CARDIOLOGIE
• CHU •
CLERMONT
FERRAND

APPAC
ACTUALISATIONS
ET PERSPECTIVES
EN PATHOLOGIE
CARDIOVASCULAIRE

Les études marquantes depuis 12 mois

Pascal Motreff

8 Juin 2017

Conflits d'intérêts

Consultant : Abbott Vascular, St Jude Medical, Terumo, Biotronik

Cardiologie interventionnelle 2016-2017

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Etudes Marquantes = 2 pièges

- Sélection arbitraire
- Interprétation subjective

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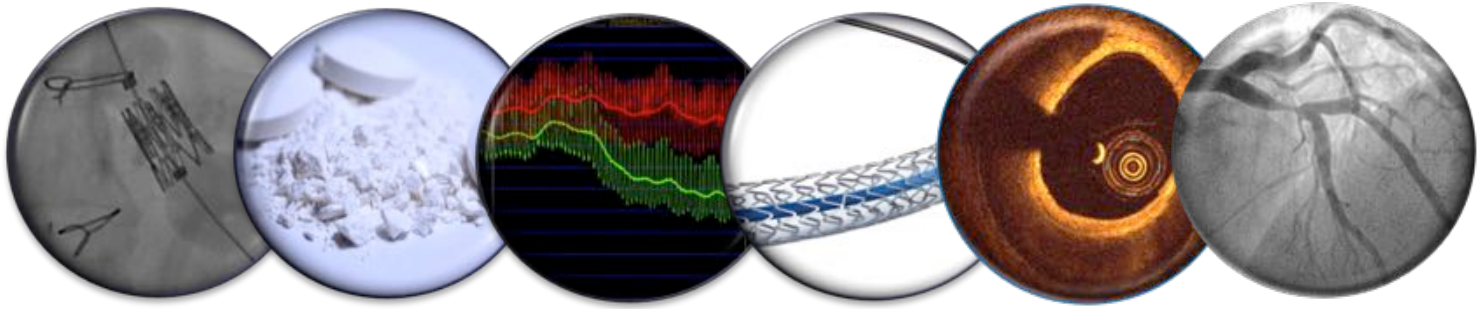
- Recommandations
- Structurel
- Stents et Stenting
- Outils diagnostic
- Pharmacologie
- Maladie coronaire



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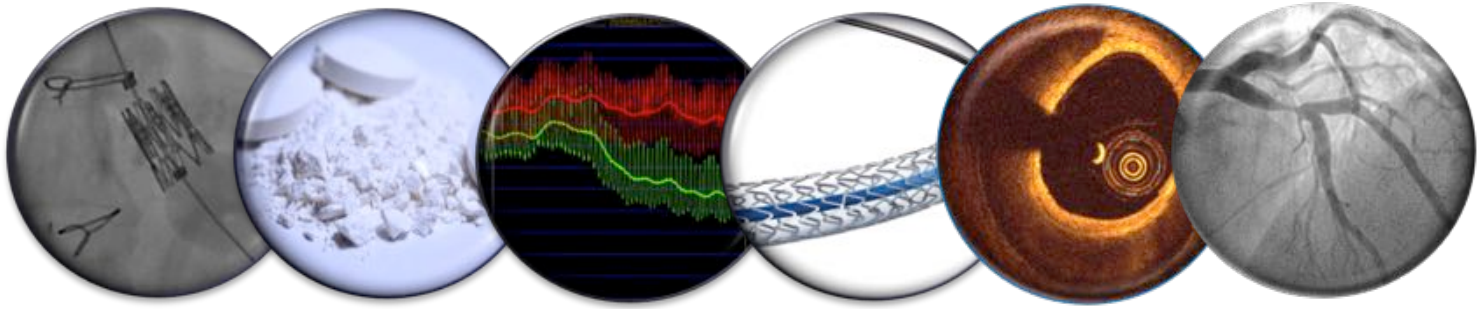

Recommandations

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Guidelines published in 2016

- **Cardio-Oncology (Position Paper)**
  Chairpersons: Jose Luis Zamorano & Patrizio Lancellotti
- **Dyslipidaemias**
  Chairpersons: Ian Graham & Alberico Catapano
- **CVD Prevention**
  Chairpersons: Massimo Piepoli & Arno W. Hoes
- **Atrial Fibrillation**
  Chairpersons: Paulus Kirchhof & Stefano Benussi
- **Heart Failure**
  Chairpersons: Piotr Ponikowski & Adriaan Voors

Publications planned in 2017

- **AMI-STEMI**
  Chairpersons: Stefan James & Borja Ibanez
- **Focused Update** on Dual Anti-platelet Therapy
  Chairperson: Marco Valgimigli
- **Peripheral Artery Disease**
  Chairpersons: Victor Aboyans & Jean-Baptiste Ricco
- **Valvular Heart Disease**
  Chairpersons: Jose Luis Zamorano, Helmut Baumgartner & Volkmar Falk

- **SCA ST+**
- **Double AAP**

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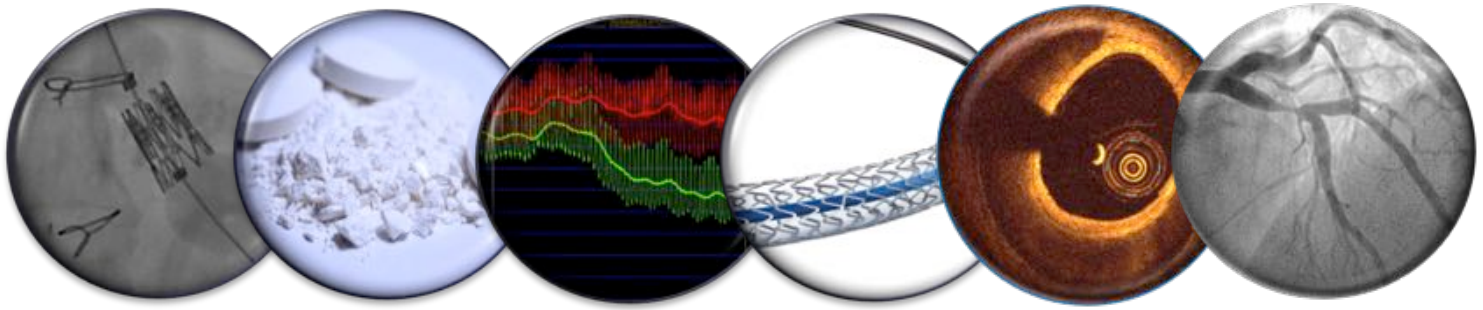


PARTNER 2

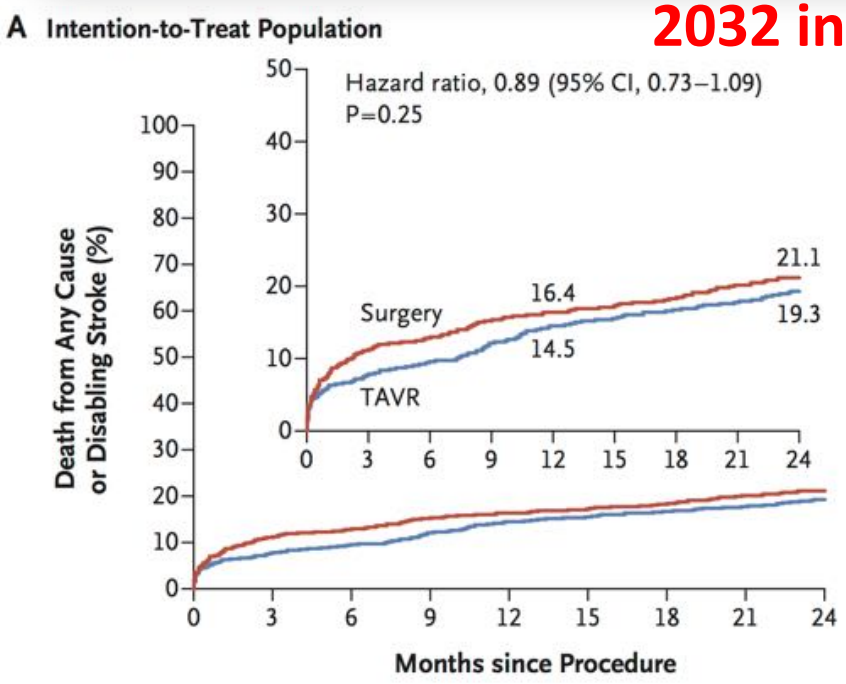
APPAC ACTUALISATIONS ET PERSPECTIVES EN PATHOLOGIE CARDIOVASCULAIRE

Leon MB, New Engl J Med 2016

The NEW ENGLAND JOURNAL of MEDICINE

Transcatheter or Surgical Aortic-Valve Replacement in Intermediate-Risk Patients

2032 intermediate-risk patients randomized



CONCLUSIONS

In intermediate-risk patients, TAVR was similar to surgical aortic-valve replacement with respect to the primary end point of death or disabling stroke.

Edwards Sapien XT ®

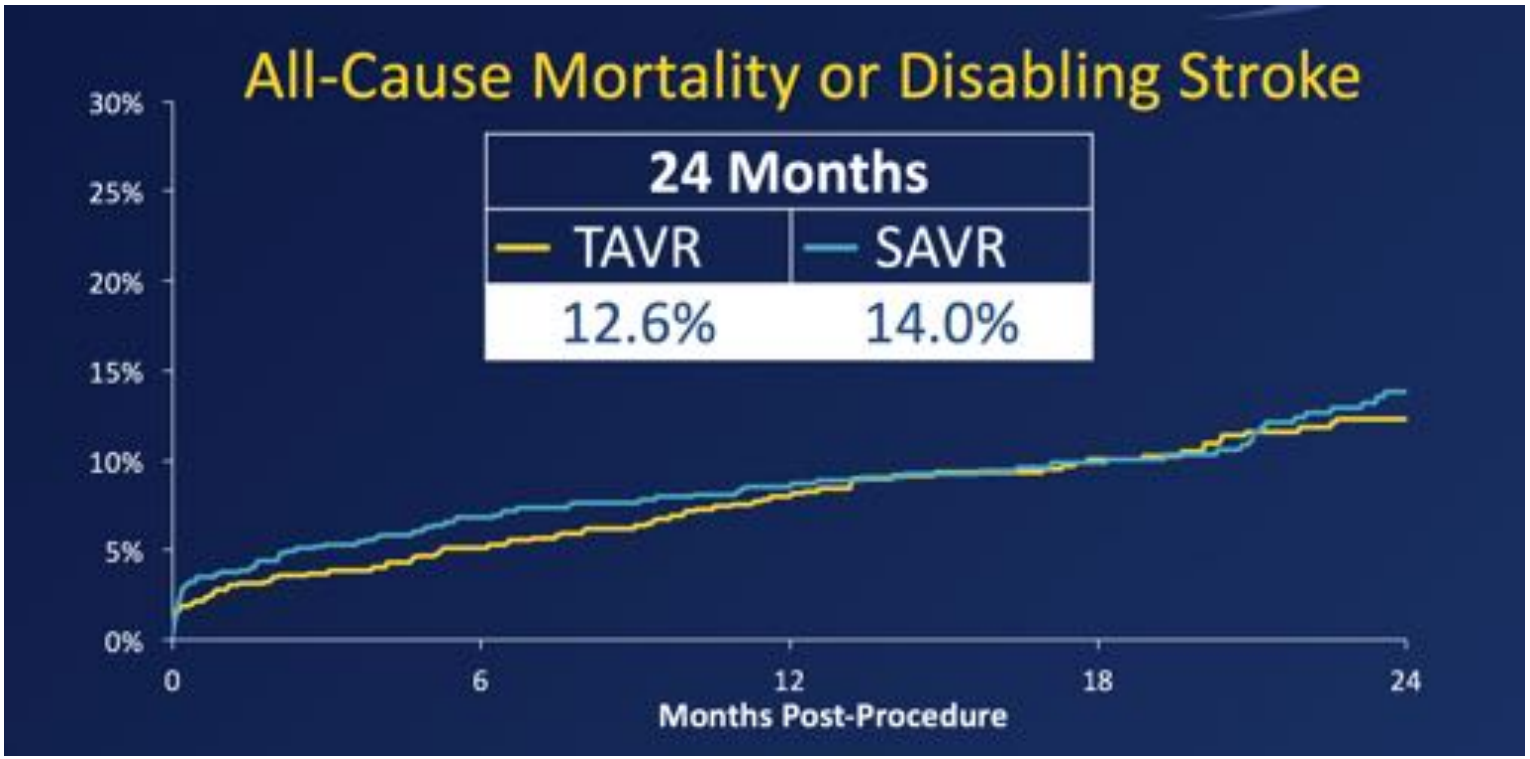
SURTAVI

Reardon MJ, New Engl J Med 2017

Surgical or Transcatheter Aortic-Valve Replacement in Intermediate-Risk Patients

1746 pts, 87 centres, Risques intermédiaires

CoreValve / Evolute R vs Chirurgie = **NON INFERIEUR**



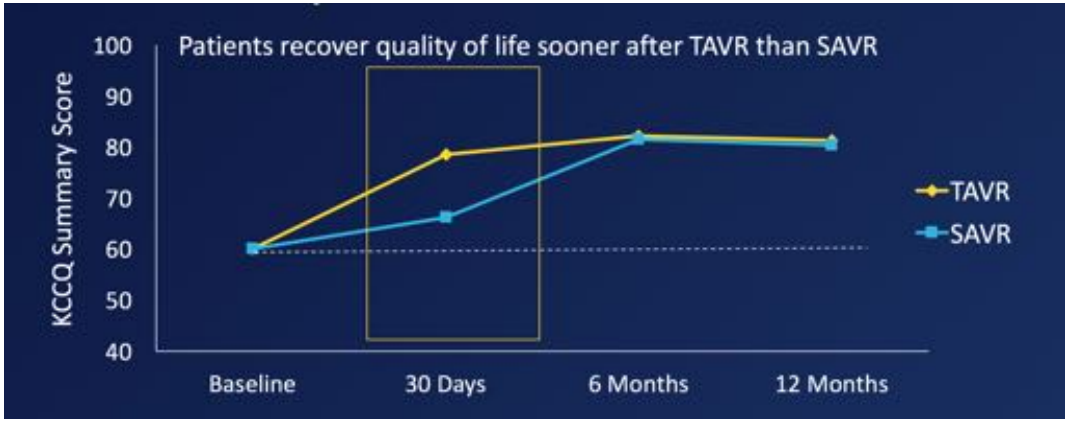
CoreValve® EvoluteR®

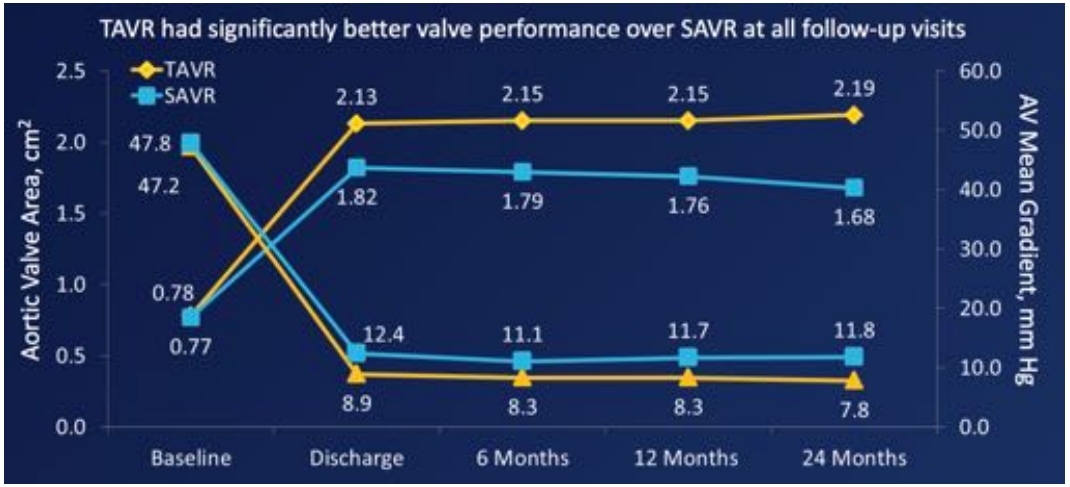
SURTAVI

Reardon MJ, New Engl J Med 2017

Chirurgie = plus d'AVC, d'insuffisance rénale, de FA, de transfusions

TAVI = plus de fuite résiduelle, de Pace Maker



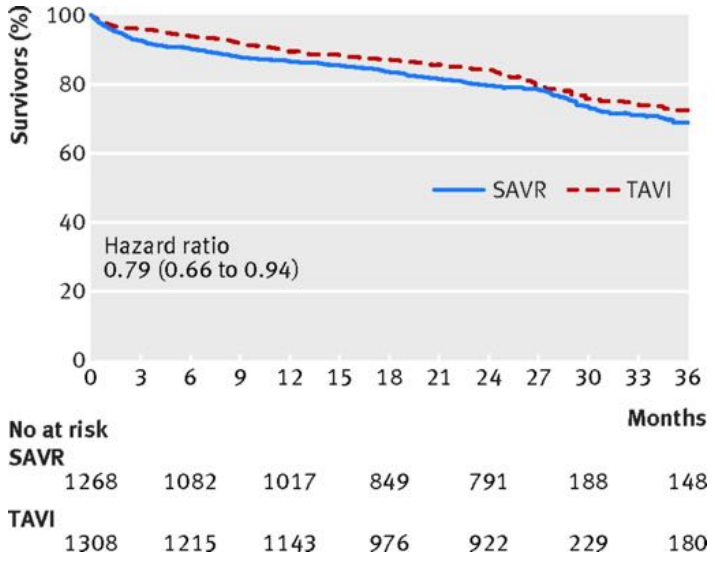


- **Qualité de vie = idem a 2 ans, récupération plus rapide avec TAVI**
- **Meilleurs résultats hémodynamiques avec TAVI**

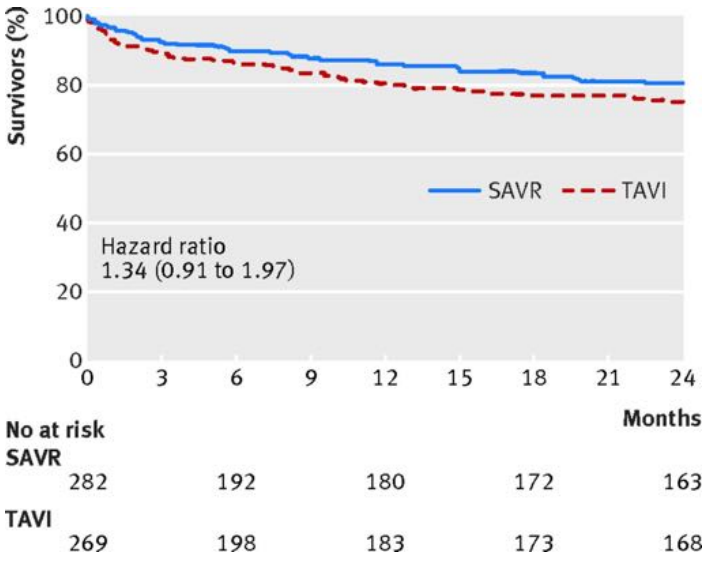
TAVI in low and intermediate risk

Low and intermediate risk : systematic review and meta-analysis
Siemieniuk RA, BMJ 2016

Trans-femoral TAVI



Trans-apical TAVI



TAVI vs SAVR for treatment of severe aortic stenosis : a meta-analysis of randomized trials *Siontis GCM, Eur Heart J 2016*

TAVI

Long term performance of TAVI

Washington TCT 2016

Partner 1 Trial, 5 years follow -up

Edwards Sapien Valves Demonstrate Excellent Durability In 5-Year Echo Study

Quality of life after TAVI

Washington TCT 2016

Partner 2, Quality of life

Compared with SAVR, **TAVR improved QOL at 1 month**
(significant improvement only in the TransFemoral subgroup (*P* <.001)
QOL scores were similar among TAVR and SAVR patients at 12 and 24 months

SENTINEL

Cerebral Embolic Protection During TAVR

Latib A, J Am Coll Cardiol 2016

363 TAVR

- Safety confirmed
- Sentinel-Trial fails to meet overall primary efficacy endpoint

Despite the finding of **histopathologic debris within filters in 99% of pts**, which included thrombus, calcification, valve tissue, artery wall and foreign material, all strokes at 30 days were not significantly different in the device and safety arms versus the control arm (5.6% vs. 9.1%, P=0.25).

Thrombose TAVI

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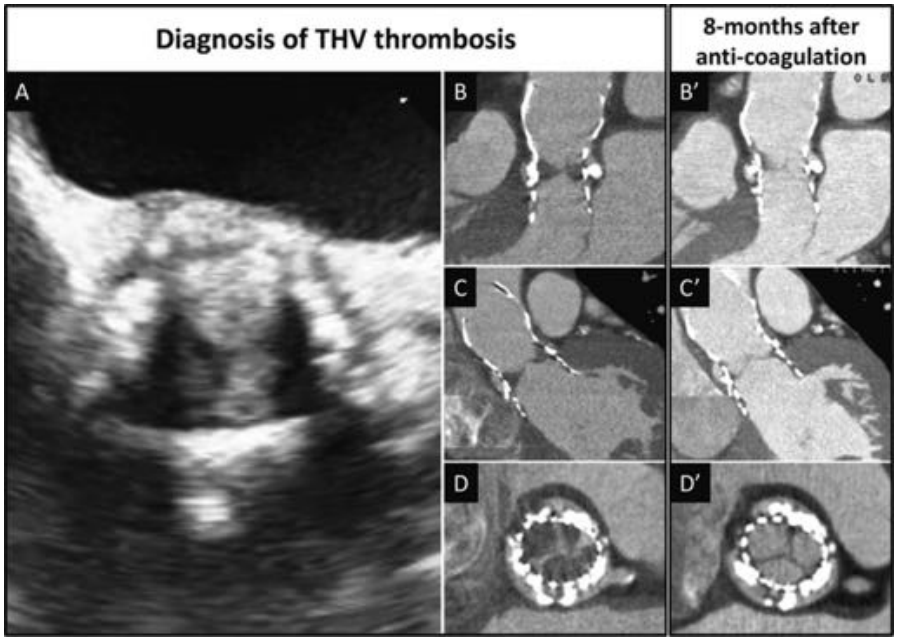
Transcatheter Aortic Valve Thrombosis: Incidence, Predisposing Factors, and Clinical Implications

Hansson NC, J Am Coll Cardiol 2016

incidence : 7%



Etudes en cours : AVK, AOD, DAPT…

(ARTE, AUREA, POPular-TAVI, AVATAR, GALILEO, ATLANTIS)

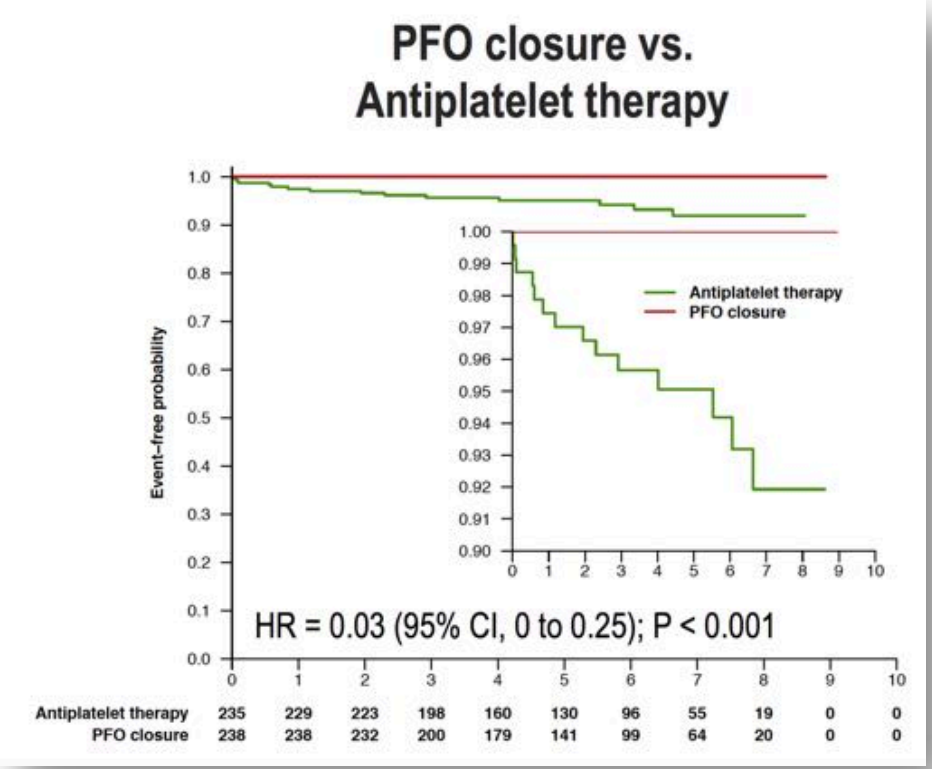
CLOSE

663 pts randomisés

Fermeture PFO vs AAP seul

Aucune récidive vs 14 récidives

JL Mas, ESOC 2017



- PFO closure plus long-term antiplatelet therapy reduced the risk of stroke recurrence in patients 16 to 60 years old with cryptogenic stroke and PFO with atrial septal aneurysm or PFO with large shunt, compared with antiplatelet therapy alone.

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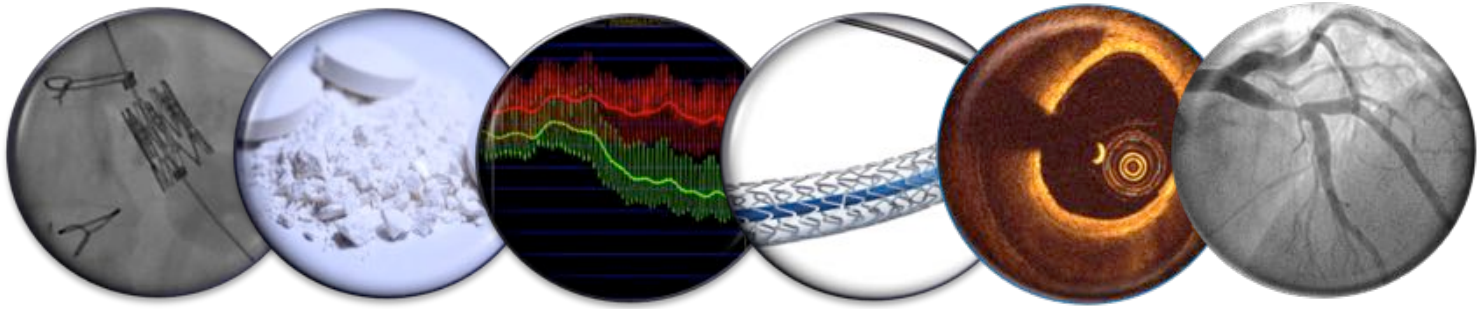


Bio-RESORT

Von Birgelen C, Lancet 2016

Very thin strut biodegradable polymer everolimus-eluting and sirolimus-eluting stents versus durable polymer zotarolimus-eluting stents in allcomers with coronary artery disease (BIO-RESORT): a three-arm, randomised, non-inferiority trial

Comparison of 3 types of Drug Eluting Stent :
3514 all comers pts randomized (70% ACS)

ORSIRO
SYNERGY
RESOLUTE INTEGRITY

Non-inferiority of the everolimus-eluting stents and sirolimus-eluting stents compared with zotarolimus-eluting stents was confirmed

12 months follow-up :

5% MACE (cardiac death, MI, TVR)

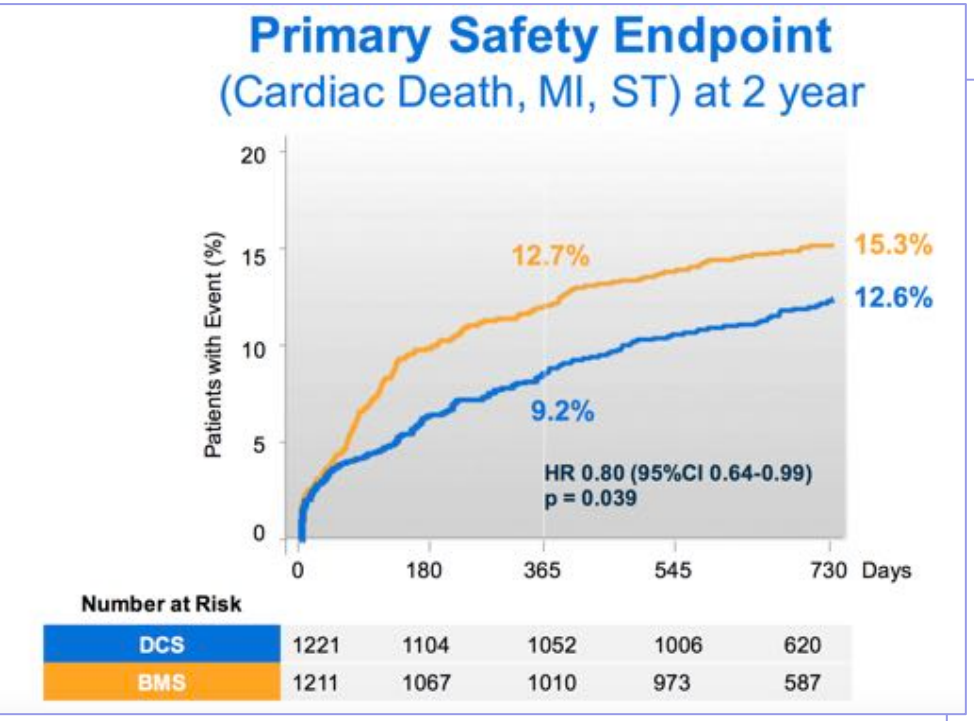
0,3% stent thrombosis

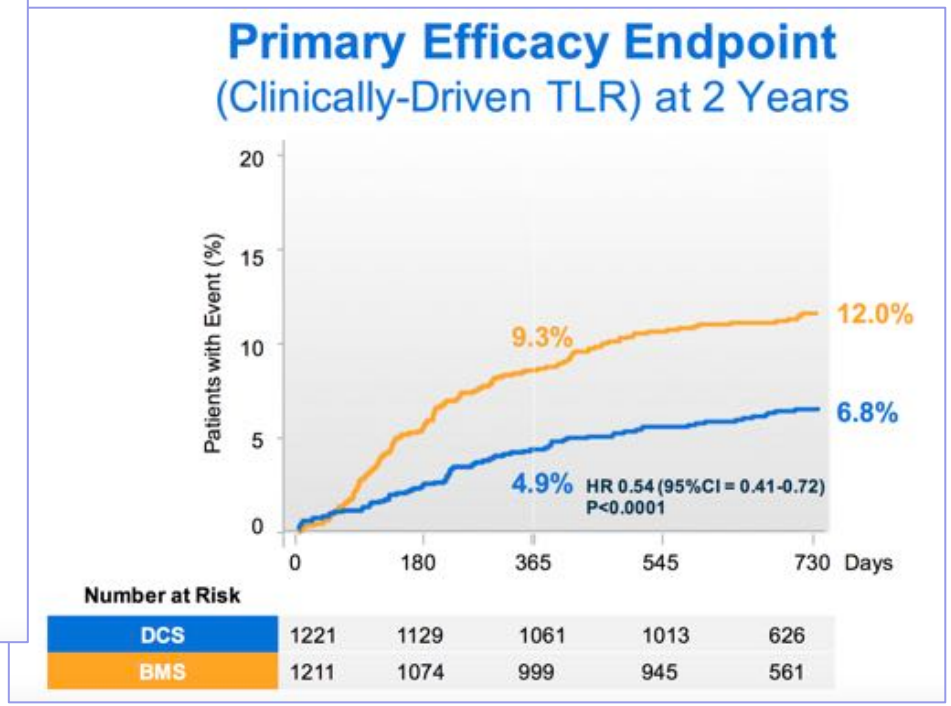
LEADERS Free

Kumbhani DJ, J Am Coll Cardiol 2016

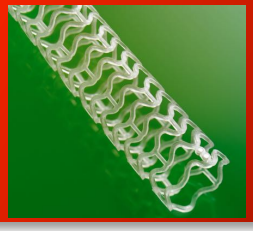
Safety, efficacy of polymer-free drug-coated stent maintained at 2 years

The LEADERS FREE trial showed that clinical outcomes following biolimus A9 DCS implantation are superior to BMS in patients with high bleeding risk and who are able to take only 1 month of dual antiplatelet therapy **(n=2466 pts)**

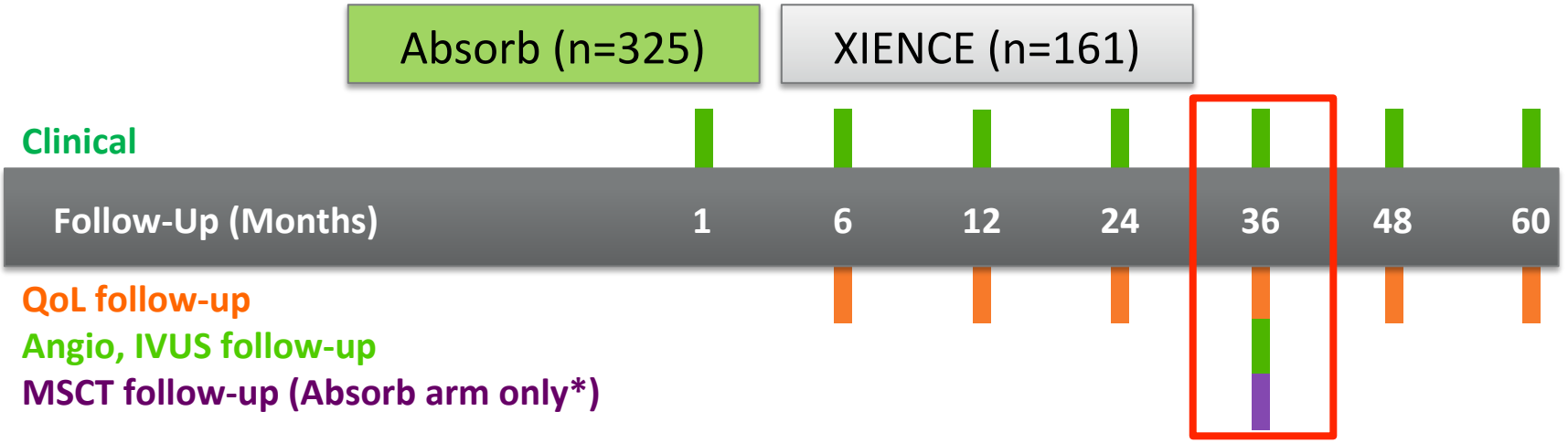




ABSORB 2



Design	Randomized 2:1 , Absorb BVS vs. XIENCE, in 501 patients, in 46 sites in Europe & New Zealand



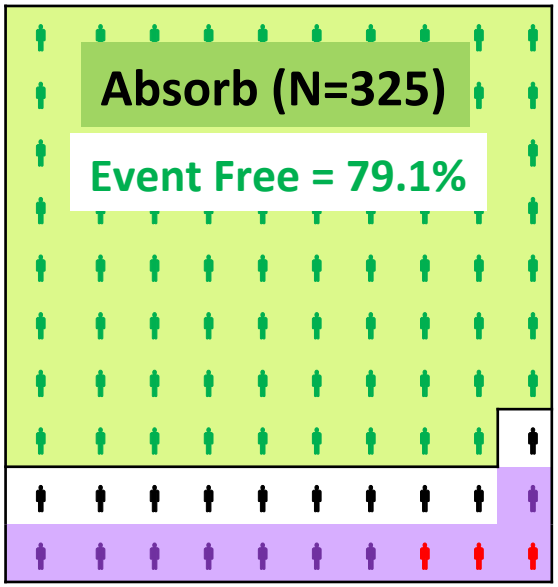
The trial did not meet its mechanistic **co-primary endpoints** of :

- **superior vasomotor reactivity** because Xience showed unexpected vasomotion.
- non-inferior **late luminal loss** with respect to Xience that was found to have lower late luminal loss than Absorb.

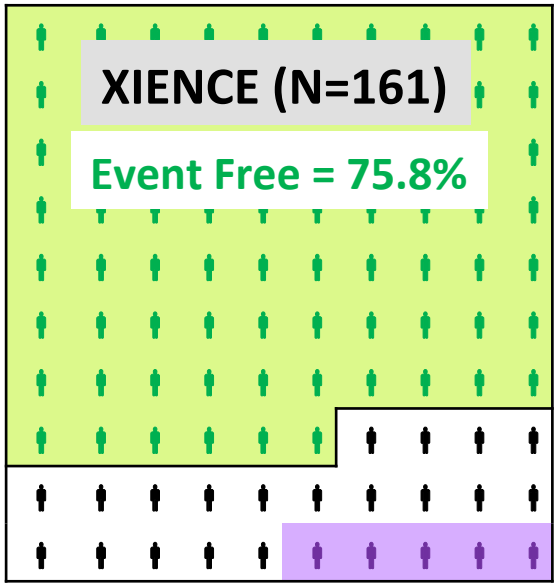
Serruys PW, Lancet 2016

ABSORB 2

ABSORB2 at 3 years, Clinical Outcomes



PoCE= 20.9%
DoCE= 10.5%
Def/Prob ST = 2.8%



PoCE= 24.2%
DoCE= 5.0%
Def/Prob ST = 0.0%

Scaffold or stent thrombosis	Absorb 335 patients	Xience 166 patients	p value
Definite	2.5% (8)	0.0% (0)	0.06
Acute (0–1 day)	0.3% (1)	0.0% (0)	1.0
Sub-acute (2–30 days)	0.3% (1)	0.0% (0)	1.0
Late (31–365 days)	0.0% (0)	0.0% (0)	1.0
Very late (>365 days)	1.8% (6)	0.0% (0)	0.19

AIDA

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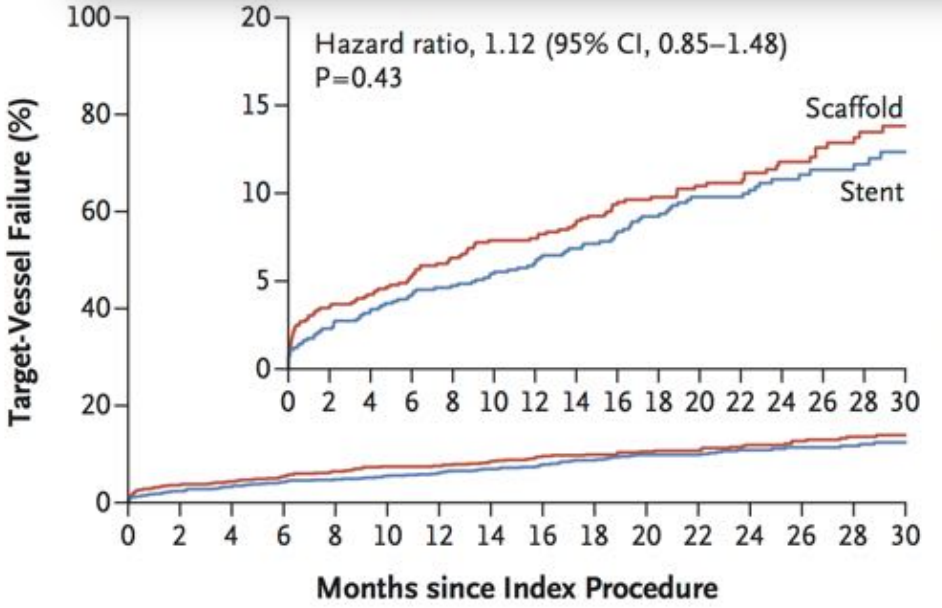
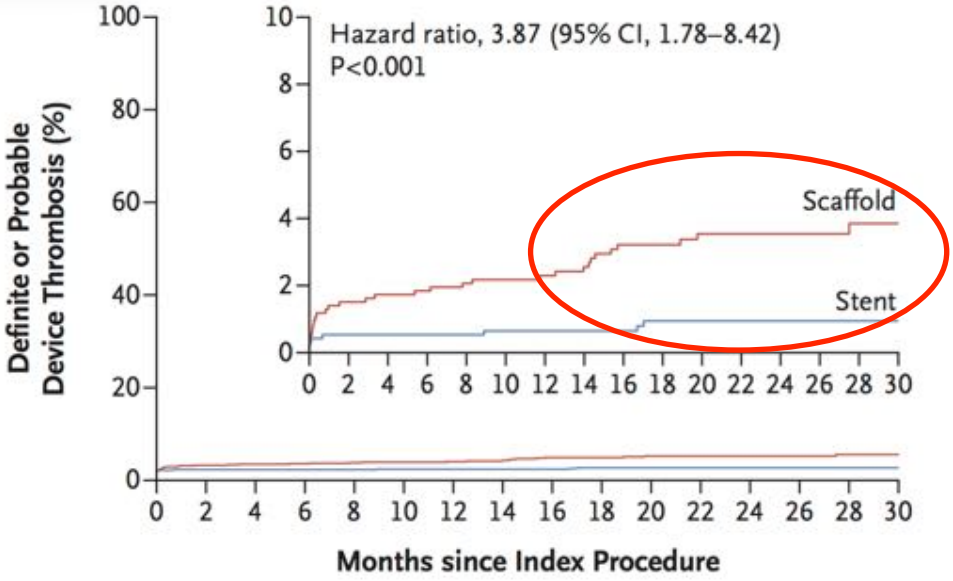
Bioresorbable Scaffolds versus Metallic Stents in Routine PCI

Wykrzykowska J, N Engl J Med 2017





<u>1845 pts randomisés (Absorb vs DES)</u>

Pas de différence sur critère principal (TVF), sur mortalité

Risque de **thrombose tardive x 4** (31 vs 8)

ABSORB 3

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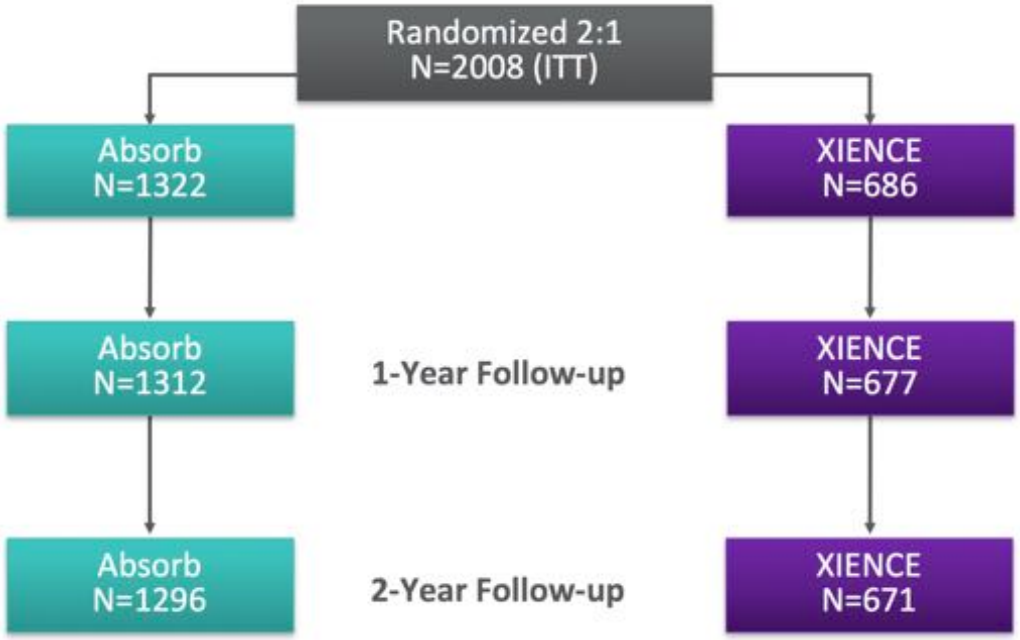
Résultats **ABSORB III** à 2 ans :

Ellis S, ACC 2017

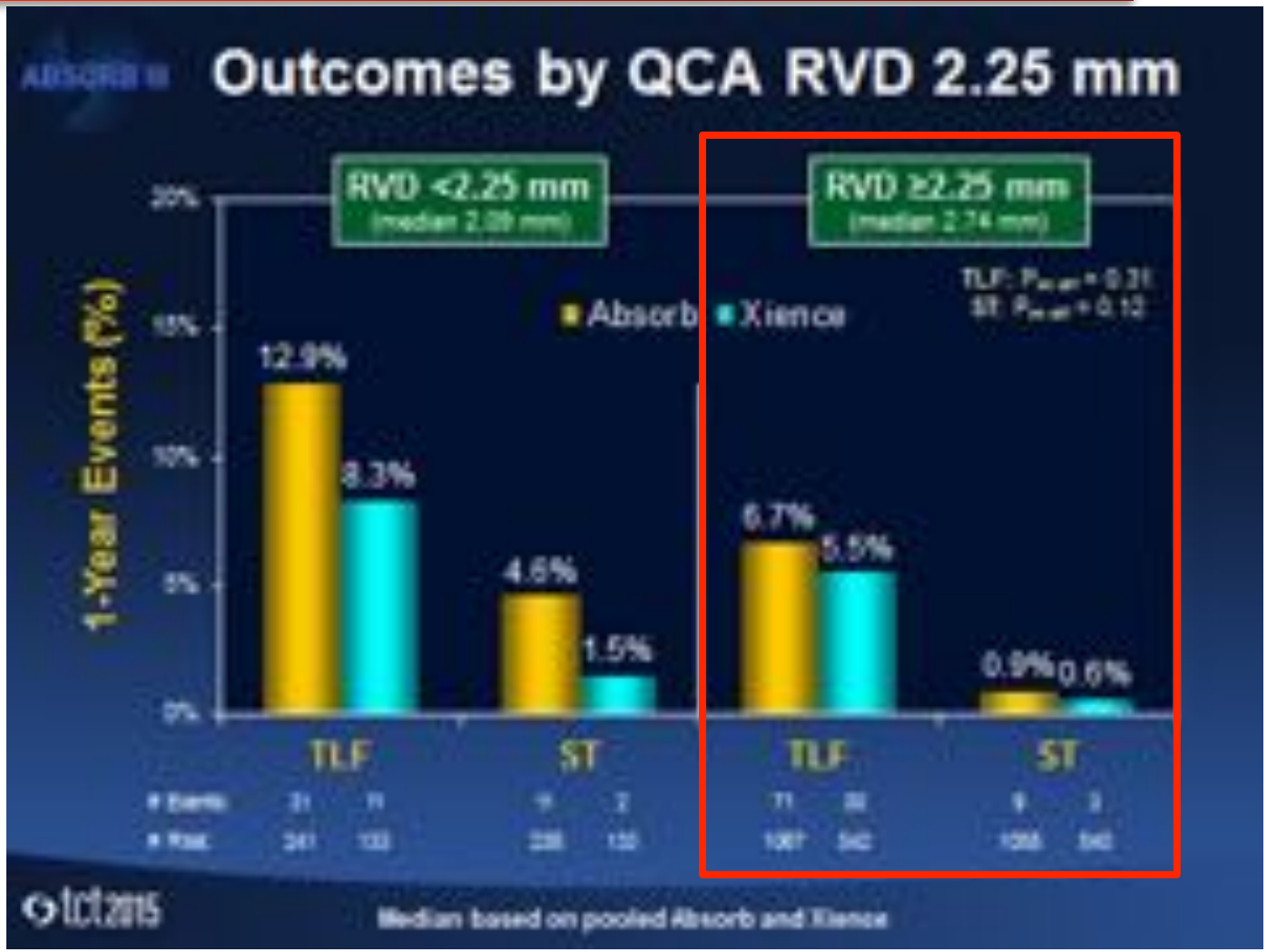


	Absorb (N=1322)	XIENCE (N=686)
TLF	7.8% (102)	6.1% (41)
Cardiac Death	0.6% (8)	0.1% (1)
TV-MI	6.0% (79)	4.6% (31)
ID-TLR	3.0% (40)	2.5% (17)
ST (Def/Prob)	1.5% (20)	0.7% (5)

Non infériorité sur critère principal

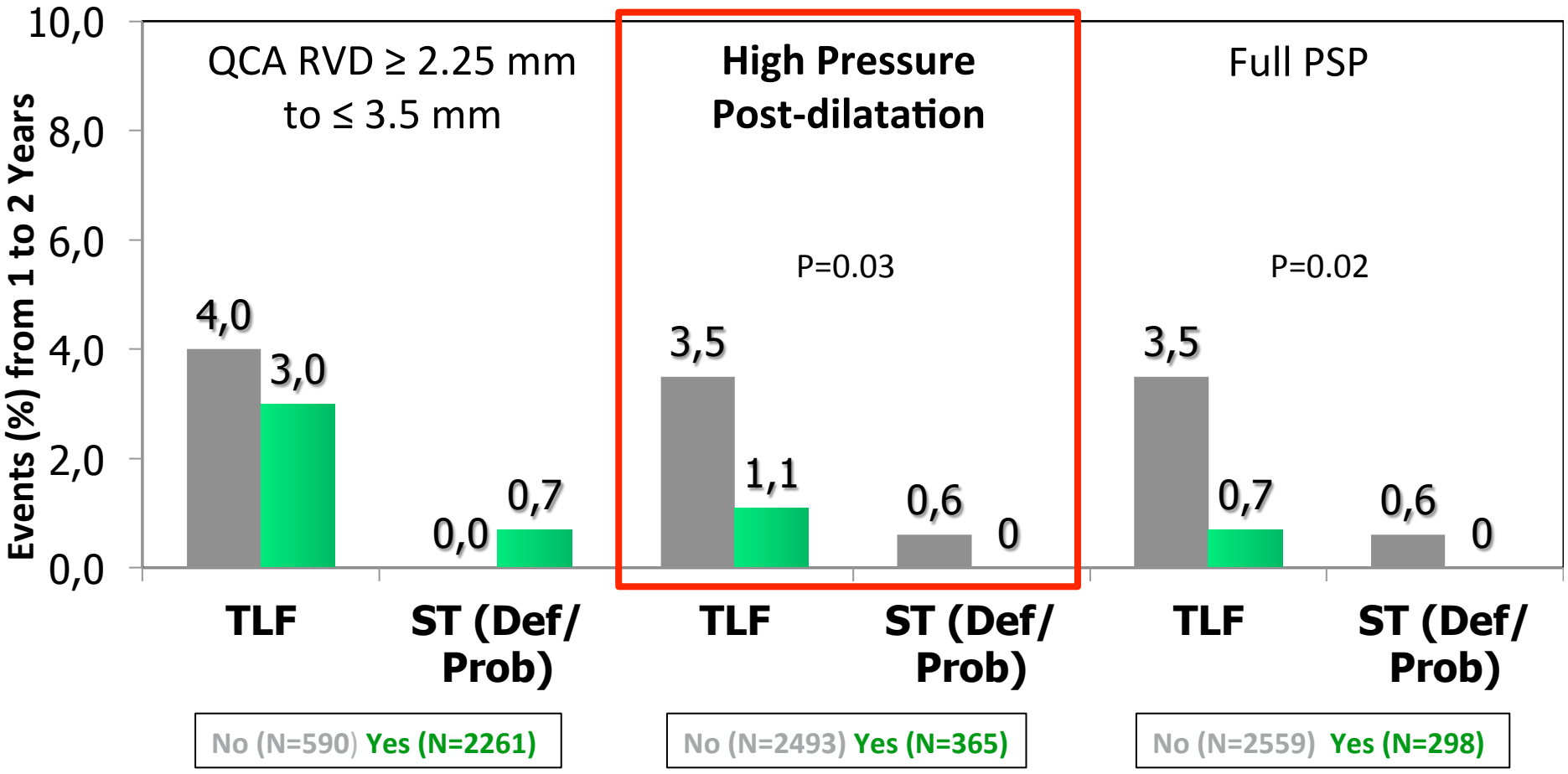
Attention +++ : **respect PSP, exclure petits vaisseaux**

ABSORB 3



Attention +++ : **respect PSP, exclure petits vaisseaux**

Recommandations ABSORB



Based on patient population treated with Absorb BVS **in ABSORB II, ABSORB III, ABSORB China, ABSORB Japan and ABSORB EXTEND**

Ellis S, ACC 2017

France-ABSORB

2072 pts (87 centres) , 2818 BVS

Koning R, Euro PCR 2017

In-Hospital and 1 year MACE

F/U, n=2039 (98.4%)

	in-hospital (n=2072) N (%)	Overall at 1 year ($n_{followed}$=2039) N (%)
Total death *Death CV* *Death non CV*	2 (0.1) *2 (0.1)*	14 (0.7) *12 (0.6)* *2 (0.1)*
Non fatal MI	17 (0.8)	45 (2.2)
Any TLR	9 (0.4)	46 (2.2)
At least 1 MACE:	19 (0.9)	81 (3.9)

France-ABSORB

2072 pts (87 centres) , 2818 BVS

Koning R, Euro PCR 2017

BVS Stent Thrombosis

	Overall 1 Year ($n_{followed}$=2039) N (%)
BVS Stent thrombosis	**33 (1.6)**
Definite	25
Probable	6
Possible	2
Acute	11
Subacute	11
Late	11

In-Hospital: 15 (0.7%)

Registres ABSORB

Euro PCR 2017

	France	Allemagne Autriche	Italie	GB	Suède
	France Absorb	GABI-Registry	IT-Disappears	Absorb-UK-Registry	SCAAR
n=	2072	3196	1002	1005	460
Thrombose à J30	**0.7% ***	**0.9%**	**0.7%**	**0.9%**	
Thrombose à 1 an	**1.6%**		**0.9%**	**1.7%**	**1.5%**

* hospitalière

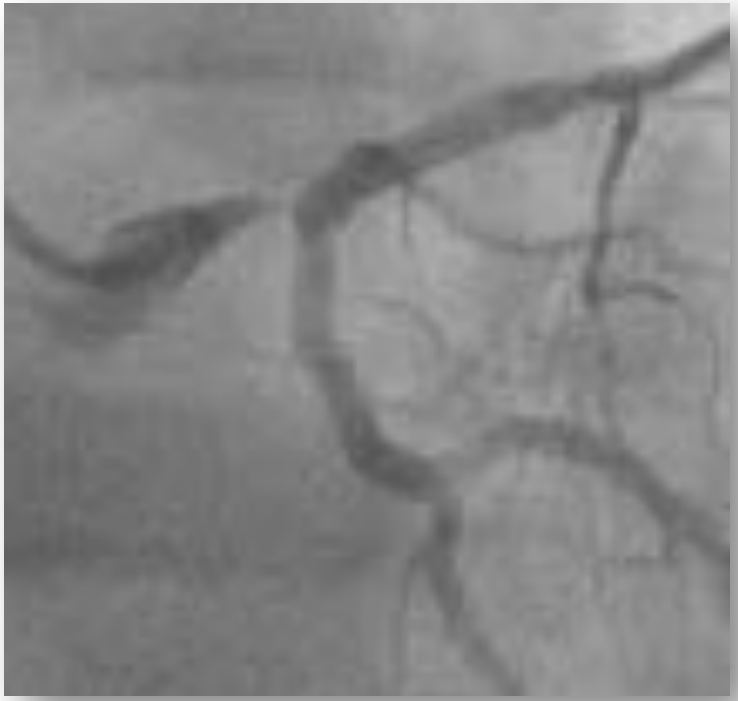
PCI & unprotected LEFT MAIN

ESC Guidelines 2014, Eur Heart J

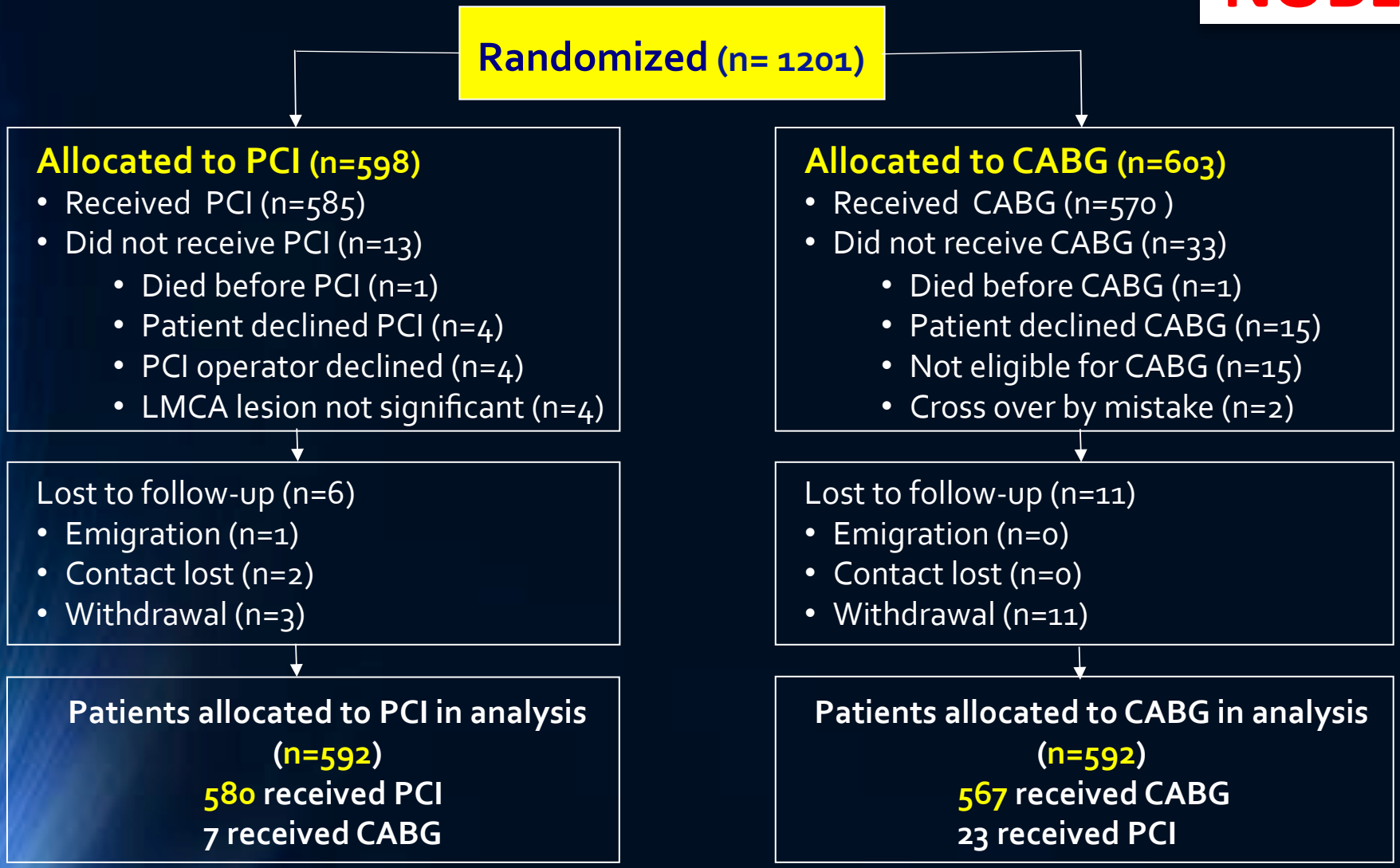
Recommendations according to extent of CAD	CABG		PCI	
	Class[a]	Level[b]	Class[a]	Level[b]
Left main disease with a SYNTAX score ≤ 22.	I	B	I	B
Left main disease with a SYNTAX score 23–32.	I	B	IIa	B
Left main disease with a SYNTAX score >32.	I	B	III	B

NOBLE *Mäkikallio T, Lancet 2016*

EXCEL *Stone GW, N Engl J Med 2016*



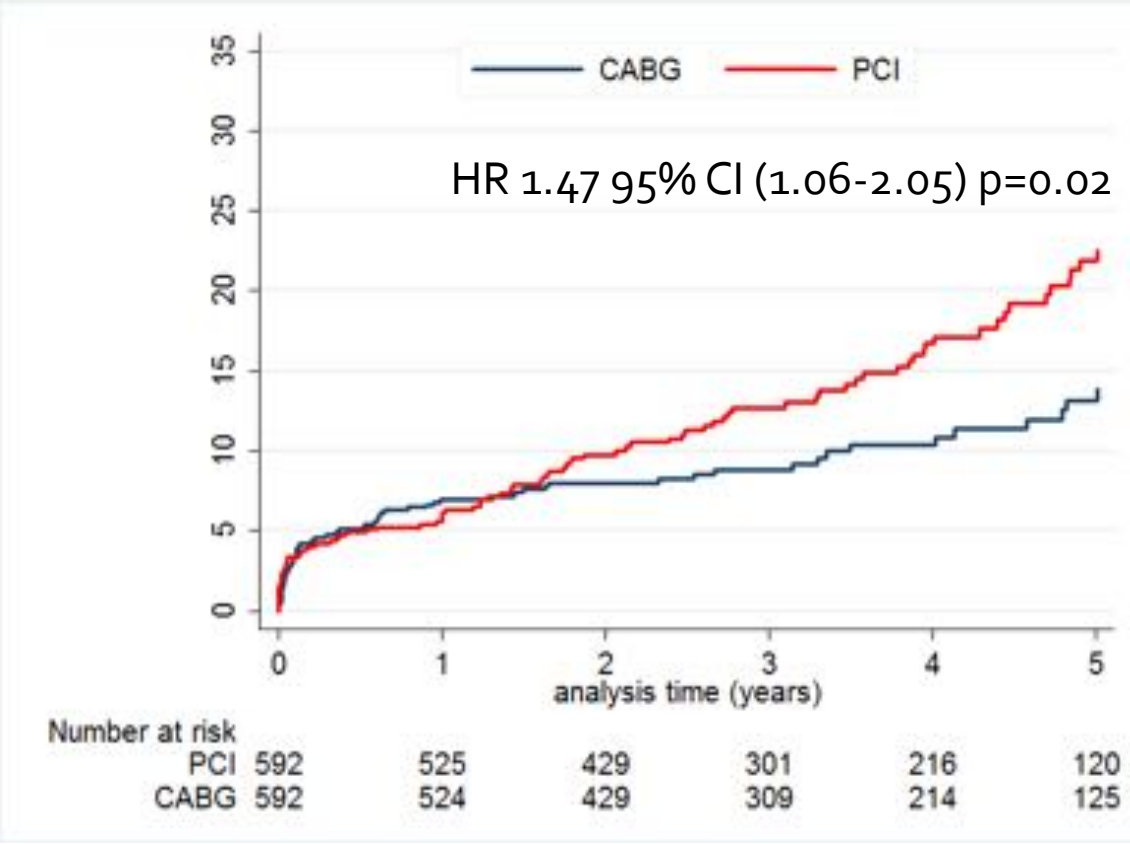
NOBLE



Mäkikallio T, Lancet 2016

NOBLE

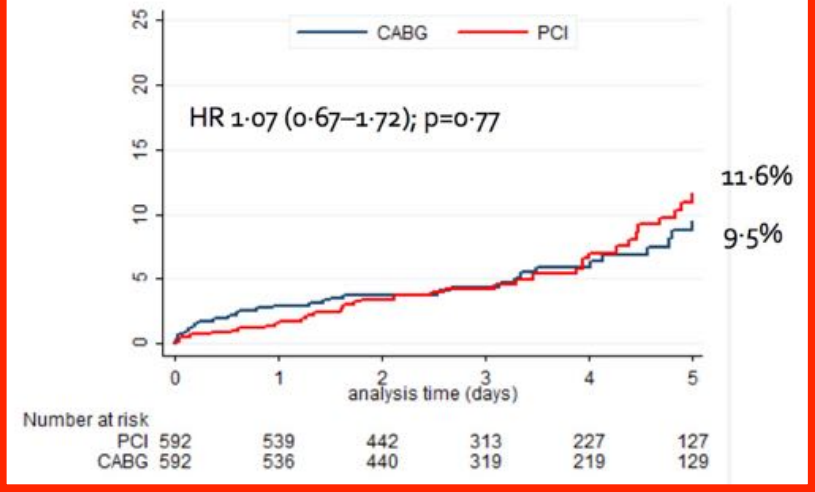
Results
MACCE: Death, MI, stroke



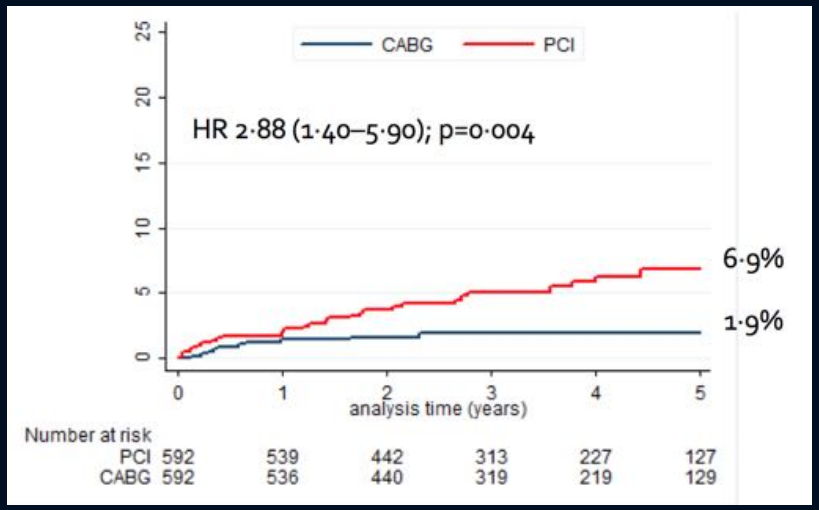
Mäkikallio T, Lancet 2016

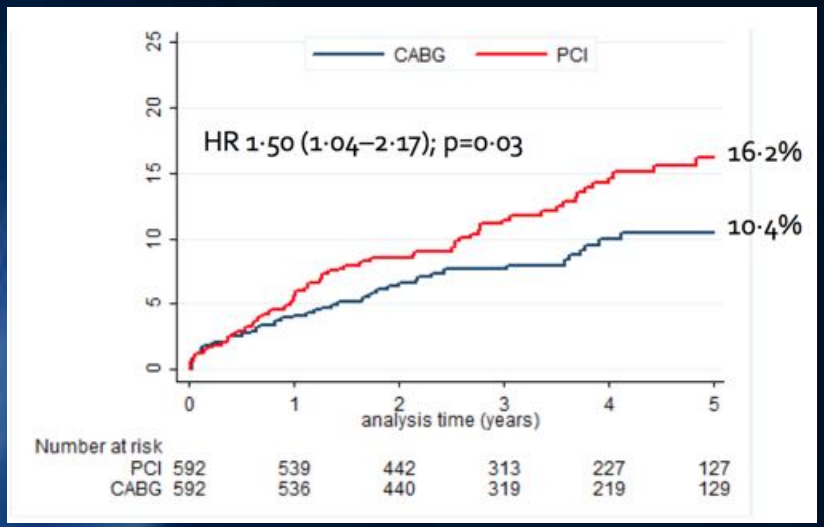
NOBLE

All Cause Mortality

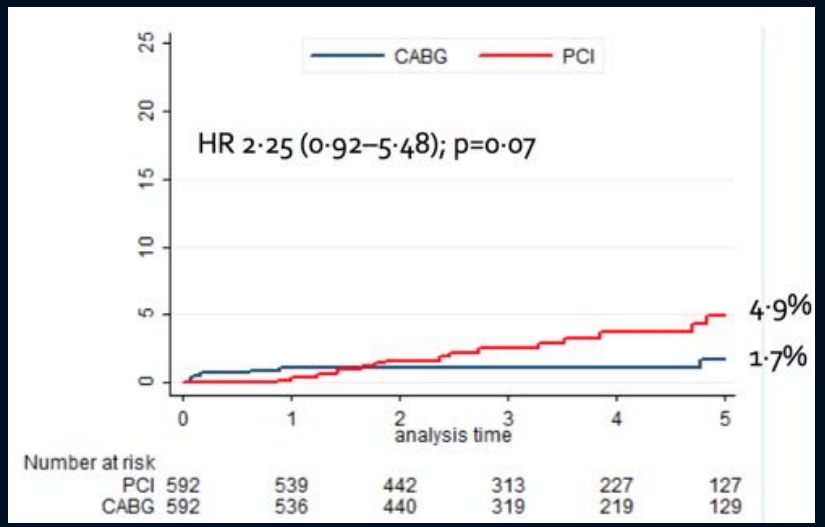


Non procedural MI





Repeat Revascularization



Stroke

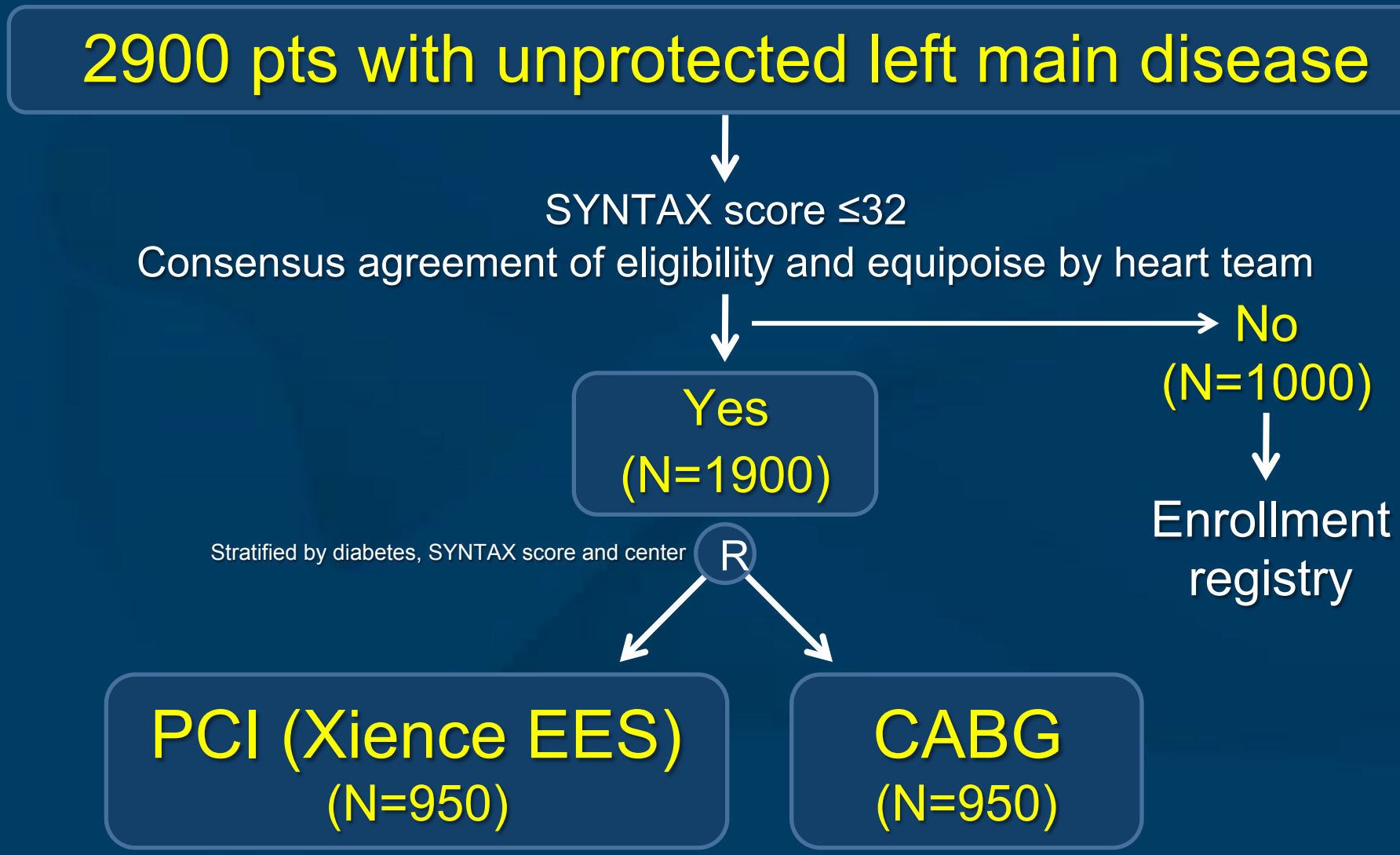
NOBLE

Conclusions

- PCI did not meet non-inferiority for the primary endpoint of 5-year MACCE compared to CABG
- **CABG was superior to PCI**
- PCI resulted in higher rates of non-procedural myocardial infarctions
- Repeat revascularization was higher after PCI, primarily due to de novo lesions and non LMCA target lesion revascularization
- All-cause mortality was similar for PCI and CABG

Mäkikallio T, Lancet 2016

Study Design

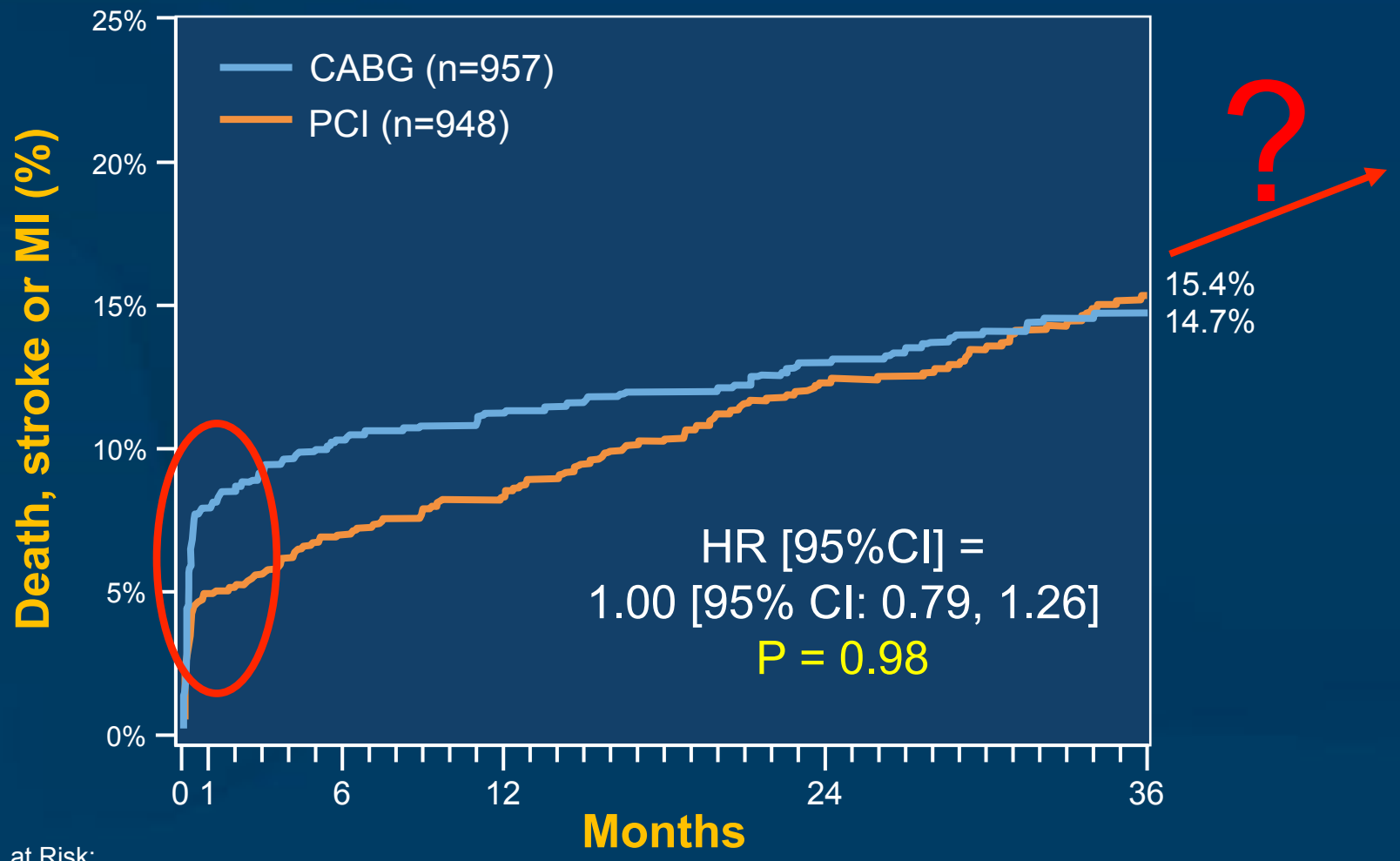


Follow-up: 1 month, 6 months, 1 year, annually through 5 years

Primary endpoint : Measured at a median 3-yr FU, minimum 2-yr FU

Primary Endpoint

Death, Stroke or MI at 3 Years



No. at Risk:

PCI	948	896	875	850	784	445
CABG	957	868	836	817	763	458

Conclusions

- Treatment of patients with LMCAD and low or intermediate SYNTAX scores with CoCr-EES resulted in similar rates of the primary endpoint of death, stroke or MI at 3 years, with fewer adverse events within 30 days compared to CABG
- **PCI may thus be considered an acceptable or even preferred revascularization modality** for selected patients with LMCAD, a decision which should be made after heart team discussion, taking into account each patient's individual circumstances and preferences

PCI & unprotected LEFT MAIN

EDITORIAL

Treatment of Left Main Coronary Artery Disease

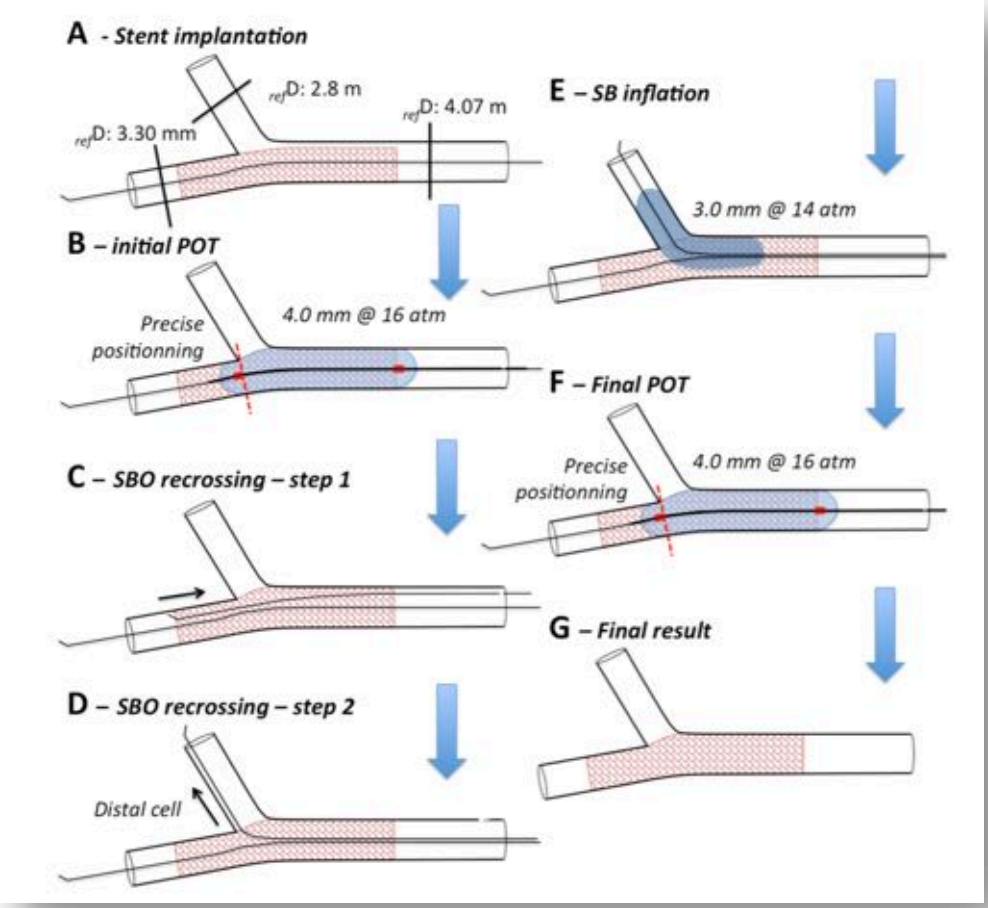
Eugene Braunwald, N Engl J Med 2016

take-home message "is that the majority of patients with unprotected left main coronary artery disease, which was a very serious, life-shortening, and disabling condition early in my professional lifetime, **can now be managed equally by means of two strategies of revascularization** if carried out by expert, experienced teams such as those participating in the EXCEL trial

Bifurcations

APPAC ACTUALISATIONS ET PERSPECTIVES EN PATHOLOGIE CARDIOVASCULAIRE

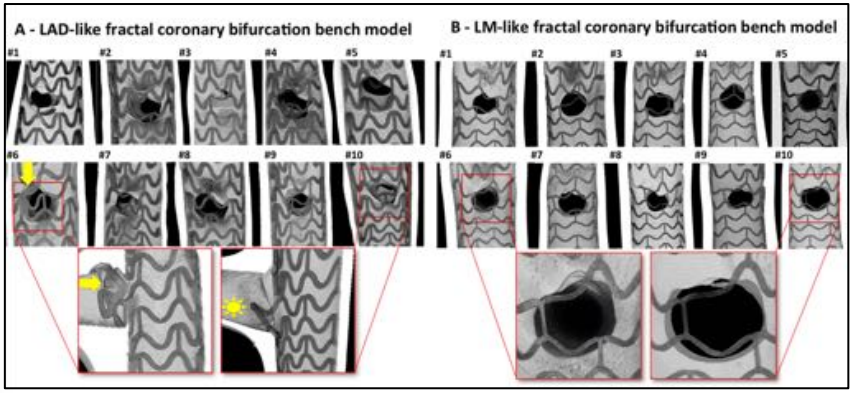
POT-Side-POT ou REPOT

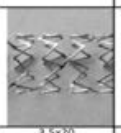
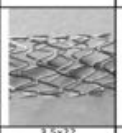
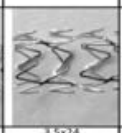
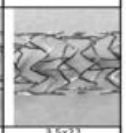


Finet G, JACC Cardiovasc Interv 2015

Derimay F, JACC Cardiovasc Interv 2016

Derimay F, Eurointervention 2017



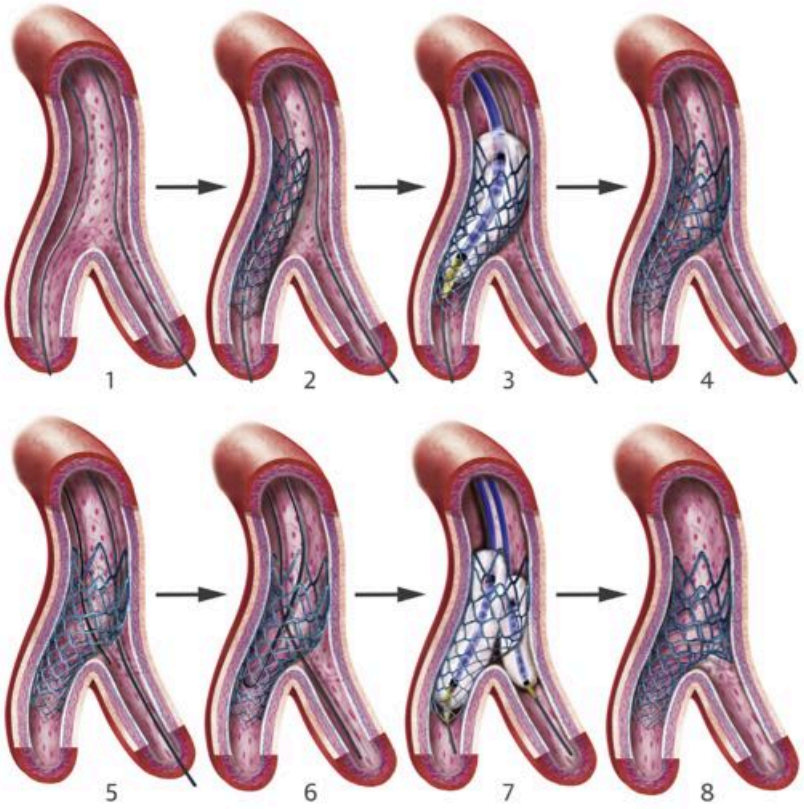
	Promus Premier™	Xience Xpedition™	Resolute Integrity™	Coroflex Isar™	Ultimaster™	Orsiro™
						
Platform size (mm)	3.5x20	3.5x23	3.5x22	3.5x27	3.5x24	3.5x22
Alloy	PtCr	CoCr	CoCr	CoCr	CoCr	CoCr
Connectors	2	3	2	3	2	3
Connector type	Peak-to-peak	Peak-to-valley	Peak-to-peak	Peak-to-valley	Peak-to-peak	Valley-to-valley
Strut thickness (µm)	86	89	95	64	95	87

Bifurcations

APPAC
ACTUALISATIONS ET PERSPECTIVES EN PATHOLOGIE CARDIOVASCULAIRE

Contemporary Approach to Coronary Bifurcation Lesion Treatment

Fadi J. Sawaya, MD,[a] Thierry Lefèvre, MD,[a] Bernard Chevalier, MD,[a] Phillipe Garot, MD,[a] Thomas Hovasse, MD,[a] Marie-Claude Morice, MD,[a] Tanveer Rab, MD,[b] Yves Louvard, MD[a]



DES Designs Overexpansion

Balloon Max Size		Synergy	Xpedition	Res. Onyx	Ultimaster	BioMatrix A	Orsiro
4.0	2.25	Small vessel (8 crowns, 2-4 connectors) *Expansion: 3.6mm*	Small vessel (6 crowns, 3 connectors) *Expansion: 4.1mm*	Small vessel workhorse (6.5 crowns, 2 connectors) *Expan: 3.3mm*	Small vessel (8 crowns, 2 connectors) *Expansion: 4.3mm*	Small vessel (6 crowns, 2 connectors) *Expansion: 4.1mm*	Small vessel (6 crowns, 3 connectors) *Expansion: 4.0mm*
	2.50						
5.0	2.75			Medium vessel workhorse (8.5 crowns, 2 connectors) *Expansion: 4.4mm*			
	3.00	Workhorse (8 crowns, 2-4 connectors) *Expansion: 4.2mm*					
	3.50		Large vessel (9 crowns, 3 connectors) *Expansion: 5.6mm*	Large vessel (9.5 crowns, 2.5 connectors) *Expansion: 5.6mm*	Large vessel (8 crowns, 2 connectors) *Expansion: 5.8mm*	Large vessel (9 crowns, 3 connectors) *Expansion: 5.9mm*	Large vessel (6 crowns, 3 connectors) *Expansion: 5.3mm*
6.0	4.00	Large vessel (10 crowns, 2-5 connectors) *Exp: 5.7mm*					
	4.50			Extra-Large vessel (10.5 crowns, 2.5 connectors) *Expansion: 6.0mm*			
	5.00						

- *Expansion : inner stent MLD excluding struts*
- *Max balloon size : Maverick 6.0mm at 14 ATM*

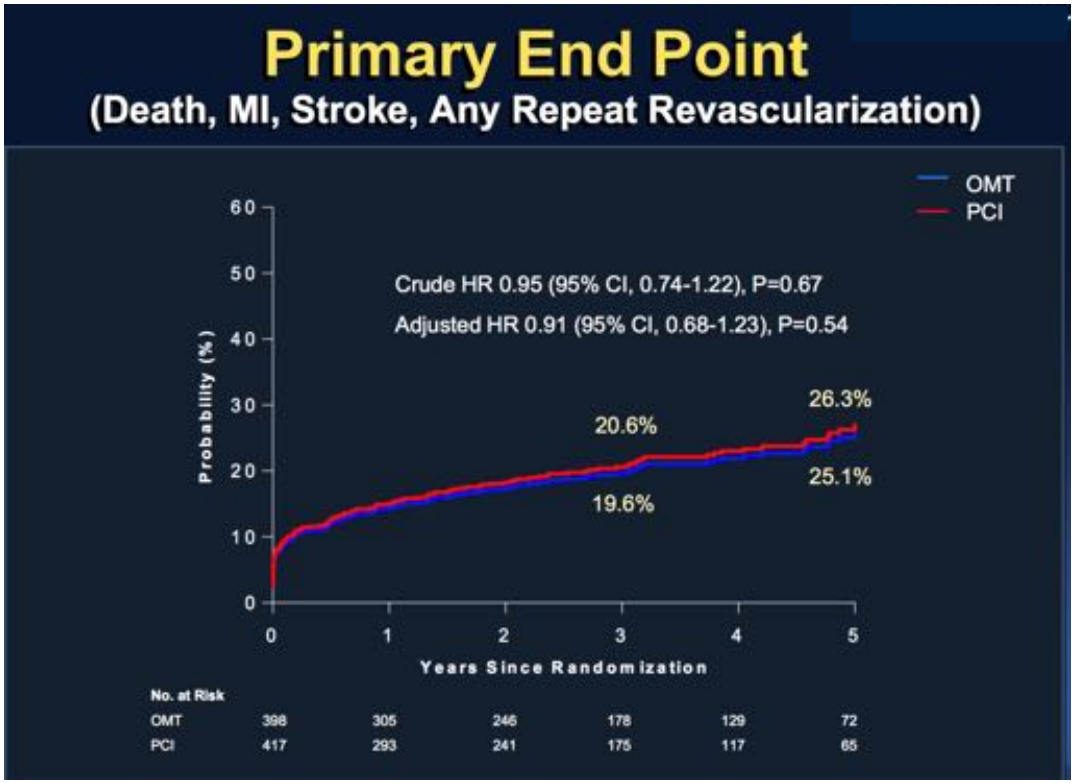
Sawaya FJ, JACC Cardiovasc Interv 2016

Occlusions Chroniques

DECISION - CTO

Park SJ, ACC 2017

the therapeutic strategy was non inferior to intervention for the primary endpoint of **death, MI, stroke or any revascularization** at 3 years



Critère principal inadapté?
Faible enrôlement (815 pour 1284 espérés), indications « poussives »
20% cross over !!!
Suivi trop court

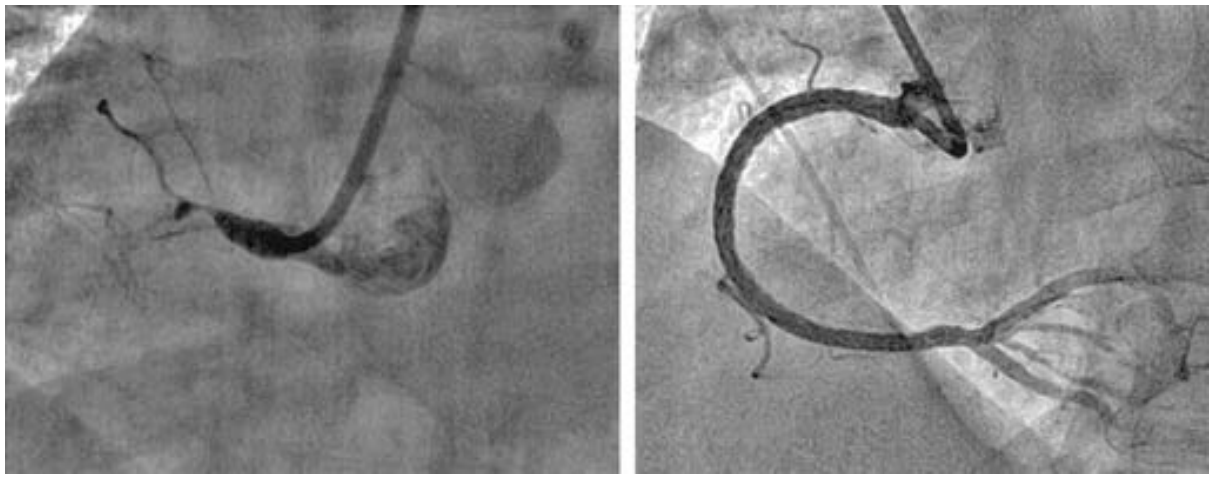
Occlusions Chroniques

Euro - CTO

Werner GS, EuroPCR 2017

396 pts randomisés (259 CTO vs 137 medical)
Etude stoppée prématurément faute de recrutement (40% prévus)

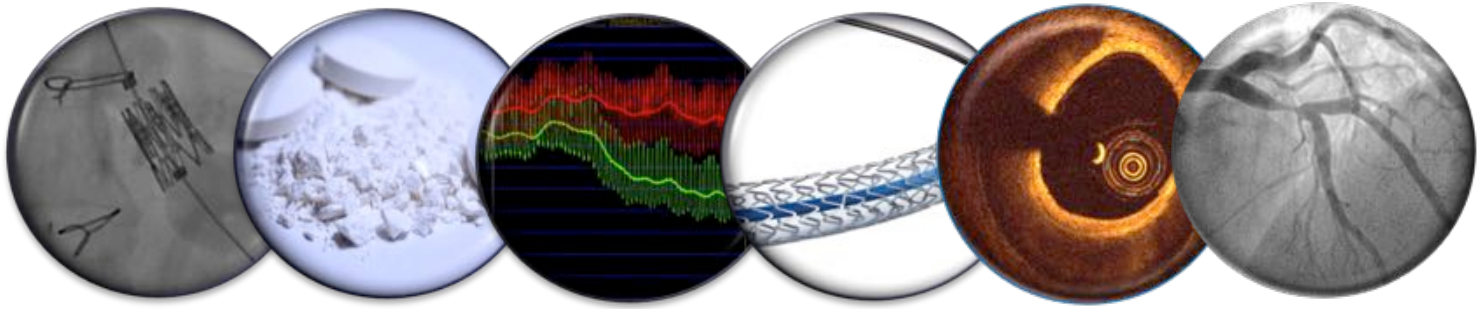
Taux de succès = **86%, complications 1.3%**
CTO = **meilleure qualité de vie** (moins d'angor, + d'activité physique)



Cardiologie interventionnelle 2016-2017

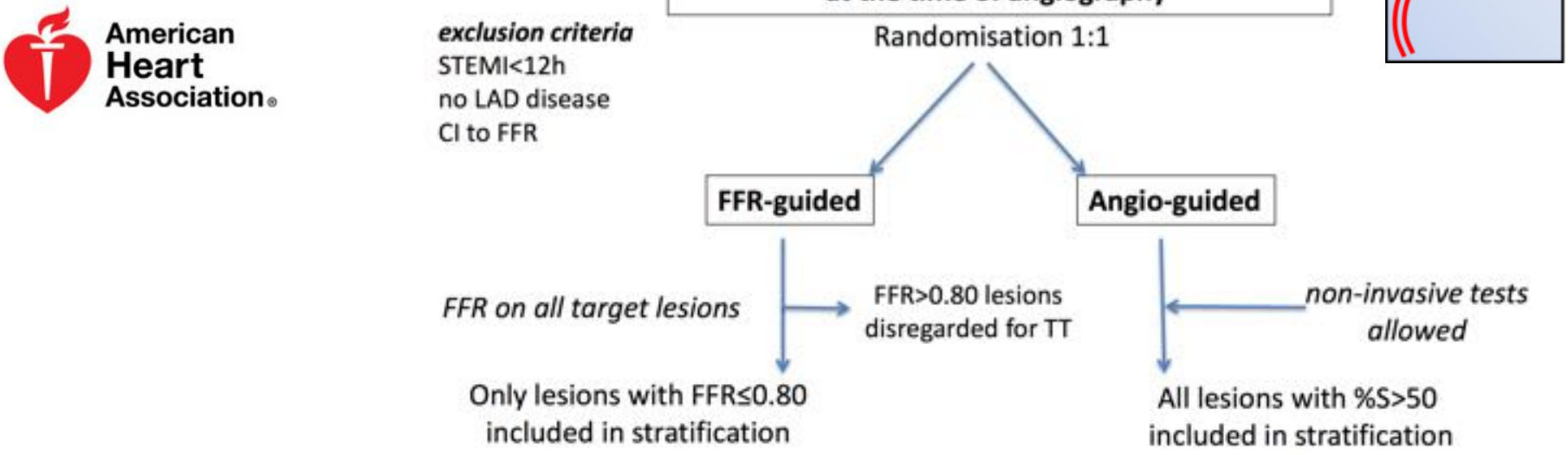
APPAC
ACTUALISATIONS ET PERSPECTIVES EN PATHOLOGIE CARDIOVASCULAIRE

- Recommandations
- Structurel
- Stents et Stenting
- Outils diagnostic
- Pharmacologie
- Maladie coronaire



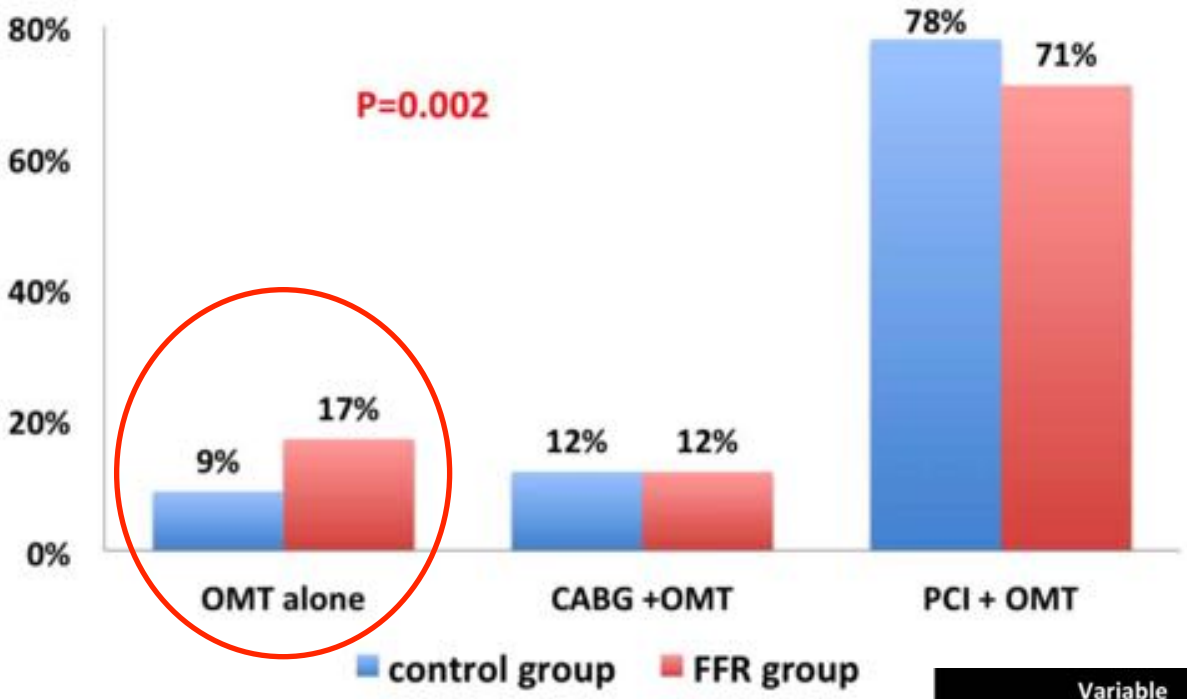
FUTURE

Rioufol G, AHA 2016



- The FUTURE trial was prematurely halted due to an excess of the all-cause mortality (HR 2.39, p=0.02) in the group of patients with FFR assessment (DSMB evaluation on n= 836 pts).
- As of today, the follow-up indicates a persistent but non significant (p=0.11) difference in the 12-month all-cause mortality (797 pts).

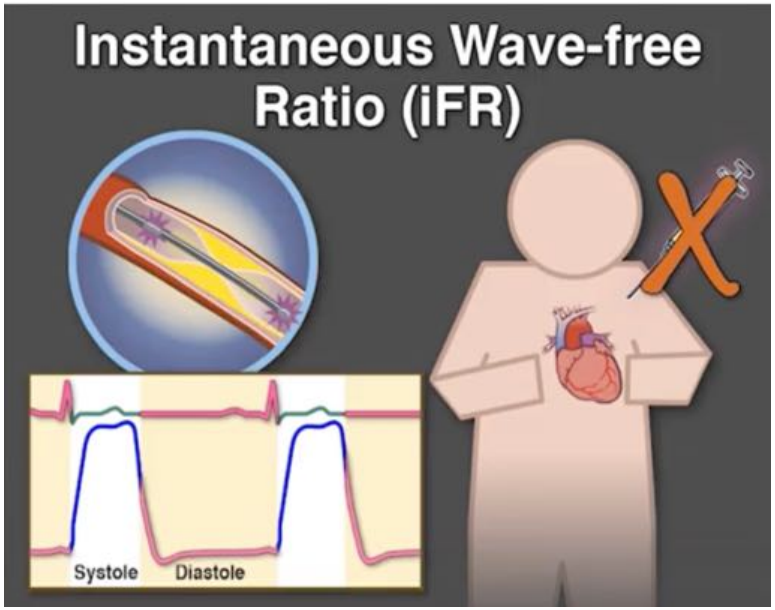
FUTURE



Variable	Control group (n=398)*	FFR Group (n=399)*	HR (95%CI)	P vlue
Death from any cause (%)	8 (1.8)	17 (3.9)	1.98 (0.85–4.60)	0.07
Cardiovascular death (%)	6 (1.3)	12 (2.7)	1.88 (0.70-5.01)	0.16
MACE(%)	58 (13.2)	65 (15.1)	1.09 (0.76-1.56)	0.63
Myocardial infarction (%)	24 (5.3)	29 (6.5)	1.23 (0.71-2.11)	0.46
Stroke (%)	4 (0.9)	2 (0.4)	0.48 (0.09-2.62)	0.40
Repeat revascularization (%)	33 (7.6)	32 (7.6)	0.97 (0.60-1.58)	0.91
EQ-5D – visual analogue scale	71±18	70±17		0.51

Rioufol G, AHA 2016

iFR vs FFR



iFR = étude du gradient de pression sans injection d'adenosine, moyennée sur 3 à 5 diastoles (cutoff=0.89)

- **DEFINE-FLAIR**
  JE Davies, New Engl J M 2017
- **iFR-SWEDEHEART**
  M Götberg, New Engl J M 2017

2 études randomisées de non-infériorité (2492 et 2037 pts)

Non infériorité de l'iFR (vs FFR), pour guider revascularisation

Beaucoup moins de symptômes indésirables (3.1% vs 30.8% et 3.1% vs 68.3%)

ILUMIEN 3

APPAC ACTUALISATIONS ET PERSPECTIVES EN PATHOLOGIE CARDIOVASCULAIRE

Ali ZA, Lancet 2016

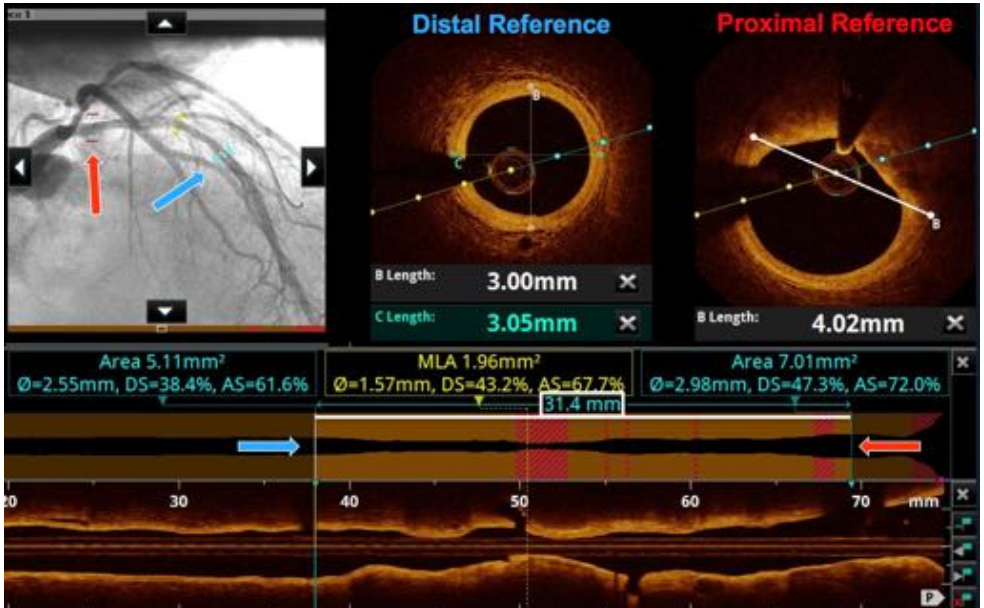
Optical coherence tomography compared with intravascular ultrasound and with angiography to guide coronary stent implantation (ILUMIEN III: OPTIMIZE PCI): a randomised controlled trial

450 Randomized

158 OCT-guided PCI

146 IVUS-guided PCI

146 angiography-guided PCI



Primary Endpoint

Final post-PCI MSA by OCT

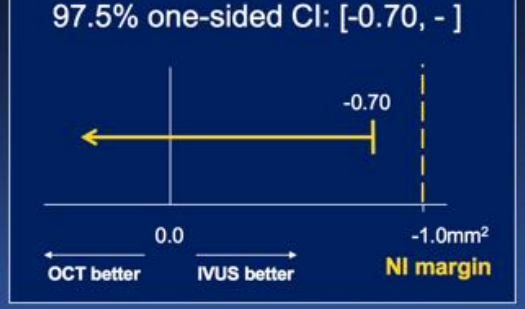
OCT 5.79 mm² [4.54, 7.34]

IVUS 5.89 mm² [4.67, 7.80]

97.5% one-sided CI: [-0.70, -]

$P_{noninferiority} = 0.001$

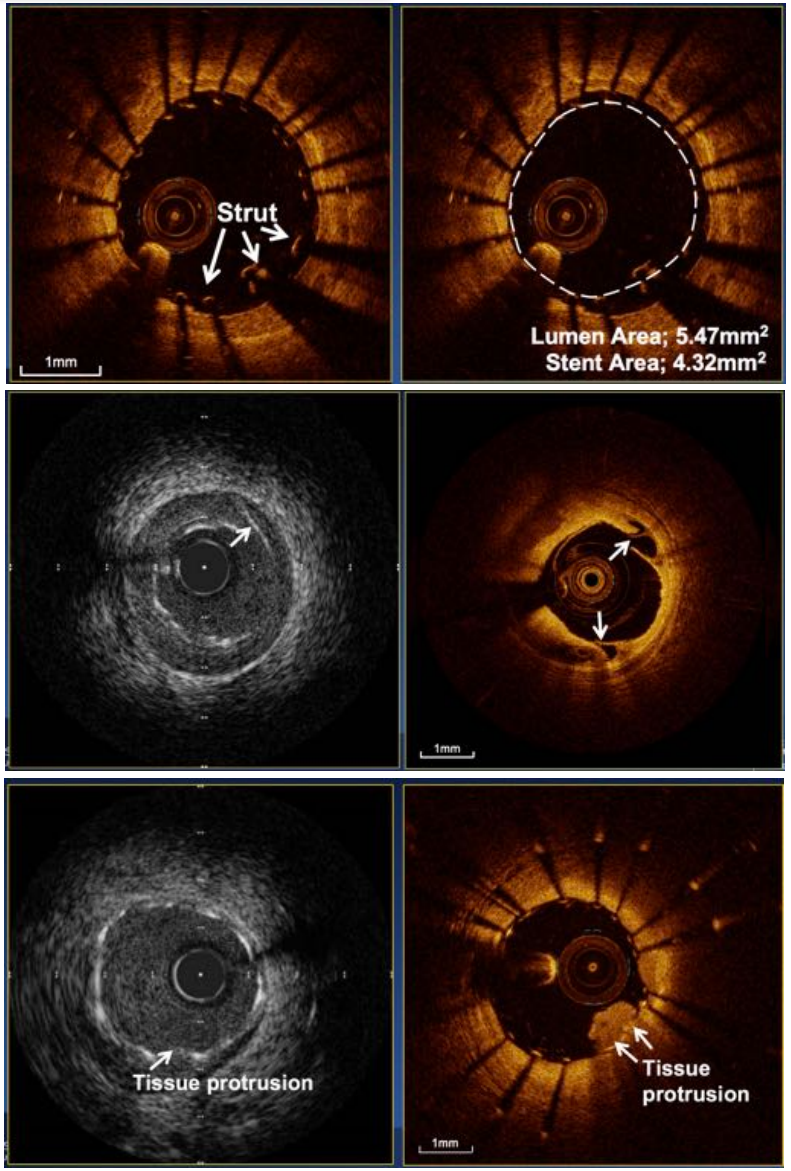
$P_{superiority} = 0.12$



ILUMIEN 3

Ali ZA, Lancet 2016

- OCT-guided PCI using a specific EEL-based stent optimization strategy **was non-inferior to IVUS-guided PCI for achieving MSA**
- OCT-guided PCI **resulted in superior stent expansion and procedural success** compared to angiography-guided PCI.
- OCT-guided PCI resulted in the fewest untreated **major dissections** and areas of **major stent malapposition**.



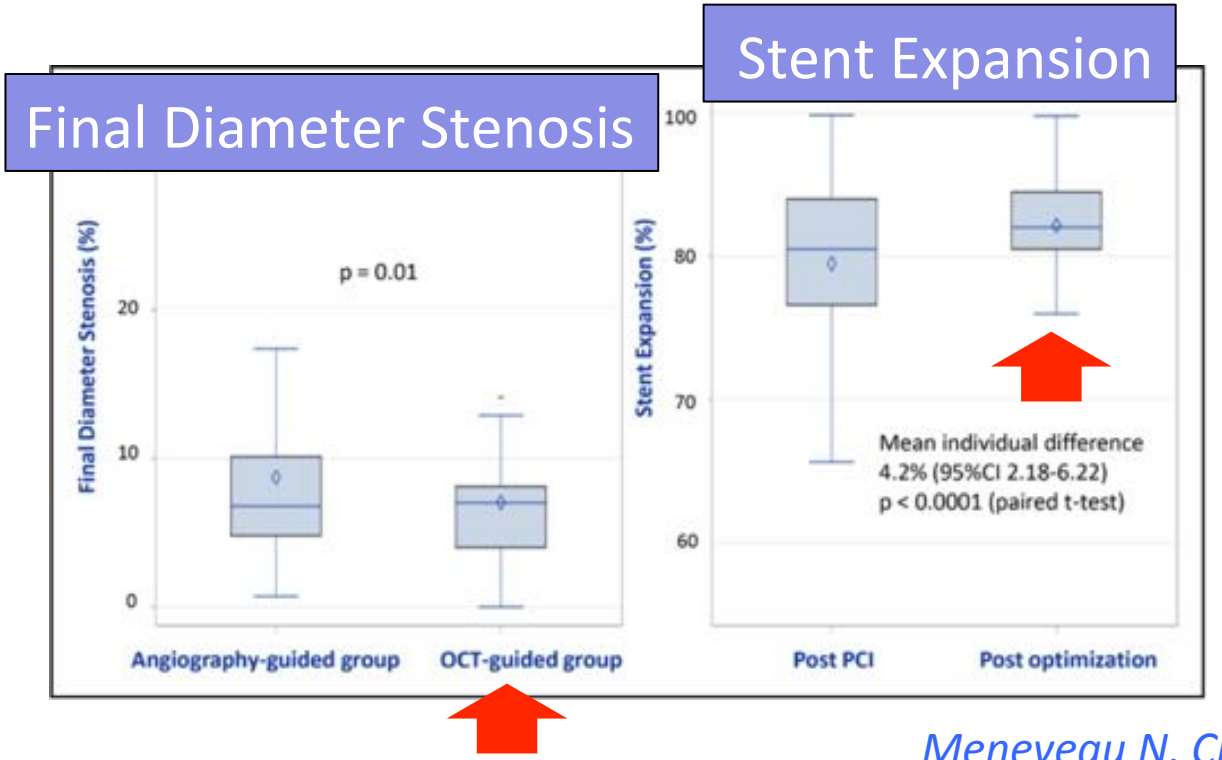
DOCTORS

OCT guidance during PCI in patients with NSTEMI

Change in **procedural strategy in half the cases** in the OCT-guided group.

OCT **improved functional outcome** compared with PCI guided by fluoroscopy alone, as assessed by FFR.

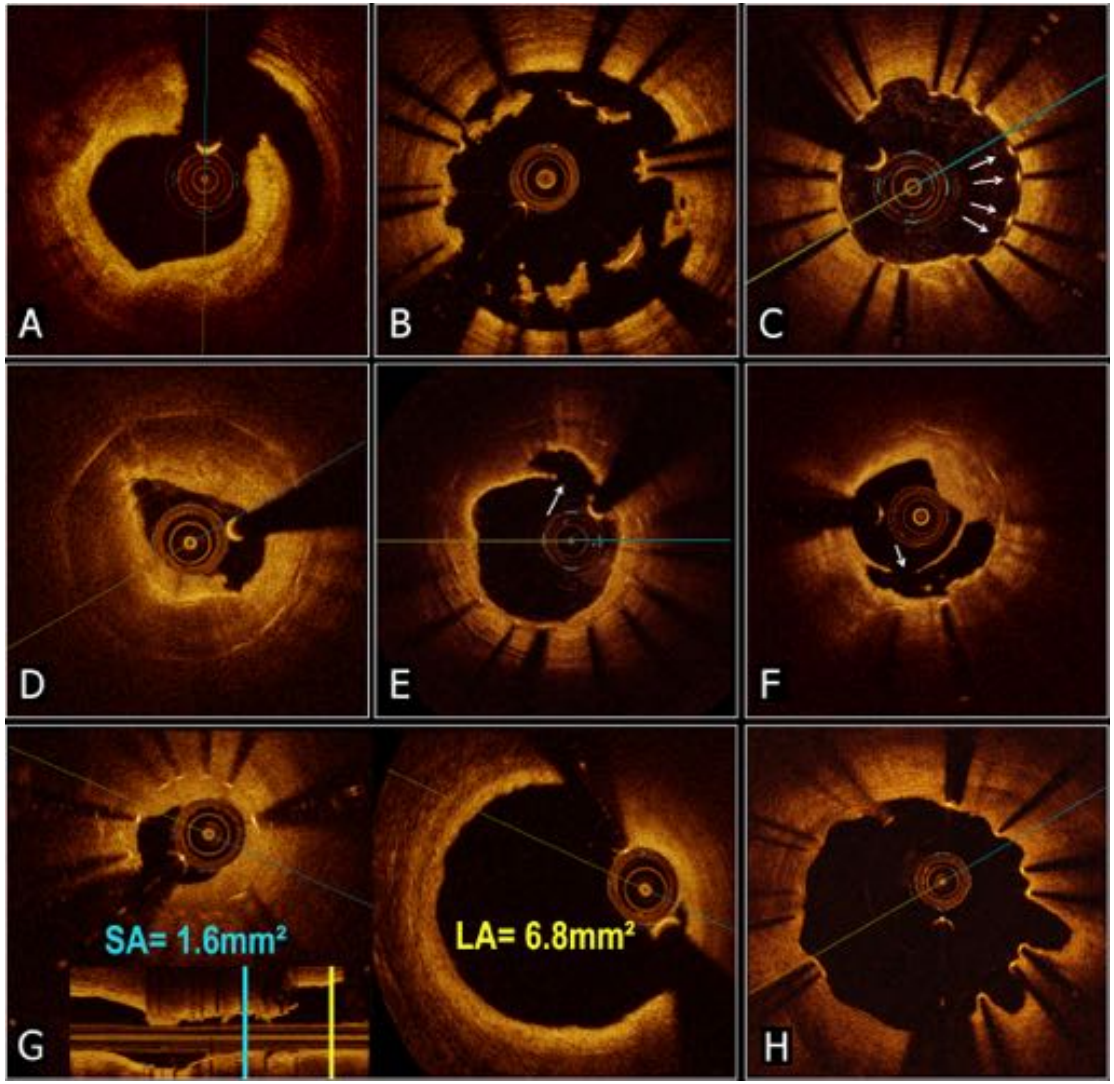
This improvement seemed to be explained by optimization of **stent expansion**.



Meneveau N, Circulation 2016

PESTO

Souteyrand G, Eur Heart J 2016



Mechanisms of Stent Thrombosis (n=120)

- *Malapposition 34%*
- *Neoatherosclerosis 22%*

OCT influences management in 55% of ST cases

- *POBA 37%*
- *Medical therapy in 32%*
- *Stenting 31%*

Cardiologie interventionnelle 2016-2017

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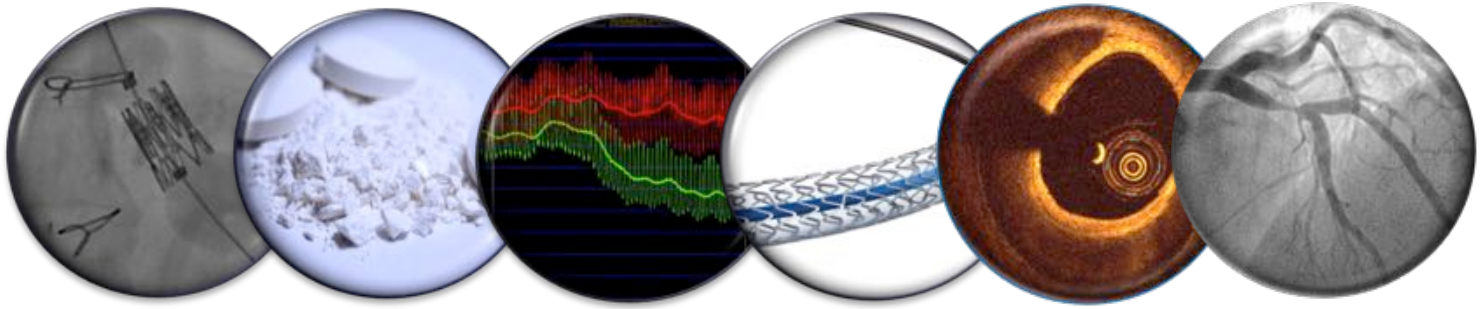
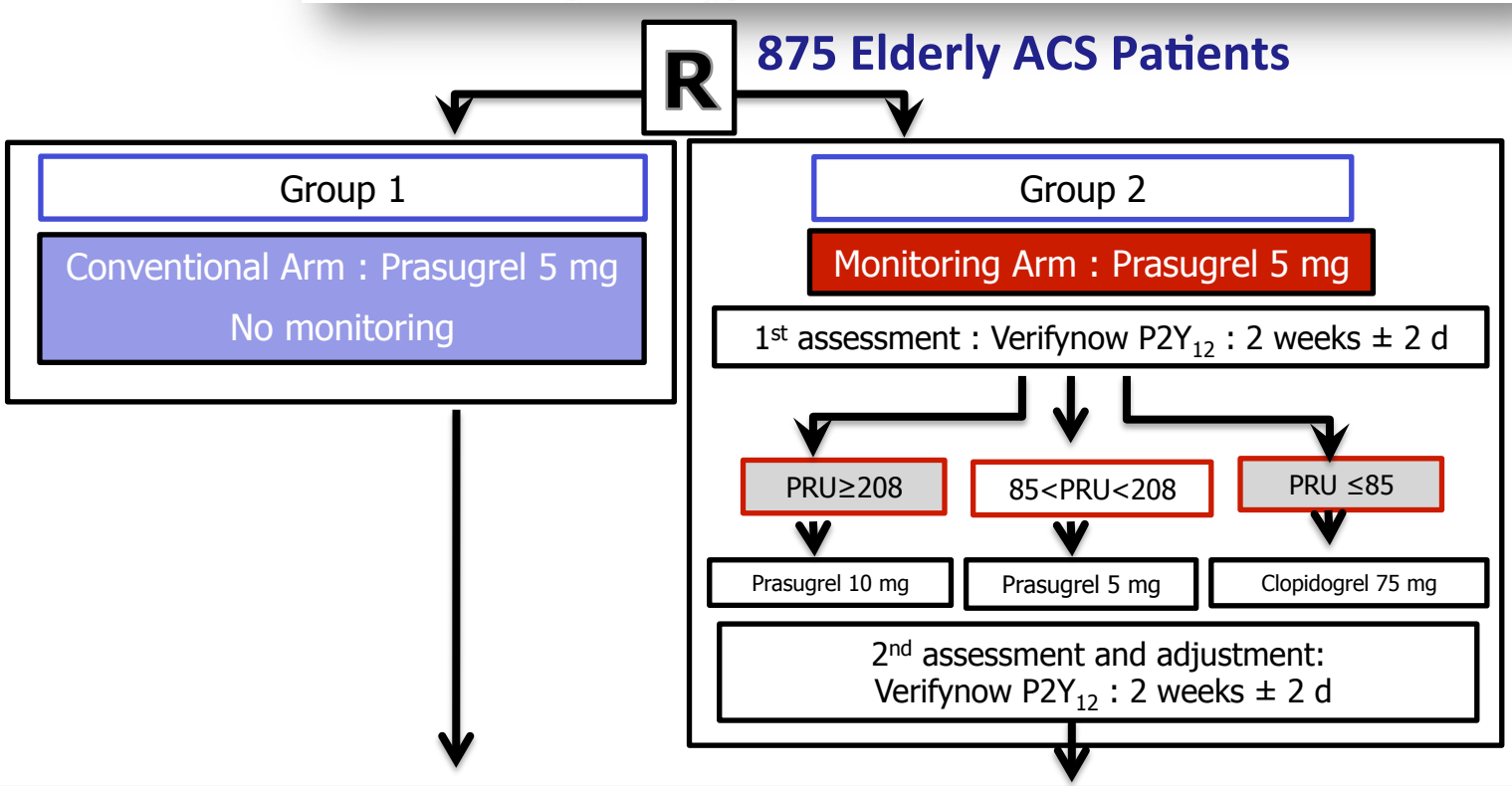
- **Pharmacologie**
- Maladie coronaire



ANTARCTIC

Cayla G, Lancet 2016

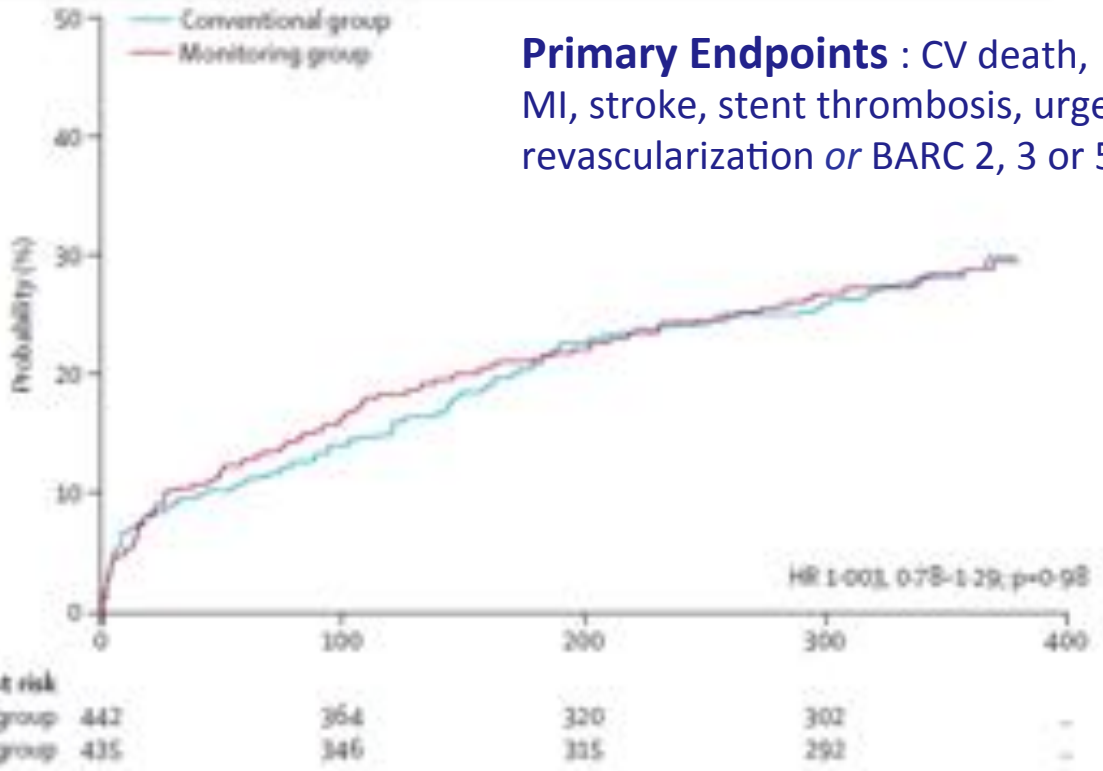
Platelet function monitoring to adjust antiplatelet therapy in elderly patients stented for an acute coronary syndrome (ANTARCTIC): an open-label, blinded-endpoint, randomised controlled superiority trial



Primary end point (net clinical benefit) over 12 months: Bleeding type 2,3,5 of the BARC definition *and* MACE (CV death, MI, urgent revascularisation, stent thrombosis, stroke)

ANTARCTIC

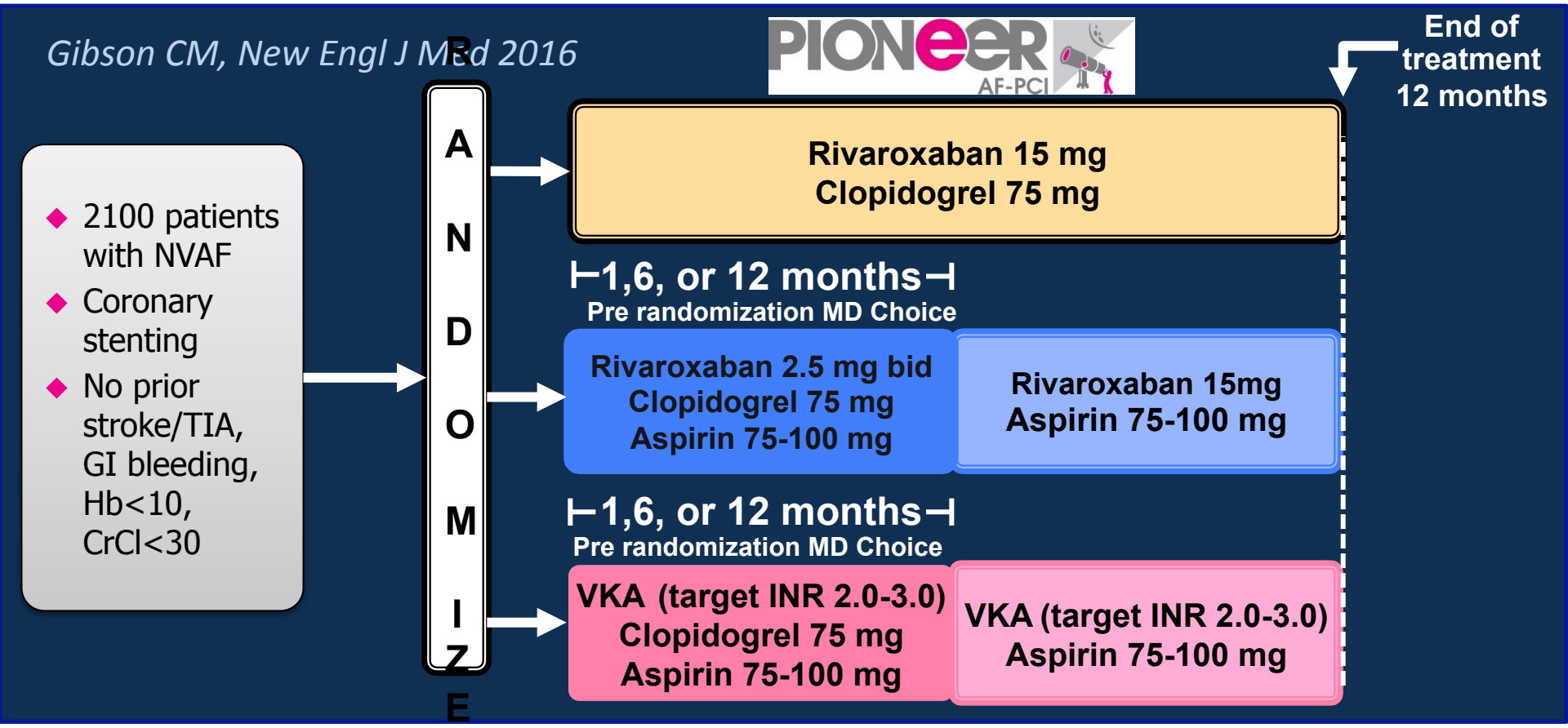
Cayla G, Lancet 2016



Primary Endpoints : CV death, MI, stroke, stent thrombosis, urgent revascularization *or* BARC 2, 3 or 5

- Largest randomized PCI **study in the elderly**
- Platelet function monitoring to adjust antiplatelet therapy in elderly patients stented for an ACS does **not improve** their clinical outcomes

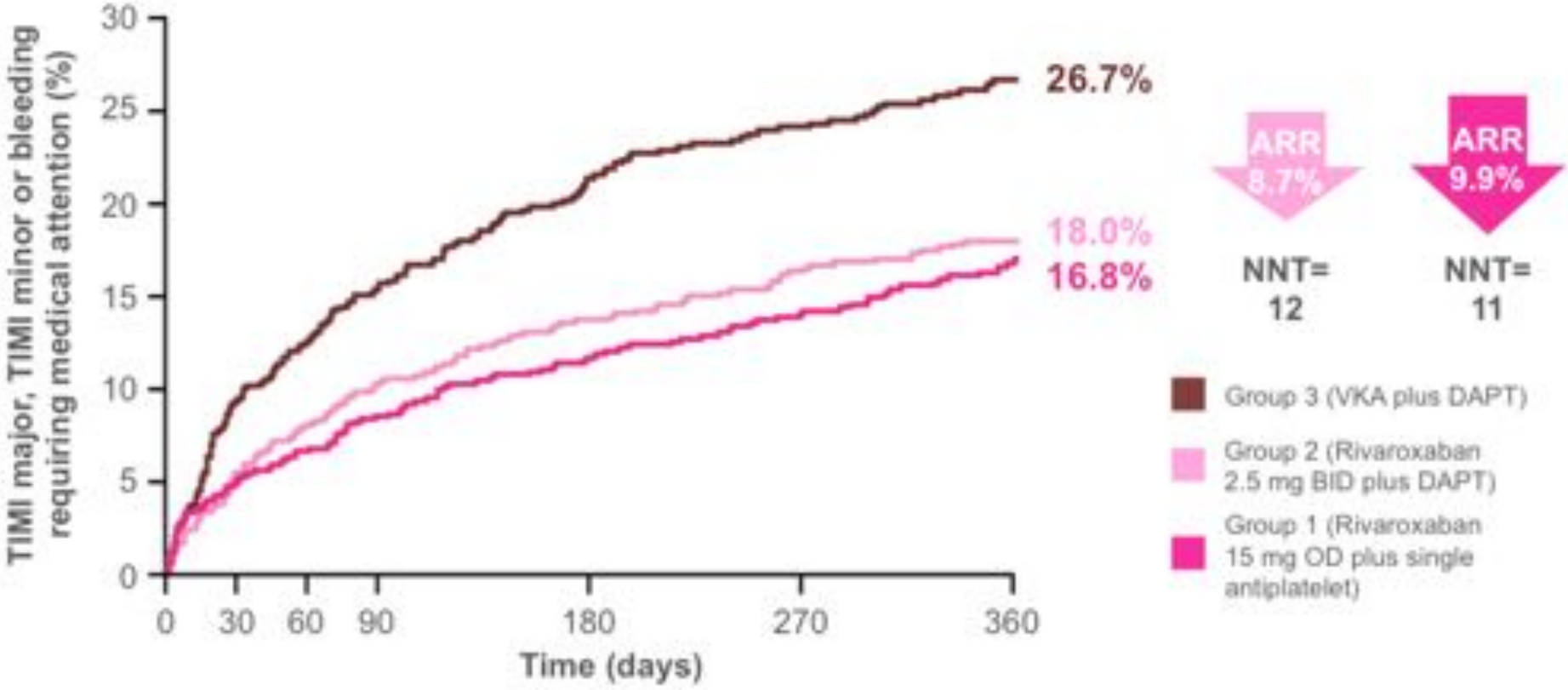
PIONEER AF-PCI



- Primary endpoint: TIMI major + minor + bleeding requiring medical attention
- Secondary endpoint: CV death, MI, and stroke (Ischemic, Hemorrhagic, or Uncertain Origin)

PIONEER AF-PCI

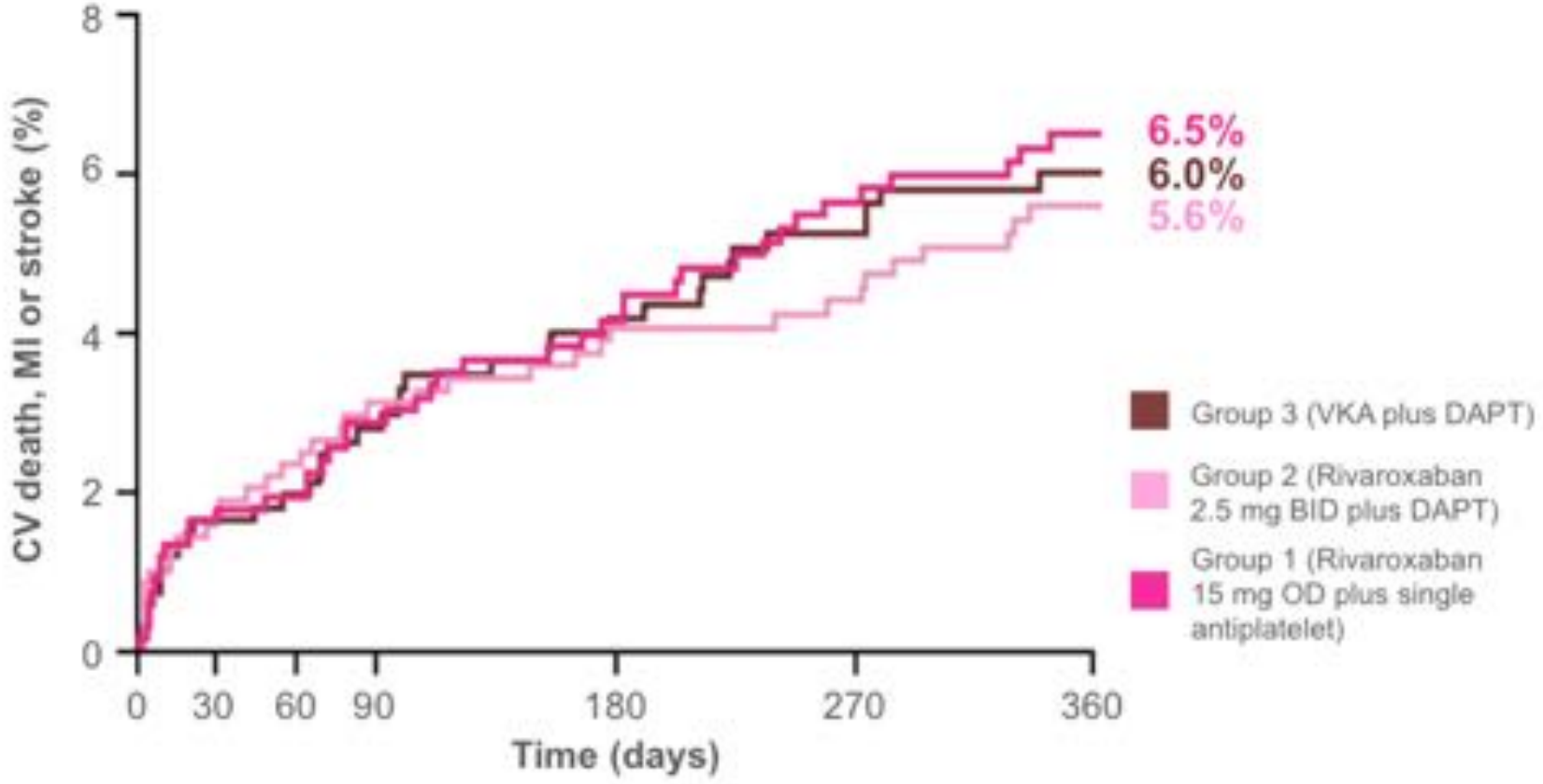
Primary endpoint : First Occurrence of Clinically Significant Bleeding Events



Gibson et al. N Engl J Med 2016

PIONEER AF-PCI

First Occurrence of CV Death, MI or Stroke



Gibson et al. N Engl J Med 2016

TOPIC

Benefit of switching dual antiplatelet therapy after acute coronary syndrome :
The TOPIC (Timing Of Platelet Inhibition after acute Coronary Syndrome) randomized study

ACS patients undergoing PCI
MACE free at one month (ischemic / bleeding BARC ≥ 2)
DAPT with aspirin and newer P2Y12 blockers

Randomization

Switched DAPT
Aspirin + Clopidogrel

Unchanged DAPT
Aspirin + Newer P2Y12 blockers

Follow–up at one year
Composite primary endpoints
Death, urgent revasc, stroke, BARC bleedings ≥ 2
Secondary endpoints
Each component of primary endpoints
All BARC bleeding, TIMI bleeding

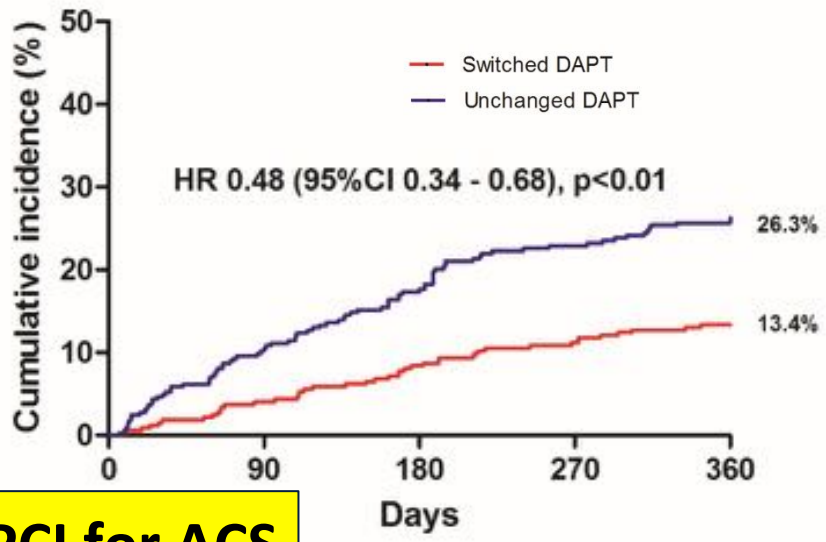
Cuisset T, Eur Heart J 2017

TOPIC

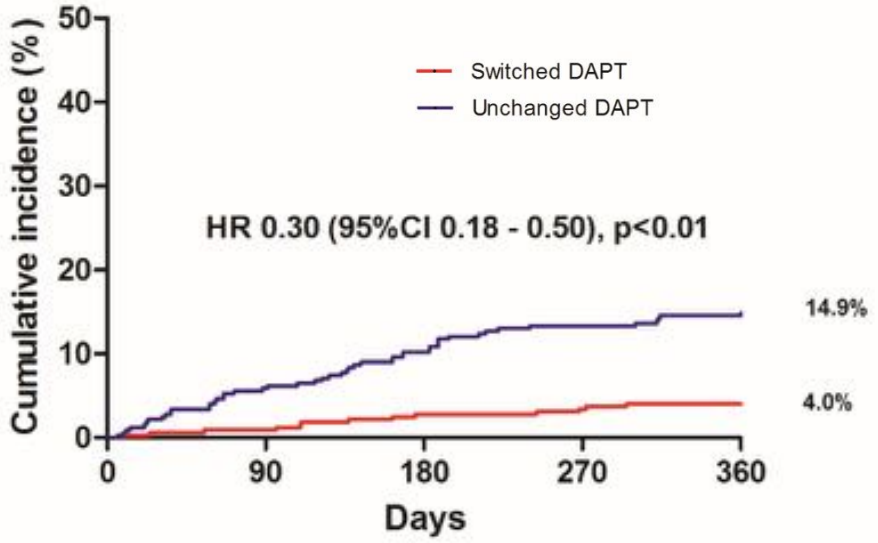
APPAC ACTUALISATIONS ET PERSPECTIVES EN PATHOLOGIE CARDIOVASCULAIRE

Primary Endpoint

Death, Urgent revasc., Stroke, BARC ≥ 2

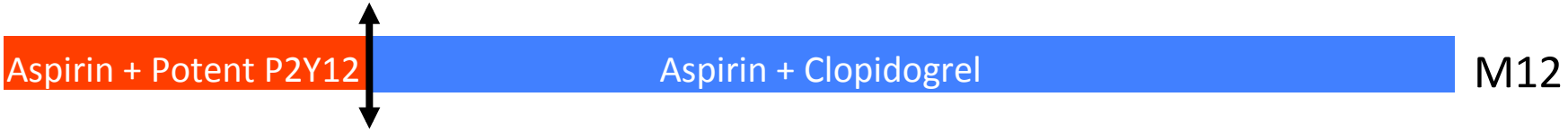


BARC bleedings ≥ 2



PCI for ACS

- Better Prognosis with **switched DAPT** with less bleedings
- New strategy integrating dynamic risk for post ACS patients



Cuisset T, Eur Heart J 2017

Cardiologie interventionnelle 2016-2017

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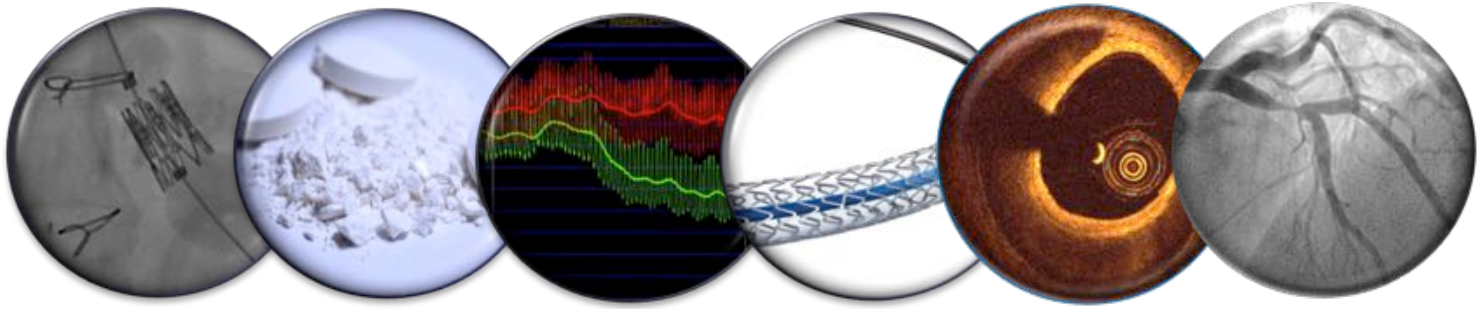
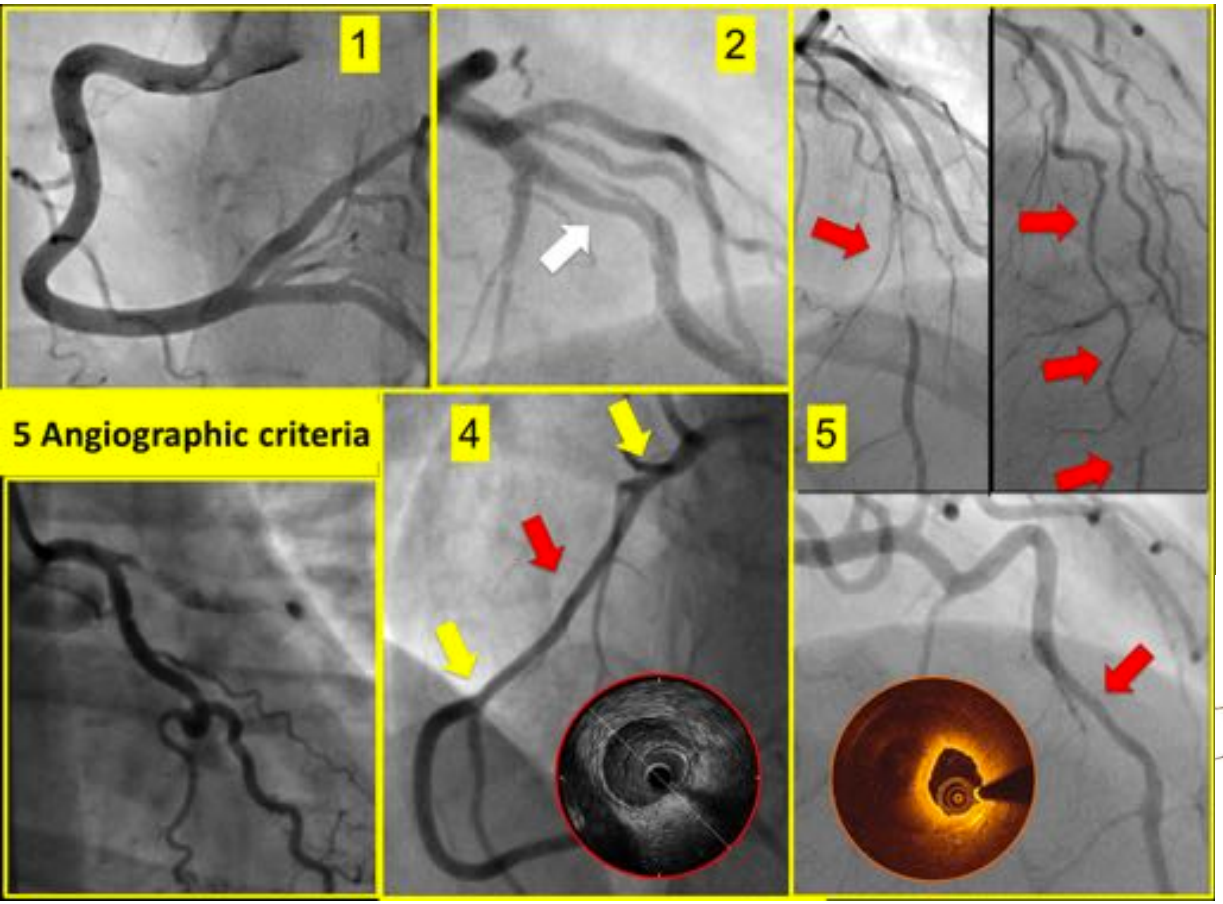


Dissections coronaires spontanées

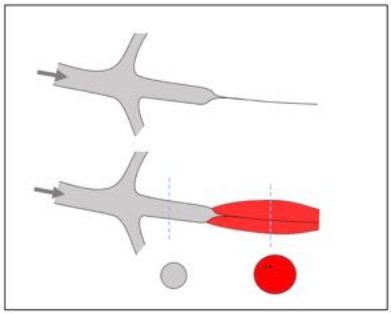
APPAC
ACTUALISATIONS ET PERSPECTIVES EN PATHOLOGIE CARDIOVASCULAIRE

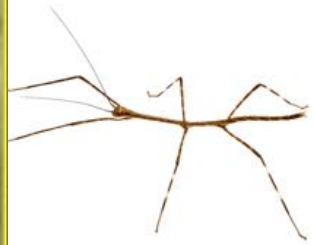
How and when to suspect spontaneous coronary artery dissection?

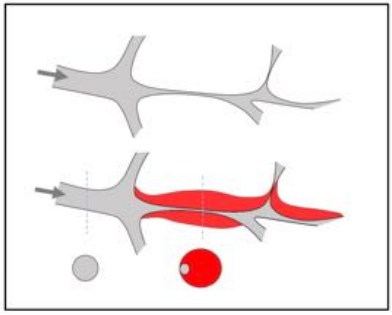
Motreff P, Eurointerv 2016



SCAD = 1/3 SCA illégitime de la femme jeune







DISCO

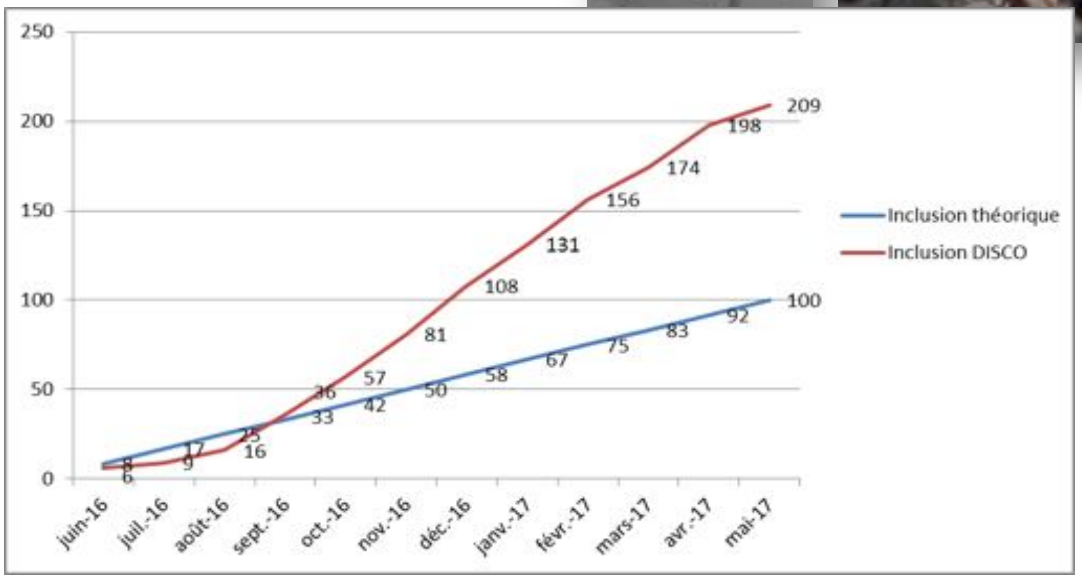
Fondation Coeur & Recherche — Société Française de Cardiologie — GACI — APPAC Actualisations et perspectives en pathologie cardiovasculaire

209 inclusions en 12 mois !

39 centres

Etude DISCO

Etude génotypique et phénotypique de la prévalence de la Dysplasie Fibro Musculaire dans une population prise en charge pour hématome ou **DIS**section **CO**ronaire Spontanés



Les études marquantes depuis 12 mois en Cardiologie Interventionnelle

- Beaucoup d'études Françaises
- Registres Nationaux

Eurointervention 2017