FA et SCA .
Que faire un an après?

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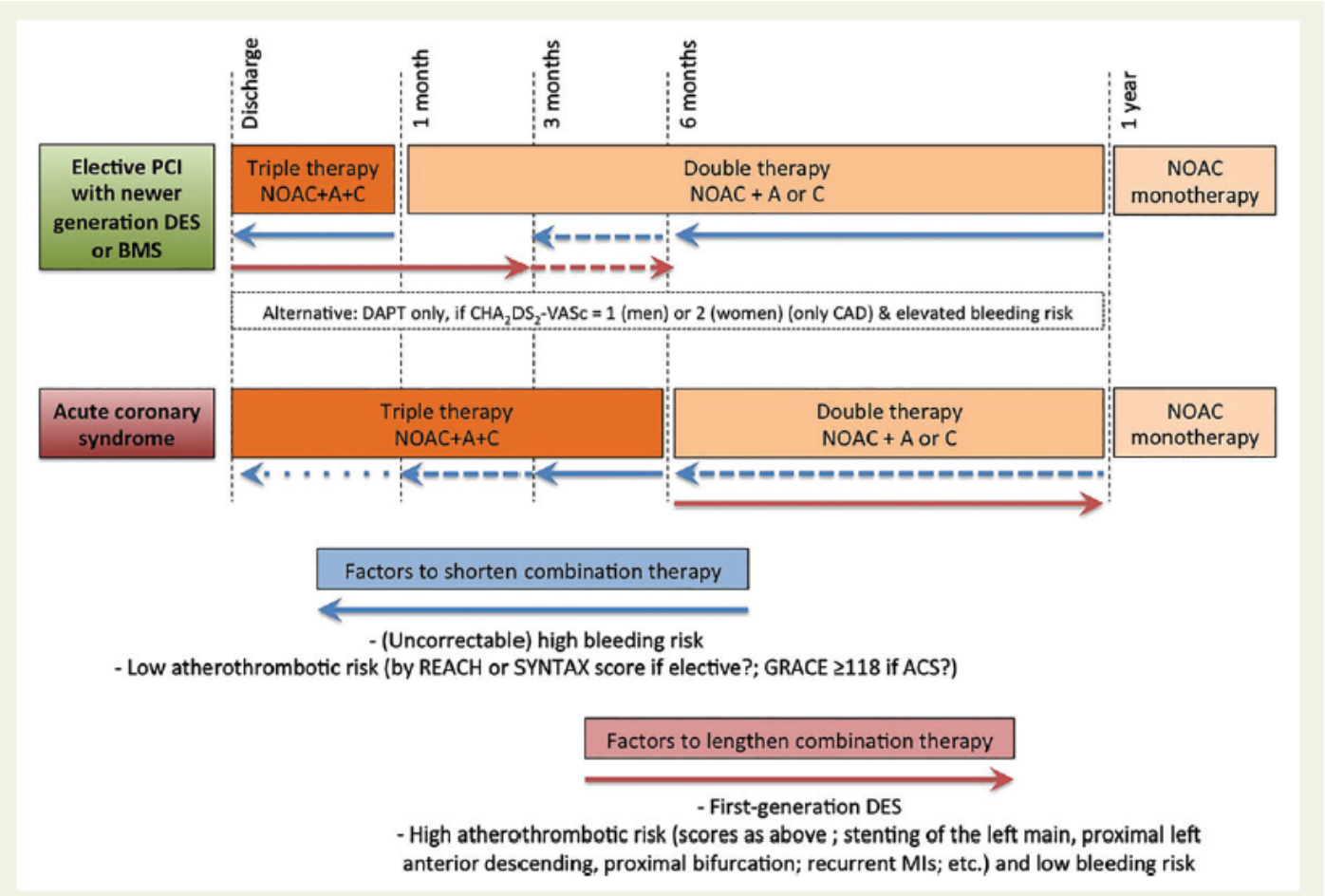
Réponse supprimer AAP
Maintenir anticoagulant seul



Pourquoi anticoagulant seul
Car association AAP + anticoagulant est plus hémorragique

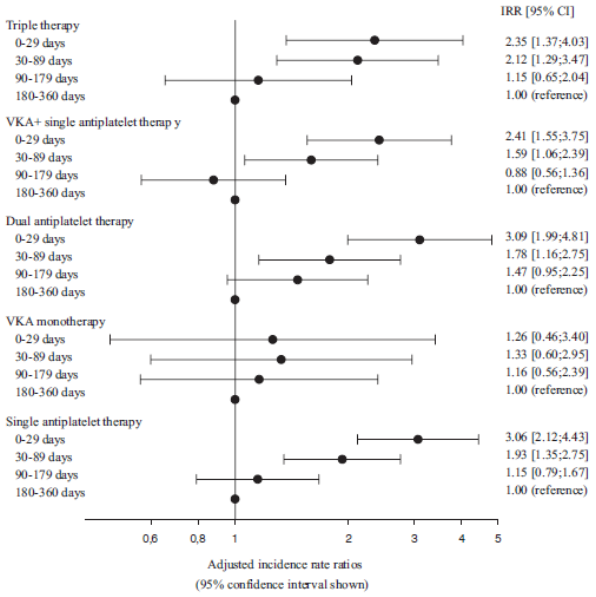
sans bénéfice sur les accidents thrombotiques

1) Windecker S, et al. 2014 ESC/EACTS Guidelines on myocardial revascularization: The Task Force on Myocardial Revascularization of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS)Developed with the special contribution of the European Association of Percutaneous Cardiovascular Interventions (EAPCI). Eur Heart J 2014;35:2541–619.

2) Hamm CW, et al. 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 Cardiolo (ESC). Eur Heart J 2011;32:2999–3054.

3) Lamberts M, Gislason GH, Lip GY, Lassen JF, Olesen JB, Mikkelsen AP et al. Antiplatelet therapy for stable coronary artery disease in atrial fibrillation patients taking an oral anticoagulant: a nationwide cohort study. Circulation 2014;129:1577–85.

4) Sørensen R[1], Hansen ML, Abildstrom SZ, Hvelplund A, Andersson C, Jørgensen C, Madsen JK, Hansen PR, Køber L, Torp-Pedersen C, Gislason GH. Risk of bleeding in patients with acute myocardial infarction treated with different combinations of aspirin, clopidogrel, and vitamin K antagonists in Denmark: a retrospective analysis of nationwide registry data. Lancet. 2009 Dec 12;374(9706):1967-74.



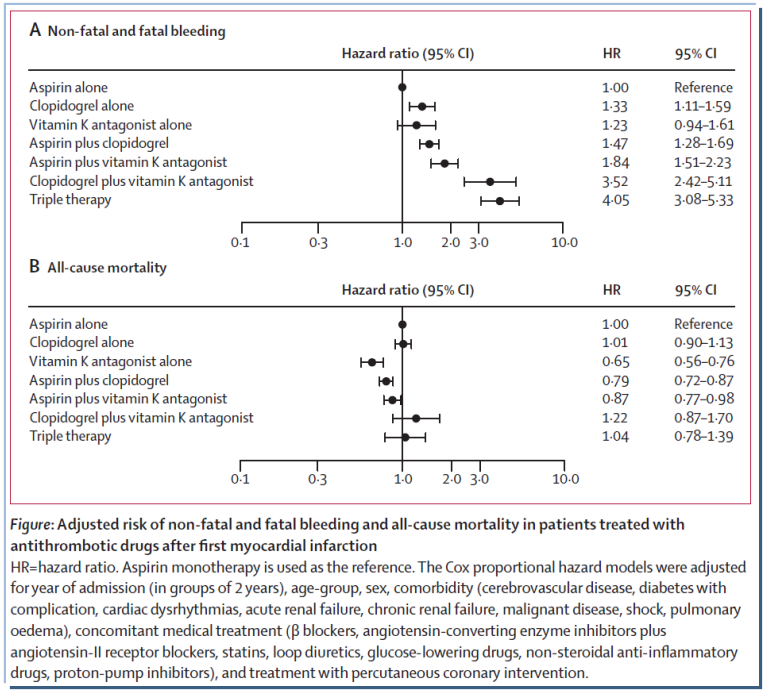
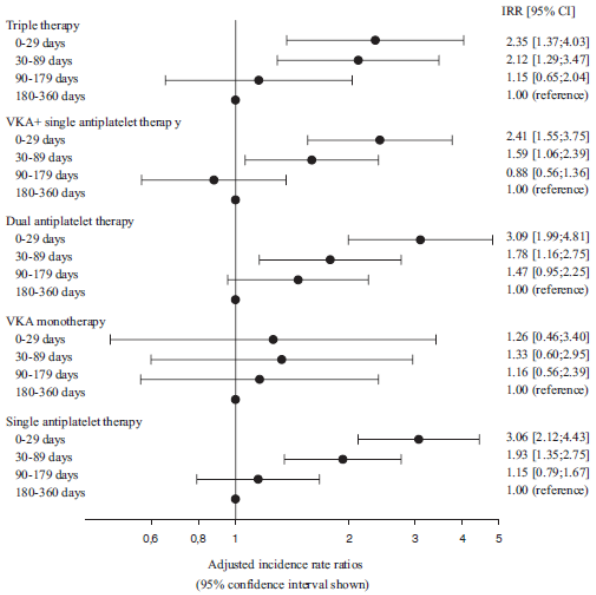


Figure: **Adjusted risk of non-fatal and fatal bleeding and all-cause mortality in patients treated with antithrombotic drugs after first myocardial infarction**

HR=hazard ratio. Aspirin monotherapy is used as the reference. The Cox proportional hazard models were adjusted for year of admission (in groups of 2 years), age-group, sex, comorbidity (cerebrovascular disease, diabetes with complication, cardiac dysrhythmias, acute renal failure, chronic renal failure, malignant disease, shock, pulmonary oedema), concomitant medical treatment (β blockers, angiotensin-converting enzyme inhibitors plus angiotensin-II receptor blockers, statins, loop diuretics, glucose-lowering drugs, non-steroidal anti-inflammatory drugs, proton-pump inhibitors), and treatment with percutaneous coronary intervention.



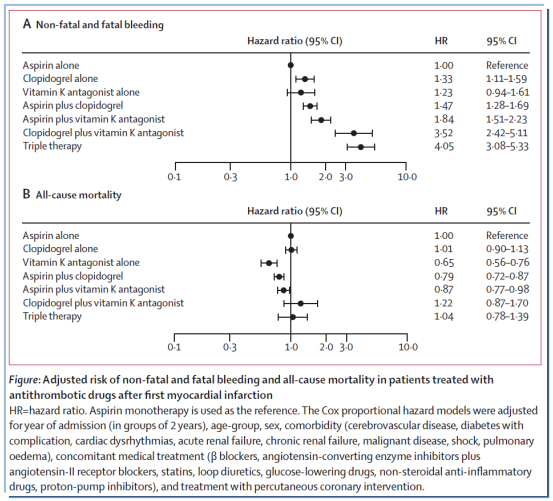


***Figure*: Adjusted risk of non-fatal and fatal bleeding and all-cause mortality in patients treated with antithrombotic drugs after first myocardial infarction**

HR=hazard ratio. Aspirin monotherapy is used as the reference. The Cox proportional hazard models were adjusted for year of admission (in groups of 2 years), age-group, sex, comorbidity (cerebrovascular disease, diabetes with complication, cardiac dysrhythmias, acute renal failure, chronic renal failure, malignant disease, shock, pulmonary oedema), concomitant medical treatment (β blockers, angiotensin-converting enzyme inhibitors plus angiotensin-II receptor blockers, statins, loop diuretics, glucose-lowering drugs, non-steroidal anti-inflammatory drugs, proton-pump inhibitors), and treatment with percutaneous coronary intervention.

Quel anticoagulant?

- AVK
- Dabigatran 110 mg
- Dabigatran 150 mg
- Rivaxoban 20 mg
- Apixaban 5mg X 2

Recommandations ESC 2015

« It is likely that the advantages of NOACs (in monotherapy) over VKAs are preserved in CAD patients with AF. “

“Since direct comparative data are lacking, there is no strong argument for choosing one NOAC over another in this setting”

Donc plutôt les NOAC : recommandations d’experts

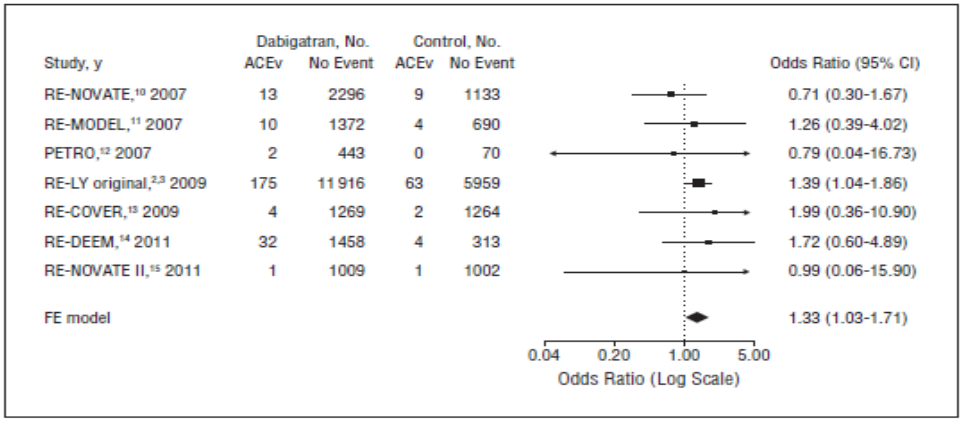
Quel NOAC ?
Dabigatran la polémique

Table 2. Efficacy Outcomes, According to Treatment Group.

Event	Dabigatran, 110 mg (N=6015)		Dabigatran, 150 mg (N=6076)		Warfarin (N=6022)		Dabigatran, 110 mg, vs. Warfarin		Dabigatran, 150 mg, vs. Warfarin		Dabigatran, 150 mg vs. 110 mg	
							Relative Risk (95% CI)	P Value	Relative Risk (95% CI)	P Value	Relative Risk (95% CI)	P Value
	no. of patients	*%/yr*	*no. of patients*	*%/yr*	*no. of patients*	*%/yr*						
Stroke or systemic embolism*	182	1.53	134	1.11	199	1.69	0.91 (0.74–1.11)	<0.001 for noninferiority, 0.34	0.66 (0.53–0.82)	<0.001 for noninferiority, <0.001	0.73 (0.58–0.91)	0.005
Stroke	171	1.44	122	1.01	185	1.57	0.92 (0.74–1.13)	0.41	0.64 (0.51–0.81)	<0.001	0.70 (0.56–0.89)	0.003
Hemorrhagic	14	0.12	12	0.10	45	0.38	0.31 (0.17–0.56)	<0.001	0.26 (0.14–0.49)	<0.001	0.85 (0.39–1.83)	0.67
Ischemic or unspecified	159	1.34	111	0.92	142	1.20	1.11 (0.89–1.40)	0.35	0.76 (0.60–0.98)	0.03	0.69 (0.54–0.88)	0.002
Nondisabling stroke	60	0.50	44	0.37	69	0.58	0.86 (0.61–1.22)	0.40	0.62 (0.43–0.91)	0.01	0.72 (0.49–1.07)	0.10
Disabling or fatal stroke	112	0.94	80	0.66	118	1.00	0.94 (0.73–1.22)	0.65	0.66 (0.50–0.88)	0.005	0.70 (0.53–0.94)	0.02
Myocardial infarction	86	0.72	89	0.74	63	0.53	1.35 (0.98–1.87)	0.07	1.38 (1.00–1.91)	0.048	1.02 (0.76–1.38)	0.88
Pulmonary embolism	14	0.12	18	0.15	11	0.09	1.26 (0.57–2.78)	0.56	1.61 (0.76–3.42)	0.21	1.27 (0.63–2.56)	0.50
Hospitalization	2311	19.4	2430	20.2	2458	20.8	0.92 (0.87–0.97)	0.003	0.97 (0.92–1.03)	0.34	1.06 (1.00–1.12)	0.04
Death from vascular causes	289	2.43	274	2.28	317	2.69	0.90 (0.77–1.06)	0.21	0.85 (0.72–0.99)	0.04	0.94 (0.79–1.11)	0.44
Death from any cause	446	3.75	438	3.64	487	4.13	0.91 (0.80–1.03)	0.13	0.88 (0.77–1.00)	0.051	0.97 (0.85–1.11)	0.66

Hohnloser SH et al. Myocardial ischemic events in patients with atrial fibrillation treated with dabigatran or warfarin in the RE-LY trial. Circulation 2012;125:669-676

Dabigatran
fin de la polémique



Pas dans les méta-analyses

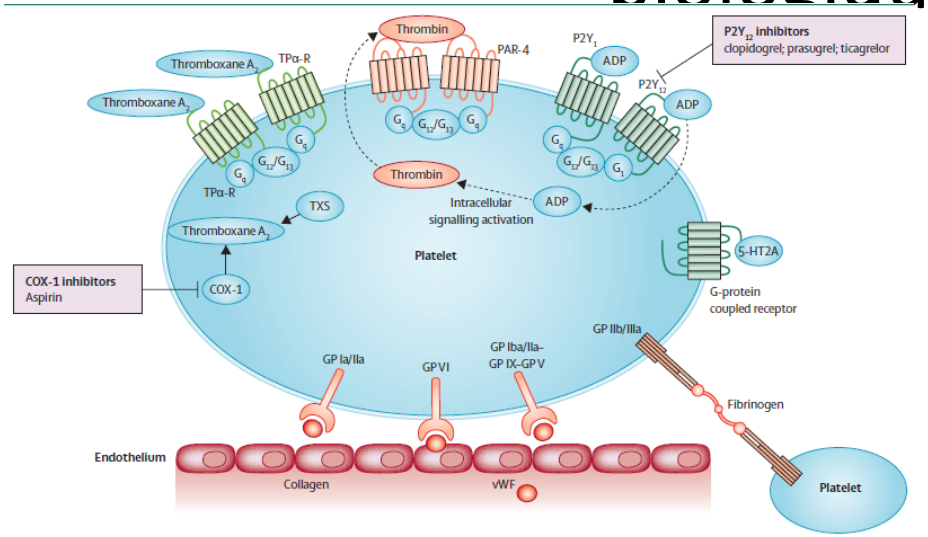
Uchino K et al. Dabigatran is associated with higher risk of acute coronary events : a metanalysis of non-inferiority randomized controlled trials. Arch Intern Med 2012

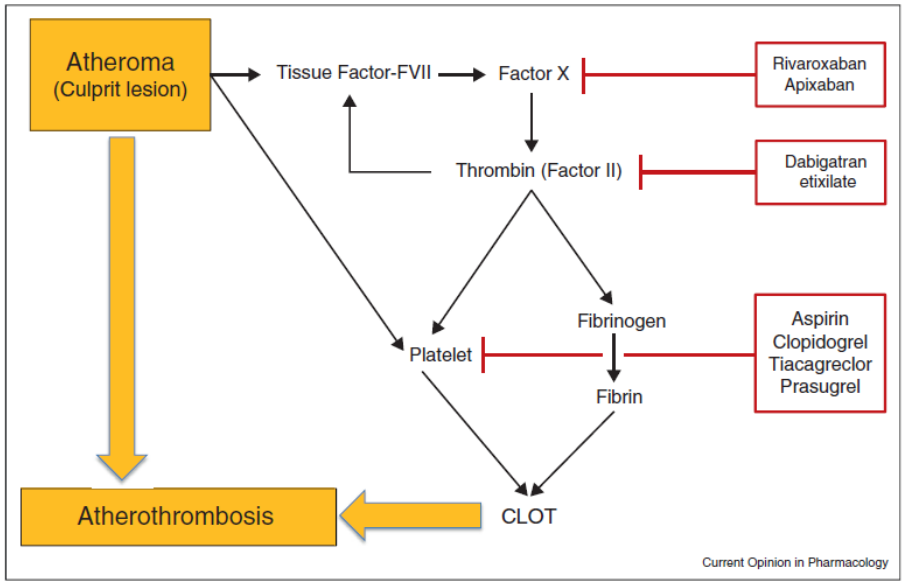
	No. of Events		Incidence Rate per 1000 Person-Years		Adjusted Hazard Ratio (95% CI)	*P* Value
	Dabigatran	Warfarin	Dabigatran	Warfarin		
Primary outcomes						
Ischemic stroke	205	270	11.3	13.9	0.80 (0.67–0.96)	0.02
Major hemorrhage	777	851	42.7	43.9	0.97 (0.88–1.07)	0.50
Gastrointestinal	623	513	34.2	26.5	1.28 (1.14–1.44)	<0.001
Intracranial	60	186	3.3	9.6	0.34 (0.26–0.46)	<0.001
Intracerebral	44	142	2.4	7.3	0.33 (0.24–0.47)	<0.001
Acute myocardial infarction	285	327	15.7	16.9	0.92 (0.78–1.08)	0.29

Pas dans la vraie vie (130 000 Pts)

Graham DL et al. **Cardiovascular, Bleeding, and Mortality Risks in Elderly Medicare Patients Treated With Dabigatran or Warfarin for Nonvalvular Atrial Fibrillation *Circulation. 2015;131:157-164.* .**

Donc comment choisir ?
Pas d'étude clinique mais des études biologiques





TRAP
RISTOCETINE
Libération de Thrombine

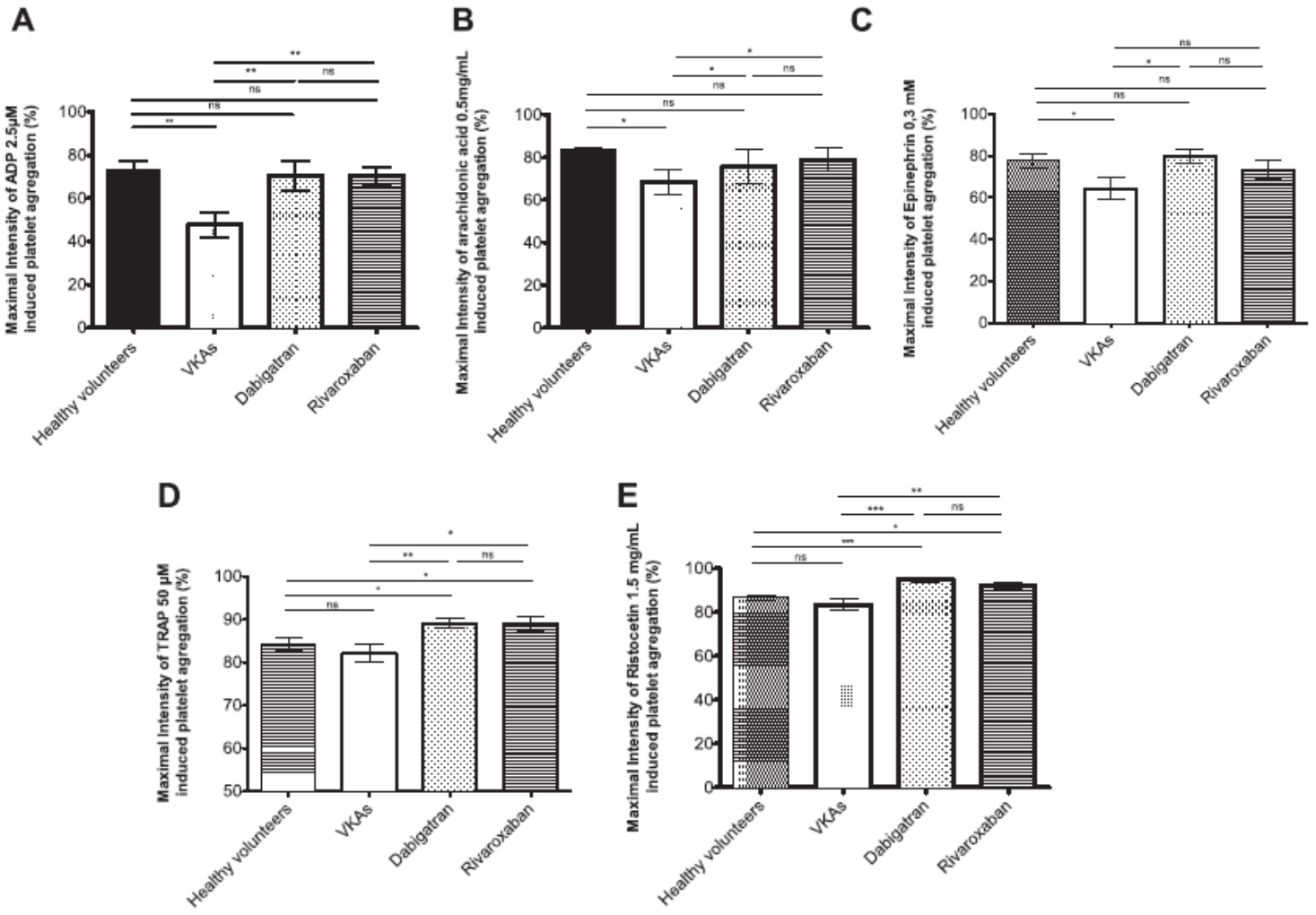
LTA
PRP
Aggrégation plaquettaire

Etude 1

International Journal of Cardiology

Antiplatelet properties of oral anticoagulants

Corinne Frère [a,b], Marc Laine [c], Franck Paganelli [c], Françoise Dignat-George [b], Laurent Bonello [b,c,*]

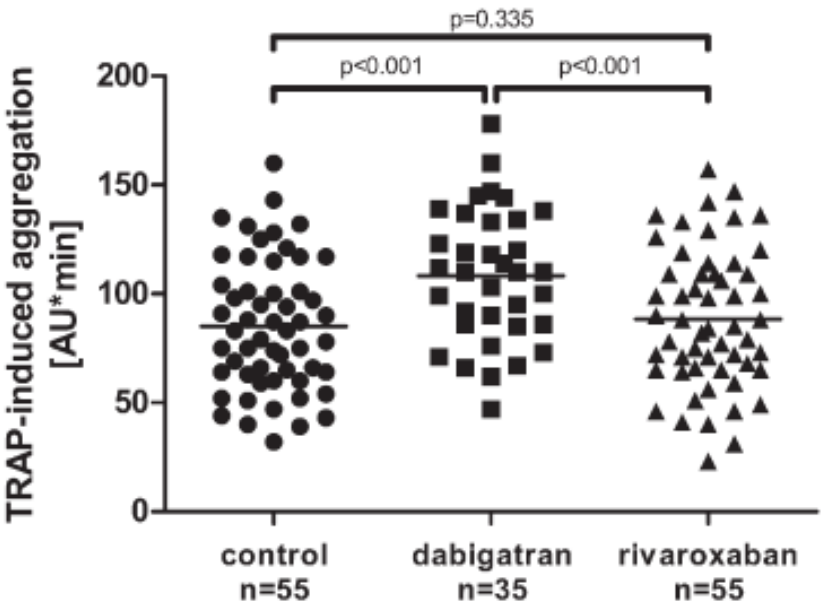


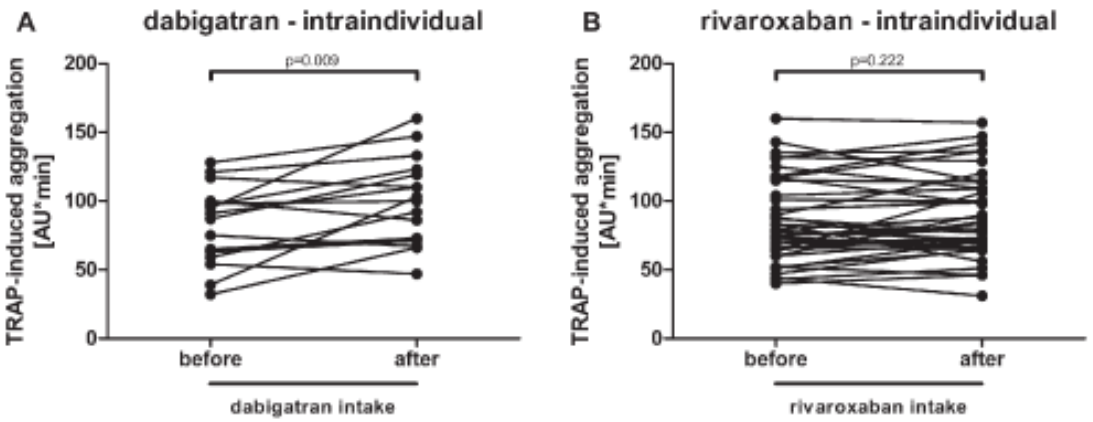
Etude 2

Thrombosis Research

TRAP-induced platelet aggregation is enhanced in cardiovascular patients receiving dabigatran

Christoph B. Olivier [a,*], Patrick Weik [a], Melanie Meyer [a], Susanne Weber [b], Nathaly Anto-Michel [a], Philipp Diehl [a], Qian Zhou [a], Ulrich Geisen [c], Christoph Bode [a], Martin Moser [a]

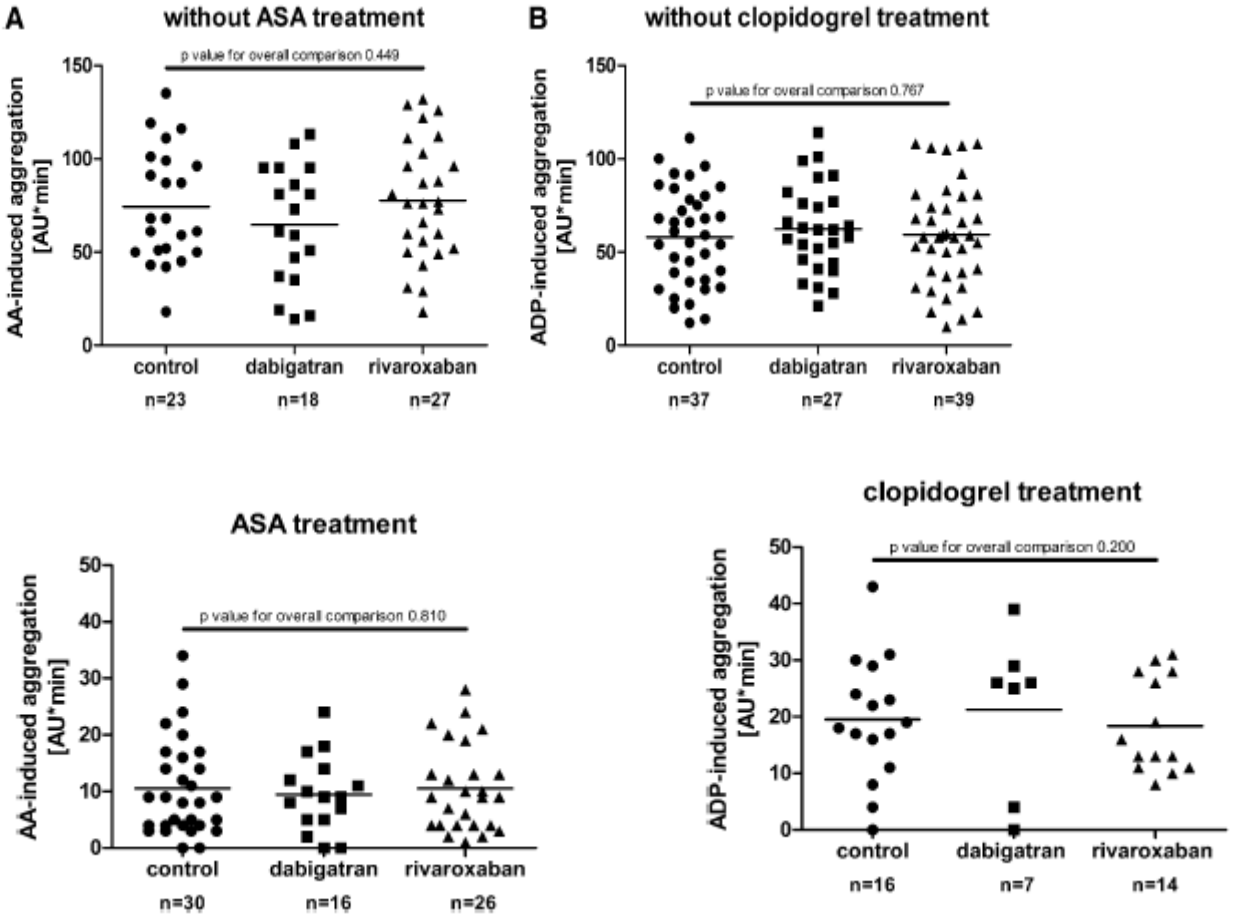




Etude 3

Dabigatran and rivaroxaban do not affect AA- and ADP-induced platelet aggregation in patients receiving concomitant platelet inhibitors.

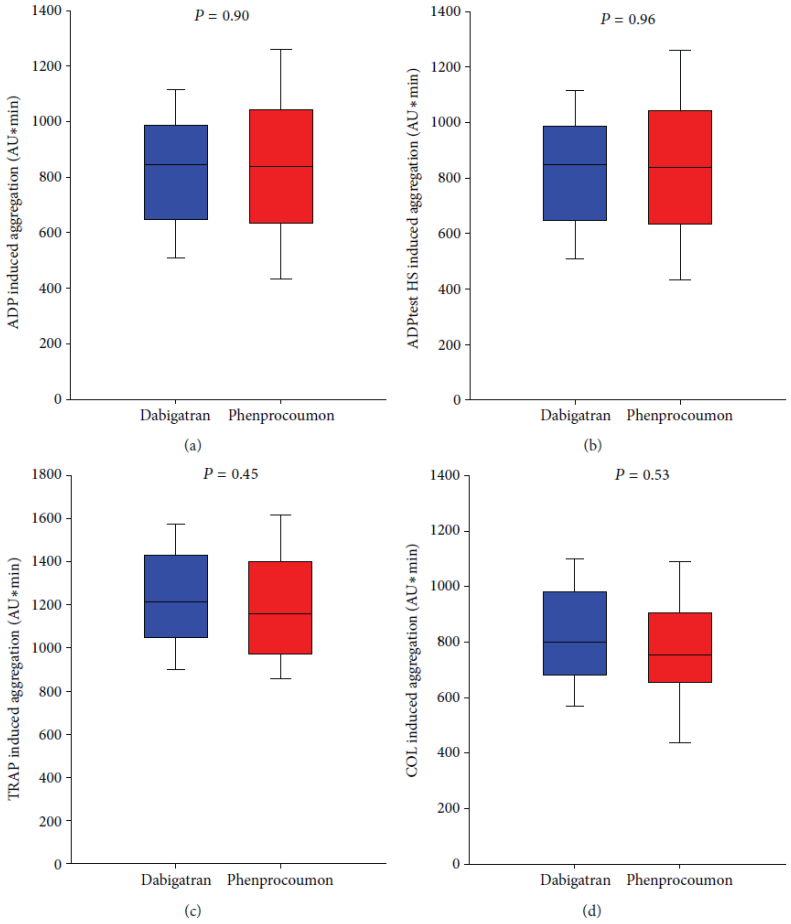
Olivier CB, Weik P, Meyer M, Weber S, Diehl P, Bode C, Moser M, Zhou Q. J Thromb Thrombolysis. 2016



Etude 4

Impact of Dabigatran versus Phenprocoumon on ADP Induced Platelet Aggregation in Patients with Atrial Fibrillation with or without Concomitant Clopidogrel Therapy (the Dabi-ADP-1 and Dabi-ADP-2 Trials)

Amadea M. Martischnig,[1] Julinda Mehilli,[2,3] Janina Pollak,[1] Tobias Petzold,[2] Anette K. Fiedler,[1] Katharina Mayer,[1] Stefanie Schulz-Schüpke,[1] Dirk Sibbing,[2,3] Steffen Massberg,[2,3] Adnan Kastrati,[1,3] and Nikolaus Sarafoff[2]



Conclusion
quel traitement après un an ?

Pas de preuve clinique ?

Pas de preuve biologique

Un nouveau test pour explorer aspect AAP des NOAC

Thrombosis Research

Regular Article

Global Thrombosis Test (GTT) can detect major determinants of haemostasis including platelet reactivity, endogenous fibrinolytic and thrombin generating potential

J. Yamamoto [a], N. Inoue [b], K. Otsui [b], H. Ishii [c], D.A. Gorog [d,e,*]

Back-up

- Pr P quel est votre opinion?

L'hypothèse de départ est fausse ….

Journal of the American College of Cardiology

Published by Elsevier Inc.

EDITORIAL COMMENT

Antithrombotic Regimens in Patients With Atrial Fibrillation and Coronary Disease

Optimizing Efficacy and Safety*

Steven M. Markowitz, MD

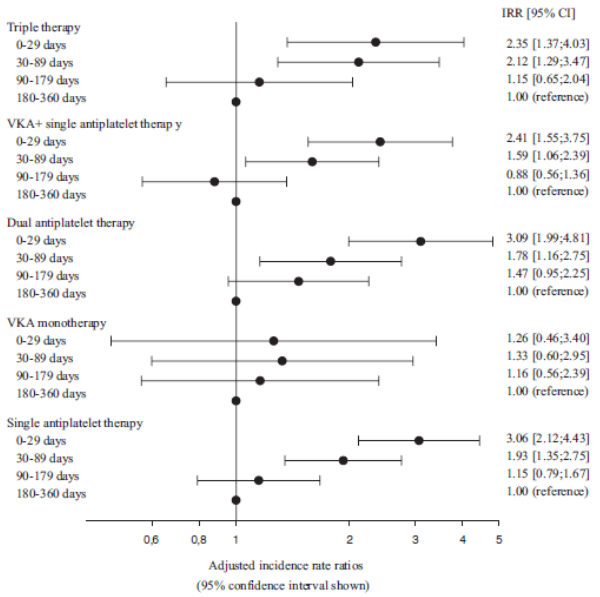
New York, New York

Oral Anticoagulation and Antiplatelets in Atrial Fibrillation Patients After Myocardial Infarction and Coronary Intervention

Morten Lamberts, MD,*† Gunnar H. Gislason, MD, PhD,*‡§ Jonas Bjerring Olesen, MD,* Søren Lund Kristensen, MD,* Anne-Marie Schjerning Olsen, MD,* Anders Mikkelsen, MB,* Christine Benn Christensen, MD,* Gregory Y. H. Lip, MD,† Lars Køber, MD, DMS,|| Christian Torp-Pedersen, MD, DMS,*¶ Morten Lock Hansen, MD, PhD*

Hellerup, Copenhagen, and Aalborg, Denmark; and Birmingham, United Kingdom

- Etude retrospective basée sur le codage
- Pas de description des DES
- AVK + SAP perdant (A ou C)
- Mais AVK + clopidogrel vainqueur…



	Dual Therapy						Triple Therapy	
	Aspirin + Clopidogrel		OAC + Aspirin		OAC + Clopidogrel		OAC + Aspirin + Clopidogrel	
	n (IR)	HR (95% CI)	n (IR)	HR (95% CI)	n (IR)	HR (95% CI)	n (IR)	HR (95% CI)
Benefit outcomes								
MI/coronary death (n = 2,255)	484 (21.3)	Reference	230 (17.7)	0.78 (0.66–0.91)	36 (9.6)	0.56 (0.40–0.79)	129 (16.2)	0.83 (0.68–1.00)
Ischemic stroke (n = 680)	151 (6.3)	Reference	75 (5.6)	0.81 (0.61–1.08)	11 (2.8)	0.51 (0.28–0.95)	34 (4.1)	0.67 (0.46–0.98)
All-cause mortality (n = 2,356)	430 (17.5)	Reference	215 (15.6)	0.91 (0.77–1.08)	28 (7.1)	0.54 (0.35–0.76)	76 (8.9)	0.61 (0.47–0.77)
Coronary death or fatal ischemic stroke (n = 605)	130 (5.3)	Reference	54 (3.9)	0.78 (0.57–1.08)	9 (1.2)	0.63 (0.32–1.24)	21 (2.5)	0.58 (0.36–0.92)
Coronary death or fatal ischemic stroke or fatal bleeding (n = 671)	133 (5.4)	Reference	64 (4.6)	0.92 (0.68–1.24)	11 (2.8)	0.74 (0.40–1.37)	27 (3.2)	0.72 (0.48–1.09)
Safety outcomes								
Bleeding (n = 769)	166 (6.9)	Reference	129 (9.7)	1.44 (1.14–1.83)	41 (10.9)	1.63 (1.15–2.30)	117 (14.3)	2.08 (1.64–2.65)
Fatal bleeding (n = 78)	6 (0.3)	Reference	11 (0.8)	3.90 (1.43–10.66)	2 (0.5)	2.73 (0.54–13.70)	8 (0.9)	4.80 (1.64–14.02)
Fatal/nonfatal intracranial bleeding (n = 89)	9 (0.4)	Reference	15 (1.1)	2.98 (1.28–6.92)	5 (1.3)	3.80 (1.26–11.44)	12 (1.5)	4.05 (1.69–9.71)
Fatal/nonfatal GI bleeding (n = 320)	70 (2.9)	Reference	53 (4.0)	1.36 (0.94–1.96)	13 (3.5)	1.24 (0.68–2.25)	47 (5.7)	1.99 (1.37–2.90)
Fatal bleeding defined as death within 30 days (n = 399)	75 (3.1)	Reference	75 (5.3)	1.51 (1.09–2.11)	13 (3.5)	1.23 (0.68–2.22)	44 (5.4)	1.85 (1.27–2.70)

Values are number of events (n), and incidence rates (IR) are events per 100 person-years within 1 year.
CI = confidence interval; GI = gastrointestinal; HR = hazard ratio; other abbreviations as in Table 1.