

La vérité peut elle venir des registres ?



C'est quoi la vérité à l'ère des fake news ?



QAnon, la pandémie venue des États-Unis

16% de platistes aux EU



La science n'y échappe pas?



« la croyance est plus forte que la raison »

Etienne Klein : la déchéance de rationalité

Même les journaux de référence !

The Lancet

Hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19: a multinational registry analysis

Mandeep R Mehra, Srey Ram Kuy, Frank Sacklani, Amit N Patel

Summary

Background Hydroxychloroquine or chloroquine, when in combination with a second-generation macrolide, are widely used for treatment of COVID-19, despite no conclusive evidence of their benefit. Although these drugs are widely used for approved indications such as autoimmune disease or malaria, the safety and benefits of these treatment regimens are poorly evaluated in COVID-19.

Methods We did a multinational registry analysis of the use of hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19. The registry comprised data from 671 hospitals in 16 countries. We included patients hospitalised between Dec 29, 2019, and April 30, 2020, with a positive laboratory test for SARS-CoV-2. Patients who received one of the treatments of interest within 48 h of diagnosis were included in one of four treatment groups: chloroquine alone, chloroquine with a macrolide, hydroxychloroquine alone, or hydroxychloroquine with a macrolide, and patients who took of none of these treatments formed the control group. Patients for whom one of the treatments of interest was initiated more than 48 h after diagnosis or while they were on mechanical ventilation, as well as patients who received resuscitation, were excluded. The main results of interest were in-hospital mortality and the occurrence of de-novo ventricular arrhythmias (defined as new-onset ventricular tachycardia or ventricular fibrillation).

Findings 14 002 patients (mean age 53·8 years, 46·3% women) with COVID-19 were hospitalised during the study period and met the inclusion criteria. Of these, 10 000 patients were in the treatment groups (5088 received chloroquine, 5781 received chloroquine with a macrolide, 3650 received hydroxychloroquine, and 4120 received hydroxychloroquine with a macrolide) and 3998 were in the control group. 30 678 (21·7%) patients died in hospital. A risk score for multiple comorbidities (coronary artery disease, prior or current tobacco use, prior or current alcohol use, prior or current diabetes, prior or current hypertension, prior or current chronic kidney disease, prior or current chronic liver disease, prior or current chronic lung disease, prior or current rheumatoid arthritis, prior or current autoimmune disease, prior or current cancer, prior or current chronic inflammatory disease, prior or current chronic obstructive pulmonary disease, smoking, immunosuppressed condition, and baseline disease severity) was significantly higher in the control group (8·3%), hydroxychloroquine (28·4%; hazard ratio 1·311, 95% CI 1·250–1·375), hydroxychloroquine with a macrolide (23·8%; 1·667, 1·568–1·770), chloroquine (6·4%; 1·365, 1·281–1·451), and chloroquine with a macrolide (22·2%; 1·279–1·460) were each independently associated with an increased risk of in-hospital mortality. Compared with the control group (0·3%), hydroxychloroquine (1·0%; 1·315–1·594), hydroxychloroquine with a macrolide (0·1%; 1·306, 1·186–1·543), chloroquine (4·1%; 1·315–12·991), and chloroquine with a macrolide (0·1%; 4·911, 3·544–6·812) were independently associated with an increased risk of de-novo ventricular arrhythmias during hospitalisation.

Interpretation There is no evidence of a benefit of hydroxychloroquine or chloroquine, when used alone or with a macrolide, on in-hospital outcomes for COVID-19. Each of these drug regimens was associated with decreased in-hospital mortality and decreased frequency of ventricular arrhythmias when used for treatment of COVID-19.

Funding William Osler (Distinguished Chair in Advanced Cardiovascular Medicine at Brigham and Women's Hospital).

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NEJM

ORIGINAL ARTICLE

Cardiovascular Disease, Drug Therapy, and Mortality in Covid-19

Mandeep R. Mehra, M.D., Srey Ram S. Desai, M.D., Ph.D., Srey Ram Kuy, M.D., M.H.S., Timothy D. Henry, M.D., and Amit N. Patel, M.D.

ORIGINAL ARTICLE



Fig 1. Independent Predictors of In-Hospital Death from Multivariable Logistic-Regression Analysis. Number and percentage of patients with each risk factor who died (risk factor present) and of patients without each risk factor who died (risk factor absent) are shown. The 95% confidence intervals (CIs) of the odds ratios have not been adjusted for multiple testing and should not be used to infer definitive effects. ACE denotes angiotensin-converting enzyme, ARB angiotensin-receptor blocker, and COPD chronic obstructive pulmonary disease.

Conditions pour qu'un registre dise la vérité

- ✓ Qualité des données
- ✓ Porté par les professionnels
- ✓ Financement institutionnel



France – PCI

Projet du GACI

Qualité des données Exhaustivité

Pas de double capture
au sein du logiciel métier

Saisie obligatoire des données

TEC sur place



Clinityx

atout cœur

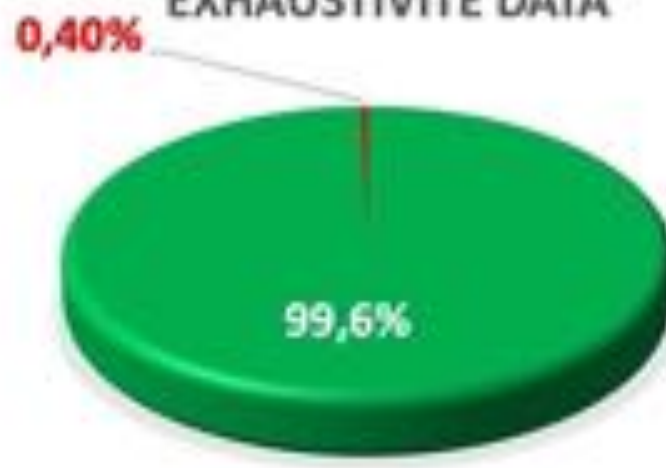


EXHAUSTIVITÉ EXAMENS



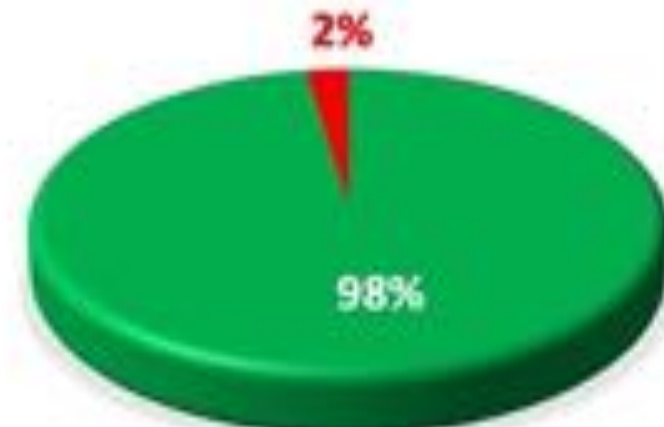
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EXHAUSTIVITÉ DATA



■ datas non obligatoires

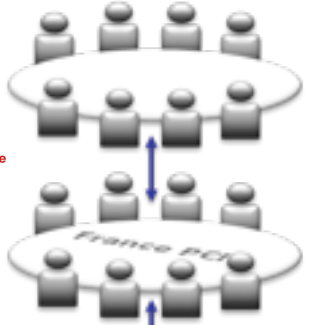
SUIVI 1 AN



■ perdu de vue



GACI / CNP



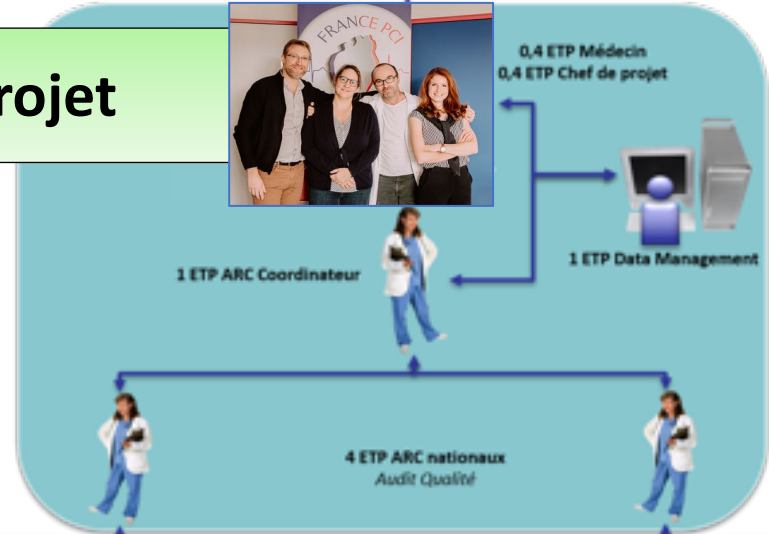
Comité de Pilotage

Financement

DGOS

Equipe Projet

URC cardiologie
Les Hôpitaux de Chartres

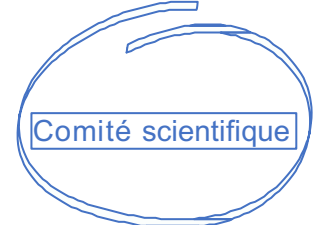
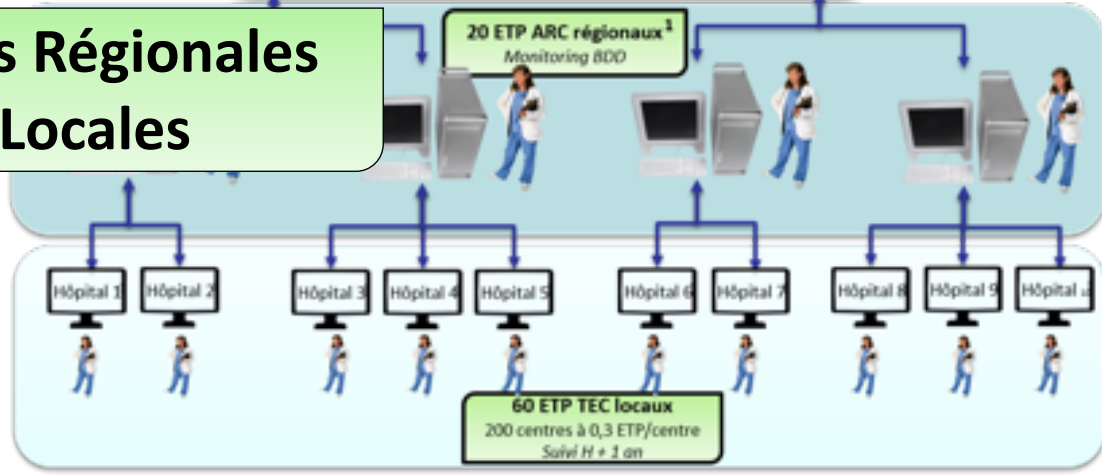


GACI

ARS

Equipes Régionales & Locales

DRCI
ou Assoc régionale



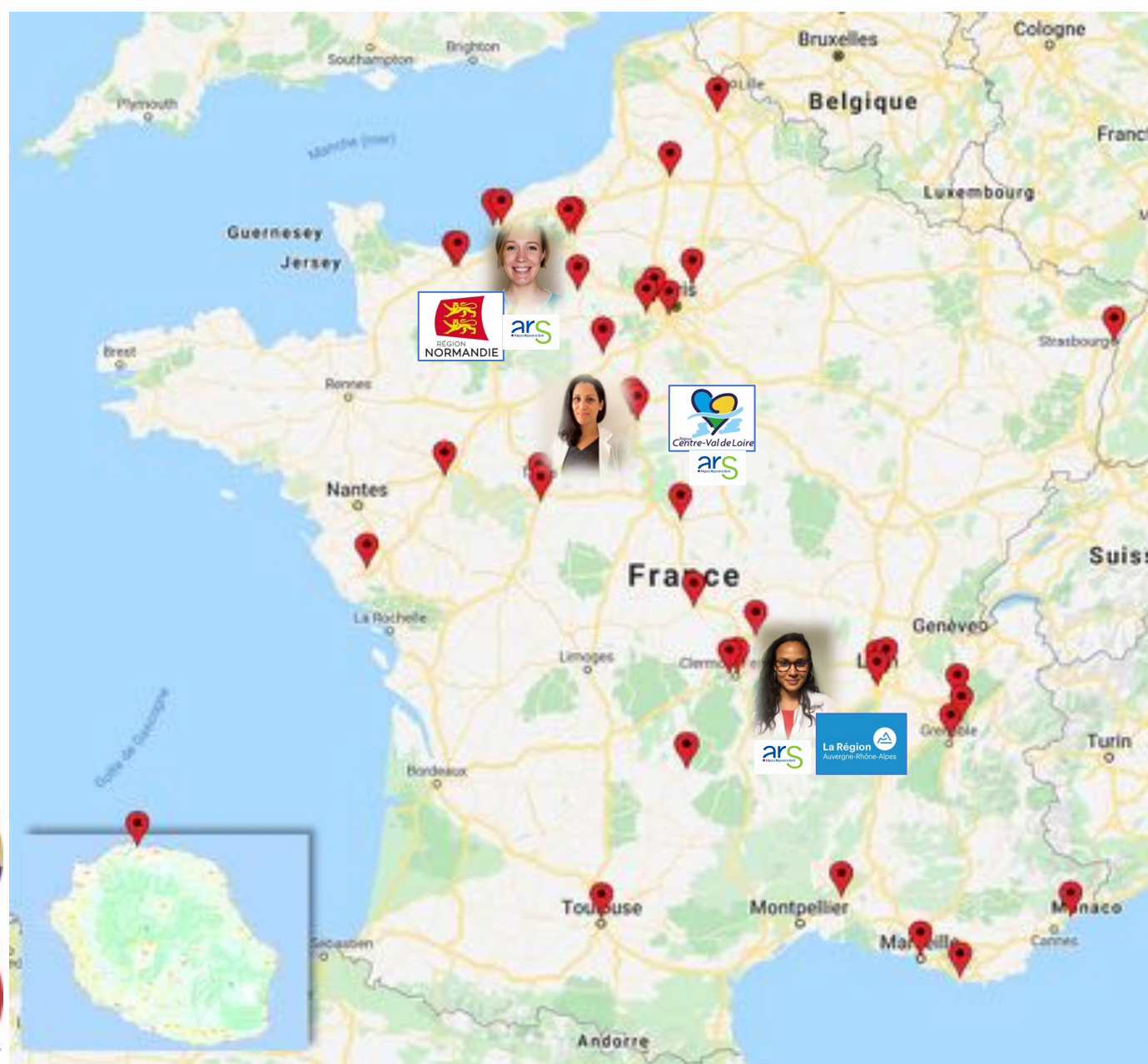
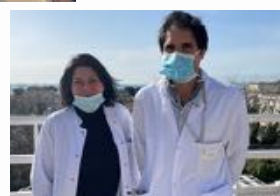
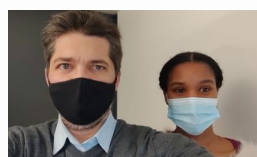
Pr JP Collet

1 : 1 ETP ARC régional pour 3,5 millions d'habitants

ETP: Equivalent temps plein

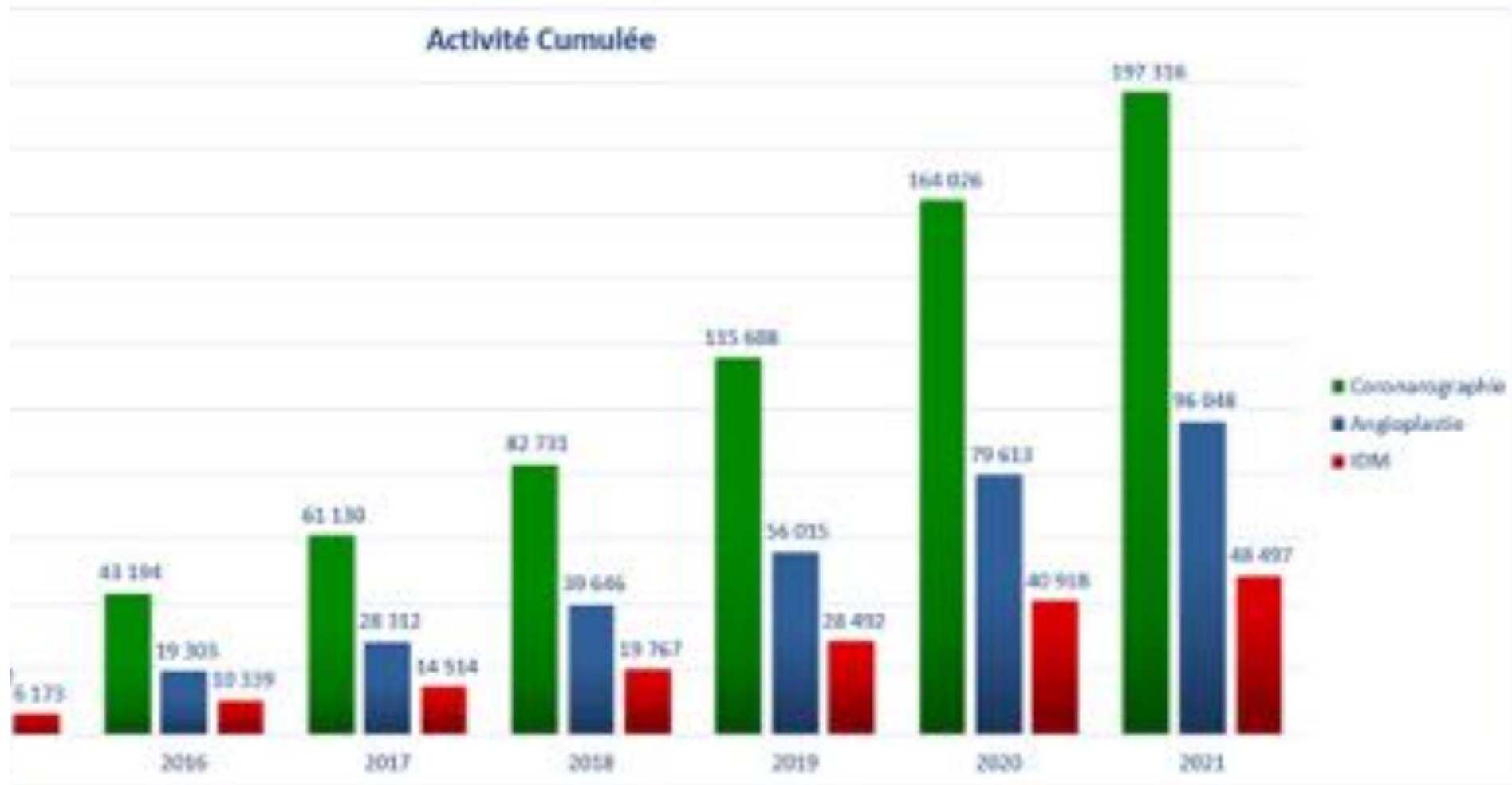


47 centres participants



- Centre Hospitalier de Chartres
- Centre Hospitalier de Bourges
- Clinique Saint Gatien (NCT+)
- CHR d'Orléans
- Clinique d'Orléance, Orléans
- CHRU de Tours
- Clinique Saint Hilaire, Rouen
- GH du Havre
- CHU de Caen
- CHU de Rouen
- Clinique Bergouignan, Evreux
- Hôpital Privé de l'Estuaire, Le Havre
- Clinique Saint Martin, Caen
- CHD Vendée, La Roche Sur Yon
- CHU Clermont Ferrand
- CH d'Aurillac
- GHM Grenoble
- CHU de Grenoble
- GVM La Rosaie, Aubervilliers
- Institut Mutualiste Montsouris, Paris
- CH Montluçon
- Pôle Santé République, Clermont Ferrand
- CH de Chambéry
- Clinique Cardiologie Urgences Amiens
- CH de Vichy
- Polyclinique Les Fleurs, Ollioules
- Institut Arnault Tzanck, St Laurent du Var
- Clinique Saint Joseph, Trélazé
- Hôpital Foch, Suresnes
- Clinique Pasteur, Toulouse
- Hôpital La Timone, Marseille
- CHU de Nîmes
- Médipôle, Lyon
- Hôpital Privé de Bois Bernard
- Clinique Sainte Clotilde, La Réunion
- Centre Hospitalier de Versailles
- CH Saint Joseph Saint Luc
- Clinique Rhéna, Strasbourg
- Clinique de la Sauvegarde, Lyon
- Clinique Convert, Bourg en Bresse
- CH de Cherbourg
- Hôpital Nord, Marseille
- Clinique Rive Gauche, Toulouse
- CHU de Lille
- CHU de Toulouse
- Clinique des Cèdres, Cornebarrieu
- Clinique Belledonne, Grenoble

Etat actuel

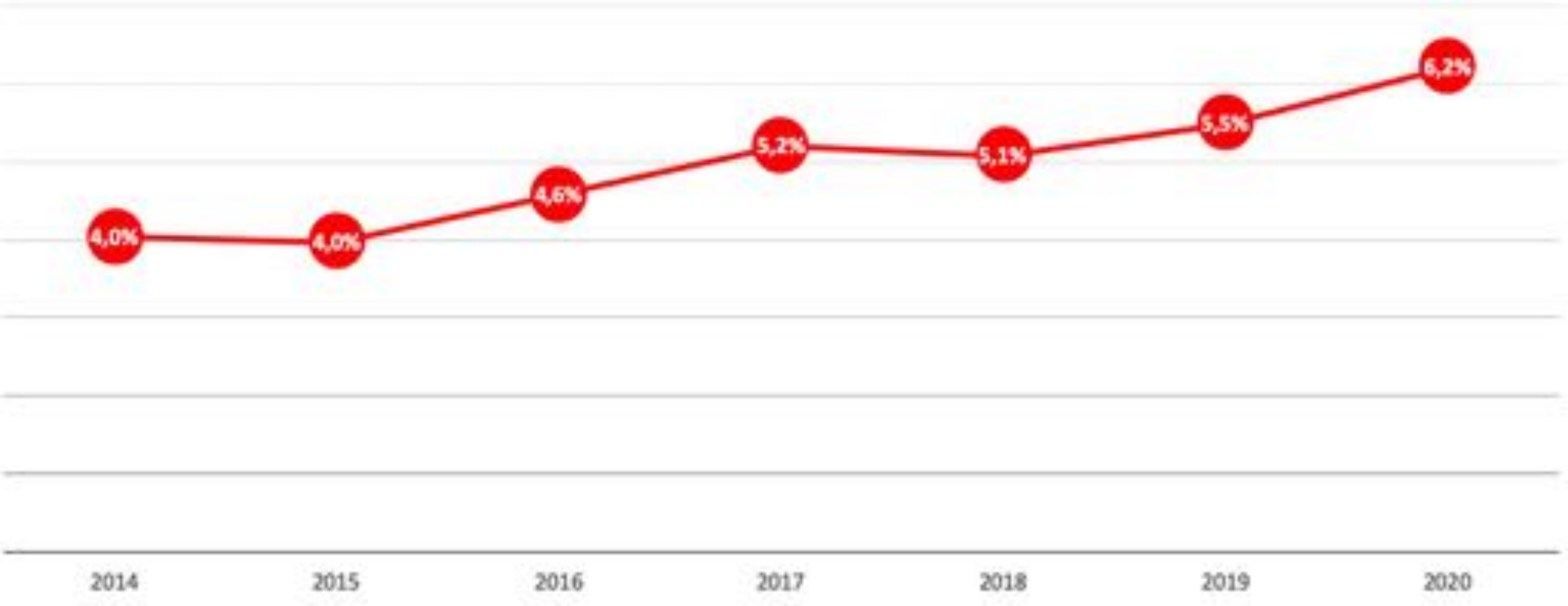




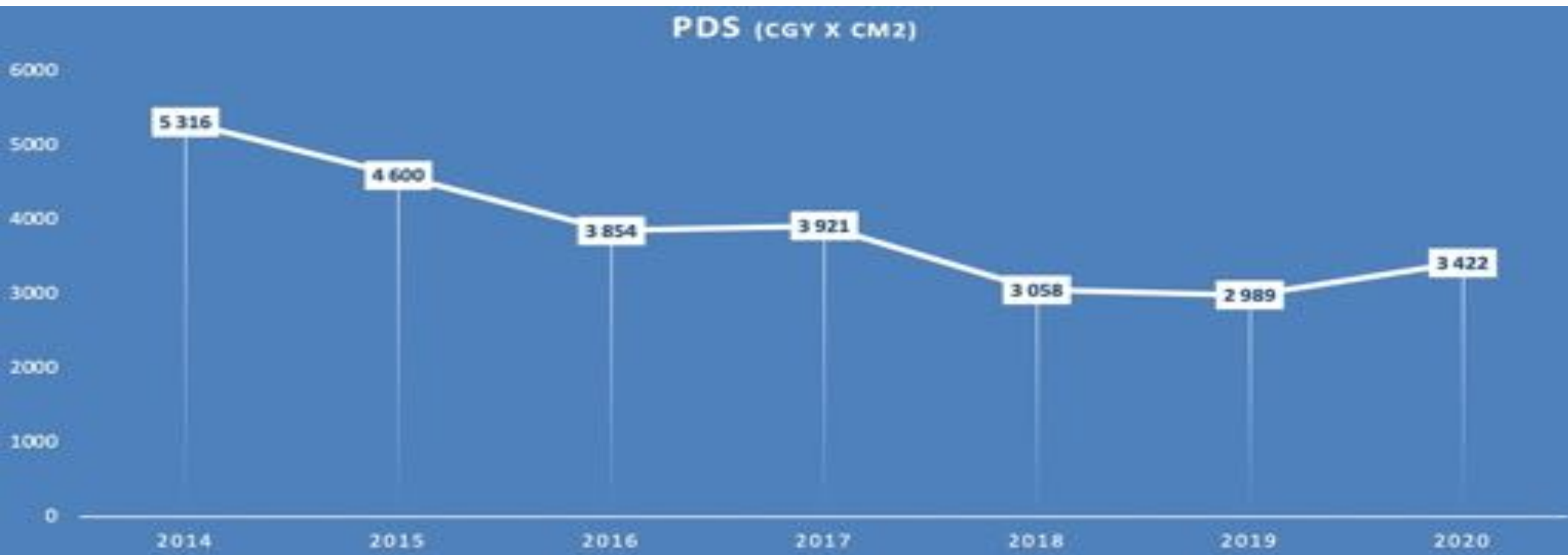
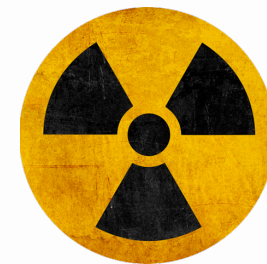
Quelles vérités peuvent donner
les registres?

Evolution des pratiques

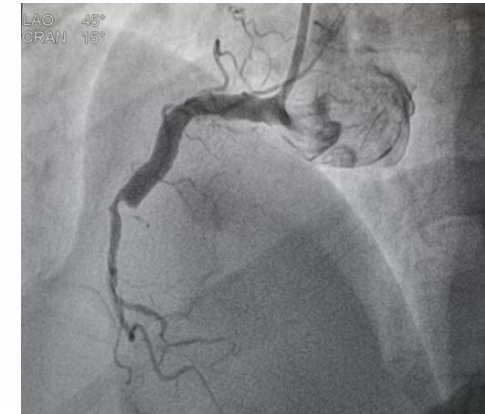
FFR/ATL



RADIO-PROTECTION / TOUTES ATL

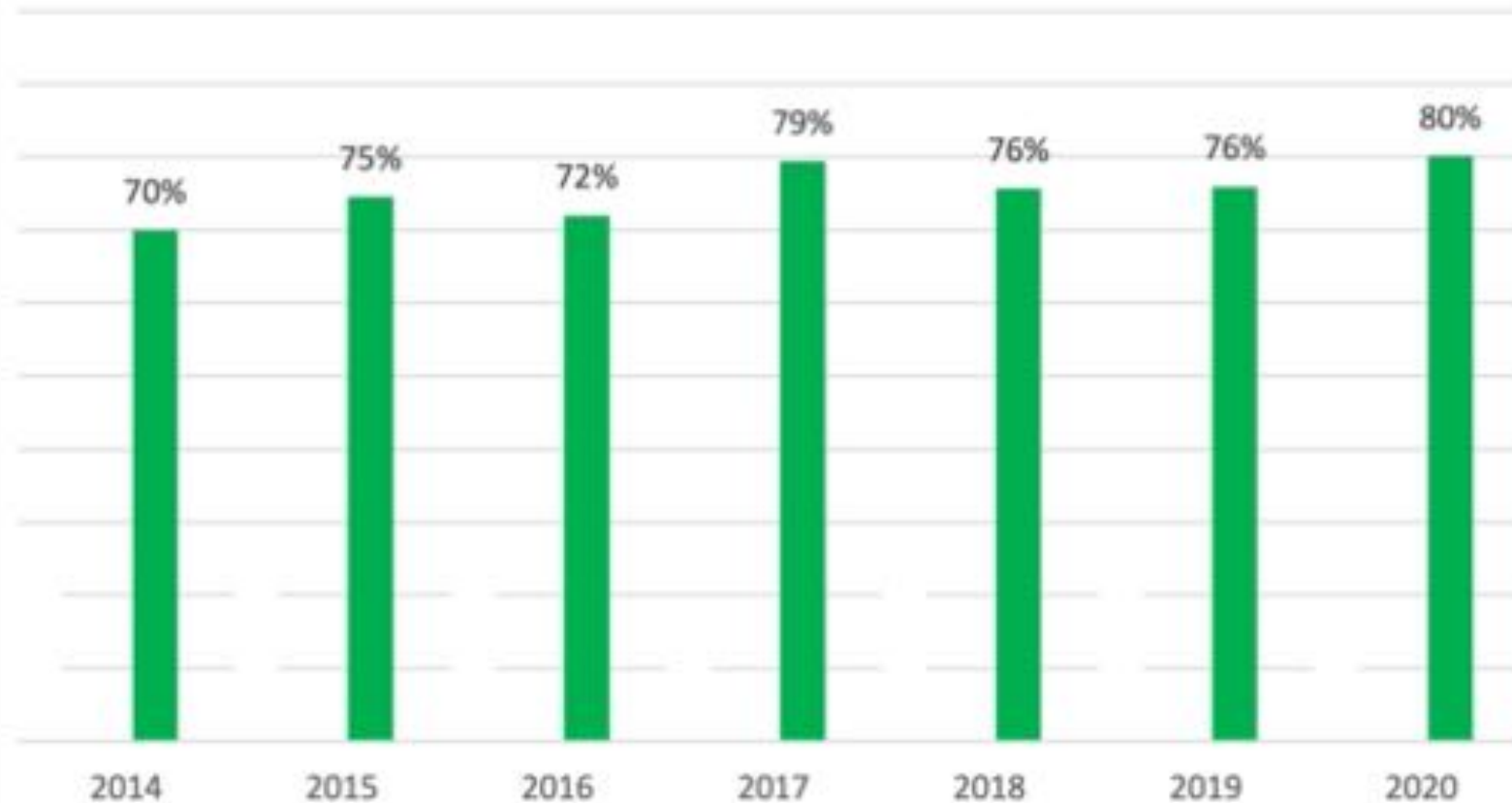


OCCLUSIONS CHRONIQUES (CTO)

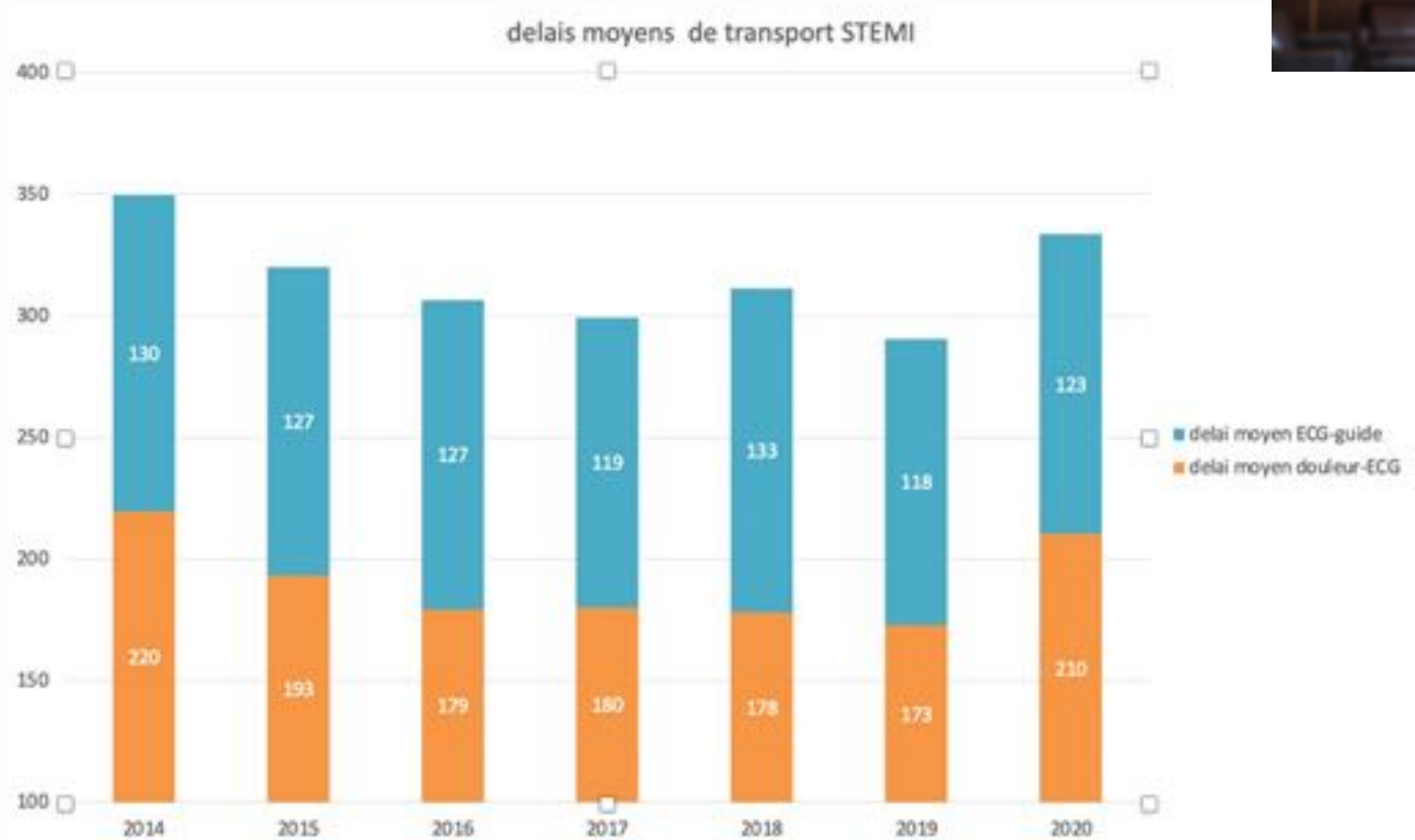
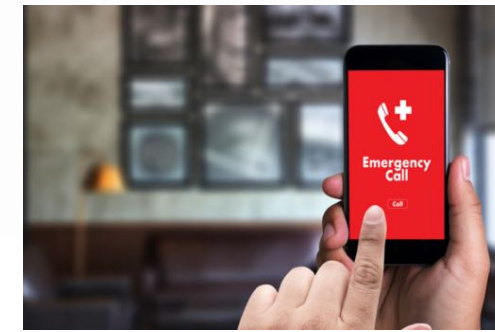


	2014	2015	2016	2017	2018	2019	2020
% CTO / ATL	3%	4%	4%	4%	4%	3%	3%

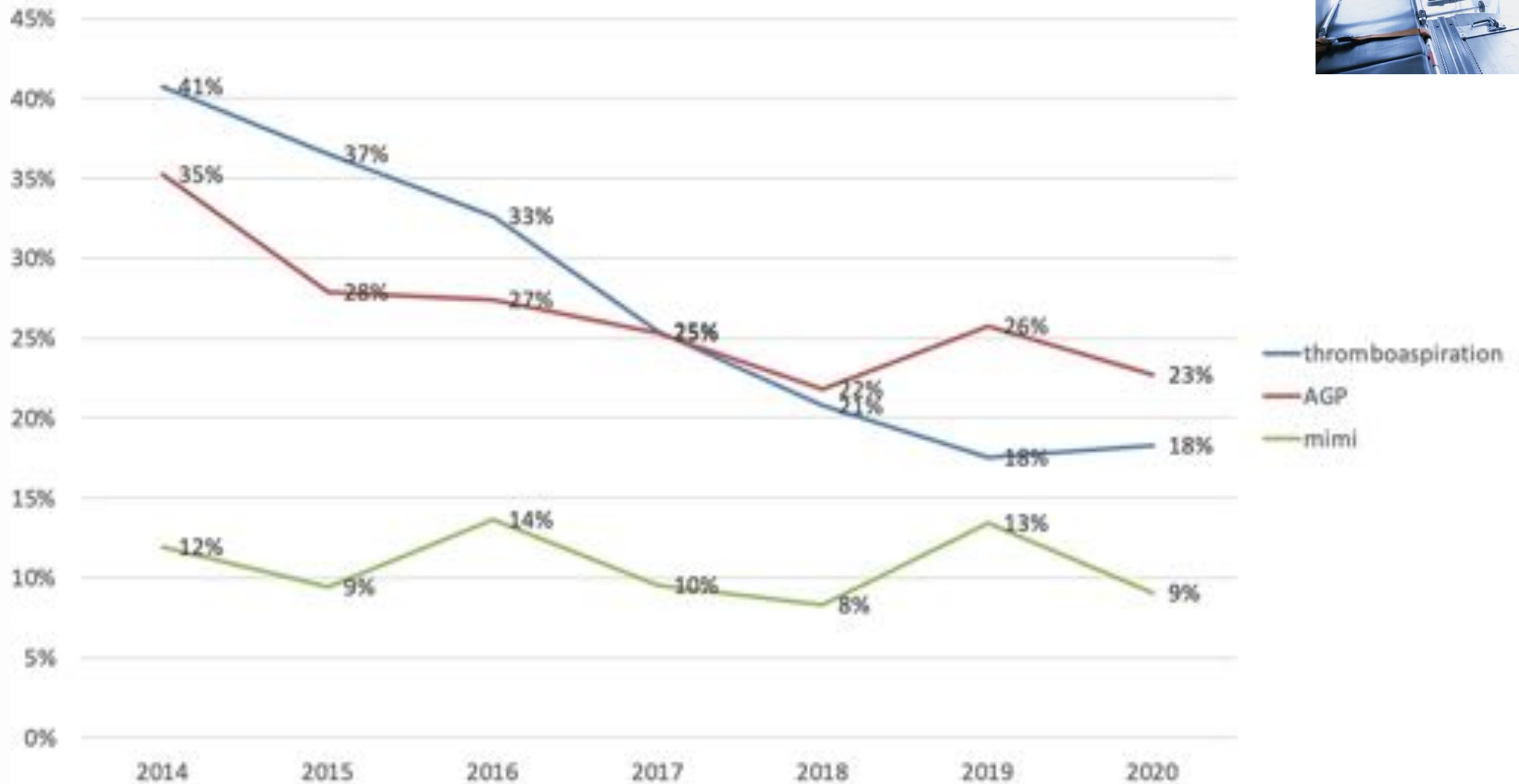
Taux de succès des CTO



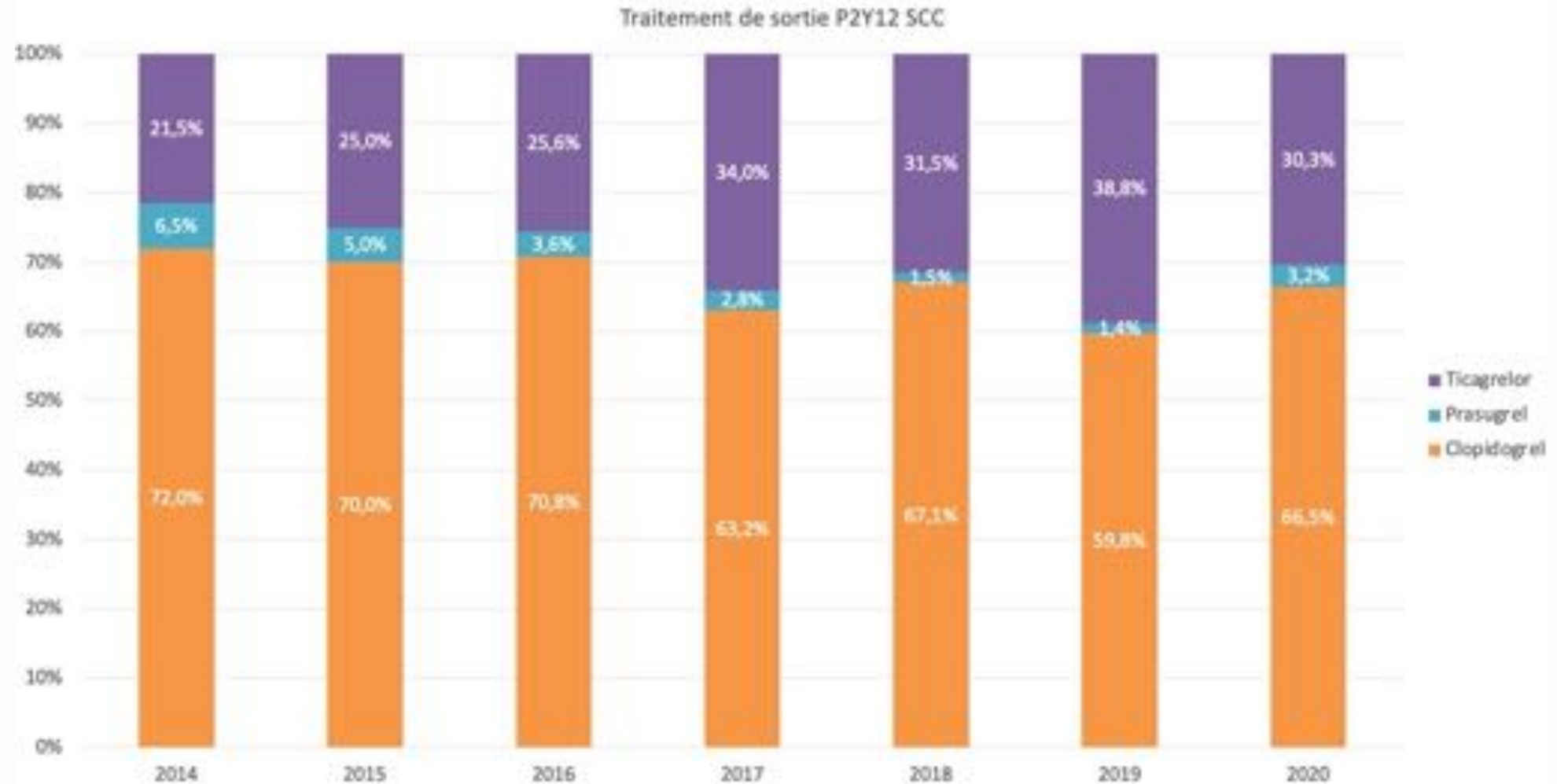
DELAIS PRE HOSPITALIERS / SCA ST+ < H24



TRAITEMENTS ASSOCIÉS / STEMI < H24



TRAITEMENT SORTIE / ANGOR STABLE

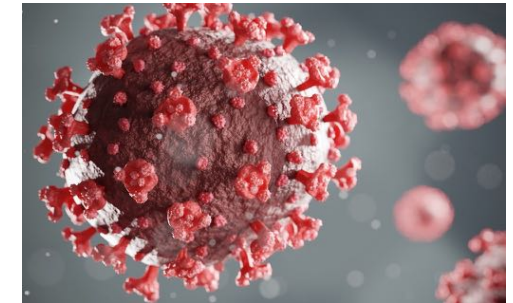
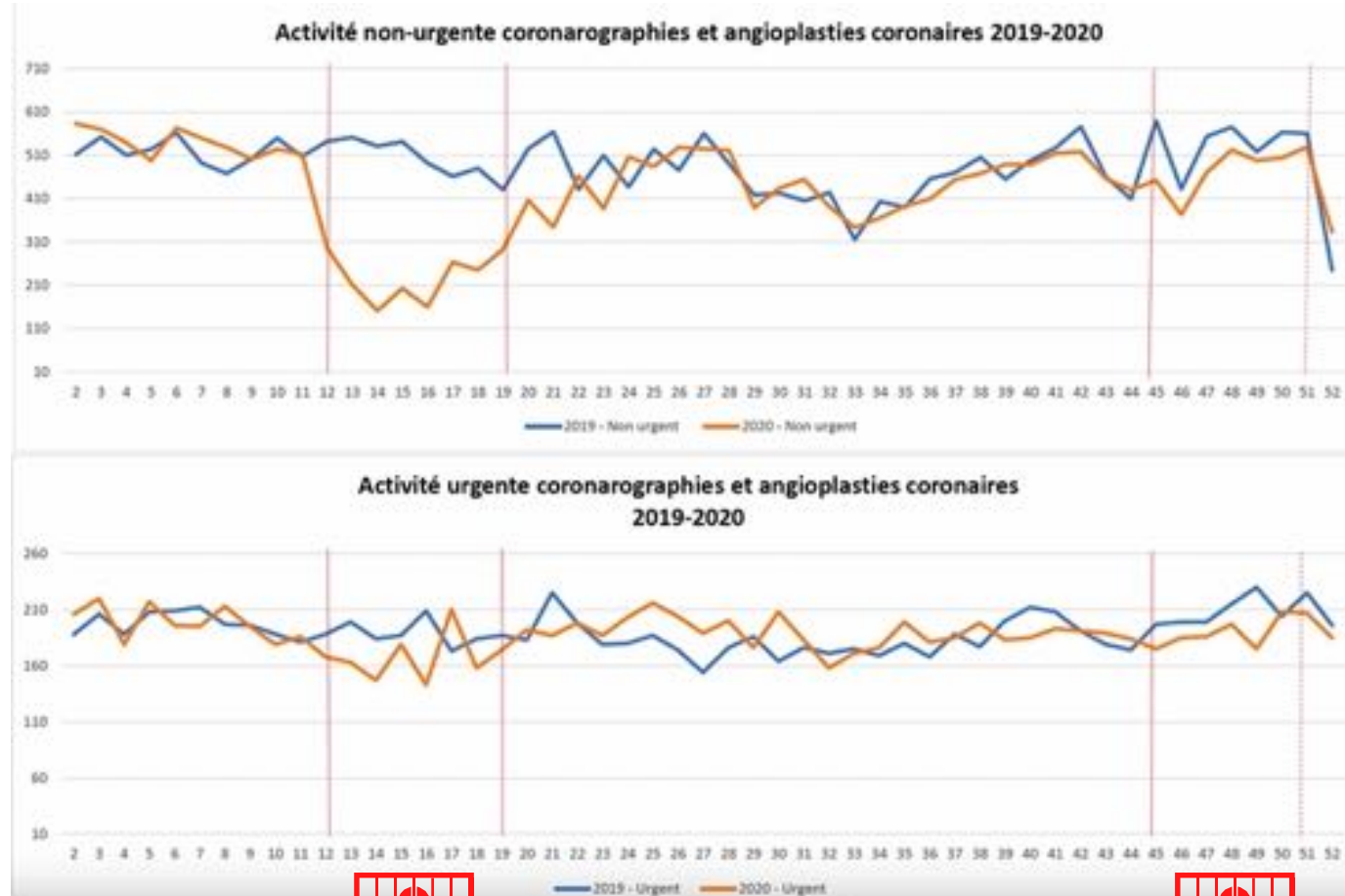


Alertes sanitaires

ACTIVITÉ MENSUELLE* : 2019 VS 2020

IMPACT DE LA PANDEMIE COVID-19

Durant le premier confinement, on a observé une baisse importante des activités programmées (-300 %) et même urgentes (-25 %) de cardiologie interventionnelle. Cette baisse d'activité n'a pas été noté durant le second confinement.



1er confinement



2d confinement

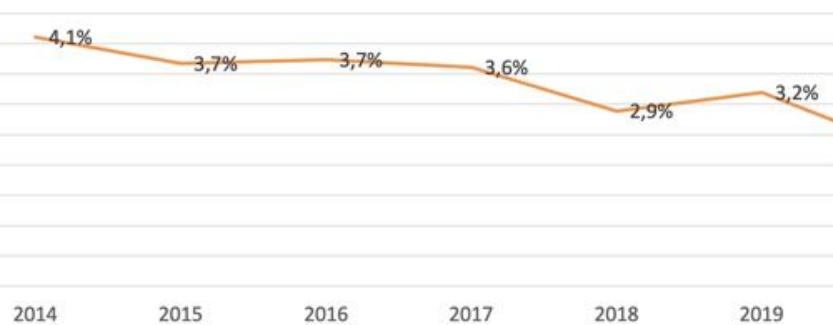


(*)Analyse faite sur les centres ouverts avant 01-01-2019

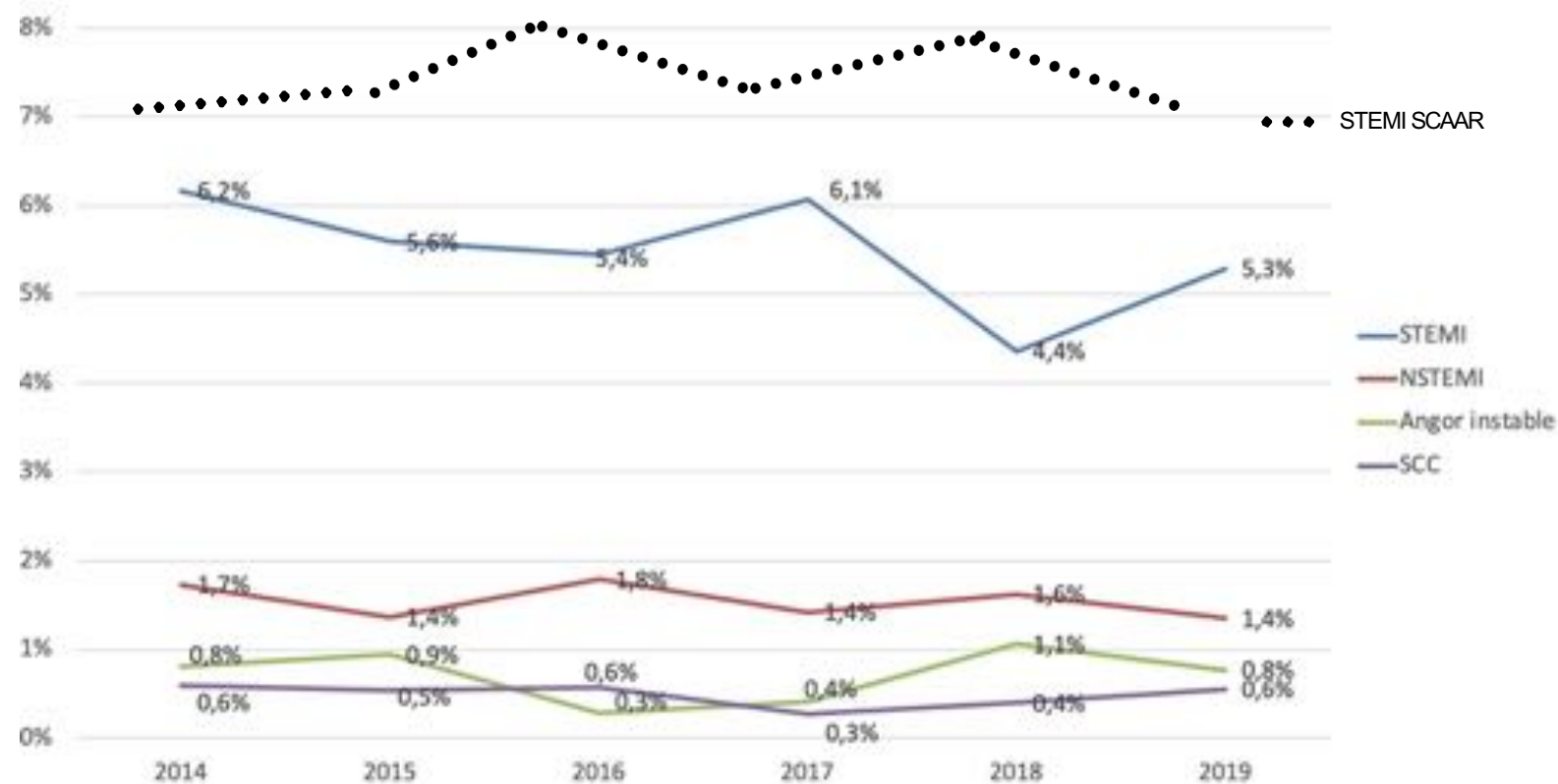
Evaluer nos pratiques

Mortalité à 1 mois / IDM (HAS / OCDE)

Mortalité à 30 jours STEMI et NSTEMI



Evolution du taux de mortalité à 30 j



Améliorer

INDICATEURS DE QUALITÉ

Indicateurs de pertinence

- Ratio ATL/coro
- Taux de coro <50 %
- ATL sans ischémie documentée

Indicateur de performance

- Taux de voie radiale
- Taux d'ATL en ambulatoire
- Taux de FFR et d'imagerie endo-coronaire (IVUS ou OCT)
- Taux de transfert direct en hôpital avec coro si appel 15

Indicateurs de sécurité

- PDS moyen et temps de scopie /ATL (radio-protection)
- Quantité moyenne de contraste /ATL (néphro-protection)

Indicateurs de bonnes pratiques

- Taux de nouveaux P2Y12 à la sortie H après ATL
- Taux de rééducation CV post STEMI

Indicateurs d'exhaustivité

- Taux de perdus de vue

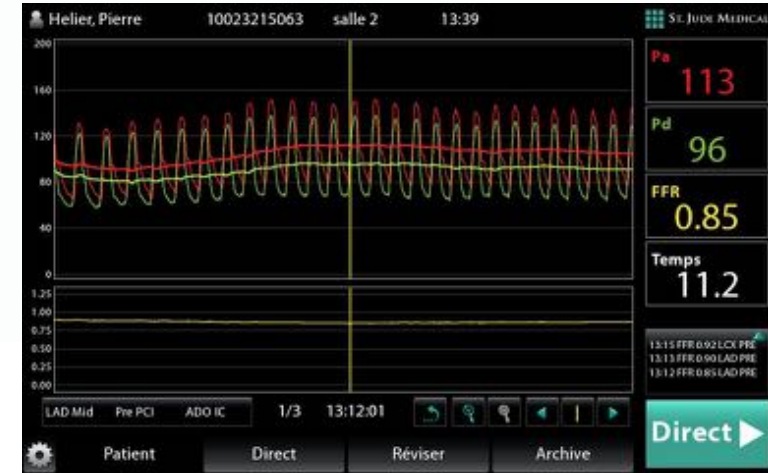
Quality



FFR

MOYENNE FPCI 2020 = 7,5 % DES ATL

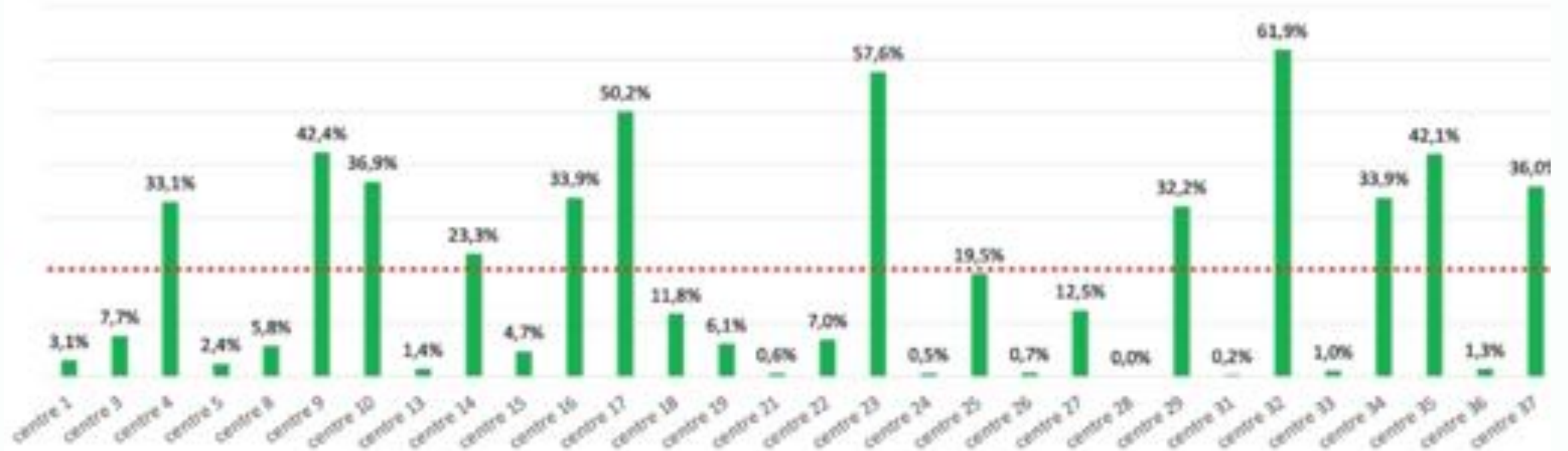
SCAAR = seuil à 30 %



INDICATEUR DE QUALITÉ ATL AMBULATOIRE / SCC

Moyenne = 20,8%

ATL ambulatoire / SCC



2 Rapports 2020 en ligne

100 pages de graphiques



Disponibles sur Francepci.com

The CRAC cohort model: A computerized low cost registry of interventional cardiology with daily update and long-term follow-up

Et un modèle de cohorte en cardiologie interventionnelle: le registre automatisé CRAC, région centre Val-de-Loire

G. Rangé¹, S. Chassaigne², P. Marcollet³, C. Saint Etienne⁴, P. Dequenne⁵, M. Gerakli⁶, P. Baudin⁷, L. Revelle⁸, L. Godillon⁹, B. Sakic¹⁰, C. Lauer¹¹, S. Gauthier¹², R. Hakim¹³, F. Albert¹⁴, D. Angouvrant¹⁵, L. Grammatico-Guilion¹⁶

Abstract
 Objective: To assess the reliability and the use of a computerized interventional cardiology (IC) registry on prospectively and retrospectively collected high quality data for all consecutive coronary patients referred to coronary angiogram (coronary angiogram) (CRAC).
 Background: Register clinical practice concerned to study long-term prognosis in ST-segment elevation myocardial infarction (STEMI) patients. The CRAC cohort model is a computerized low cost registry of interventional cardiology with daily update and long-term follow-up.
 Methods: The CRAC cohort model is a computerized low cost registry of interventional cardiology with daily update and long-term follow-up. The CRAC cohort model is a computerized low cost registry of interventional cardiology with daily update and long-term follow-up.
 Results: The CRAC cohort model is a computerized low cost registry of interventional cardiology with daily update and long-term follow-up.
 Conclusions: The CRAC cohort model is a computerized low cost registry of interventional cardiology with daily update and long-term follow-up.

Keywords: PCI, Interventional cardiology, Register, Cost, Computerized database

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CLINICAL RESEARCH

Factors associated with delay in transfer of patients with ST-segment elevation myocardial infarction from first medical contact to catheterization laboratory: Lessons from CRAC, a French prospective multicentre registry

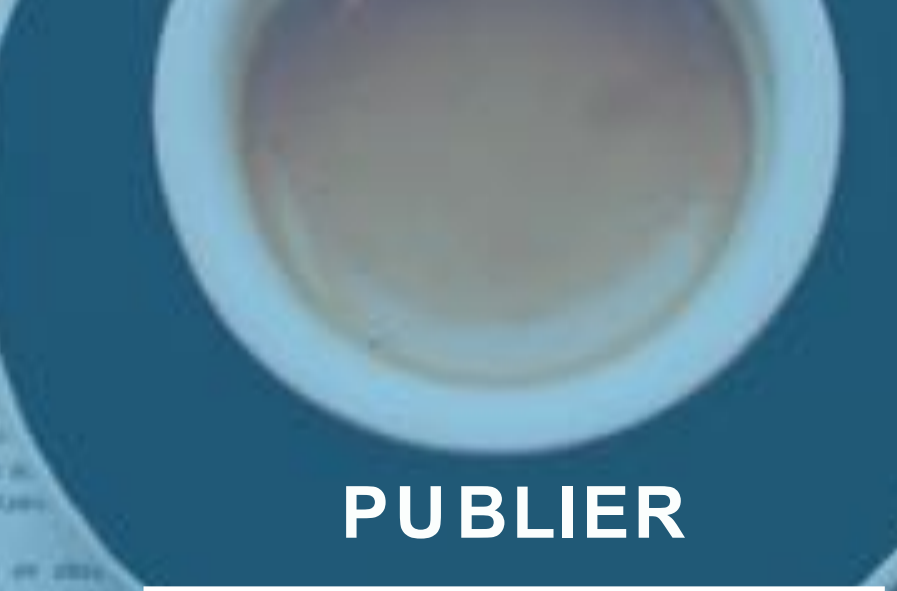
Facteurs associés au délai de transfert entre le premier contact médical et la salle de coronarographie des patients présentant un infarctus du myocarde avec sus-décalage du segment ST : données issues du registre français prospectif multicentrique CRAC

Gregoire Rangé^{1*}, Christophe Saint Etienne², Pierre Marcollet³, Radwan Hakim⁴, Jean Capecc⁵, Christophe Laure⁶, Sandra Gautier⁷, Frank Albert⁸, Lucile Godillon⁹, Pelle Stolt¹⁰, Pascal Motreff¹¹, Leslie Grammatico-Guilion¹²

¹Cardiology Department, Les Hôpitaux de Chartres, 4, rue Claude-Bernard, 28030 Le County, France
²Cardiology Department, Centre Hospitalier Universitaire de Tours, 27100 Centre-les-Tours, France
³Cardiology Department, Centre Hospitalier de Bourges, 18000 Bourges, France
⁴Cardiology Department, Clinique Saint-Gatien, 37000 Tours, France
⁵Cardiology Department, Clinique Orléans, 45070 Soran, France

Abstract
 Objective: To assess the reliability and the use of a computerized interventional cardiology (IC) registry on prospectively and retrospectively collected high quality data for all consecutive coronary patients referred to coronary angiogram (coronary angiogram) (CRAC).
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 Conclusions: The CRAC cohort model is a computerized low cost registry of interventional cardiology with daily update and long-term follow-up.

Keywords: PCI, Interventional cardiology, Register, Cost, Computerized database



Does helicopter transport delay prehospital transfer for STEMI patients in rural areas? Findings from the CRAC France PCI registry

Radwan Hakim¹, Eric Reveu², Christophe Saint Etienne³, Pierre Marcollet⁴, Stephan Chassaigne⁵, Marie Pascale Deconis⁶, Wael Yafi⁷, Christophe Laure⁸, Sandra Gautier⁹, Lucile Godillon¹⁰, Julie Akkoyun-Farinez¹¹, Denis Angouvrant¹², Rene Koning¹³, Pascal Motreff¹⁴, Leslie Grammatico-Guilion¹⁵ and Gregoire Rangé¹⁶

Abstract
 Aim: The aim of this study was to analyse delays in emergency medical system transfer of ST-segment elevation myocardial infarction (STEMI) patients to percutaneous coronary intervention (PCI) centres according to transport modality in a rural French region.
 Methods and results: Data from the prospective multicentre CRAC / France PCI registry were analysed for 1911 STEMI patients: 410 transferred by helicopter and 1501 by ground transport. The primary endpoint was the percentage of transfers with first medical contact to primary percutaneous coronary intervention within the 90 minutes recommended by guidelines. The secondary endpoint was time of first medical contact to primary percutaneous coronary intervention. With helicopter transport, time of first medical contact to primary percutaneous coronary intervention in under 90 minutes was less frequently achieved than with ground transport (9.8% vs. 37.2%, odds ratio 5.49, 95% confidence interval 1.90, 7.73, P<0.0001). Differences were greatest for transfers under 50 km (11.7% vs. 44.7%, P<0.0001) and for primary transfers (22.4% vs. 49.6%, P<0.0001). The median time from first medical contact to primary percutaneous coronary intervention and from symptom onset to primary percutaneous coronary intervention (total ischemic time) were significantly higher in the helicopter transport group than in the ground transport group (respectively, 137 vs. 103 minutes, P<0.0001 and 261 vs. 195 minutes, P<0.0001). There was no significant difference in in-hospital mortality between the helicopter and ground transport groups (6.9% vs. 6.6%, P=0.88).
 Conclusions: Helicopter transport of STEMI patients was five times less effective than ground transport in maintaining the 90-minute first medical contact to primary percutaneous coronary intervention time recommended in guidelines, particularly for transfer distances less than 50 km.

Keywords: Helicopter transport, PCI-related delay, STEMI, primary PCI
 Date received: 12 April 2019; accepted: 17 April 2019

¹Cardiology Department, Les Hôpitaux de Chartres, France
²Emergency Unit Department, Les Hôpitaux de Chartres, France
³Cardiology Department, Centre Hospitalier-Universitaire de Tours, France
⁴Cardiology Department, Centre Hospitalier de Bourges, France
⁵Cardiology Department, Clinique Saint-Gatien, France
⁶Cardiology Department, Clinique Orléans, France
⁷Cardiology Department, Centre Hospitalier-régional de Orléans, France
⁸Unité Régionale d'Épidémiologie Hospitalière (UREH), France
⁹Cardiology Department, Clinique Saint-Hilaire, France
¹⁰Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, France
¹¹Corresponding author: Gregoire Rangé, Department of Cardiology, Les Hôpitaux de Chartres, 4 rue Claude-Bernard, Le County, 28030, France. Email: gregor@ch-chartres.fr

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 DOI: 10.1080/13620135.2021.1915427

CLINICAL INVESTIGATIONS **WILEY**

Is coronary multivessel disease in acute myocardial infarction patients still associated with worse clinical outcomes at 1-year?

Etienne Puymirat MD, PhD^{1,2} | Ariel Nakache MD^{3,4} | Christophe Saint Etienne MD, PhD⁵ | Pierre Marcollet MD⁶ | Olivier Fichaux MD⁵ | Marie-Pascale Deconis MD⁷ | Stephan Chassaigne MD⁸ | Philippe Commaud MD⁹ | Nicolas Danchin MD¹⁰ | Guillaume Cayla MD, PhD⁹ | Gilles Montalescot MD, PhD¹⁰ | Hakim Benamer MD¹¹ | Rene Koning MD¹² | Pascal Motreff MD, PhD¹³ | Grégoire Rangé MD¹⁴

¹Department of Cardiology, Assistance Publique-Hôpital de Paris (AP-HP), Hôpital Européen Georges Pompidou, Paris, France
²Hospitale de Paris, Paris, France
³Cardiology Department, Centre Hospitalier Universitaire de Tours, Tours, France
⁴Cardiology Department, Centre Hospitalier de Bourges, Bourges, France
⁵Cardiology Department, Centre Hospitalier-régional d'Orléans, Orléans, France
⁶Cardiology Department, Clinique Orléans, Soran, France
⁷Cardiology Department, Nouvelle Clinique Tournaing, Tours, France
⁸Cardiology Department, Polyclinique les Feuilles, Orléans, France
⁹Cardiology Department, CHU Nîmes, Université Montpellier, Nîmes, France
¹⁰Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹¹Cardiology Department, Clinique de la Beauvoisine (CHU) Médecine Régionale, Paris 13, France
¹²Cardiology Department, Clinique Saint-Hilaire, Bourges, France
¹³Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹⁴Cardiology Department, Les Hôpitaux de Chartres, Chartres, France

Correspondence: Etienne Puymirat, MD, PhD, Department of Cardiology, Assistance Publique-Hôpital de Paris (AP-HP), Hôpital Européen Georges Pompidou, 20 rue Leclercq, Paris 75015, France. Email: etienne.puymirat@aphp.fr

Abstract
 Background: ST-elevation myocardial infarction (STEMI) patients with multivessel disease (MVD) are associated with a worse prognosis. However, few comparisons are available according to coronary status in the era of modern reperfusion and optimized secondary prevention.
 Hypothesis: We hypothesized that the difference in prognosis according to number of vessel disease in STEMI patients has reduced.
 Methods: All consecutive STEMI patients undergoing primary percutaneous coronary intervention (PCI) within 24 h of symptom onset between January 1, 2014 and June 30, 2016 enrolled in the CRAC (Cohort Régionale des Angioplastiques de la Région Centre) France PCI registry were analysed. Baseline characteristics, management, and

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 wileyonlinelibrary.com/journal/clc 429

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 DOI: 10.1111/ccc3.12520

ORIGINAL RESEARCH **WILEY**

Incidence, delays, and outcomes of STEMI during COVID-19 outbreak: Analysis from the France PCI registry

Gregoire Rangé MD¹ | Radwan Hakim MD¹ | Farzin Beygdi MD, PhD² | Denis Angouvrant MD, PhD³ | Pierre Marcollet MD⁴ | Matthieu Godin MD⁵ | Ronan Debailon MD⁶ | Philippe Bonnet MD⁷ | Olivier Fichaux MD⁸ | Christophe Barbey MD⁹ | Louis Villard MD¹⁰ | Pierre François Lesault MD¹¹ | Eric Durand MD, PhD¹² | Emmanuel Boffard MD¹³ | Gerard Durball MD¹⁴ | Jean-Philippe Collet MD, PhD¹⁵ | Hakim Benamer MD¹⁶ | Philippe Commaud MD¹⁷ | Gilles Montalescot MD, PhD¹⁸ | Rene Koning MD¹⁹ | Pascal Motreff MD, PhD¹⁹

¹Cardiology Department, Les Hôpitaux de Chartres, Chartres, France
²Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
³Cardiology Department, Centre Hospitalier-Universitaire de Tours, Tours, France
⁴Cardiology Department, Centre Hospitalier de Bourges, Bourges, France
⁵Cardiology Department, Clinique Saint-Gatien, Bourges, France
⁶Cardiology Department, Clinique Orléans, Orléans, France
⁷Cardiology Department, Clinique Orléans, Orléans, France
⁸Cardiology Department, Centre Hospitalier-régional d'Orléans, Orléans, France
⁹Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹⁰Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹¹Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹²Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹³Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹⁴Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹⁵Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹⁶Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹⁷Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹⁸Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France
¹⁹Cardiology Department, Centre Hospitalier-Universitaire de Clermont-Ferrand, Clermont-Ferrand, France

Abstract
 Objective: The aim of this study was to assess the impact of the coronavirus disease 2019 (COVID-19) outbreak on incidence, delays, and outcomes of ST-elevation myocardial infarction (STEMI) patients undergoing primary percutaneous coronary intervention (PPCI) in France.
 Methods: We analysed all patients undergoing PPCI <24 hours STEMI included in the prospective France PCI registry. The 2 groups were compared on mean monthly

Where have the ST-segment elevation myocardial infarction (STEMI) cases gone during COVID-19 lockdown?

The coronavirus disease 2019 (COVID-19) outbreak has threatened to overwhelm European healthcare systems, potentially overwhelming other emergencies including ST-segment elevation myocardial infarction (STEMI).
 We analysed the impact of the COVID-19 national lockdown on STEMI care in 3318 patients enrolled in the prospective France

Percutaneous Coronary Intervention registry between 15 January 2019 and 14 April 2020. The registry prospectively follows all patients undergoing coronary angiography at 12 interventional cardiology centres located in the western part of France which is considerably the area least impacted by the outbreak. The study included all patients with a confirmed diagnosis of STEMI during the COVID-19 lockdown. Our results are in line with a recently published analysis from STEMI registries for nine high-volume US centres, although the cut-off date in this study was not a lockdown date but 1 March, the date when US social life and medical operations were becoming significantly affected.
 Physician surveys have also indicated a decline in the incidence in stroke admissions.²

Total number of STEMI per month

STEMI <24h >24h 2019
 STEMI <24h >24h 2020

France
 ● France-PCI Centers
 ■ High volume of critical COVID-19 cases area
 ■ Low volume of critical COVID-19 cases area

Figure 1 Total number of acute and late presentation STEMI referred to catheterization laboratory per month in the multi-centre France PCI registry from 15 January 2019 to 14 April 2020.

Projets 2021



EXTENSION NATIONALE



APPARIEMENT SNDS

HEALTH DATA HUB



APPLI CONNECTÉE PATIENT



TRANSFERT PROMOTION ASSOCIATION CRAC VERS FPCI



Conclusions

- S'il veut dire la vérité, un registre doit être
 - de (haute) qualité
 - Porté par les spécialistes
 - Avoir un financement institutionnel
- Le registre France PCI répond à ces conditions et permet
 - D'avoir un état des lieux précis de l'activité de CI
 - De suivre l'évolution des pratiques en temps réel et permettre des alertes sanitaires
 - D'évaluer et comparer les PP (indicateurs de qualité)
 - De publier de nombreux travaux scientifiques
 - De s'apparier avec d'autres BDD (SNDS via HDH)
 - D'envisager une extension nationale à terme
- Au final d'améliorer nos pratiques et le pronostic de nos patients coronariens