La sous-estimation du risque hémorragique

Hôpital Pitié-Salpêtrière AP-HP

Gilles Montalescot

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ACTION Group

SORBONNE UNIVERSITÉ

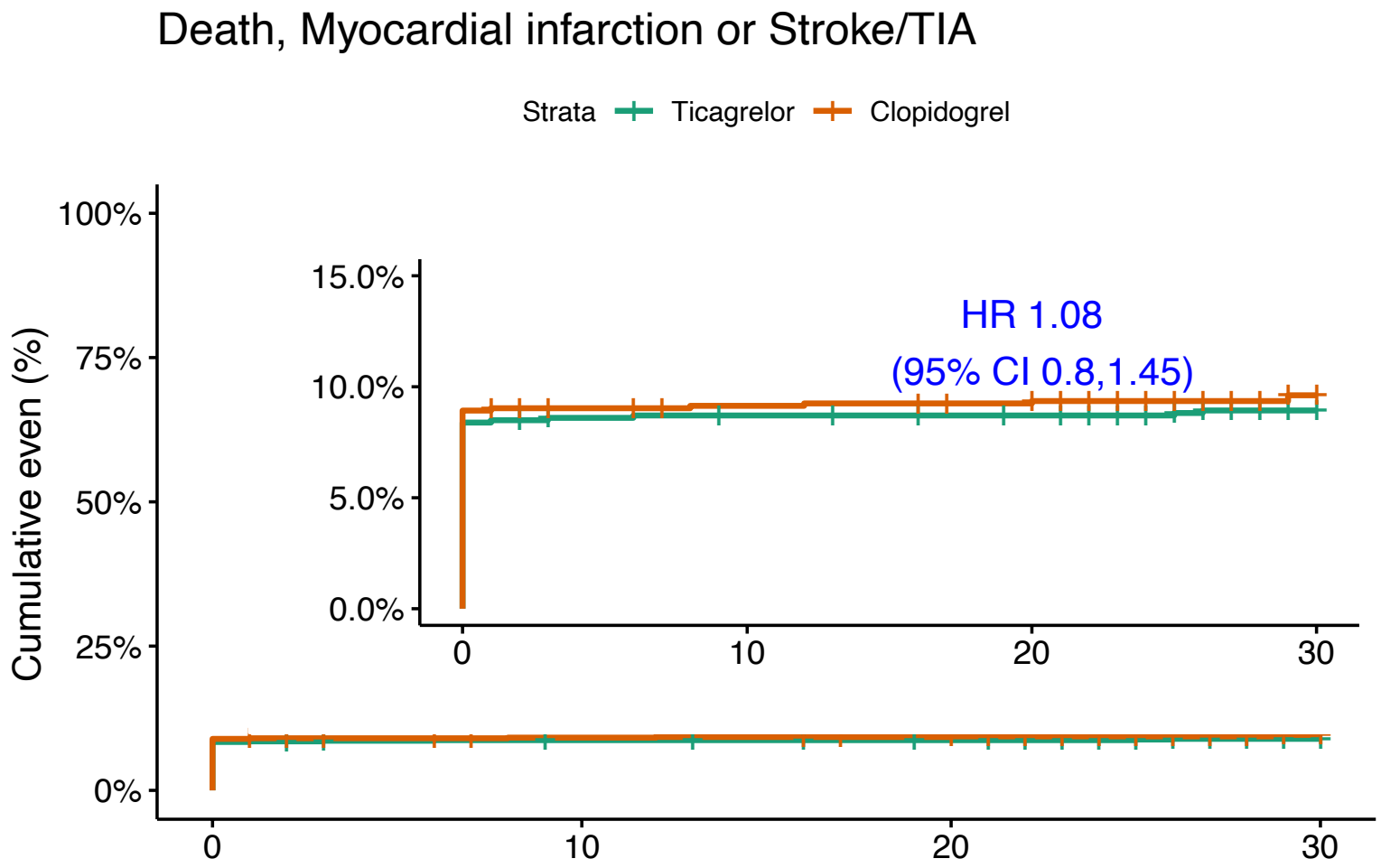
INSTITUT DE CARDIOLOGIE
Pitié-Salpêtrière
Paris

www.action-groupe.org

APPAC
ENSEMBLE, IMAGINONS LA CARDIOLOGIE DE DEMAIN

Sur-estimation du risque ischémique

Clinical Outcomes at 30 days



*"**death and stroke/TIA were rare events** (0·2% vs 0% and 0·2% vs 0·1%) in the ticagrelor and clopidogrel group respectively "*

J. Silvain et al for the ACTION group. Lancet 2020

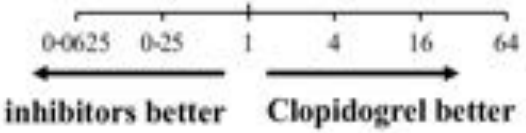
Pooled Analysis n=2654 patients

SASSICAIA trial (Prasugrel) – ALPHEUS trial (Ticagrelor)

781 patients

1883 patients

	Ticagrelor or Prasugrel (n/N)	Clopidogrel (n/N)	Event rates (%)		Odds ratio	95% CI	P value
Death, MI, ST or stroke	156/1323	158/1341	11·8	11·8	1·01	0·80 – 1·28	0·94
Death	3/1323	0/1341	0·23	0	4·09	0·46 – 36·70	0·21
Any MI	148/1323	154/1341	11·2	11·5	0·98	0·77 – 1·24	0·85
Stent Thrombosis	7/1323	4/1341	0·53	0·30	1·77	0·52 – 6·07	0·36
Stroke	4/1323	4/1341	0·30	0·30	1·03	0·26 – 4·13	0·97
Urgent vessel revascularization	5/1323	10/1341	0·38	0·75	0·51	0·17 – 1·48	0·21
BARC ≥ 2	48/1323	37/1341	3·6	2·8	1·34	0·86 - 2·07	0·19
BARC ≥ 3	12/1323	8/1341	0·91	0·60	1·55	0·63 - 3·82	0·34



SASSICAIA - Mehilli J. Circulation: Cardiovascular Interventions. 2020

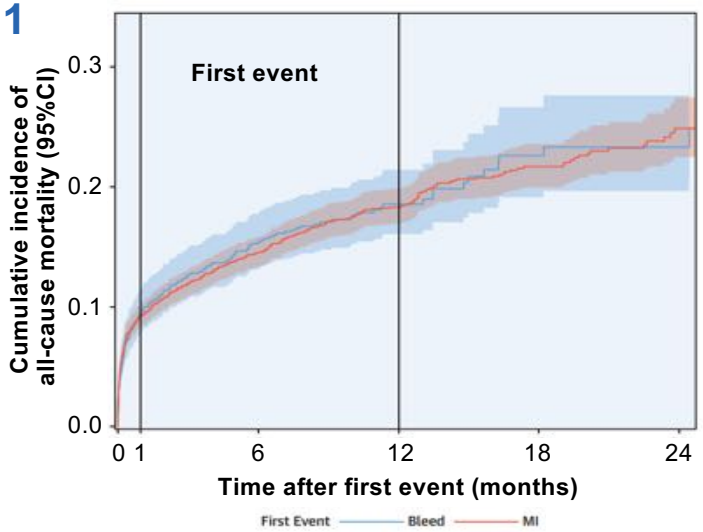
ALPHEUS – Silvain J. Lancet. 2020

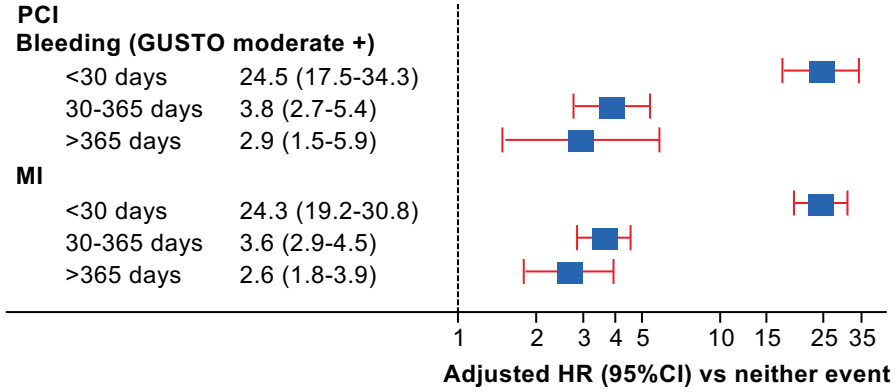
Sous-estimation du risque hémorragique

Trade-off of MI vs. bleeding

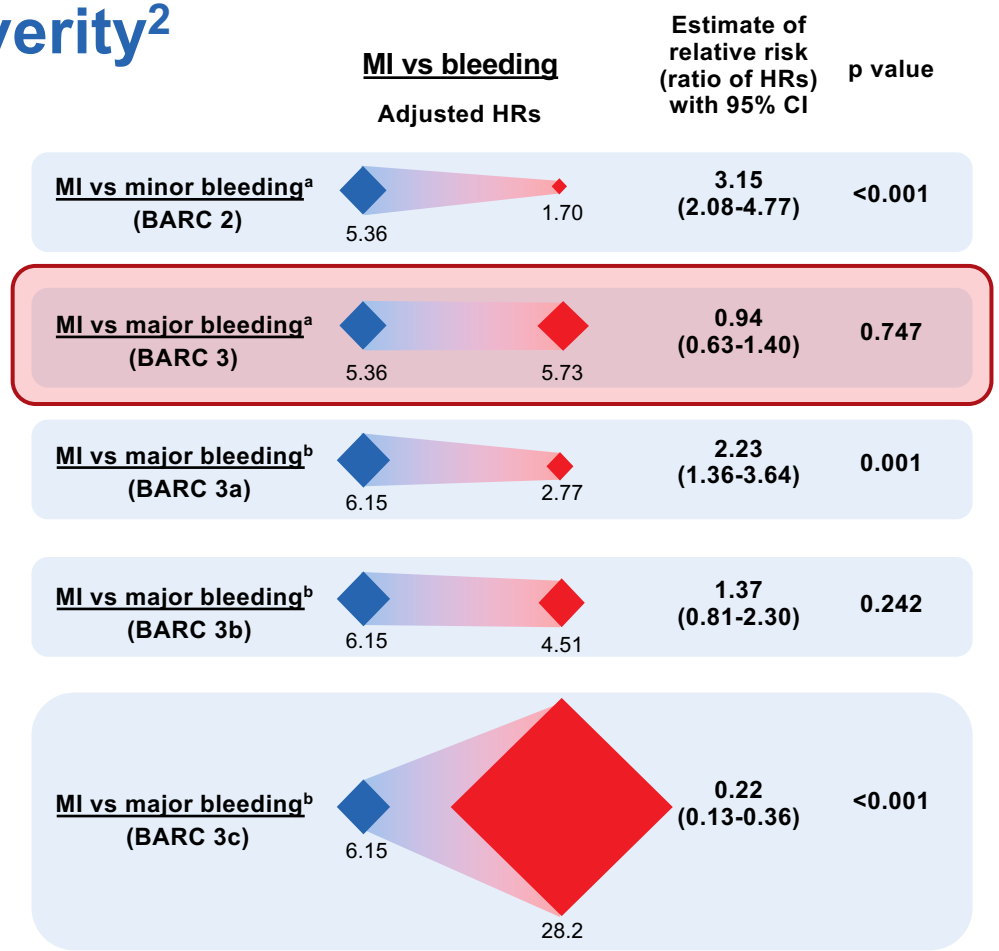
Mortality after MI = mortality after major bleeding

a.) Timing[1]





b.) Severity[2]



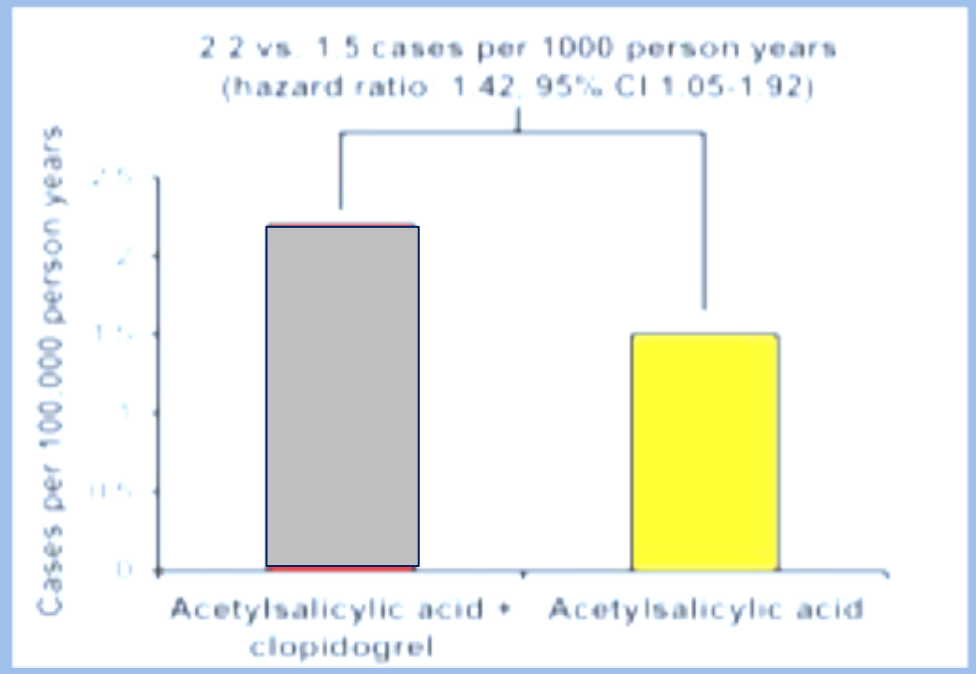
BARC, Bleeding Academic Research Consortium grade; CI, confidence interval; GUSTO, global use of strategies to open occluded coronary arteries; HR, hazard ratio; MI, myocardial infarction; PCI, percutaneous coronary intervention

1. Marquis-Gravel G, et al. J Am Coll Cardiol. 2020;76:162-71; 2. Valgimigli M, et al. Eur Heart J. 2017;38:804-10

Risk of ICH (drugs)

ASA→ ASA+clopi

HR 1.42 (1.05-1.92)



ASA+clopi→ ASA+tica

HR 1.87 (0.98-3.48) - PLATO

ASA+clopi→ ASA+prasu

HR 1.12 (0.58-2.15) - TRITON

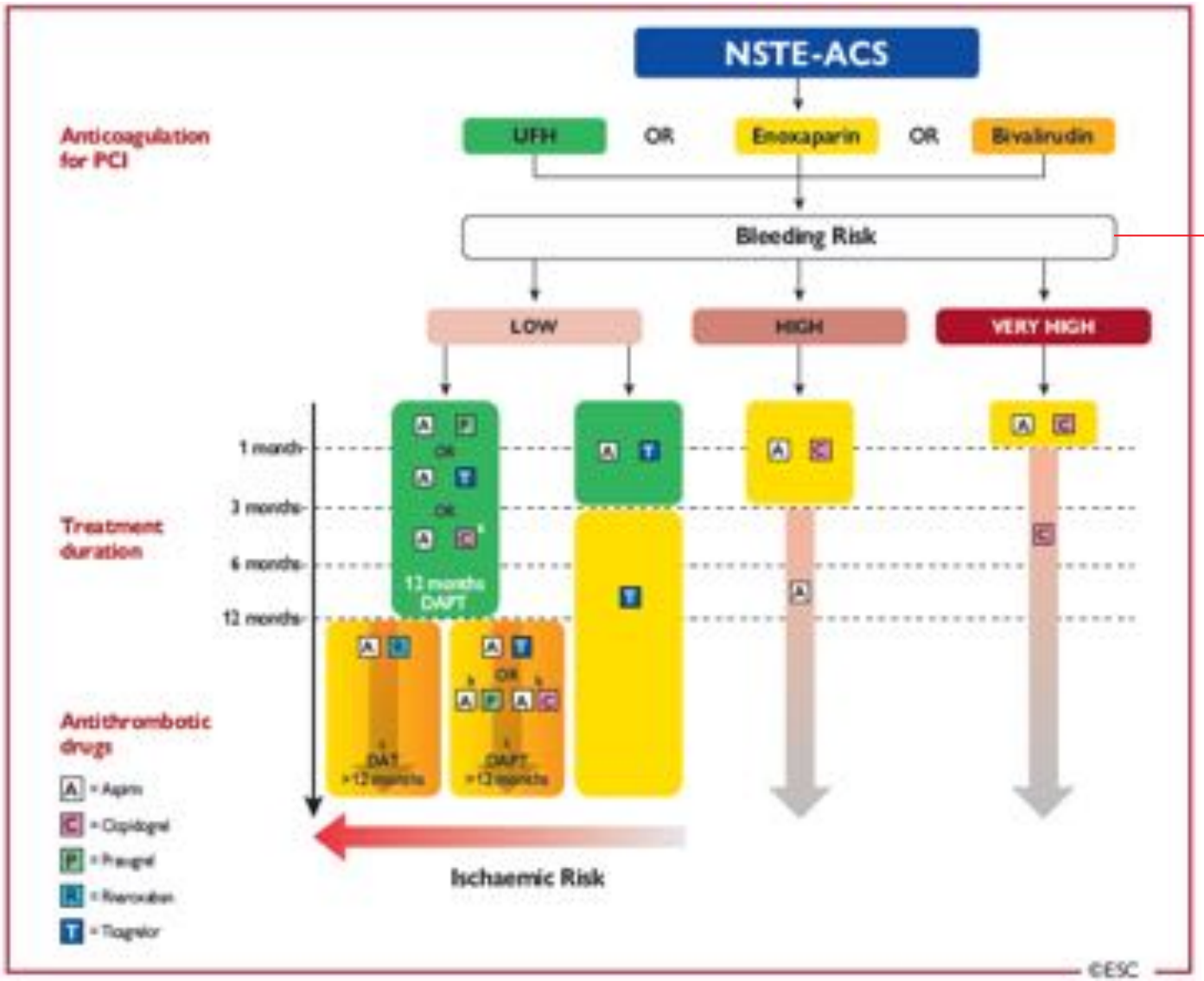
Risk of ICH (patients)

Intracranial-B2LEED3S

BMI (<25 = 1 point; ≥25 = 0 point) Blood Pressure (high) (Yes = 2 points; No = 0 point)
Lacune / small disease (Yes = 1 point; No = 0 point)
Elderly (≥75 = 1 point; <75 = 0 point)
Ethnicity (Asian = 2 point; Non-Asian = 0 point)
Disease Cardiovascular (Yes = 2 points; No = point)
Disease Cerebrovascular (Yes = 2 points; No = point)
DAPT or anticoagulant (Yes = 1 point; No = point)
Sex (Male = 1 point; Female = 0 point)

IC B2LEED3 score of ≥5 predicts a ≥1% annual risk of ICH

Amarenco P et al. Cerebrovasc Dis2017;43:145-151



Ongoing bleeding

Medical **Angio only**

PCI if uncontrolled ischemic situation

= Class I = Class IIa = Class IIb

Very HBR is defined as recent bleeding in the past month and/or not deferrable planned surgery.

2020 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation (European Heart Journal 2020 - doi/10.1093/eurheartj/ehaa575)

Estimation du risque hémorragique

HBR PCI (one factor or more)

- Elderly age ≥75 years
- OAC planned after PCI — M
- Renal failure (CrCl <40 ml/min) — M
- Planned surgery <1 year — M
- Anemia (Hgb <11 g/dl) — M
- Hospitalization for bleeding within 1 — M
- Thrombocytopenia (<100,000/mm^3) — M
- Cancer diagnosed or treated w/i 3 years — M
- Stroke within 1 year or any prior ICH — M
- Severe chronic liver disease — M
- Long-term NSAID or steroid use
- ❑ Expected DAPT non-compliance

Assess easily bleeding risk

A AGE

- **Frail elderly >75 years***
- **Advanced age >85 years***
- **Life expectancy <1 year**

** Must be accompanied with an additional risk factor*

B BLEEDING

- **Spontaneous intracranial haemorrhage**
- **Recurrent gastrointestinal bleeding**
- **Haemoglobin <9 g/dL**

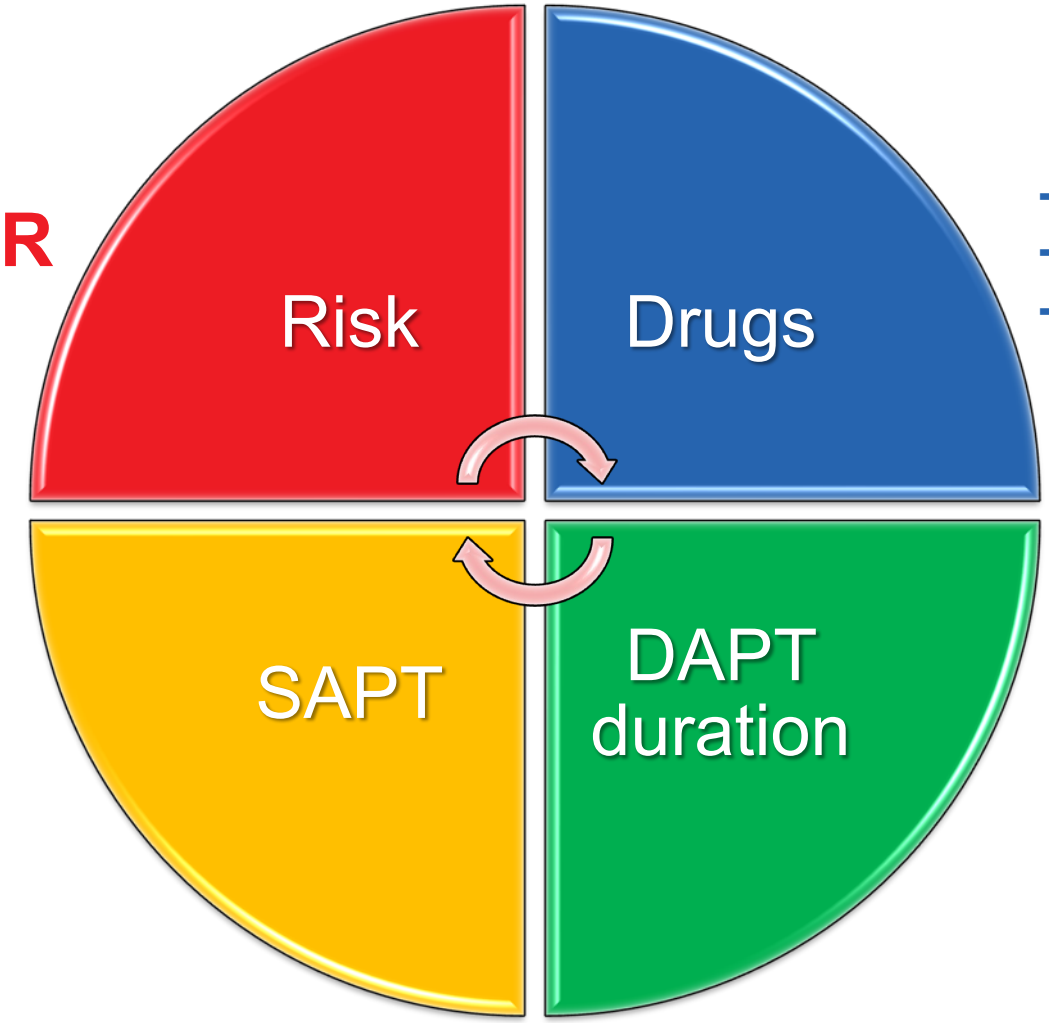
O ORGAN DYSFUNCTION

- **Liver cirrhosis**
- **End-stage renal failure, requiring dialysis**
- **Bone marrow failure, e.g. severe thrombocytopaenia, platelet count < 50,000/µL**
- **Stroke in the last 6 months**

Estimation du risque global

How?

HBR / HIR



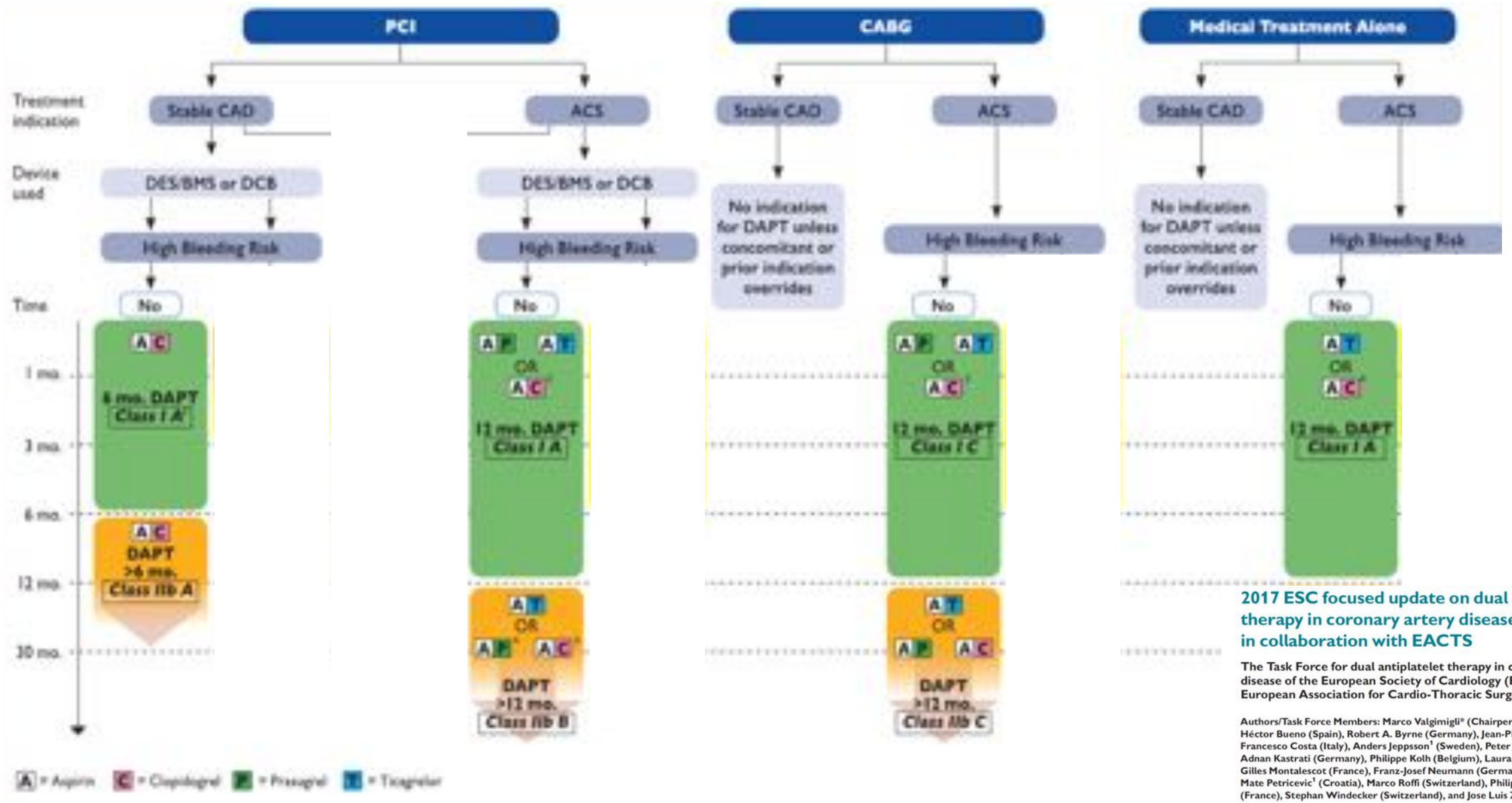
-Prasugrel/ticagrelor
-Doses
-Clopidogrel

Clopidogrel
Ticagrelor
Aspirin

-Define mandatory duration @ cathlab exit
-Adjust duration @ FU

Quand ne pas faire de désescalade?

DAPT indications



2017 ESC focused update on dual antiplatelet therapy in coronary artery disease developed in collaboration with EACTS

The Task Force for dual antiplatelet therapy in coronary artery disease of the European Society of Cardiology (ESC) and of the European Association for Cardio-Thoracic Surgery (EACTS)

Authors/Task Force Members: Marco Valgimigli* (Chairperson) (Switzerland), Héctor Bueno (Spain), Robert A. Byrne (Germany), Jean-Philippe Collet (France), Francesco Costa (Italy), Anders Jeppsson[1] (Sweden), Peter Jüni (Canada), Adnan Kastrati (Germany), Philippe Kolh (Belgium), Laura Mauri (USA), Gilles Montalescot (France), Franz-Josef Neumann (Germany), Mate Petricevic[1] (Croatia), Marco Roffi (Switzerland), Philippe Gabriel Steg (France), Stephan Windecker (Switzerland), and Jose Luis Zamorano (Spain)

Quand et comment faire une désescalade?

LE RISQUE HEMORRAGIQUE 11h30 - 12h30

Modérateurs : Thomas CUISSET - Bernard KARSENTY - Gilles MONTALESCOT

La sous-estimation du risque	Gilles MONTALESCOT (Paris)
Anti-agrégation plaquettaire: la double pas si simple	Guillaume CAYLA (Nimes)
Conception des DES et DAPT	Bernard KARSENTY (Pessac)
Quel stent pour une DAPT plus courte ?	Nicolas MENEVEAU (Besançon)