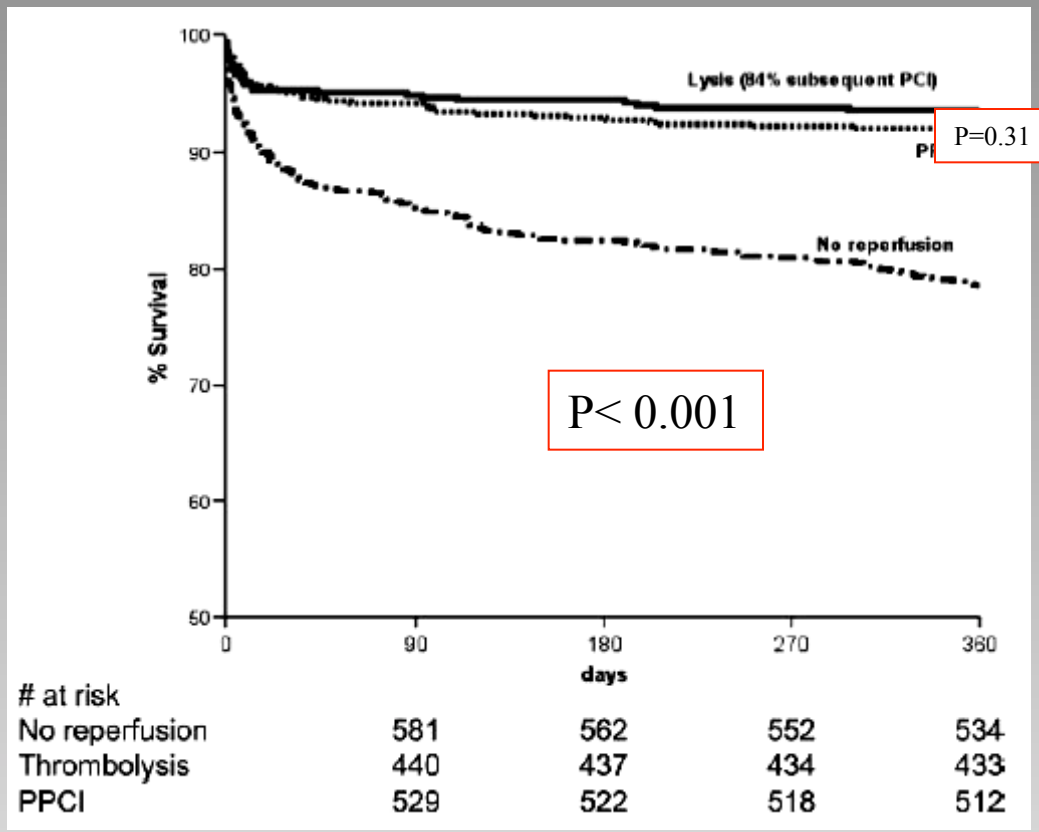

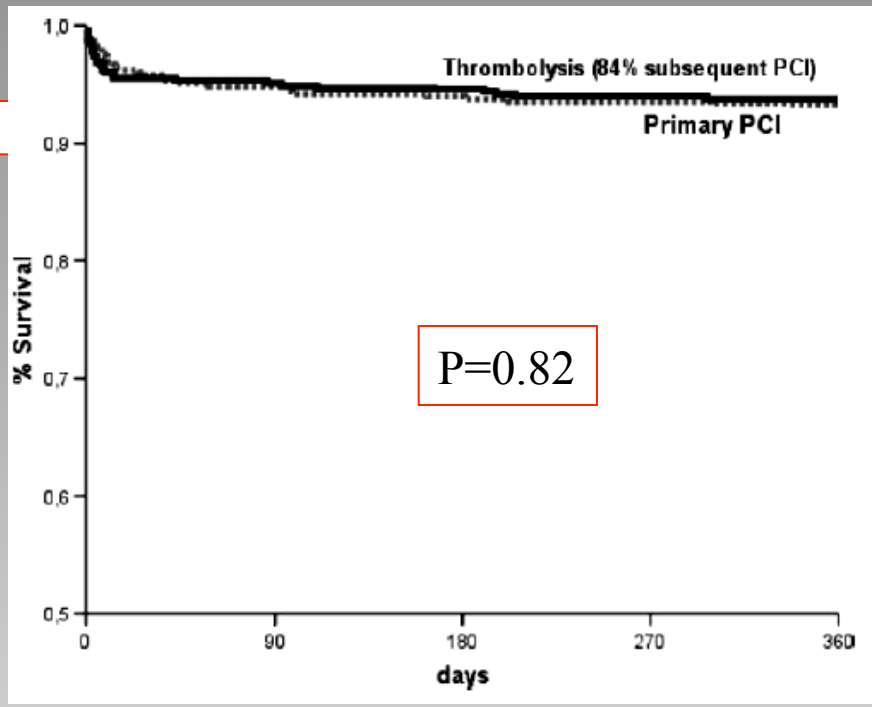

Danchin et al Circulation 2008, 118:268-76

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	PHT (n=301)	IHT (n=165)	Any Thrombolysis	PPCI	PPCI Without Transfer (n=510)	PPCI With Transfer (n=54)	No Reperfusion
Time to first call, min	60 (20–102)	73 (30–164)	60 (20–120)	75 (30–234)	75 (30–225)	96 (30–250)	180 (52–832)
Time to admission, min	180 (135–255)	120 (60–240)	170 (114–250)	180 (112–320)	180 (116–322)	180 (74–317)	330 (142–1073)
Time to reperfusion, min	110 (80–162)	195 (125–314)	130 (90–215)	300 (200–555)	290 (194–546)	425 (279–701)	...
Time from first call to reperfusion, min	45 (30–74)	90 (50–155)	57 (30–98)	170 (110–265)	165 (105–250)	245 (169–391)	...

Thrombolyse: 70% ont une TIV < 3 h

Thrombolyse: 96% ont une coro et 84% ont une ATC

Danchin et al Circulation 2008, 118:268-76

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STENT FOR LIFE

SFL 2010
France

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France

Phase 1

- **Prospective** registry: delay, first contact (SAMU, GP, Cardiologist, Emergency room…), decision of revascularization, transfer to PCI centre if PHT…
- One **month** period: November 2010
- In **all the centres** of each department with ICU.
- All **consecutive AMI** hospitalized within 48hours after onset.

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Phase 2

- **Analyze** the data

- **Improve the management** of AMI
  Public campaigns
  Improvement of delay
  Increase the transfer to PCI centres

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STENT FOR LIFE

SFL 2010
France

Phase 3

- New evaluation: November 2011
- **Compare** the results
- In case of improvement, extend to all centres in France

UNITE-SOINS DE CARDIOLOGIE INTERVENTIONNELLE

NOUVELLES CLINIQUES NANTAISES

PLATO

Comparison of ticagrelor with clopidogrel in patients with a planned invasive strategy for acute coronary syndromes (PLATO): a randomised double-blind study.

Cannon CP, Harrington RA, James S, Ardissino D, Becker RC, Emanuelsson H, Husted S, Katus H, Keltai M, Khurmi NS, Kontny F, Lewis BS, Steg PG, Storey RF, Wojdyla D, Wallentin L; PLATelet inhibition and patient Outcomes Investigators.

TIMI Study Group, Brigham and Women's Hospital, Boston, MA 02115, USA

Lancet. 2010 Jan 23;375(9711):283-93. Epub 2010 Jan 13.

PLATO

- a more potent reversible P2Y12 inhibitor with clopidogrel in such patients.
- 13 408 (72.0%) of 18 624 patients hospitalised for acute coronary syndromes (with or without ST elevation).

- ticagrelor and placebo (180 mg loading dose followed by 90 mg twice a day),

- or t clopidogrel and placebo (300-600 mg loading dose or continuation with maintenance dose followed by 75 mg per day) for 6-12 months.

- All patients were given aspirin.
- The primary composite endpoint was cardiovascular death, myocardial infarction, or stroke.

PLATO

- 6732 patients were assigned to ticagrelor and 6676 to clopidogrel.
- (569 [event rate at 360 days 9.0%] vs 668 [10.7%], hazard ratio 0.84, 95% CI 0.75-0.94; p=0.0025).
- no difference between clopidogrel and ticagrelor groups in the rates of total major bleeding (691 [11.6%] vs 689 [11.5%], 0.99 [0.89-1.10]; p=0.8803) or severe bleeding, as defined according to the Global Use of Strategies To Open occluded coronary arteries, (198 [3.2%] vs 185 [2.9%], 0.91 [0.74-1.12]; p=0.3785).
- Ticagrelor seems to be a better option than clopidogrel for patients with acute coronary syndromes for whom an early invasive strategy is planned.

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NOUVELLES CLINIQUES NAMUROISES

GENETIQUE

A variant at chromosome 9p21 is associated with recurrent myocardial infarction and cardiac death after acute coronary syndrome: the GRACE Genetics Study.

Buysschaert I, Carruthers KF, Dunbar DR, Peuteman G, Rietzschel E, Belmans A, Hedley A, De Meyer T, Budaj A, Van de Werf F, Lambrechts D, Fox KA Leuven, Belgium.

Eur Heart J. 2010 May;31(9):1132-41. Epub 2010 Mar 15.

The GRACE Genetics study

- ✓ Le variant rs 1333049 situé sur le chromosome 9p21 identifié comme locus majeur de suceptibilité a une MAC et IDM
- ✓ n=3473
- ✓ Facteur indépendant de recidive d'IDM ou décès 6 mois après IDM

Apical-sparing variant of Tako-Tsubo cardiomyopathy: prevalence and characteristics.

Mansencal N, Abbou N, N'Guetta R, Pillière R, El Mahmoud R, Dubourg O. hôpital Ambroise-Paré,

Arch Cardiovasc Dis. 2010 Feb;103(2):75-9. Epub 2010 Feb 1.

Forme de TakoTsubo epargnant l'Apex

- ✓ 24%
- ✓ Plus jeunes

- ✓ Plus de stress chirurgical, ou forme induite par pathologie aigue
- ✓ FEVG supérieure 55 vs 48%
- ✓ Pronostic à 1 an idem

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MERCI!

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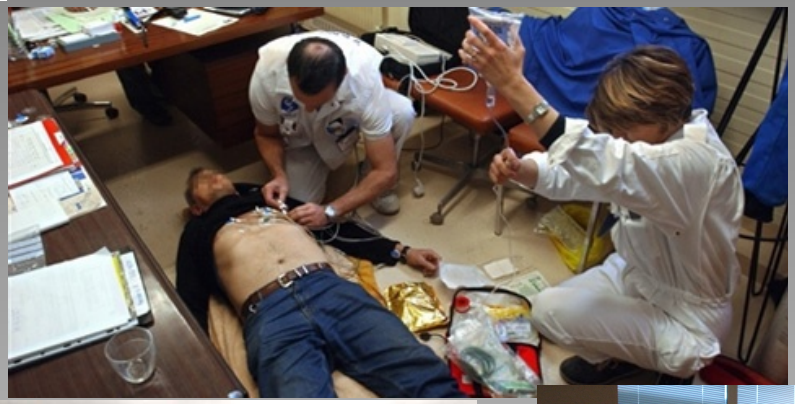

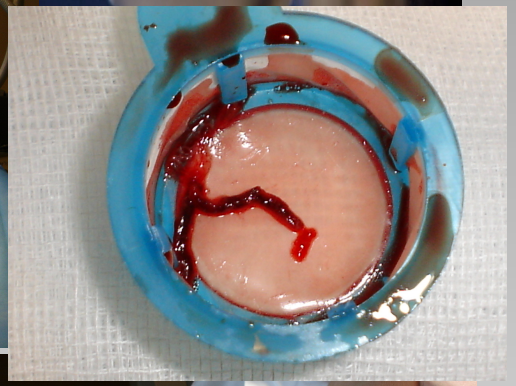

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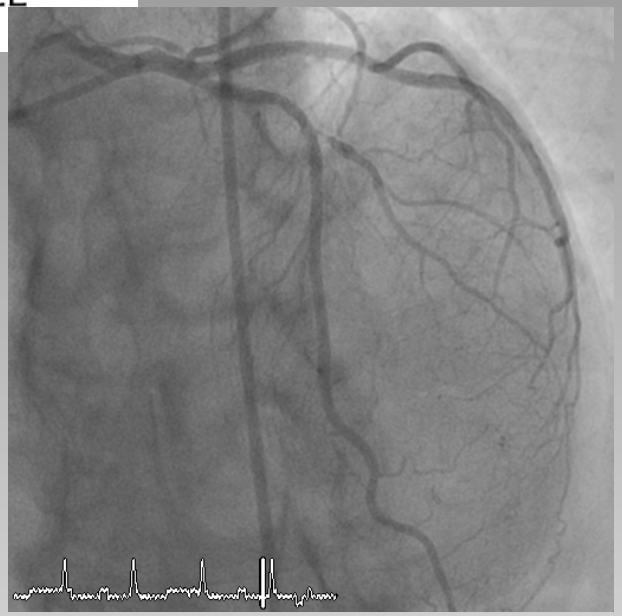

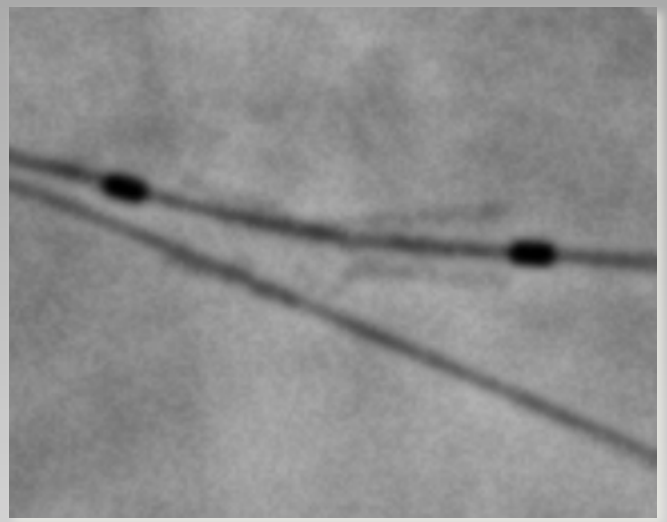

brunel-philippe@wanadoo.fr