

Optimisation du traitement AAP dans le SCA avec angioplastie: SCA sans sus ST

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Disclosure of Conflict of Interest

J'ai actuellement, ou j'ai eu au cours des deux dernières années, une affiliation ou des intérêts financiers ou intérêts de tout ordre avec une société commerciale ou je reçois une rémunération ou des redevances ou des octrois de recherche d'une société commerciale :

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Affiliation/Financial Relationship

- Grant/Research Support
- Consulting Fees/Honoraria

Company

- Abiomed
- Lilly Daiichi
- Astra Zeneca
- Saint Jude Medical
- Terumo
- Servier

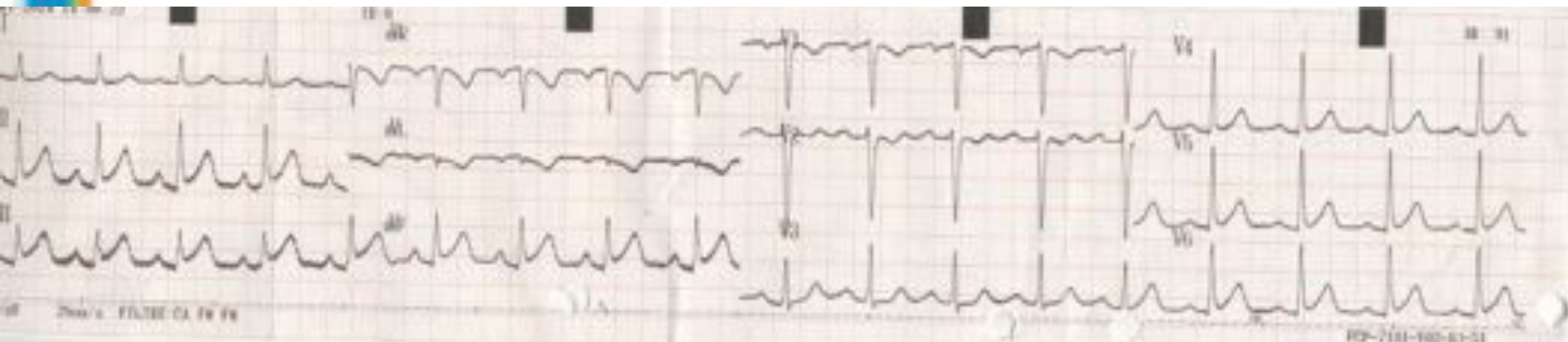
Eric 45 ans

- **Facteur de risque:**
 - Diabète non insulino dépendant
 - Tabagisme actif 10 PA
- **ATCD: 0**

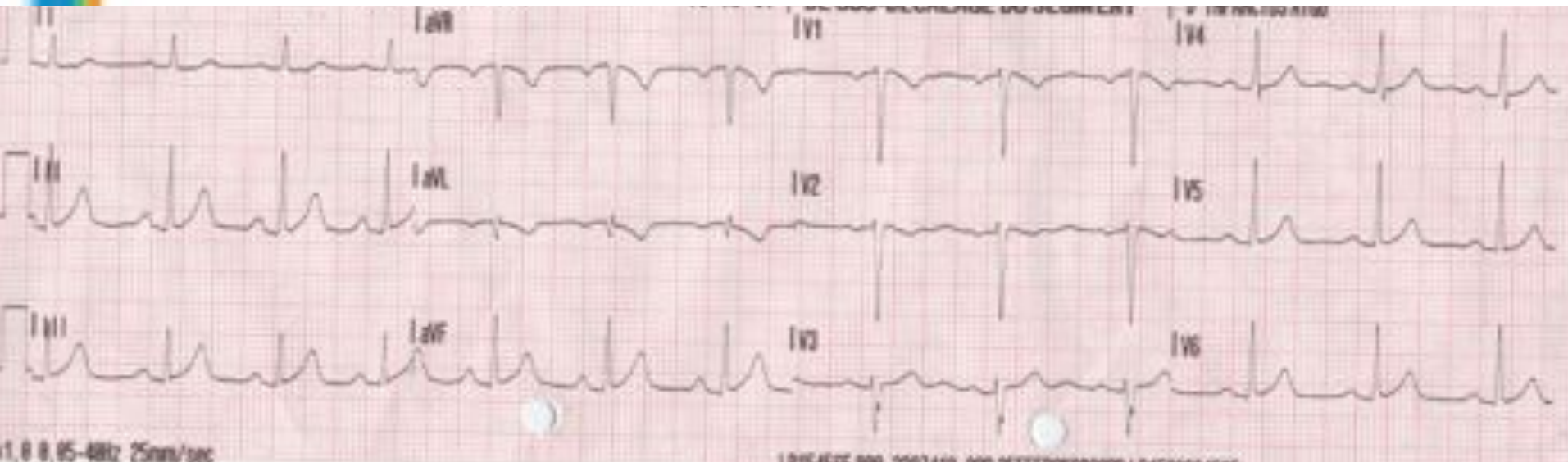
HDM

- 12h: après montée d'escalier (2 étages)
- Douleurs épigastriques atypiques de repos à type de "sensation aériques" sans irradiation,
- Evolution spontanément favorable en 20 minutes.
- Associée à une sensation de malaise avec prodromes à type de sueurs, de bouffées de chaleur et de nausées, sans perte de connaissance. Pas de palpitation. Pas de fièvre, pas de frisson, pas de notion de contagé récent.
- SOS médecin: PA 152/110 mmHg, FC 73/min, SpO2 100%

ECG 1



SMUR: ECG



Conduite à tenir

1. Pré traitement
2. USIC coroTDM
3. Coronarographie < 120 min
4. Coronarographie 24-48h

Traitement Immédiat

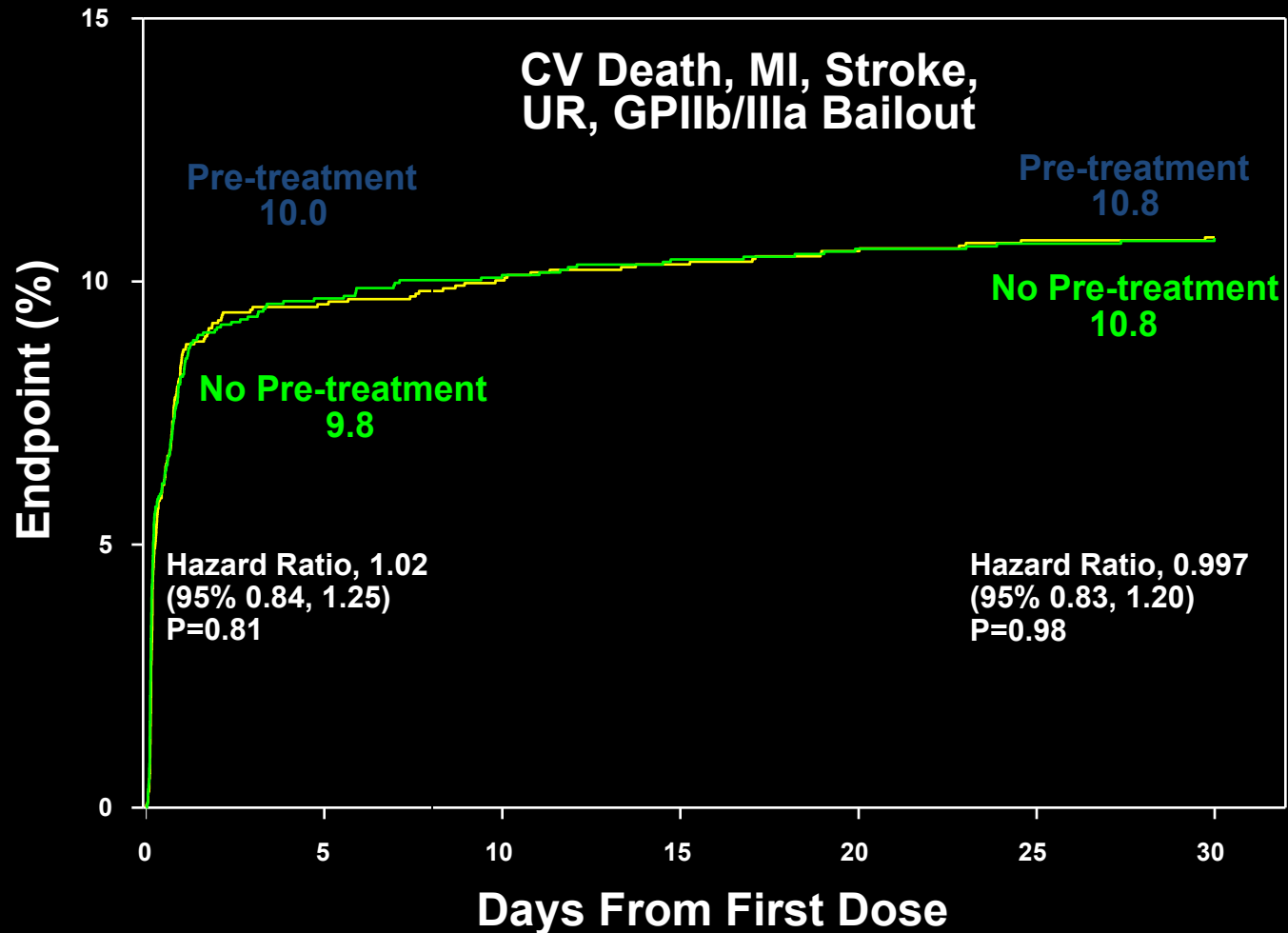
1. Antiagrégant:

1. Aspirine
2. Clopidogrel
3. Ticagrelor
4. Prasugrel
5. Anti GPIIbIIIa

2. Anticoagulant:

1. HNF
2. HBPM
3. Bivalirudine

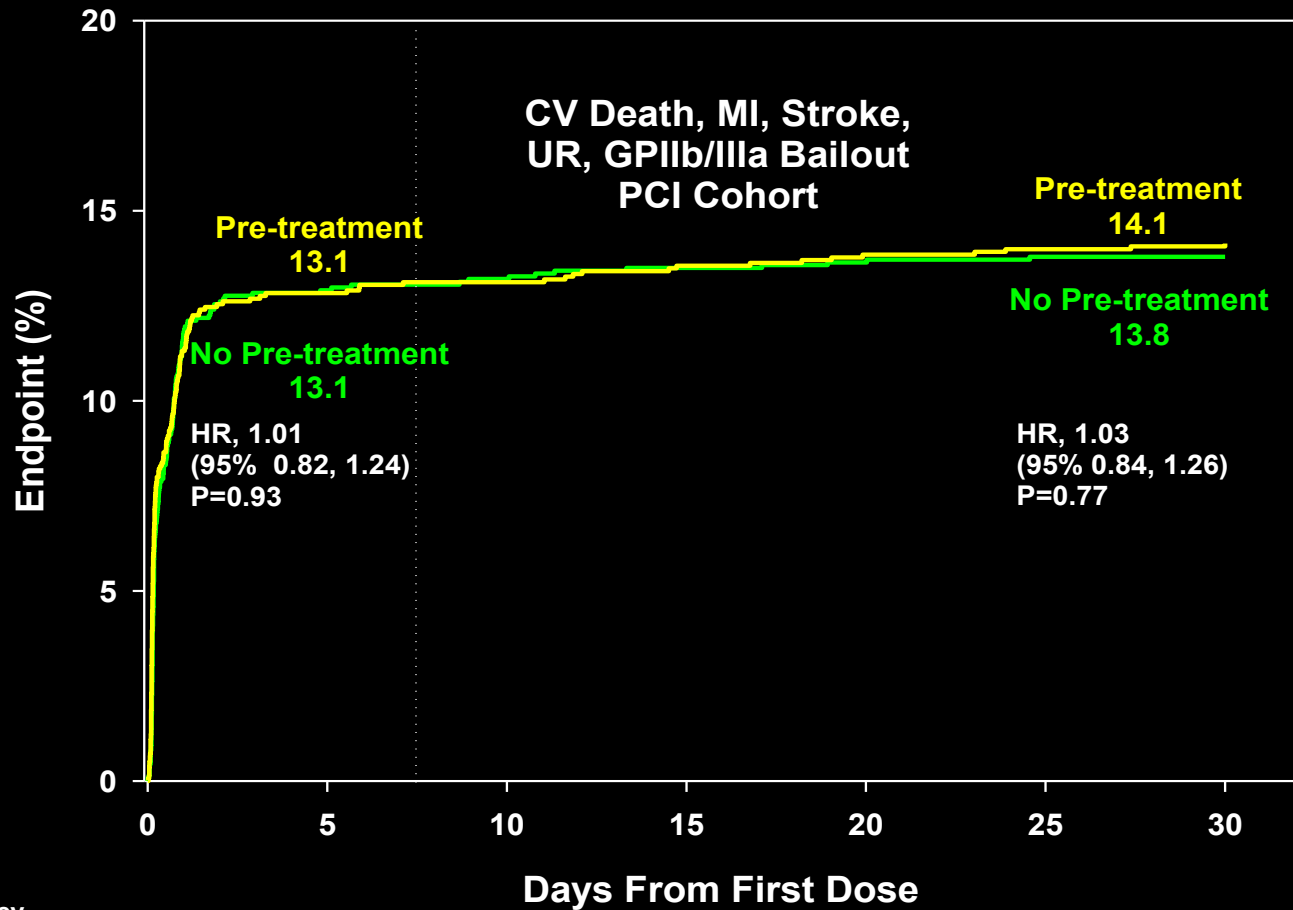
ACCOAST: 1° Efficacy End Point @ 7 + 30 days (All Patients)



No. at Risk, Primary
Efficacy End Point:

No pre-treatment	1996	1788	1775	1769	1762	1752	1621
Pre-treatment	2037	1821	1809	1802	1797	1791	1616

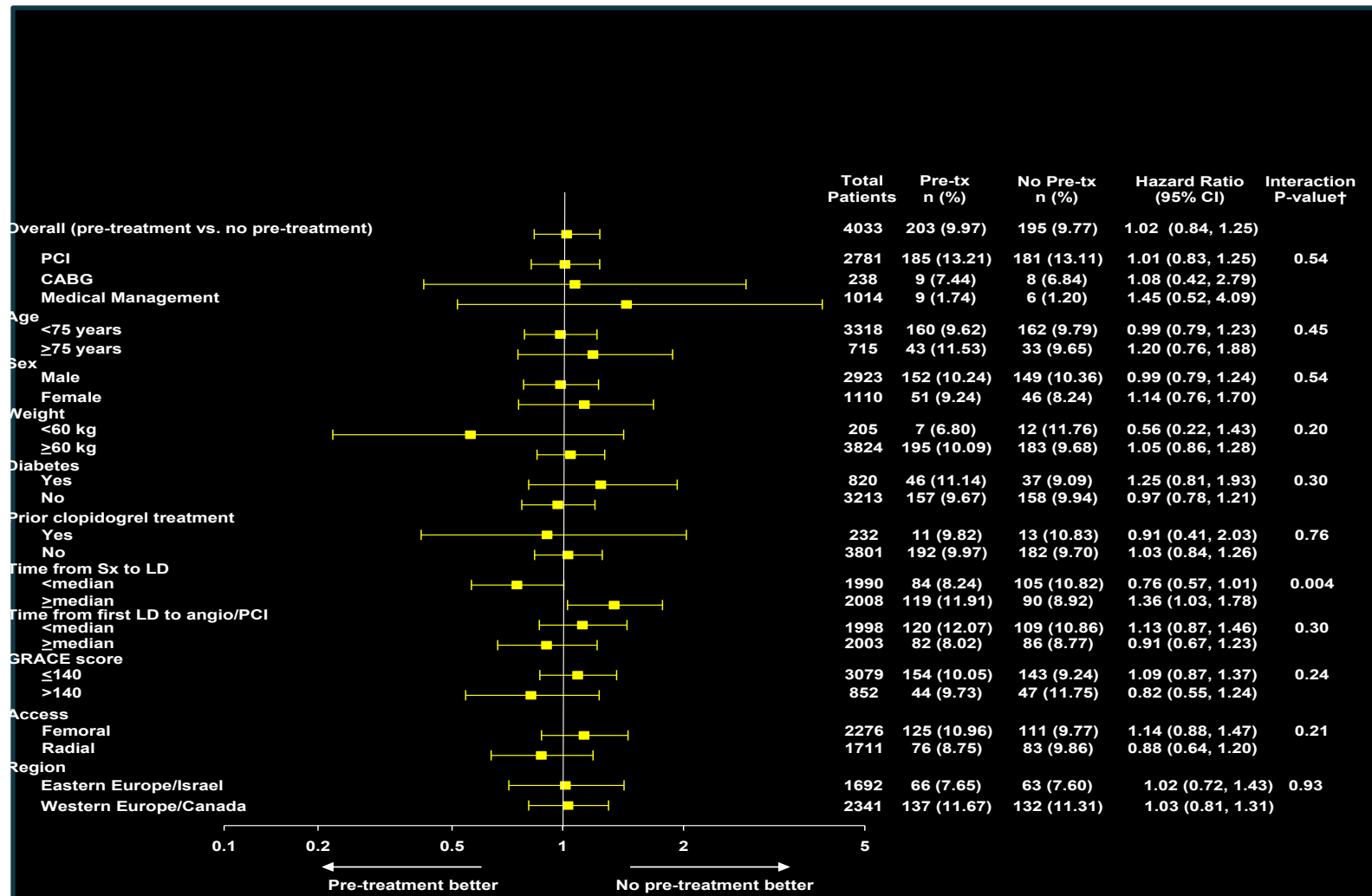
ACCOAST: 1° Efficacy Endpoint (PCI Patients)



No. at Risk, Efficacy
End Point:

No pre-treatment	1372	1191	1187	1183	1179	1177	1177
Pre-treatment	1389	1206	1202	1194	1189	1186	1172

ACCOAST: 1° Efficacy Endpoint Through 7 Days for Prespecified Subgroups (All Patients)



*Hazard ratio not evaluated for <10 events.

†Interaction p-value is from a Cox proportional hazards model with treatment, subgroup, and the treatment-by-subgroup interaction as fixed effects; PCI includes 11 patients with PCI + CABG.

G Montalescot, NEJM 2013

SMUR : decision

► EVOLUTION DES CONSTANTES											
Constantes / Modèles											
Glasgow		15/11/0									
PA		15/11/0									
FC		15/11/0									
PR / SaO2		15/11/0									
ENS / EVA		15/11/0									

► TRAITEMENTS ADMINISTRES											
Soins / Traitements		Nal 200 500									
Médicaments / Soins		Aspirine 200 500									

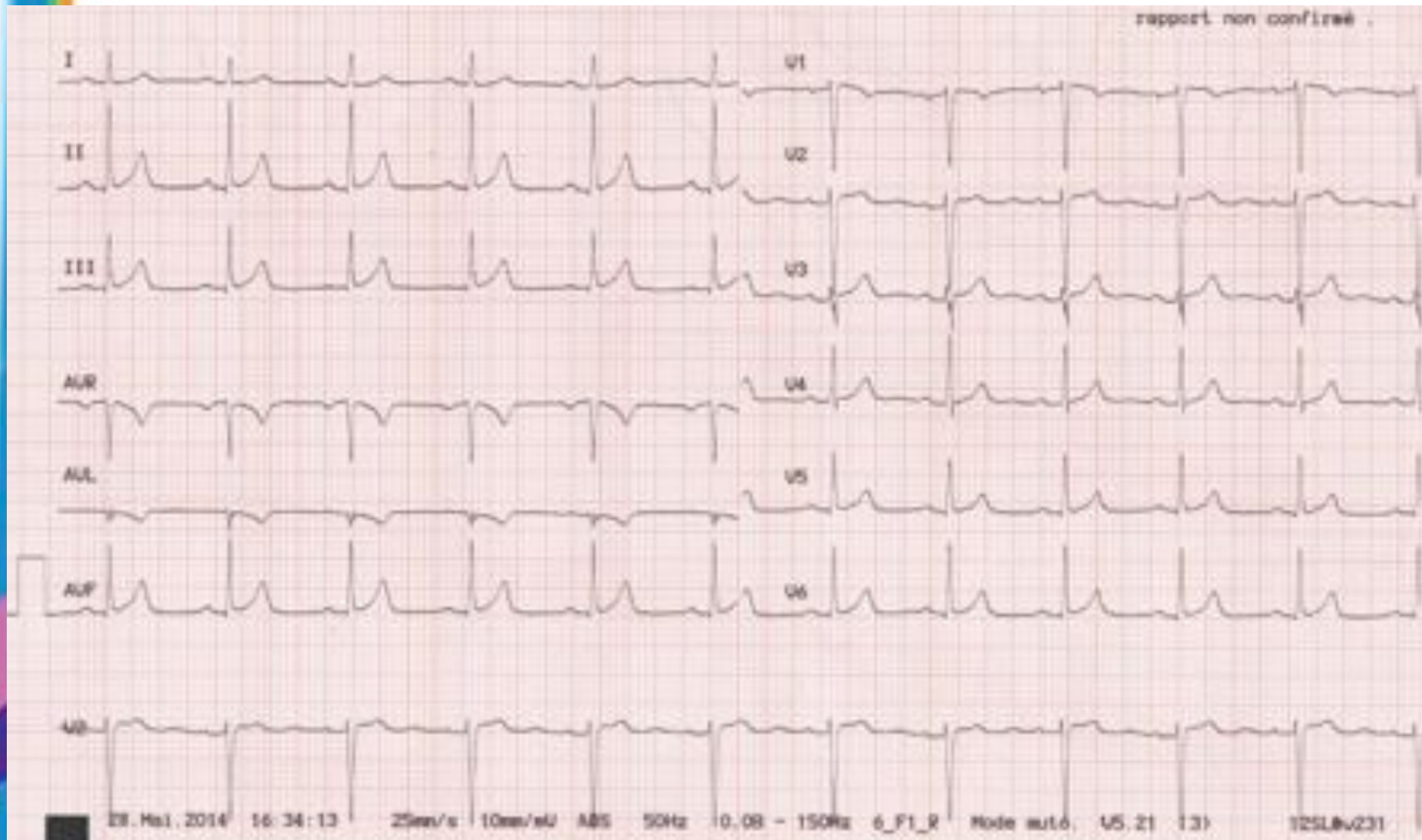
► MISE EN CONDITION											
Oxygène (l/min)		Ventilateur		Régulateur de température		VVF n°1		VVF n°2		Dren Thoracique n°1	
VAF / PSIP		mm Hg		FIO2		FIO2		FIO2		Dren Thoracique n°2	
VOT		Bande n°		Volume		Hélice		Vite Centrale		Sonde urinaire	
Respirateur		Vitesse		Vitesse		Vitesse		Vitesse		FIO2	

► EVOLUTION GLOBALE			
Anesthésique		Agoniste	
Statut		OCC	

► DECONTAMINATION DE L'U.M.H.			
OUI		NON	

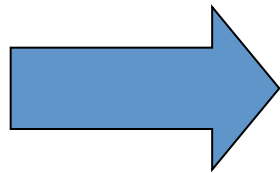
►► DIAGNOSTICS EVOQUES ◀◀			
SCA, a glomérulopathie, - Acrogalactose			
Dysfonction rénale, - Acrogalactose			
Certificat (naissance) (décès) remis OUI () NON ()			

USIC : ECG



Conduite à tenir

1. USIC coroTDM
2. Coronarographie < 120 min
3. Coronarographie 24-48h



GRACE ?

CRUSADE ?

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)

“ST depression combined with transient ST elevation identifies an even higher risk subgroup.”

Criteria for high risk with indication for invasive management

Primary

- Relevant rise or fall in troponin.
- Dynamic ST- or T-wave changes (symptomatic or silent).

Secondary

- Diabetes mellitus.
- Renal insufficiency (eGFR < 60 mL/min/1.73 m²).
- Reduced LV function (ejection fraction < 40%).
- Early post infarction angina.
- Recent PCI.
- Prior CABG.
- Intermediate to high GRACE risk score.

Recommendations for diagnosis and risk stratification (1)

Recommendations	Class	Level
In patients with a suspected NSTEMI-ACS, diagnosis and short-term (ischemic/bleeding) risk stratification should be based on a combination of clinical history, symptoms, physical findings, ECG (repeated or continuous ST monitoring), and biomarkers.	I	A
ACS patients should be admitted preferably to dedicated chest pain units or coronary care units.	I	C
It is recommended to use established risk scores for prognosis and bleeding (e.g. GRACE, CRUSADE).	I	B
A 12-lead ECG should be obtained within 10 min after first medical contact and immediately read by an experienced physician. This should be repeated in the case of recurrence of symptoms, and after 6–9 and 24 h, and before hospital discharge.	I	B
Additional ECG leads (V_1R , V_4R , V_7-V_9) are recommended when routine leads are inconclusive.	I	C

GRACE



At Admission (in-hospital/to 6 months)

At Discharge (to 6 months)

Age

40-49



HR

70-89



SBP

140-159



Creat.

106-140



CHF

I (no CHF)



☐ Cardiac arrest at admission

☒ ST-segment deviation

☐ Elevated cardiac enzymes/markers

Probability of

Death

Death or MI

In-hospital

92

123

To 6 months

67

93

US Units

Reset

Display Risk

CRUSADE



Bleeding Score
Calculator

INTRODUCTION

CALCULATOR

ABOUT

REFERENCES

LINKS

DISCLAIMER

DOWNLOADS

Last Updated:
March 2008

Enter values in drop-down boxes below:

Baseline Hematocrit [?]

> 39.9

Prior Vascular Disease [?]

No

GFR: Cockcroft-Gault [?]

61 - 90

[Calculate GFR](#)

Diabetes Mellitus

Yes

Heart rate on admission

71 - 80

Signs of CHF on admission [?]

No

Systolic blood pressure
on admission

121 - 180

Sex

Male

[Clear Selections](#)

CRUSADE
Bleeding Score [?]

25

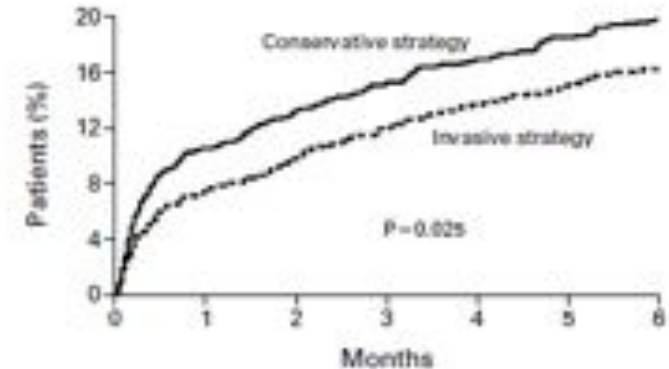
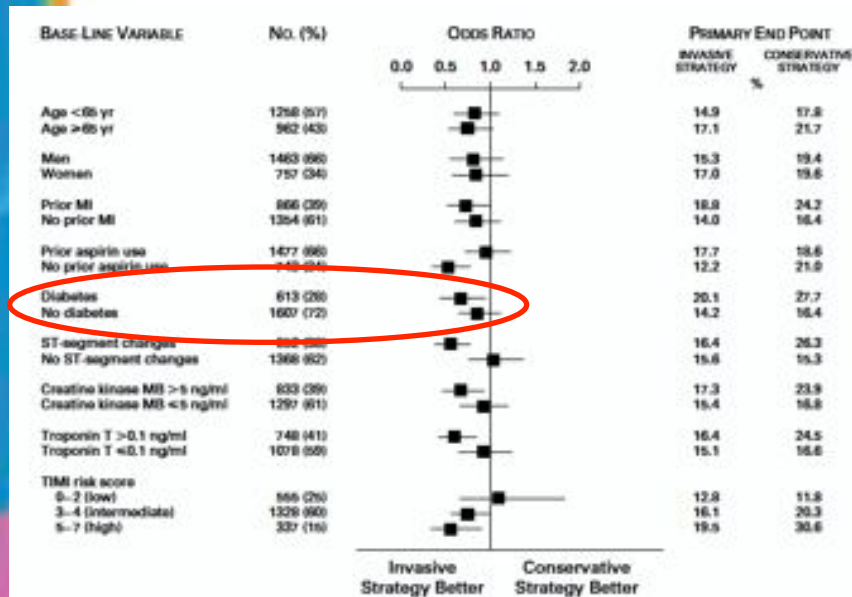
Low Risk

Risk of In-Hospital
Major Bleeding [?]

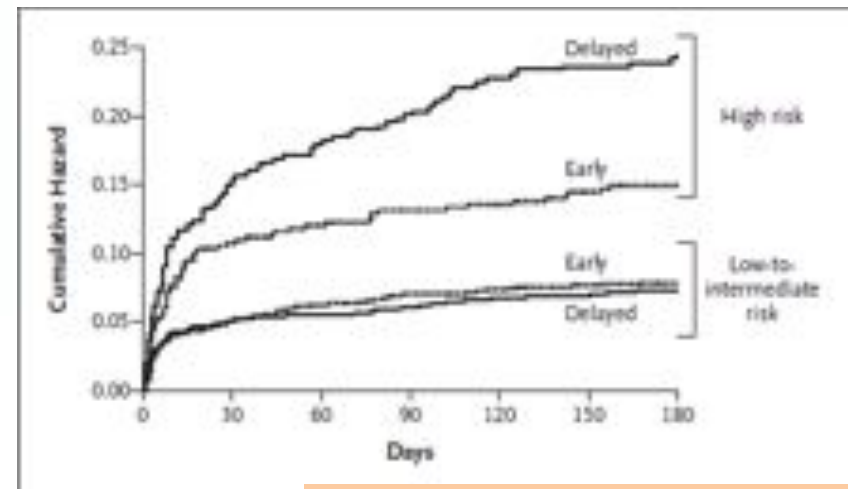
5.7%

Traitement invasif

- Approche invasive précoce
- Bénéfice supérieur/ non diabétique

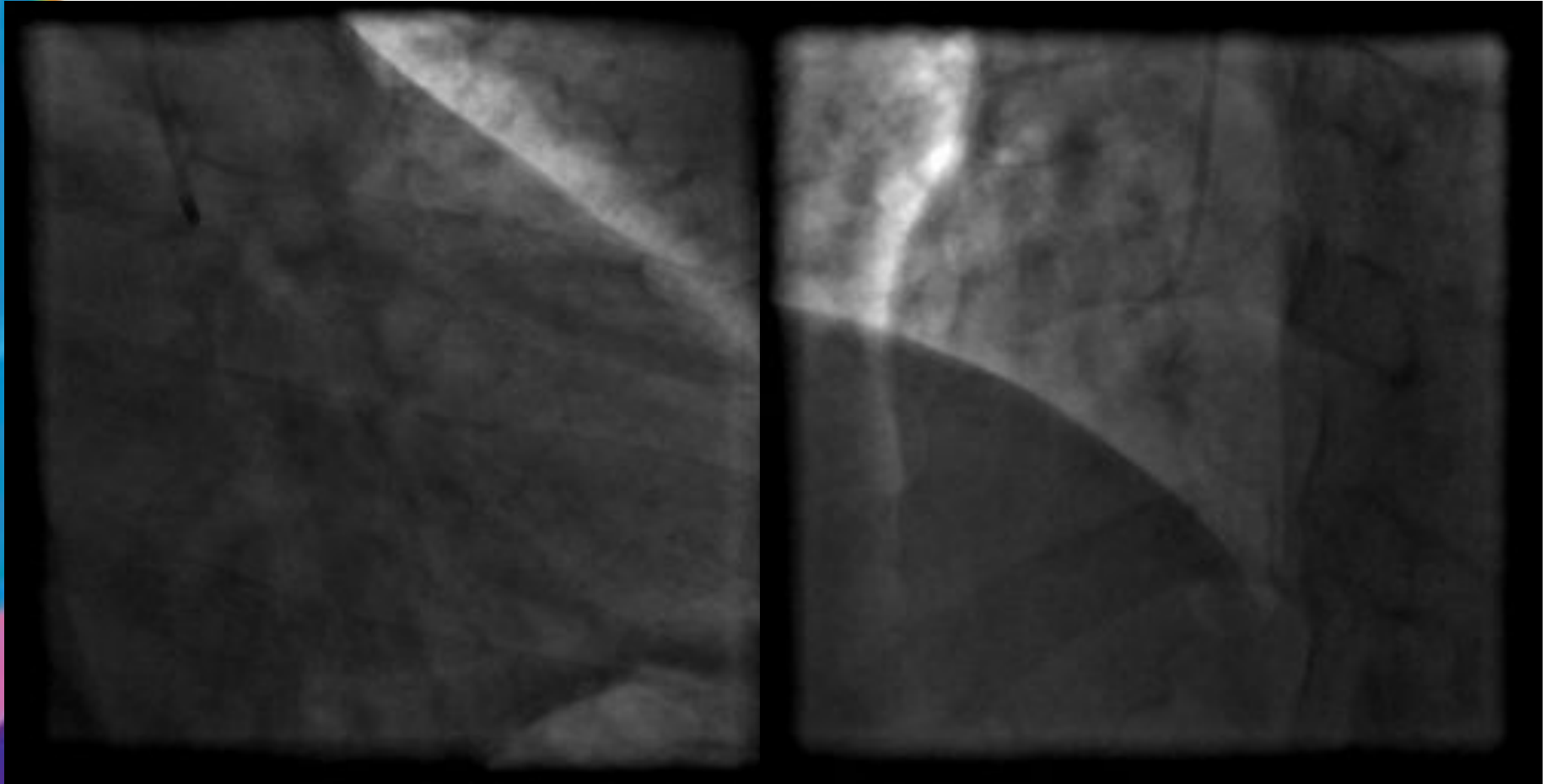


Cannon CP et al. N Engl J Med 2001

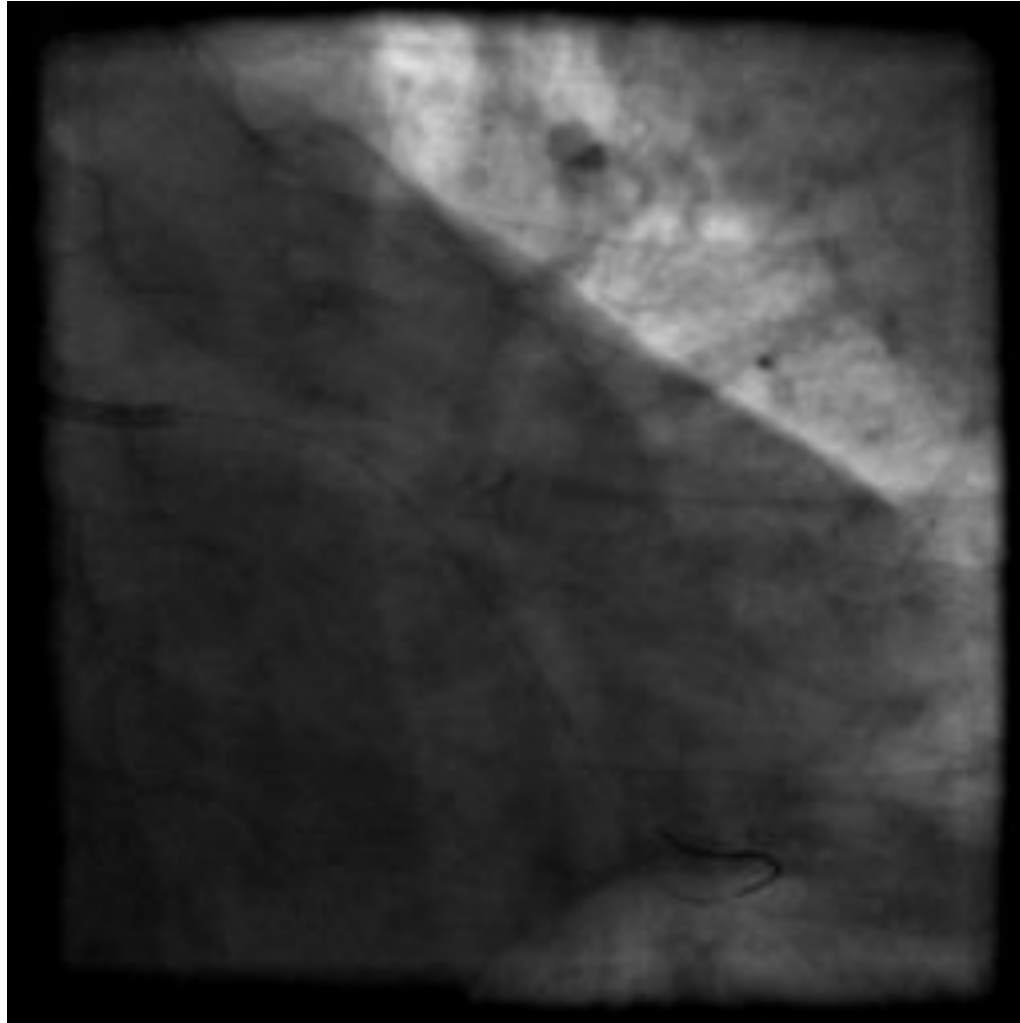


Mehta SR et al. N Engl J Med 2009

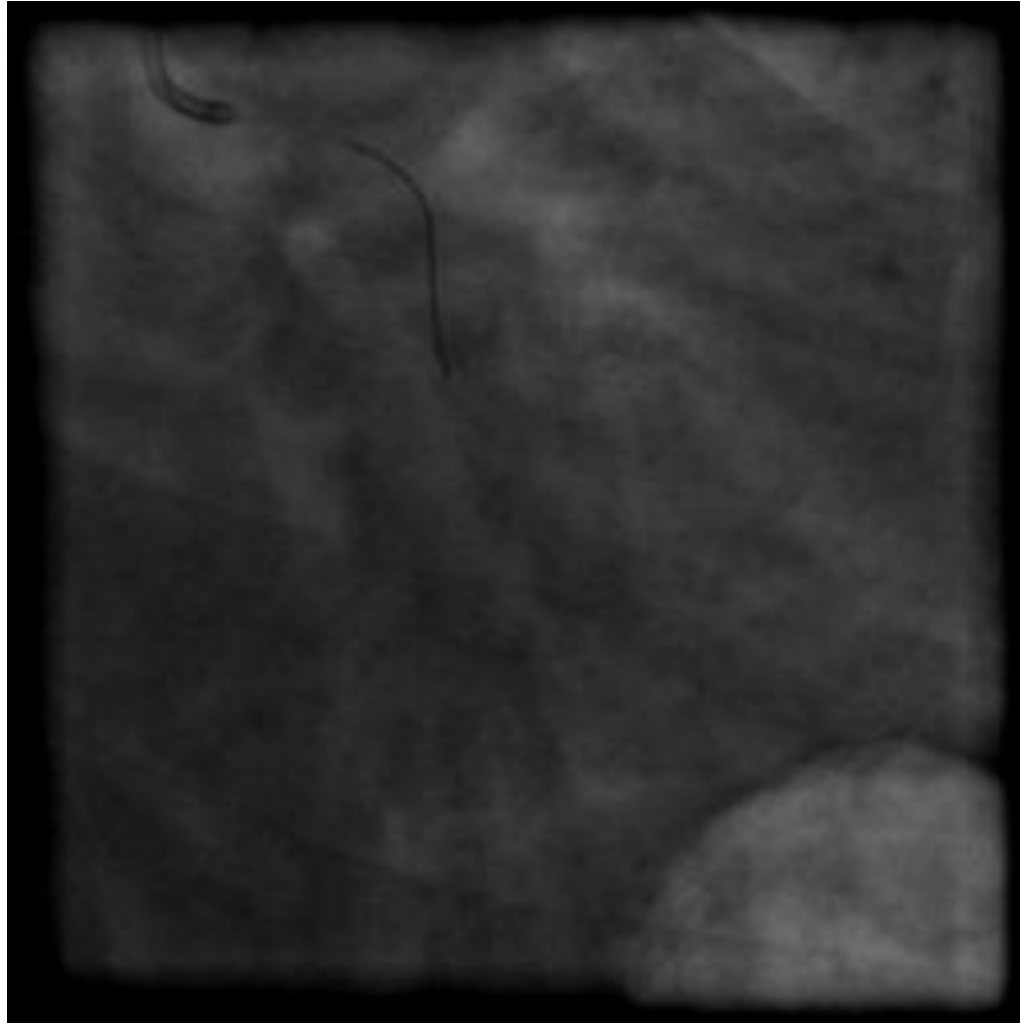
CORONAROGRAPHIE



ANGIOPLASTIE



ANGIOPLASTIE



Stent Pro-kinetic Energy 2.75/15mm

Quel traitement Antiagrégant?

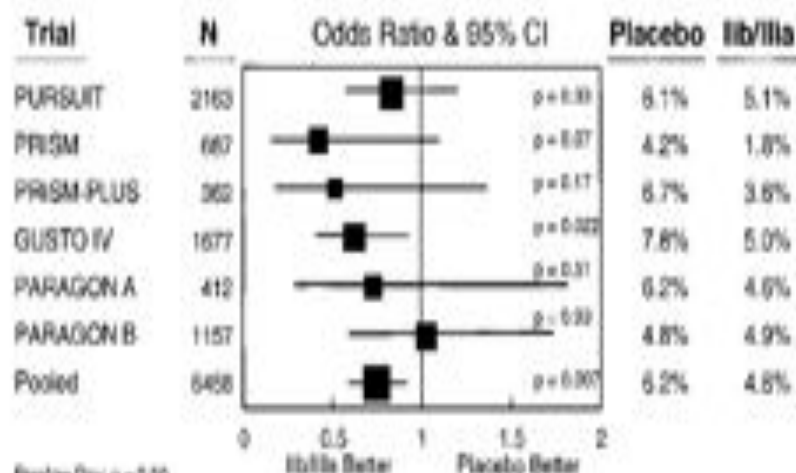
1. Clopidogrel
2. Ticagrelor
3. Prasugrel
4. Anti GPIIbIIIa

Platelet Glycoprotein IIb/IIIa Inhibitors Reduce Mortality in Diabetic Patients With Non-ST-Segment-Elevation Acute Coronary Syndromes

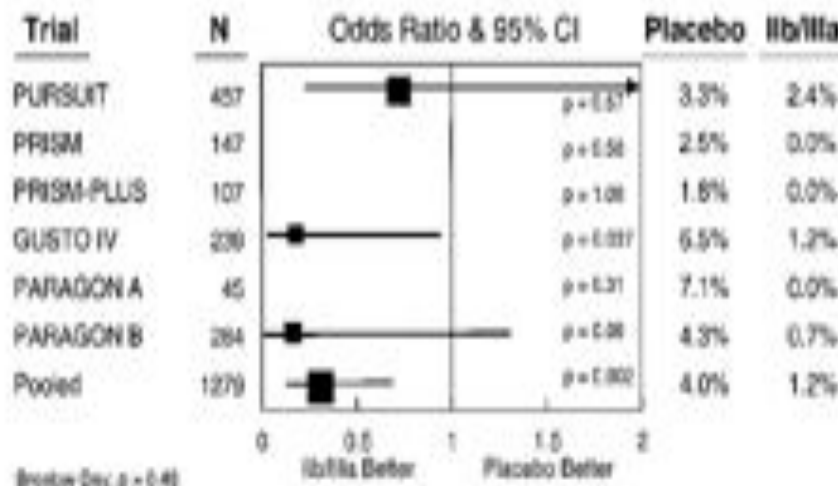
Marco Roffi, Derek P. Chew, Debabrata Mukherjee, Deepak L. Bhatt, Jennifer A. White, Christopher Heeschen, Christian W. Hamm, David J. Moliterno, Robert M. Califf, Harvey D. White, Neal S. Kleiman, Pierre Thérault and Eric J. Topol

Circulation. 2001;104:2767-2771

30-Day Mortality
Diabetic Patients



30-Day Mortality
Diabetic Patients
PCI



Comparison of Prasugrel and Ticagrelor Loading Doses in ST-Segment Elevation Myocardial Infarction Patients

RAPID (Rapid Activity of Platelet Inhibitor Drugs) Primary PCI Study

Guido Parodi, MD, PhD, Renato Valenti, MD, Benedetta Bellandi, MD, Angela Migliorini, MD, Rossella Marcucci, MD, Vincenzo Comito, MD, Nazario Carrabba, MD, Alberto Santini, MD, Gian Franco Gensini, MD, Rosanna Abbate, MD, David Antonucci, MD

Florence, Italy

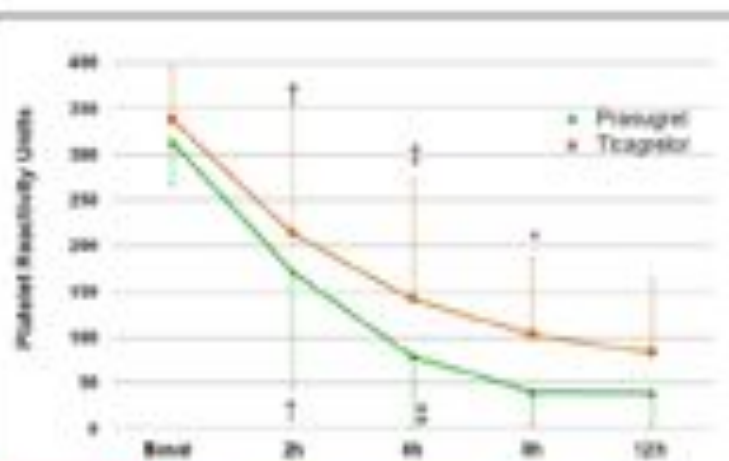


Figure 3 Kinetics of Platelet Inhibition Over Time

Residual platelet reactivity values assessed by platelet reactivity units (VWF:Ag) at baseline and 2, 4, 8, and 12 h after drug loading dose in patients with prasugrel (orange) and ticagrelor (green). *p < 0.05 versus ticagrelor. †p < 0.05 versus baseline, ‡p < 0.05 versus 2 h.

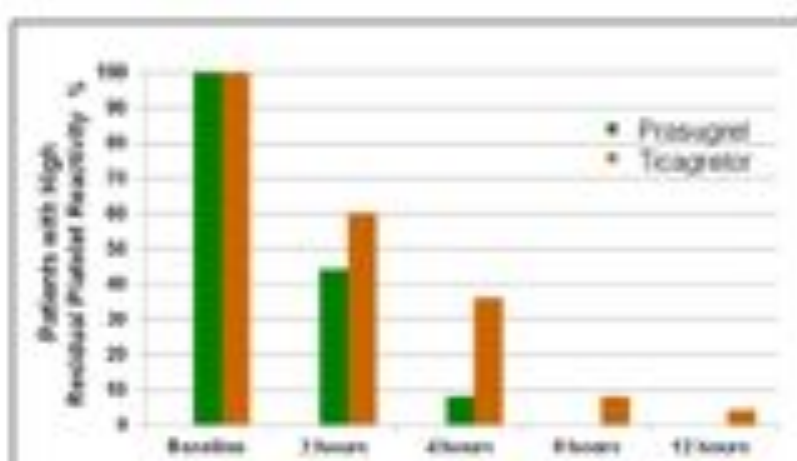


Figure 5 Patients With High Residual Platelet Reactivity Over Time

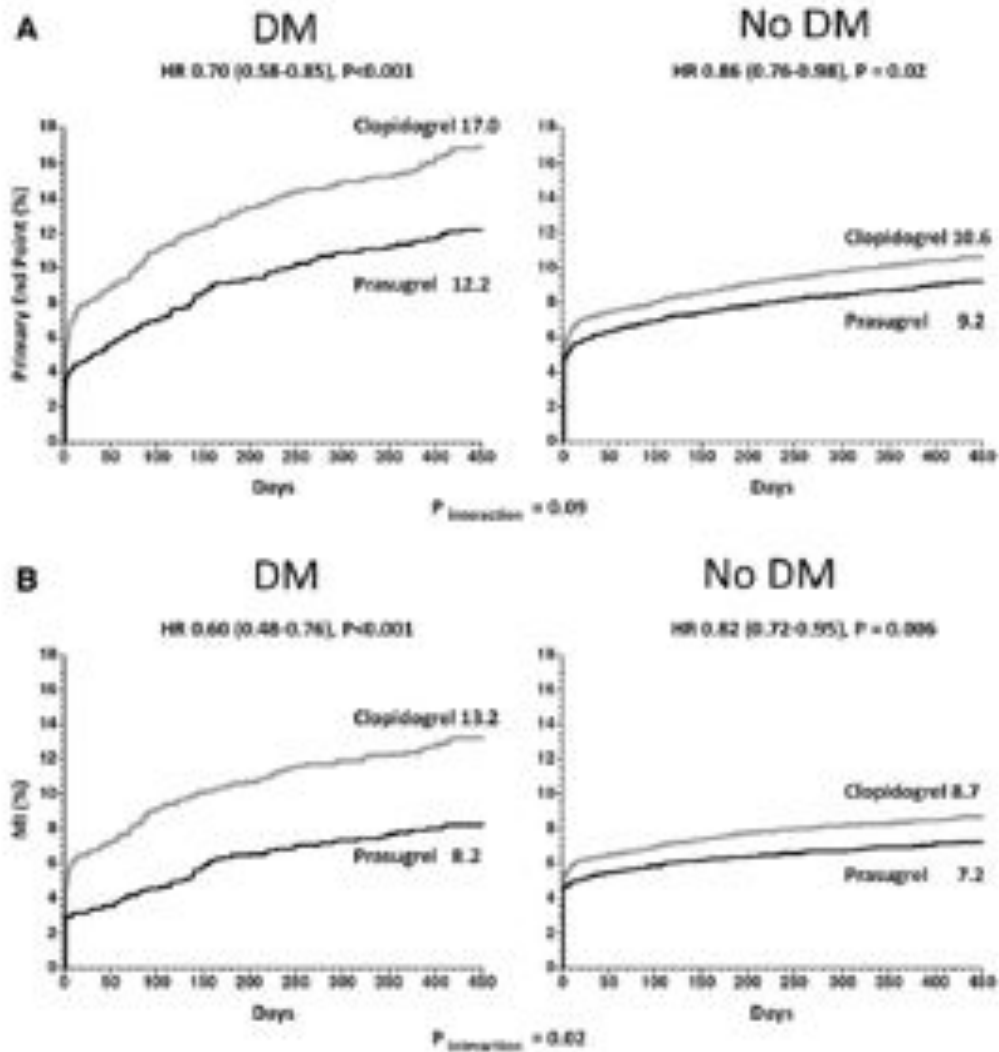
The percentage of high residual platelet reactivity (VWF:Ag) patients at different time points in the prasugrel (green bars) and ticagrelor (orange bars) groups.

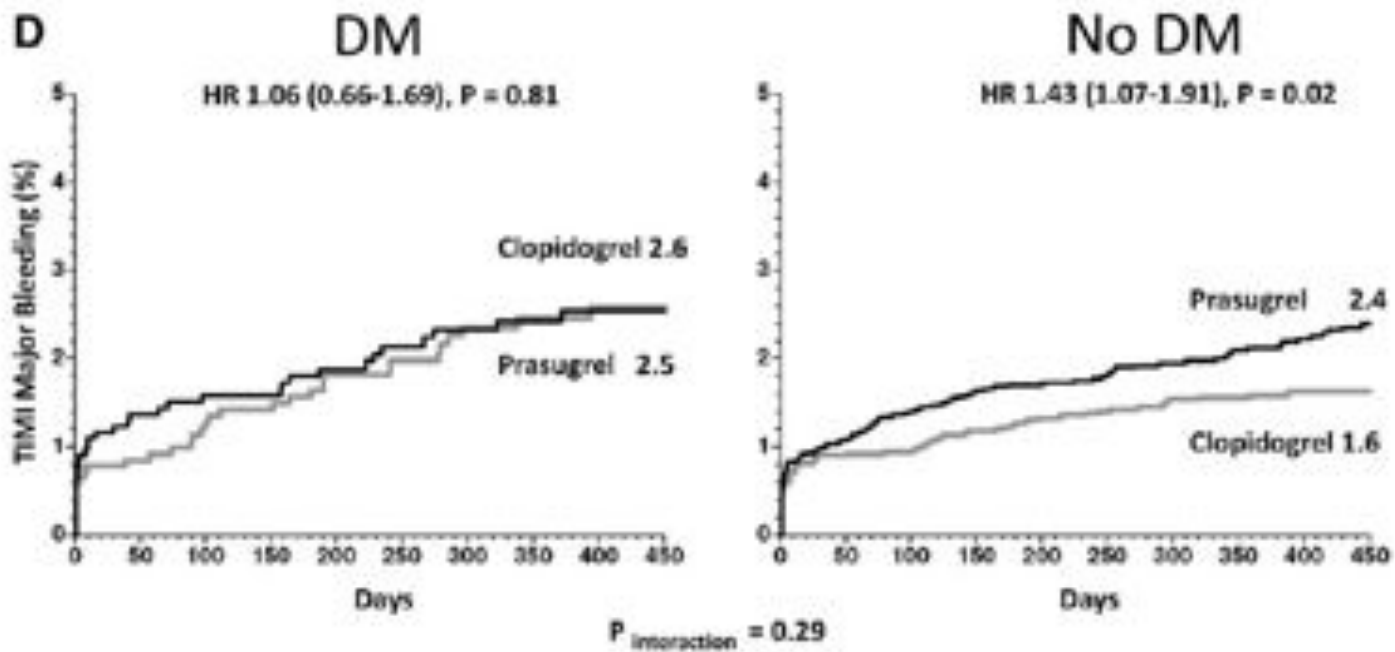
Quel traitement Antiagrégant?

1. Clopidogrel
2. Ticagrelor
3. Prasugrel
4. **Anti GPIIbIIIa**

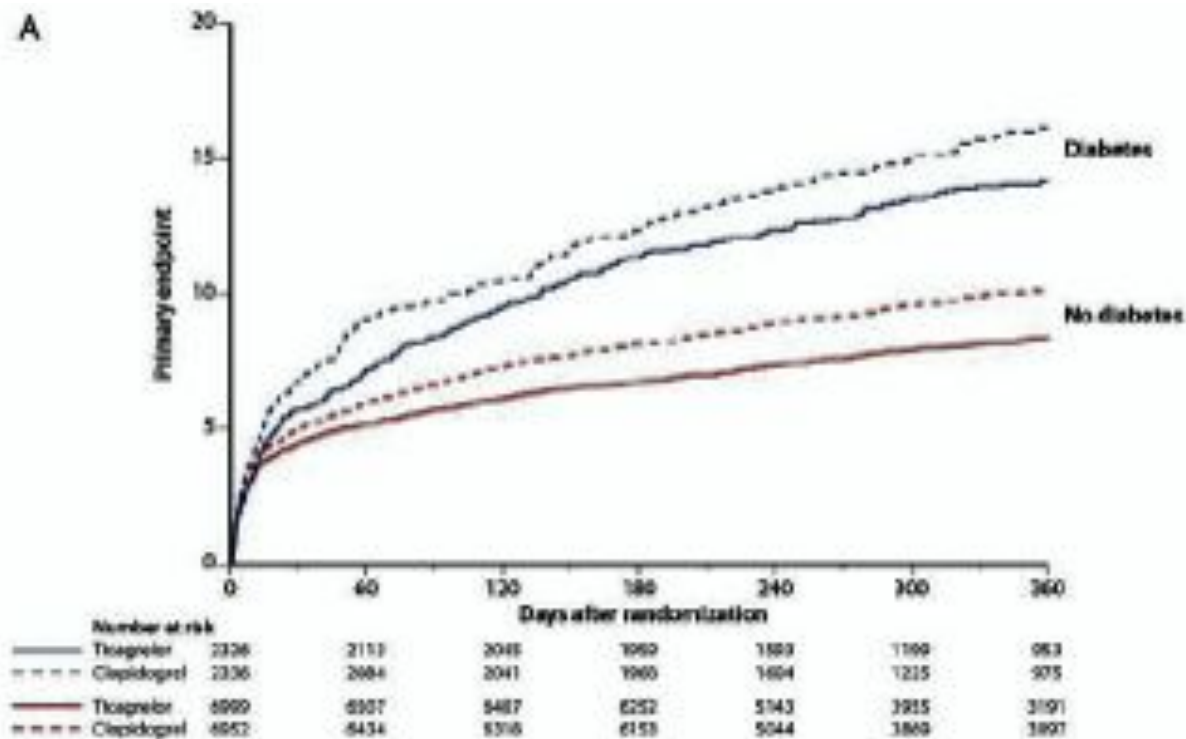
ESC 2013 : Recommandations chez le diabétique

Antiplatelet therapy in patients with diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
Antiplatelet therapy with aspirin in DM-patients at low CVD risk is not recommended.	III	A	184-186
Antiplatelet therapy for primary prevention may be considered in high risk patients with DM on an individual basis.	IIb	C	-
Aspirin at a dose of 75-160 mg/day is recommended as secondary prevention in DM.	I	A	182
A P2Y ₁₂ receptor blocker is recommended in patients with DM and ACS for 1 year and in those subjected to PCI (duration depending on stent type). In patients with PCI for ACS preferably prasugrel or ticagrelor should be given.	I	A	188, 189, 192, 194, 196
Clopidogrel is recommended as an alternative antiplatelet therapy in case of aspirin intolerance.	I	B	192, 197

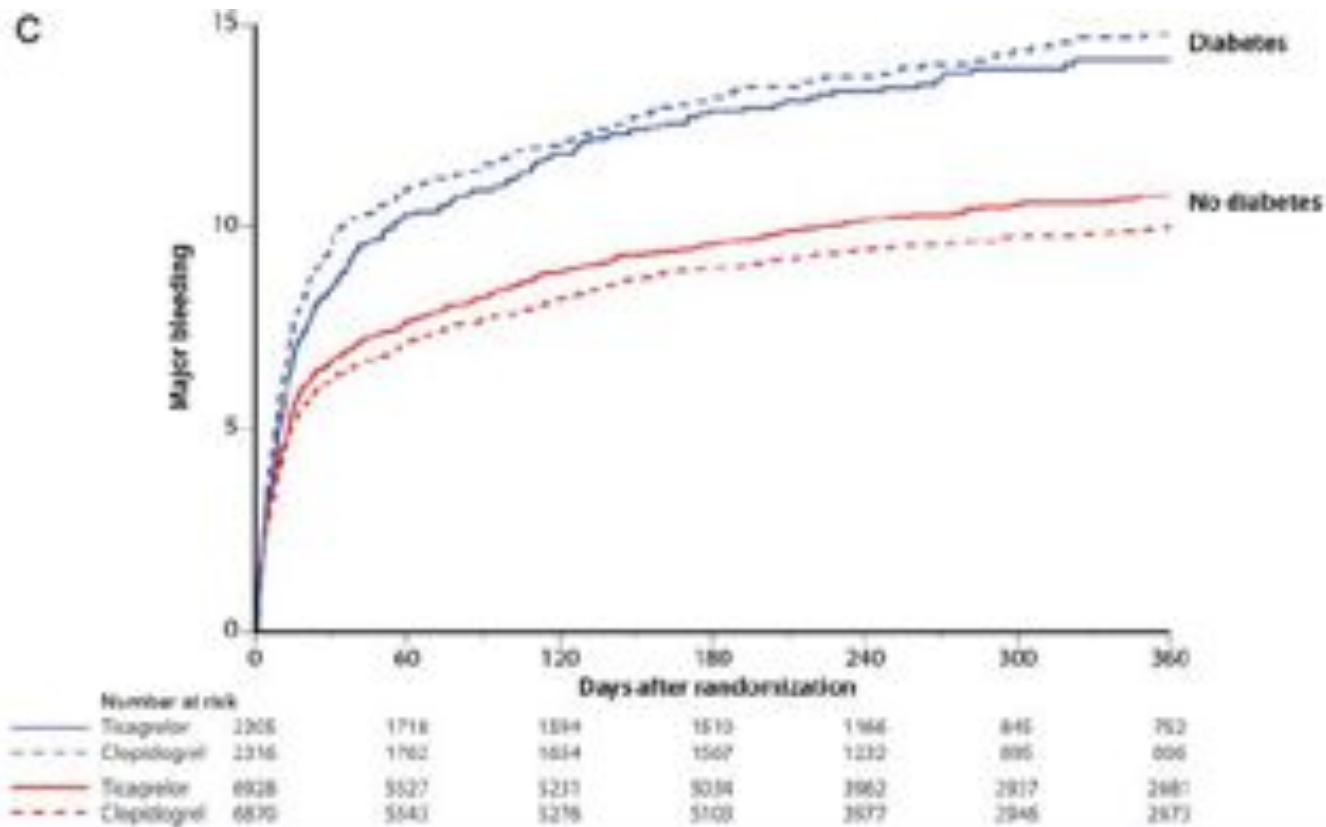




PLATO

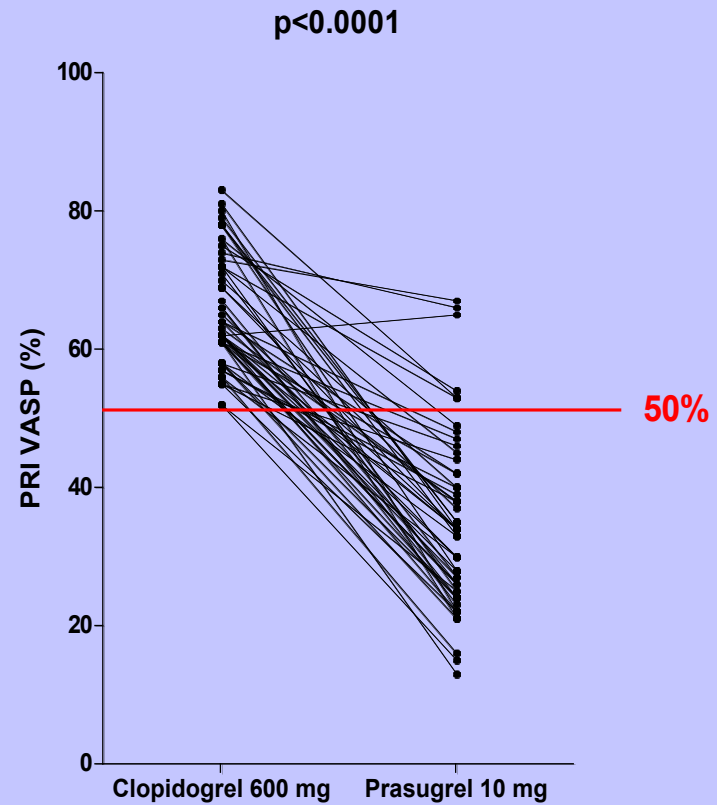
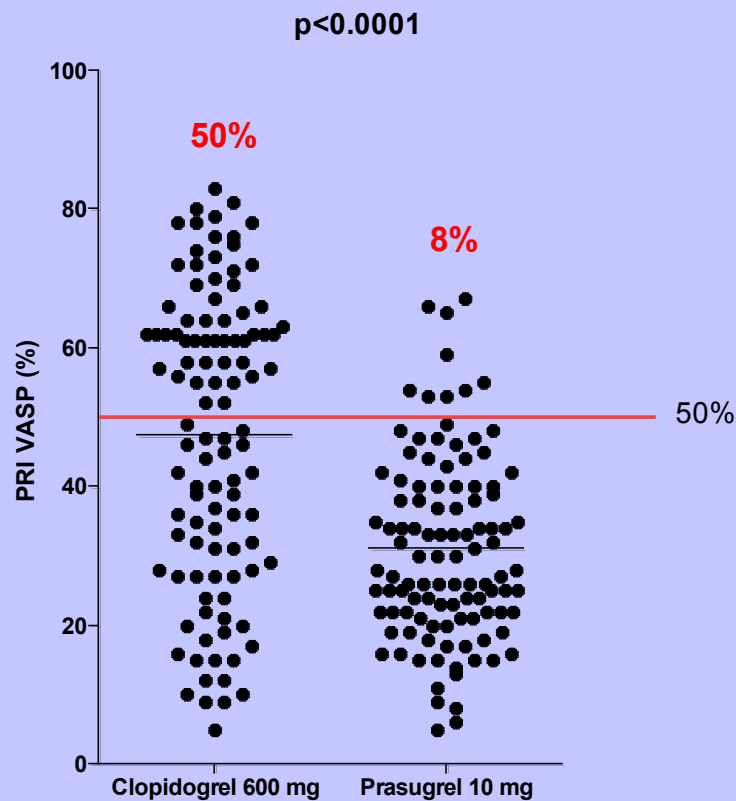


PLATO



Prasugrel in Diabetics

N=107, NSTEMI ACS diabetics undergoing PCI, platelet reactivity by PRI VASP



Low rate of HTPR with prasugrel in diabetics

	Non DM	DM	DM not on Insulin	DM on insulin
Primary endpoint TRITON <i>prasugrel/clopidogrel</i> (NNT)	9.2/10.6 71	12.2/17 21	11.5/15.3 26	14.3/22.2 13
Primary endpoint PLATO <i>ticagrelor/clopidogrel</i>	8.4/10.2	14.1/16.2	13.1/14.2	17.7/22.8
MI TRITON <i>prasugrel/clopidogrel</i>	7.2/8.7	8.2/13.2	7.7/11.9	9.9/17.3
MI PLATO <i>ticagrelor/clopidogrel</i>	5.0/6.2	8.4/9.1		
ST TRITON <i>prasugrel/clopidogrel</i>	0.9/2.0	2.0/3.6		
ST PLATO <i>ticagrelor/clopidogrel</i>	1.3/1.8	1.6/2.4		
Bleeding (major TIMI not related CABG) TRITON <i>prasugrel/clopidogrel</i>	2.4/1.6	2.5/2.6	2.7/2.7	1.9/2.3
Bleeding (major TIMI) PLATO <i>ticagrelor/clopidogrel</i>	7.6/7.0	9.0/9.9		

Wiviott SD et al. Circ 2008

James S et al. Eur Heart J 2010

Quel traitement?

1. Antiagrégant:

1. Clopidogrel

2. Ticagrelor

3. Prasugrel

4. Anti GPIIbIIIa

Evolution

- Pic de troponine : $29.29\mu\text{g/l}$ (à l'arrivée: $0,143\mu\text{g/l}$)
- ETT J2: très légère hypokinésie de la paroi inféro-latérale FEVG visuelle normale à 68 %.
- Retour domicile J3

Traitement de sortie

- Aspirine : 75 mg/jour
- Prasugrel : 10 mg/jour
- Rosuvastatine: 20 mg/j
- Tenormine 50 mg: 1cp/j
- Ramipril: 5 mg/j
- Metformine 500mg: 1cp X2/j
- Sevrage tabac

Merci de votre attention