

Stent chez le patient anticoagulé



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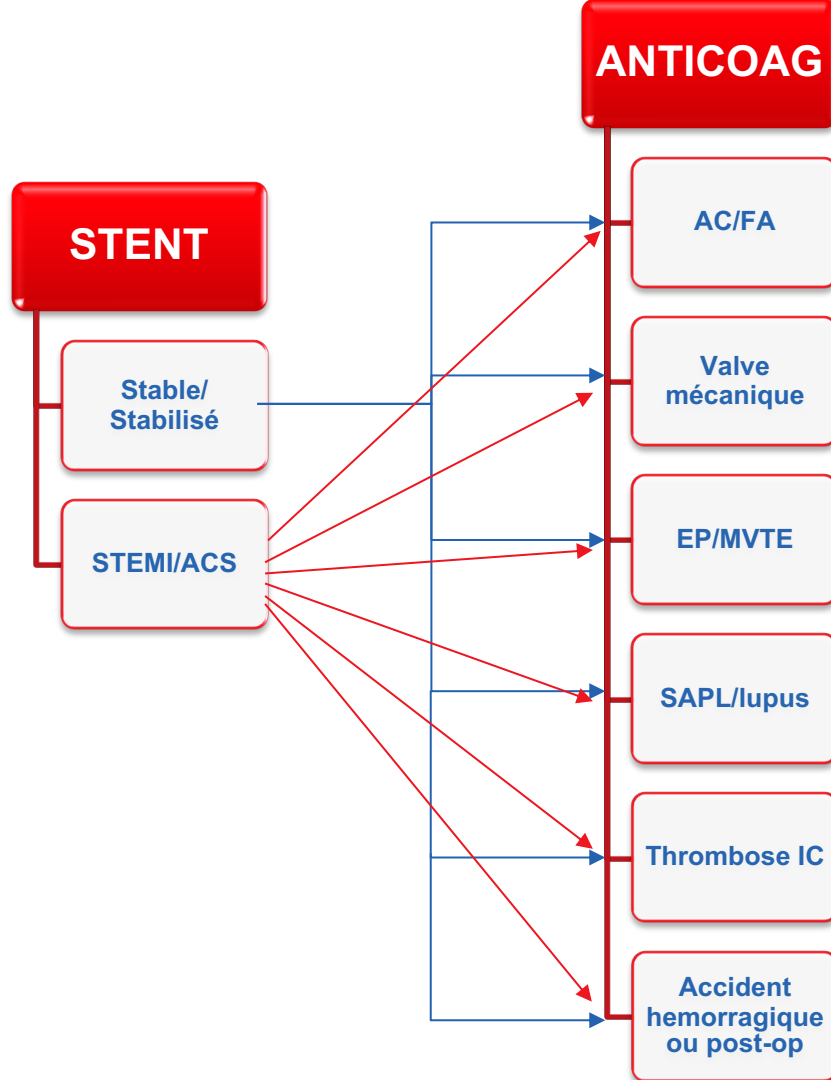
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Paris, France



www.action-groupe.org



Situations cliniques multiples

Pas de recette unique

Orientations et principes



Reconnaitre le HBR

HBR PCI (one factor or more)



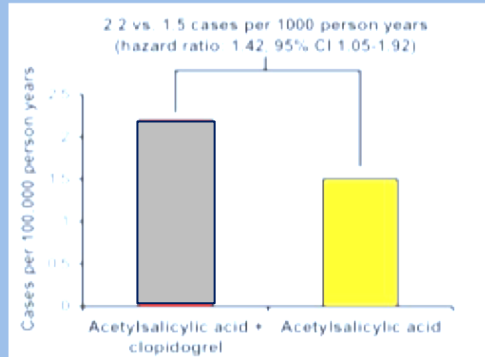
OAC planned after PCI



- risque $\geq 4\%$ de saignement important (BARC 3 ou 5)
ou
- risque $\geq 1\%$ de saignement intracrânien

Risk of ICH (drug)

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

ASA+clopi → **ASA+prasu**
HR 0.67 (0.28-1.65) - TRILOGY

ASA+prasu → **0,2%**

ASA+tica → **0,4%**

ISAR-REACT5

Risk of ICH (patient)

Intracranial-B2LEED3S

BMI (<25 = 1 point; $\geq$ 25 = 0 point) **Blood Pressure (high)** (Yes = 2 points; No = 0 point)

Lacune / small disease (Yes = 1 point; No = 0 point)

Elderly ($\geq$ 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 $\geq$ 5 predicts a $\geq$ 1% annual risk of ICH



Avant et au Cath Lab

Décisions

01

Radiale

Low HBR ou urgence

Sous A/C
Peu d'héparine
Pas d'antiplaq IV

High HBR programmé

Sous A/C
Peu ou pas d'héparine
Pas de pré-traitement

02

Fémorale

Urgence

Ponction sous echo
Peu d'héparine
Pas d'antiplaq IV
Système de fermeture

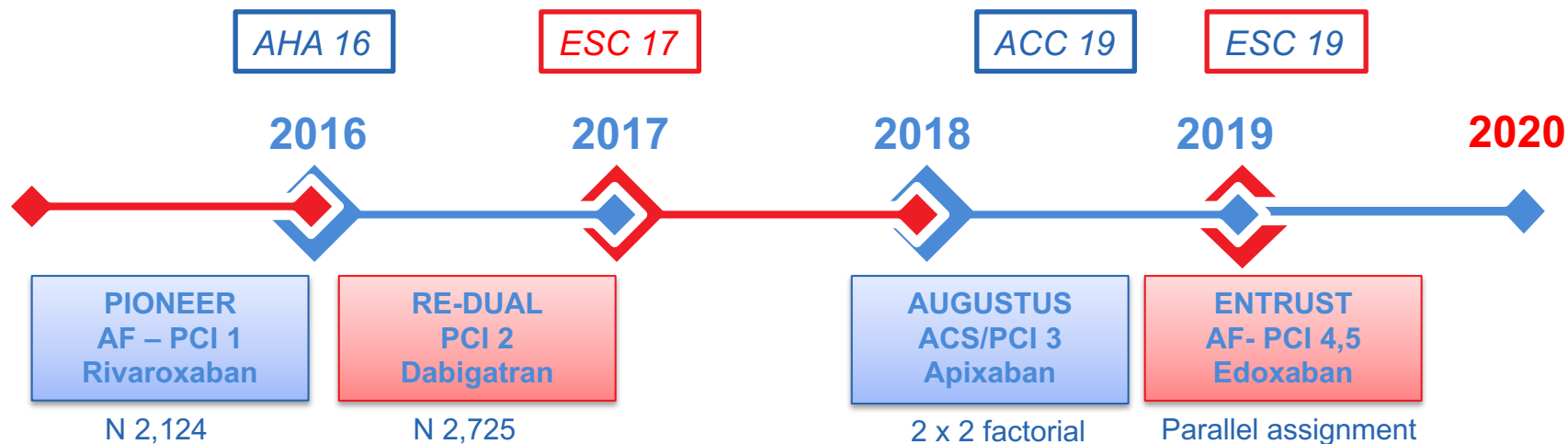
Programmé

Discuter arrêt A/C sans relais
Ponction sous echo
Pas de pré-traitement
Système de fermeture



Après le Cath Lab

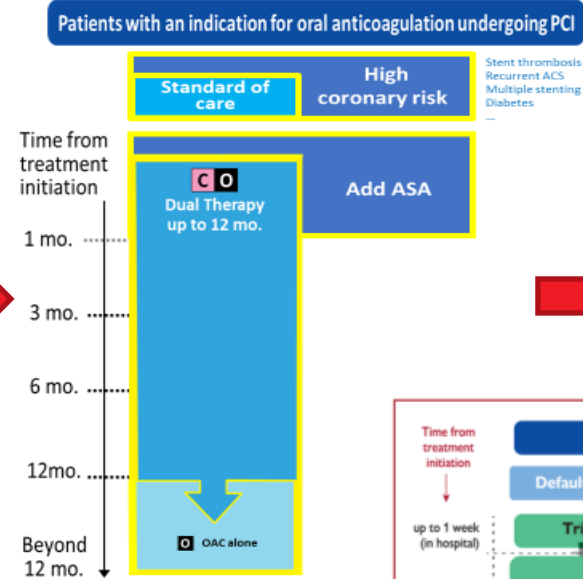
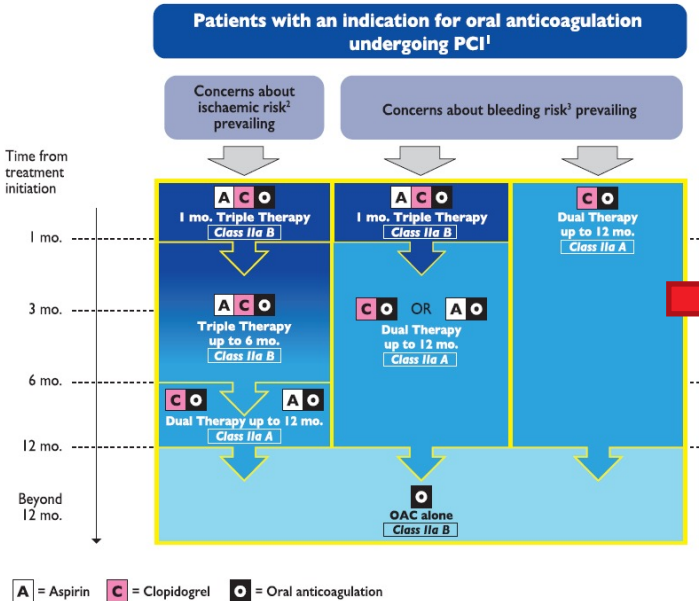
Le modèle FA et stent



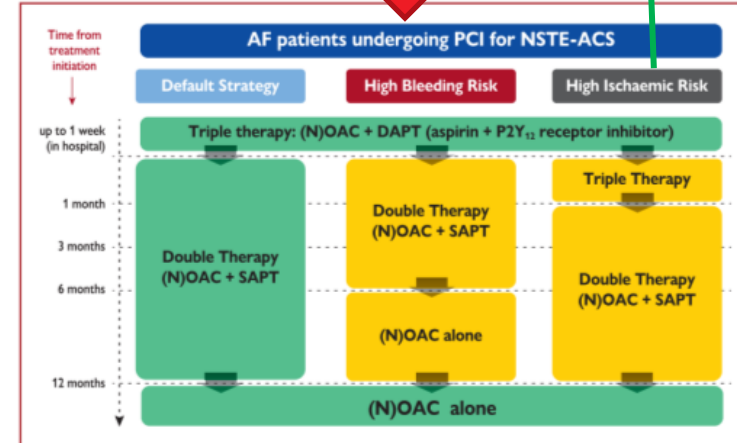
None of these trials were powered for efficacy



ESC Guidelines 2017 → 2020



Who are those?



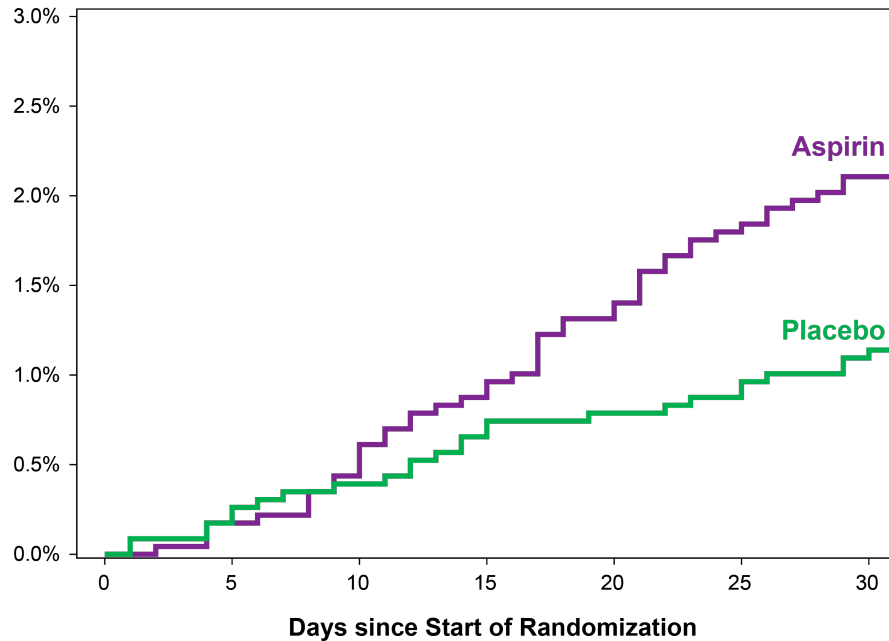
Hammoudi N, Montalescot G. Eur Heart J 2018

Collet JP, Thiele H et al. ESC NSTEMI-ACS Guidelines 2020

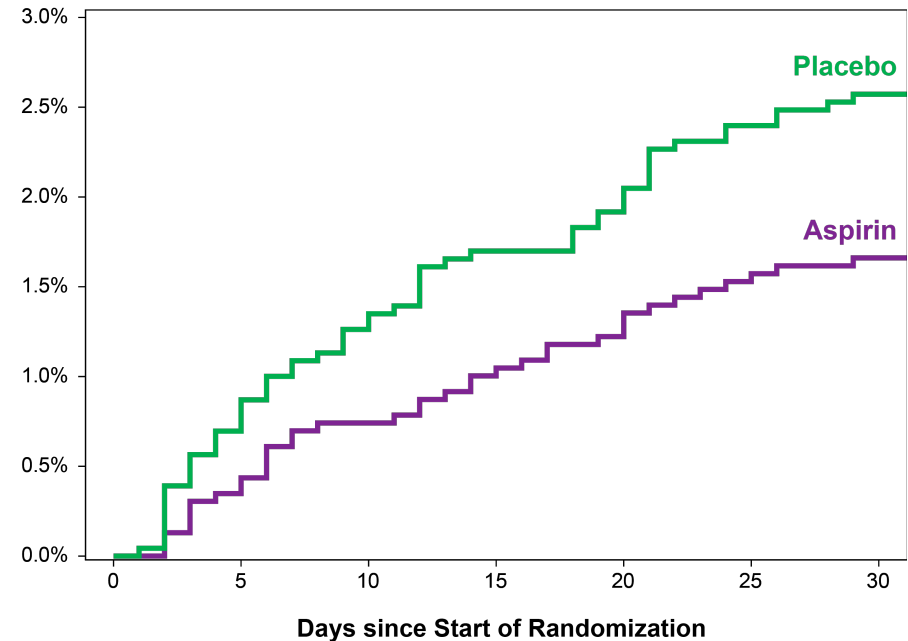
Severe Bleeding and Ischemic Outcomes in AUGUSTUS

Randomization to 30 Days

Fatal, ICH, Major Bleeding



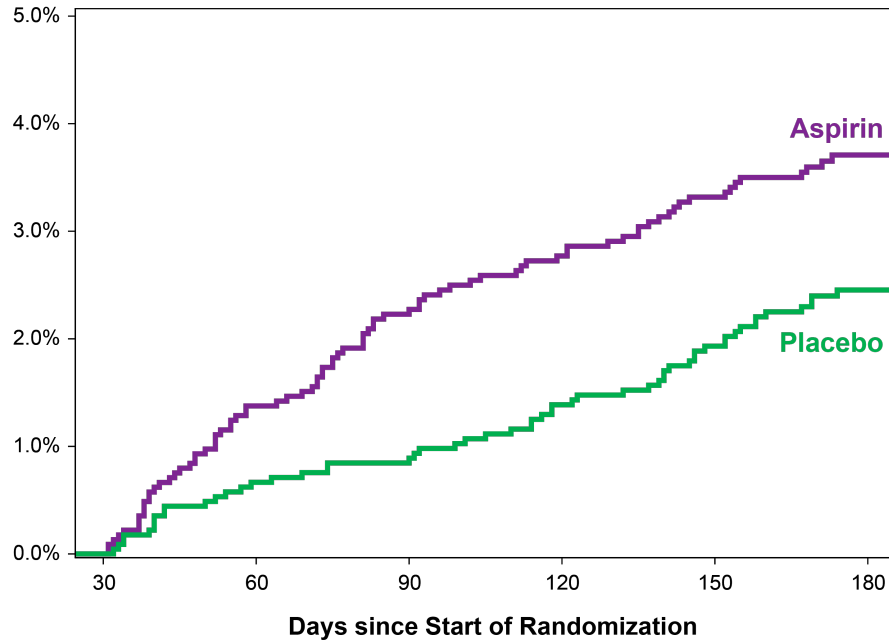
CV Death, Stroke, MI, Stent Thrombosis



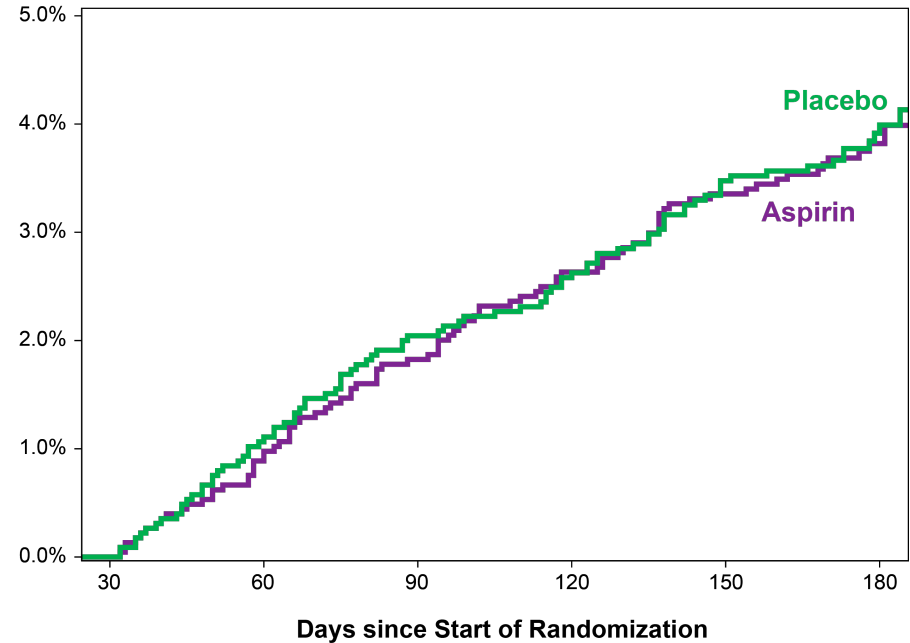
Severe Bleeding and Ischemic Outcomes in AUGUSTUS

30 Days to 6 Months

Fatal, ICH, Major Bleeding



CV Death, Stroke, MI, Stent Thrombosis

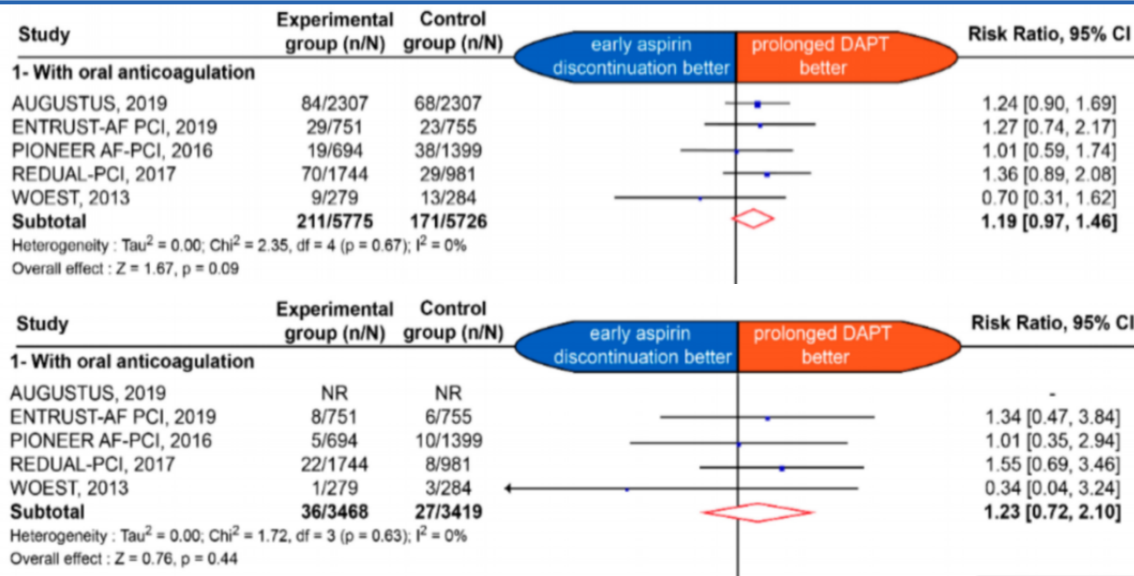


Early Aspirin Discontinuation Following Acute Coronary Syndrome or Percutaneous Coronary Intervention: A Systematic Review and Meta-Analysis of Randomized Controlled Trials

Paul Guedeney ¹, Jules Mesnier ¹, Sabato Sorrentino ², Farouk Abcha ¹ , Michel Zeitouni ¹, Benoit Lattuca ¹, Johanne Silvain ¹, Salvatore De Rosa ² , Ciro Indolfi ² , Jean-Philippe Collet ¹, Mathieu Kerneis ¹ and Gilles Montalescot ^{1,*}

Myocardial
Infarction

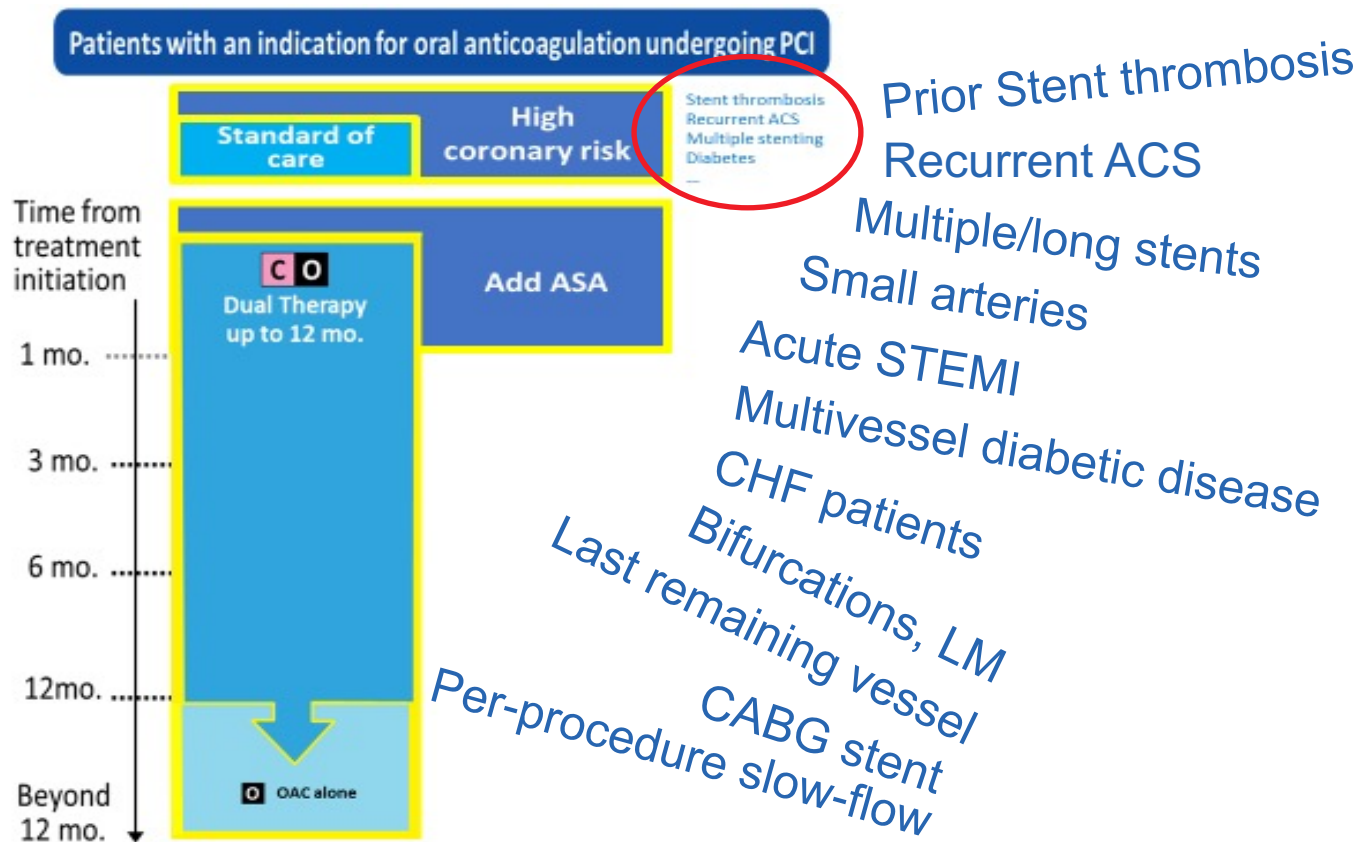
Stent
Thrombosis



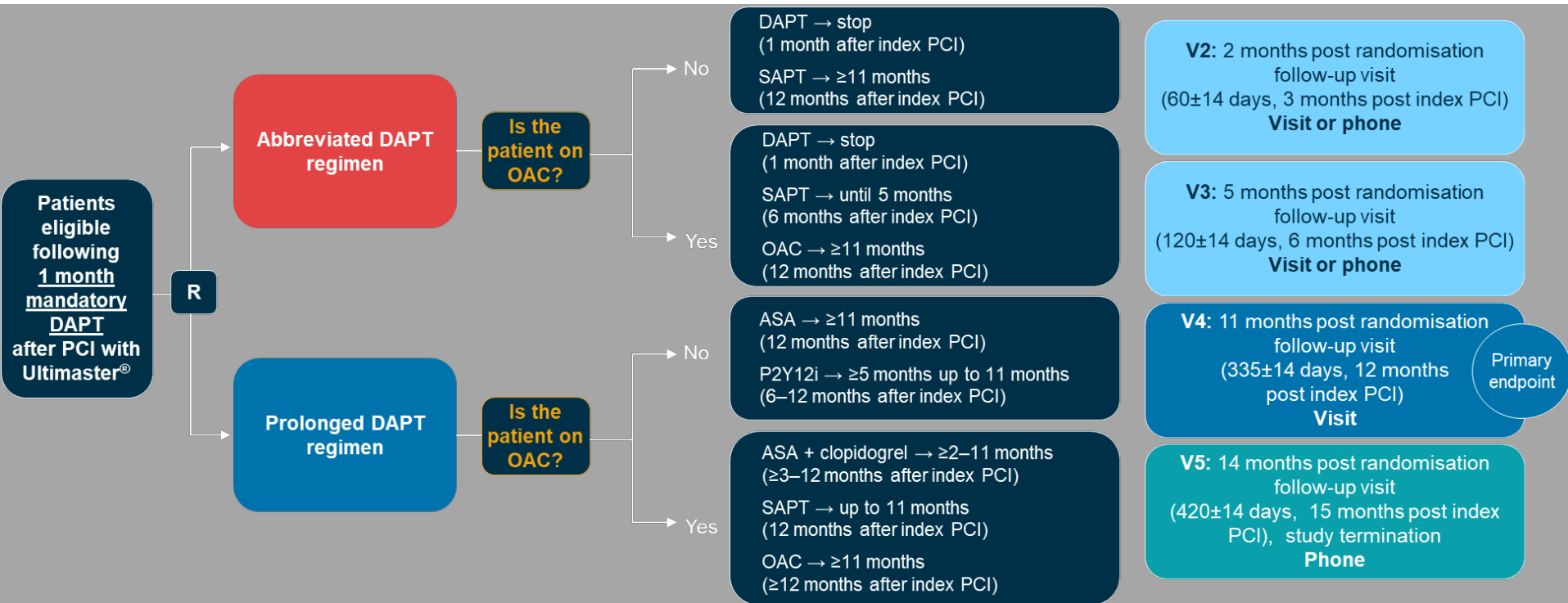
When shall we drop the antiplatelet agent?

	NOAC+P2Y12
PIONEER	Rx up to 72 hrs after PCI
REDUAL	Rx up to 120 hrs after PCI
AUGUSTUS	Rx up to 15 days after ACS or PCI (average 6,6 days)
ENTRUST	Rx up to 5 days after PCI (average 45hrs)

High ischemic risk...lots of patients



MASTER-DAPT





Après la période APT
obligatoire (6mois-1an)

Durée de l'aspirine

2200 patients with AF (CHADS₂ ≥ 1) and stable CAD

Key inclusion criteria

- ◆ Underwent PCI or CABG more than 1 year earlier
- ◆ Angiographically confirmed CAD (with stenosis of ≥ 50%) not requiring revascularization

Key exclusion criteria

- ◆ A history of stent thrombosis
- ◆ Coexisting active tumor
- ◆ Poorly controlled hypertension

R
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Rivaroxaban Monotherapy

◆ Rivaroxaban 10 or 15 mg/day ²⁾*

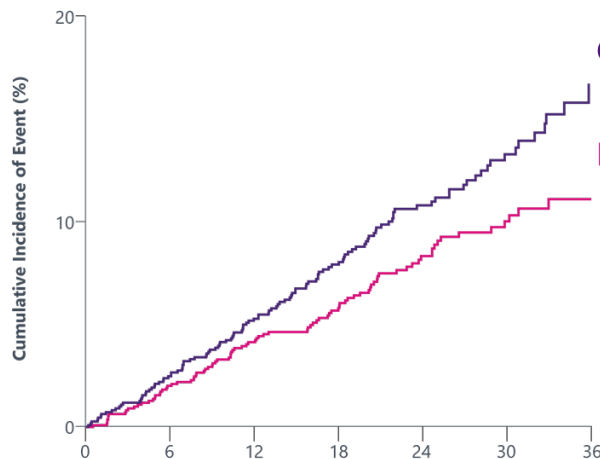
*The level of rivaroxaban in blood samples obtained from Japanese patients who were taking rivaroxaban at the 15-mg dose was similar to the level in white patients who were taking the 20-mg dose.

Combination Therapy

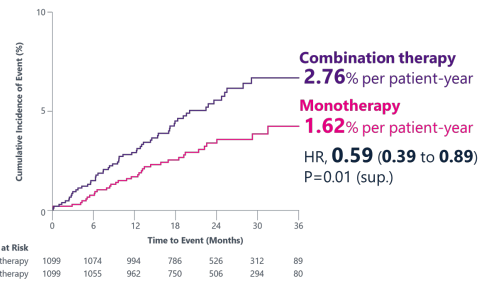
◆ Rivaroxaban 10 or 15 mg/day

◆ Single antiplatelet

Aspirin 81 or 100 mg/day,
Clopidogrel 50 or 75 mg/day, Prasugrel 2.5 or 3.75 mg/day



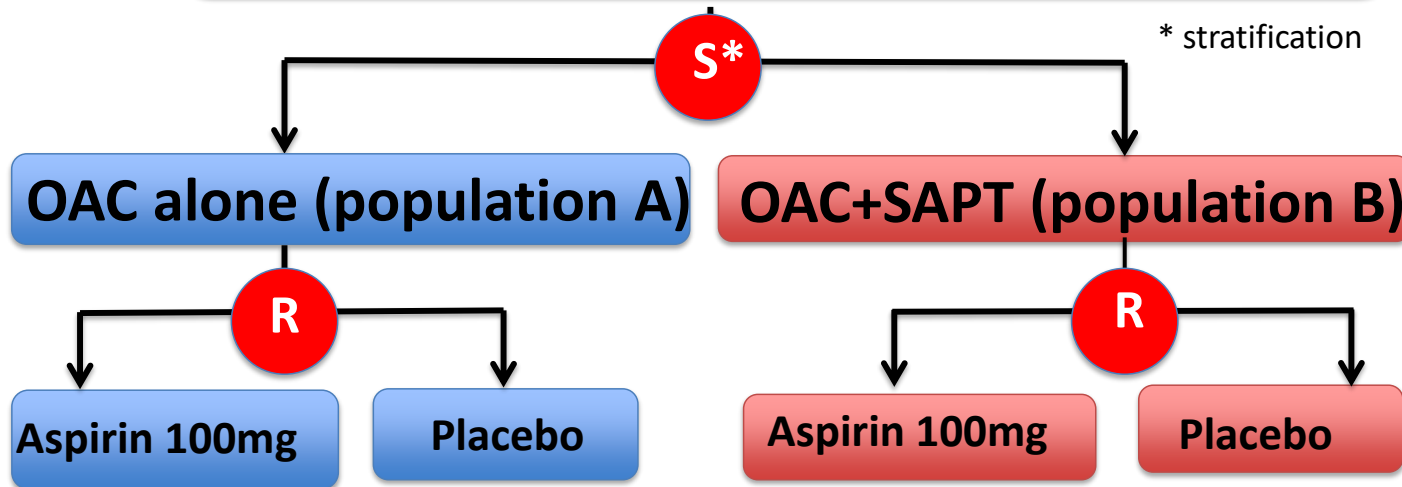
Kaplan-Meier Estimates of First Occurrence of Primary Safety Events



All-cause death: HR 0.55 (0.38-0.81)

Yasuda et al. AFIRE - NEJM 2019

AF patients on OAC therapy (+/- SAPT)
History of stent implantation > 12 months
High ischemic risk-Low bleeding risk



Primary ischemic endpoint : CV death, MI, Stroke, any coronary revasc, systemic embolism, ALI
Primary safety endpoint: Major bleeding events (ISTH)

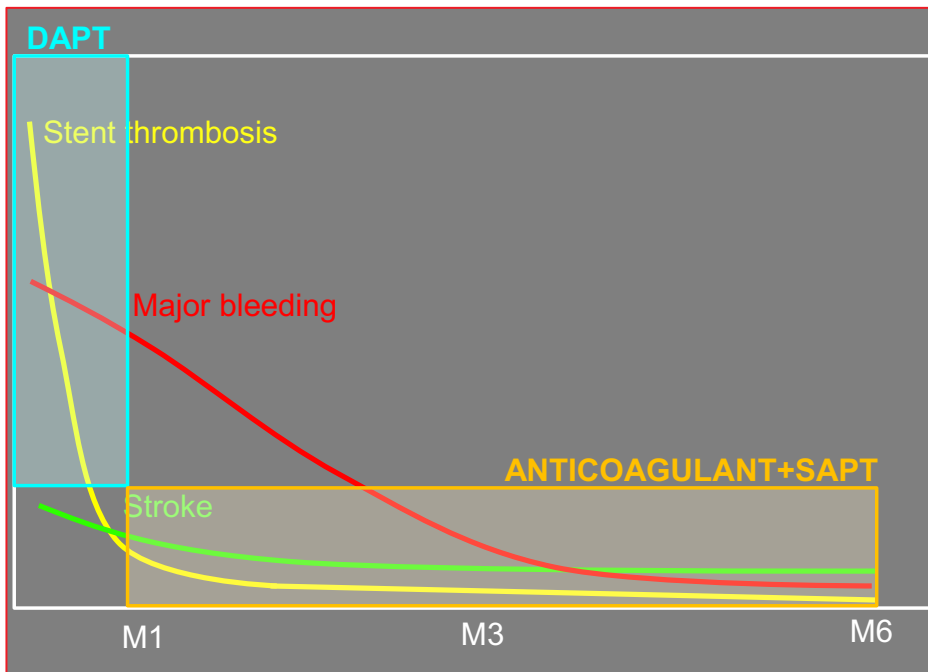
Conclusions

- 01 Avant et au KT: réduire les risques (hémorragiques)
- 02 Reconnaître le haut risque hémorragique
- 03 Dans l'urgence ischémique: garder le bénéfice attendu en tête
- 04 Après le KT: arrêt rapide de l'aspirine
- 05 Stratégies individuelles possibles au cas par cas
- 06 Arrêt du dernier antiplaquettaire → randomiser

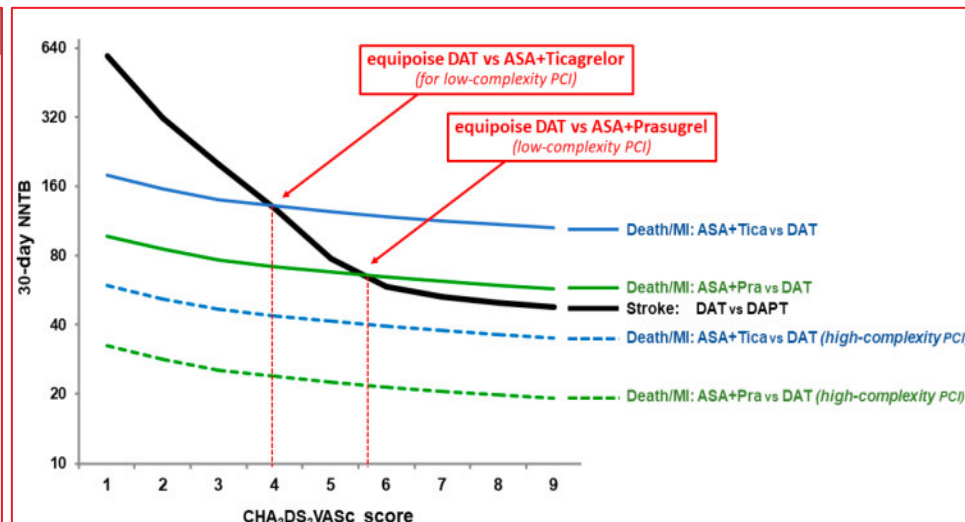


Autres possibilités au cas par cas

Other options may allow safe DAPT for 1Month



Hammoudi N, Montalescot G. Eur Heart J 2018



Limbruno U et al. J Clin Med. 2020 Aug; 9(8): 2673.

Reduced DOA dose

984

Patients ≥80 years of age with nonvalvular AF who were not candidates for standard-dose anticoagulation



Edoxaban
(15 mg daily)



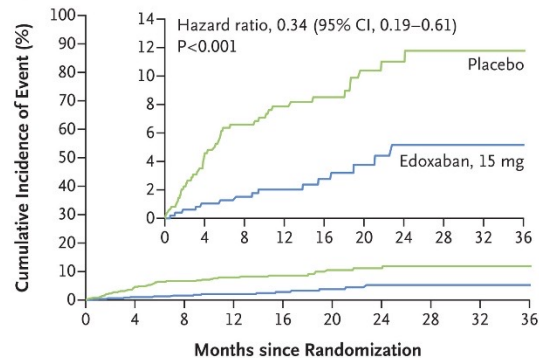
(N=492)

Placebo



(N=492)

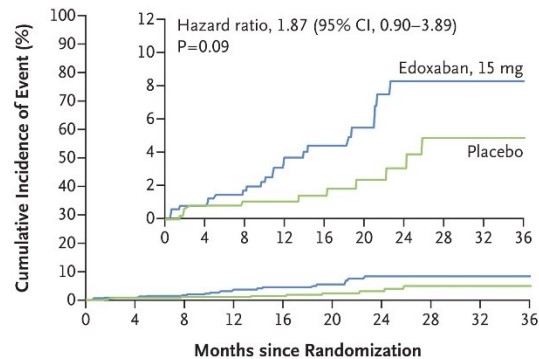
A Stroke or Systemic Embolism



No. at Risk

Edoxaban, 15 mg	492	451	394	323	238	163	116	71	30	7
Placebo	492	439	388	314	237	170	120	74	32	6

B Major Bleeding (ISTH criteria)



No. at Risk

Edoxaban, 15 mg	492	452	391	314	231	158	107	64	28	7
Placebo	490	451	398	322	243	173	122	74	33	7

