FERMETURE AG, une alternative aux AOD?

Hôpital Pitié-Salpêtrière AP-HP

CARDIO RUN 2023

ACTION Group

G. Montalescot

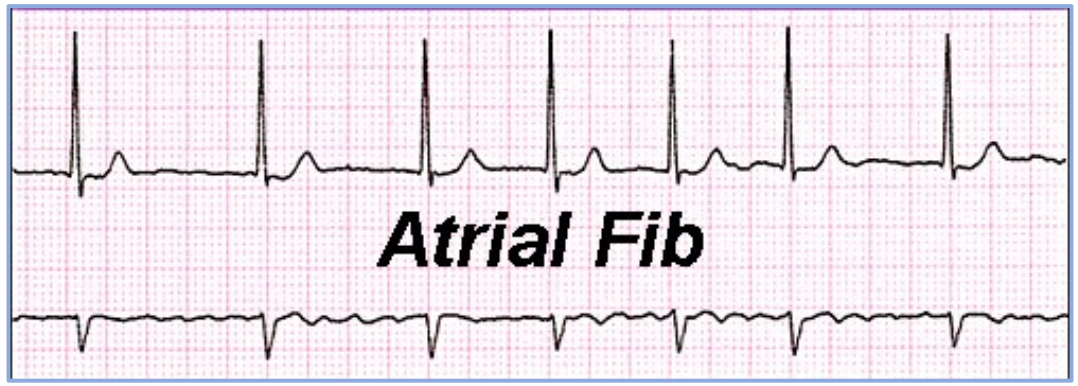
Dr. Montalescot reports research Grants to the Institution or Consulting/Lecture Fees from Abbott, Amgen, AstraZeneca, Bayer, Boehringer Ingelheim, Boston Scientific,Bristol-Myers-Squibb, Cell-Prothera, CSL-Behring, Europa, Idorsia, Servier, Medtronic, MSD, Novartis, Pfizer, Quantum Genomics, Sanofi-Aventis.

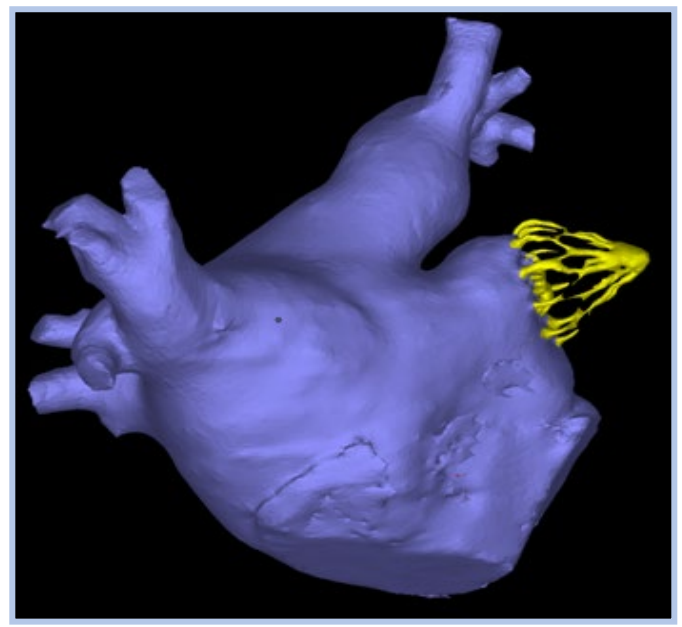
SORBONNE UNIVERSITÉ

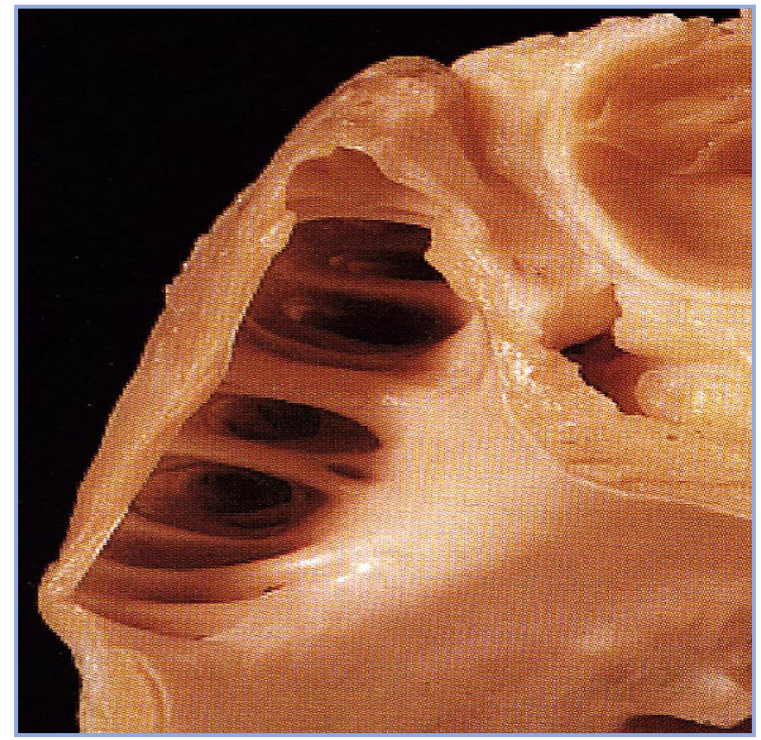
Paris, France

action-groupe.org

Twitter: @ActionCoeur

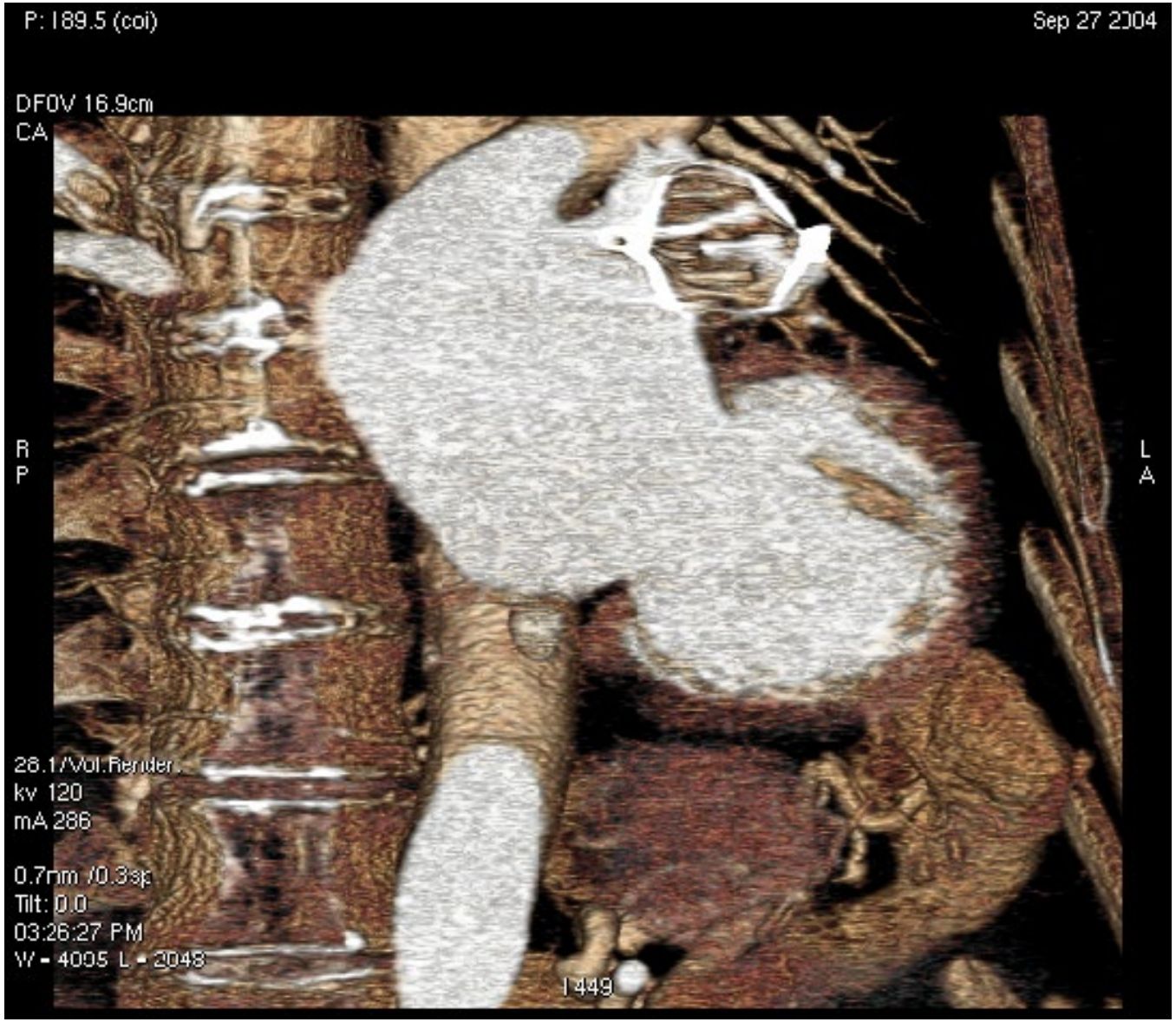

Atrial Fib



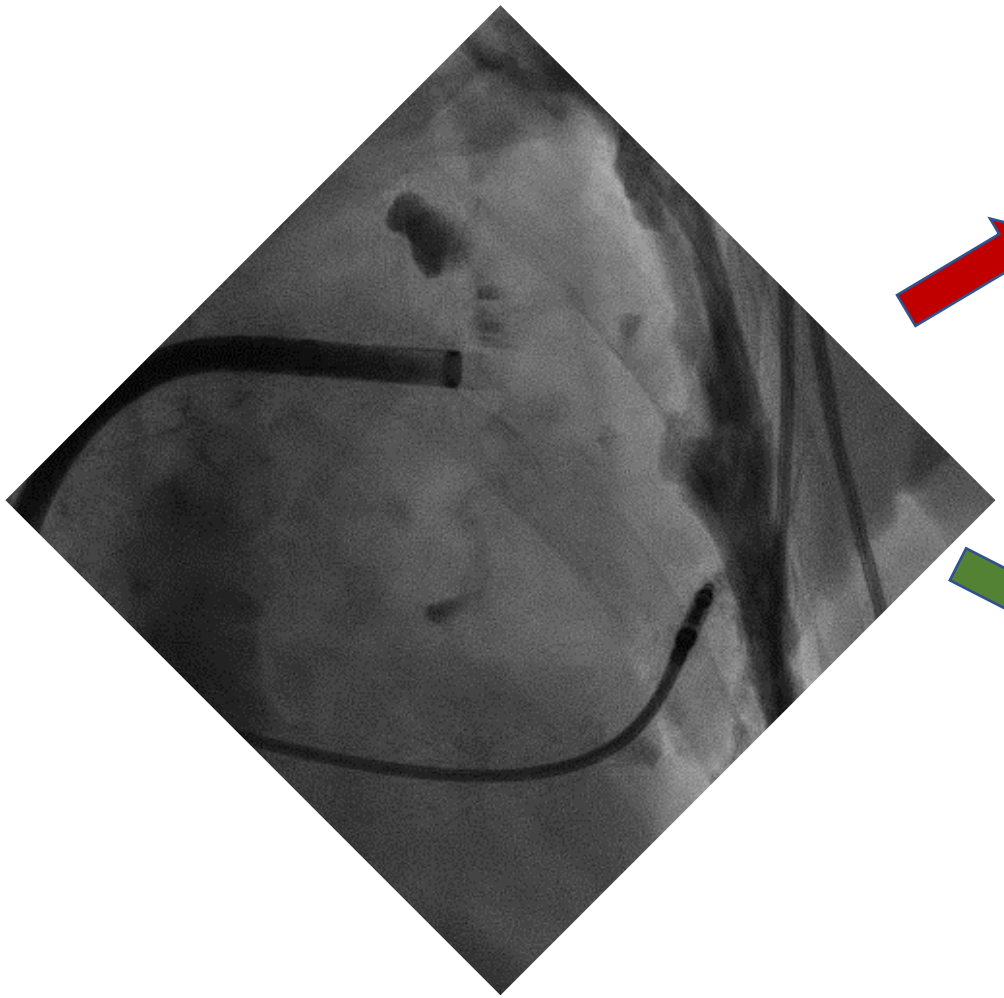


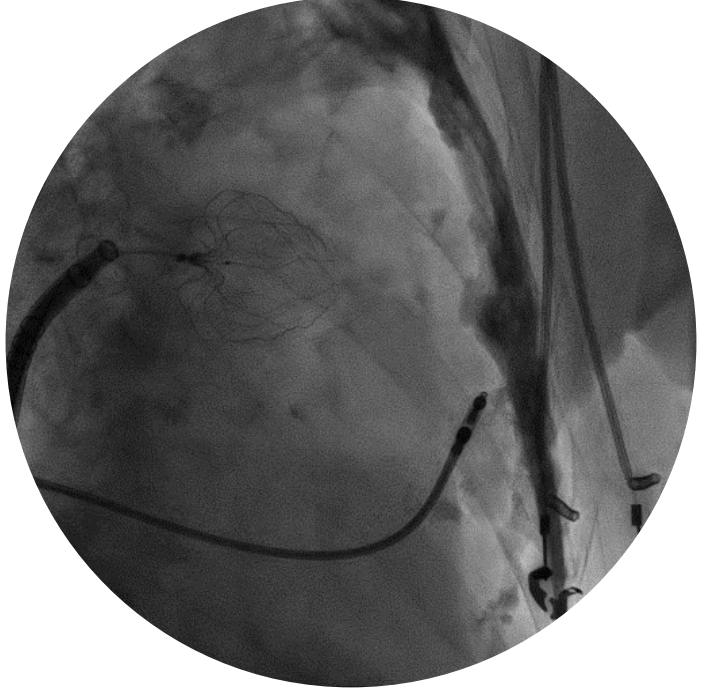
PLAATO®

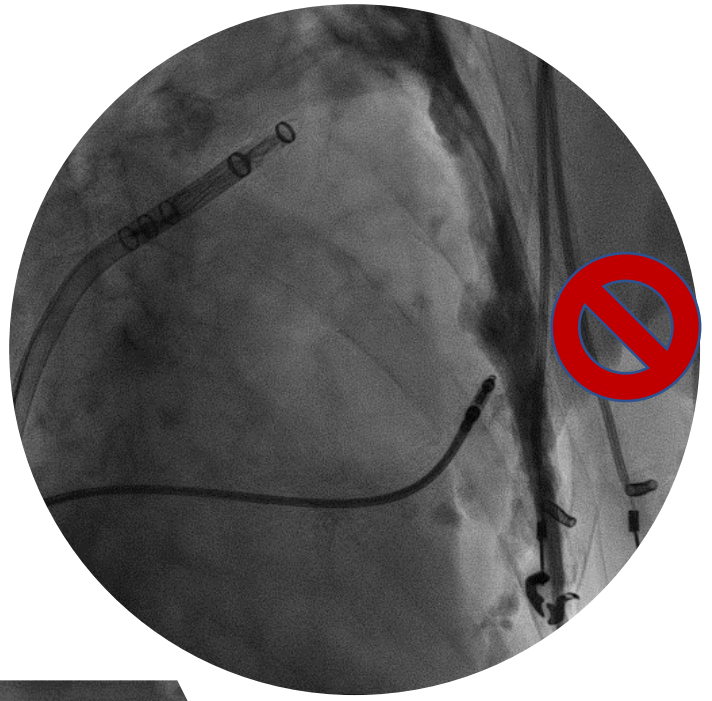
Expérience initiale

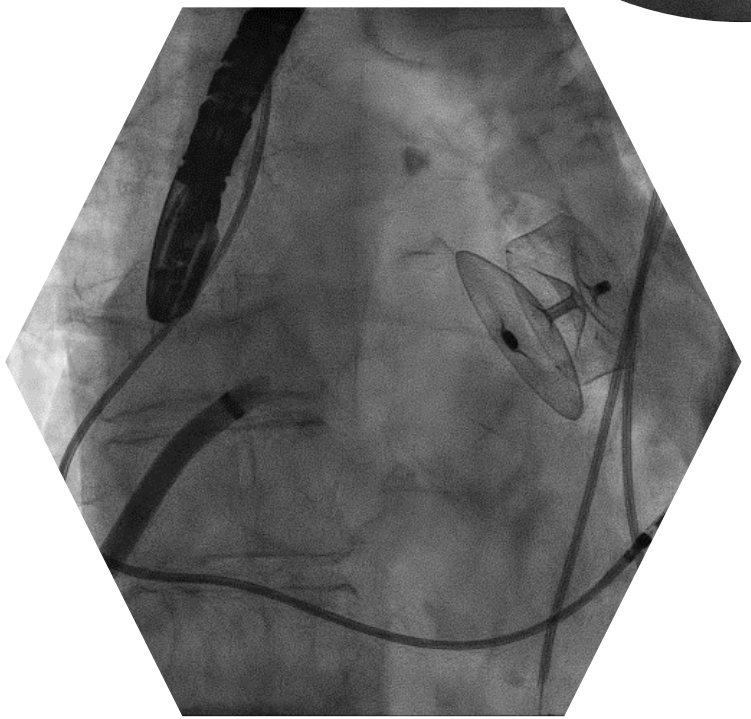


Fermer tout auricule

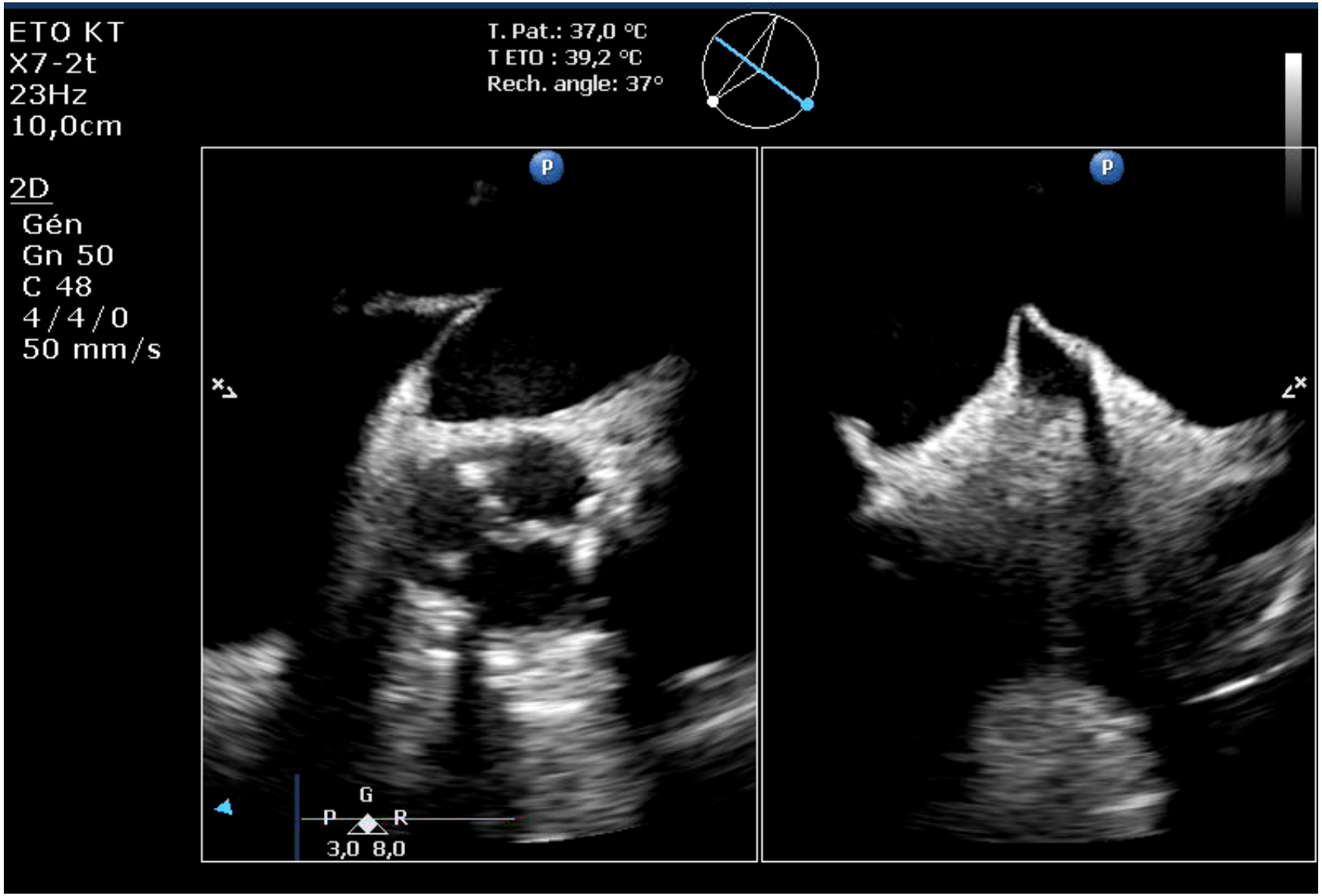




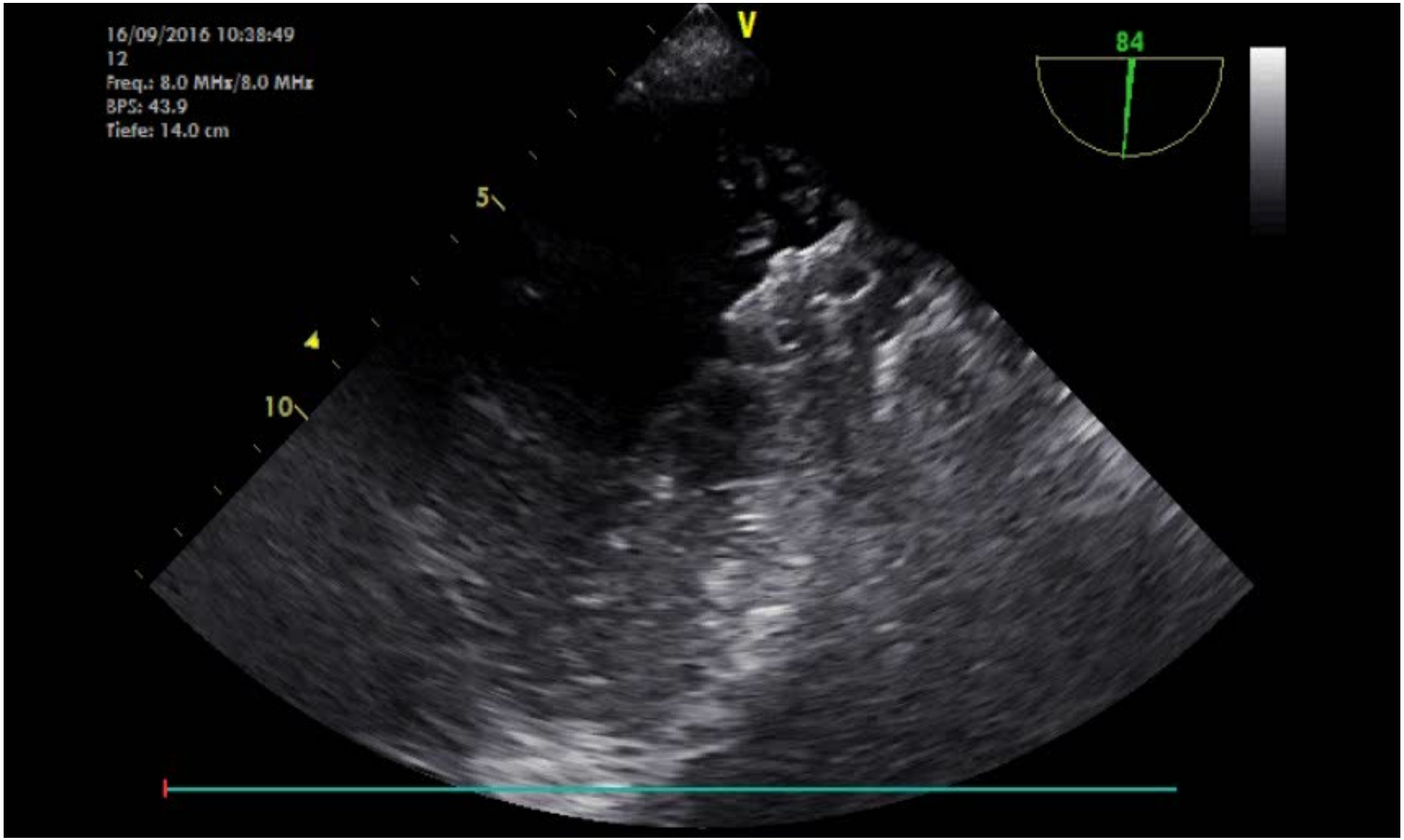




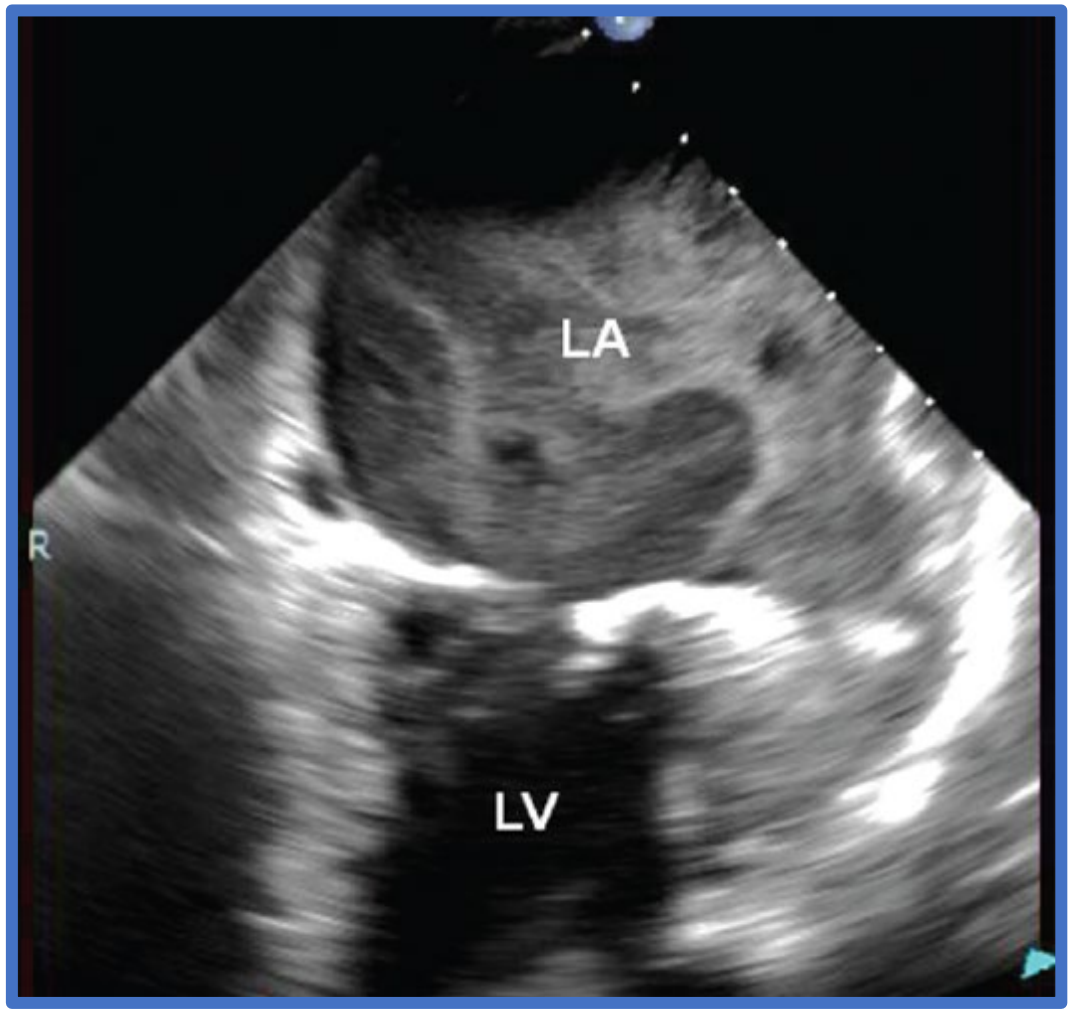
Eviter les complications

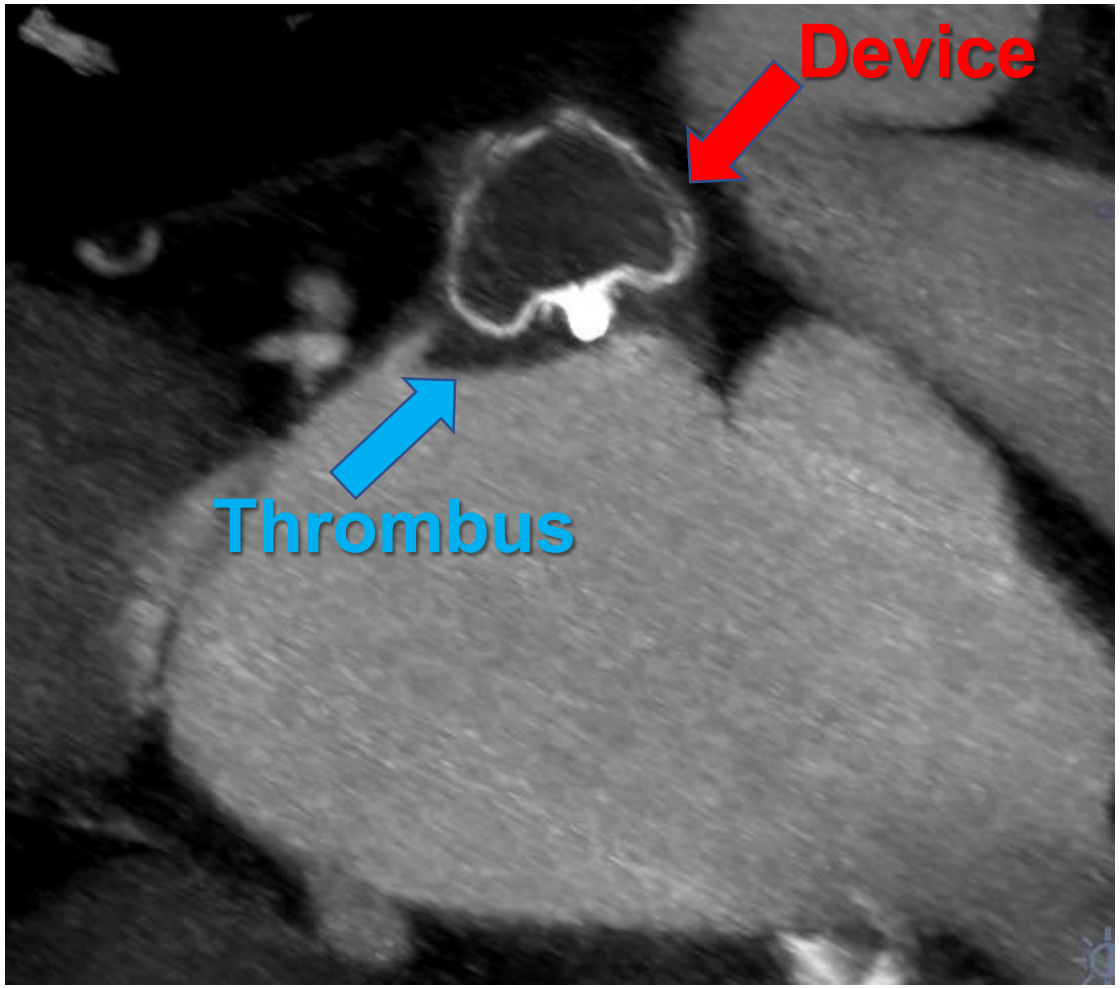


Eviter les complications

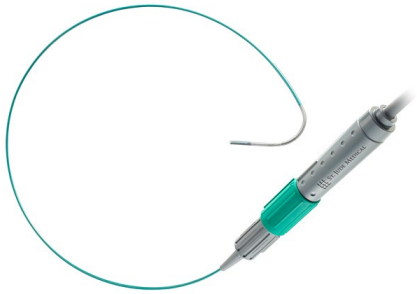


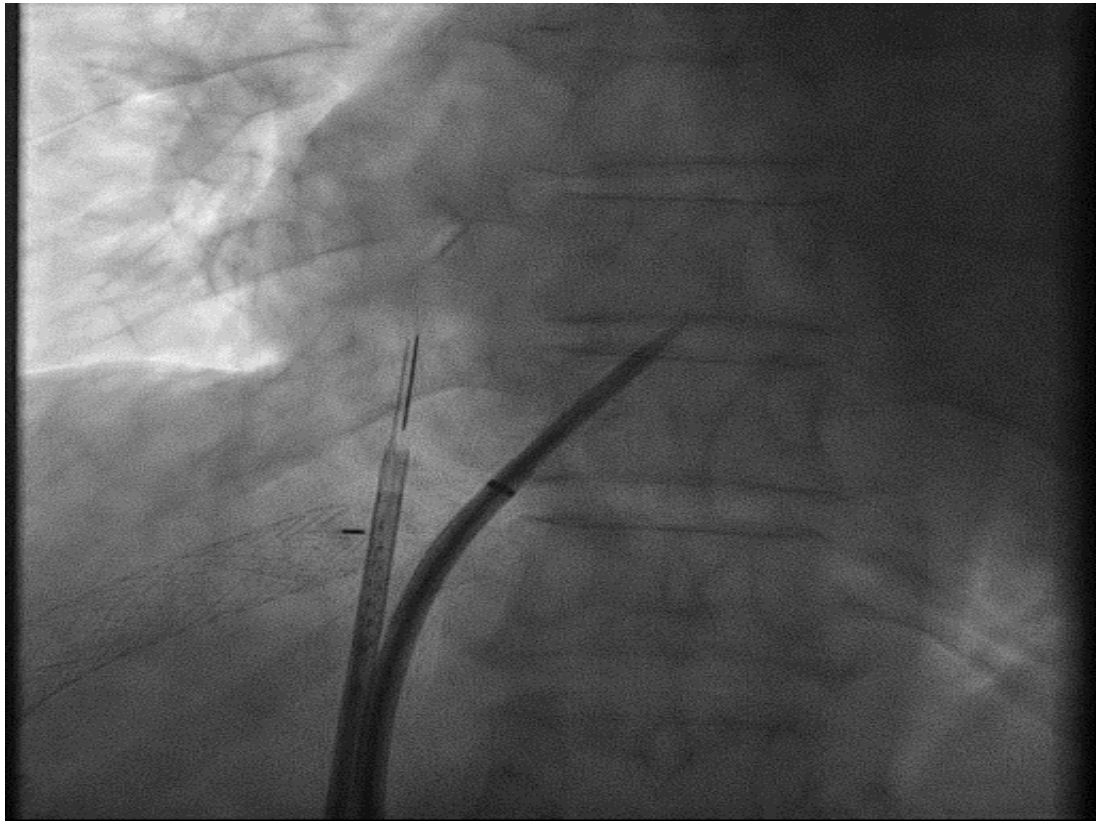
Eviter les complications

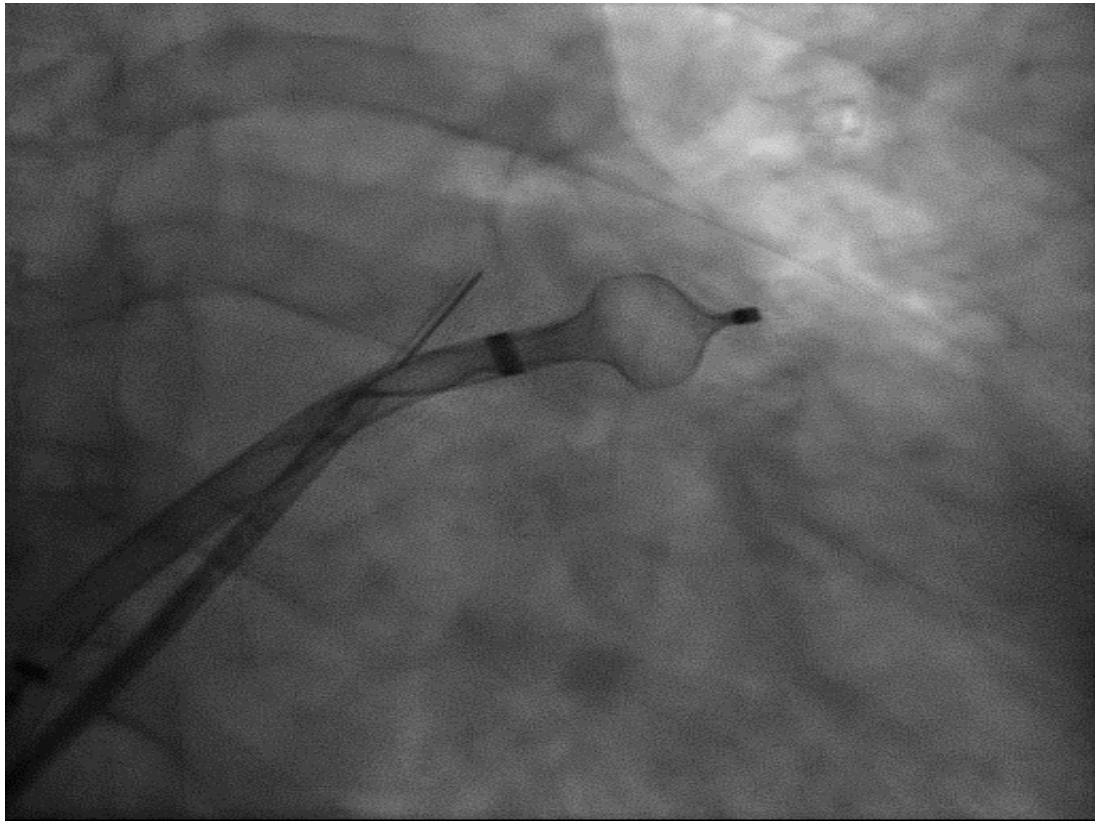




Adapter les techniques aux patients







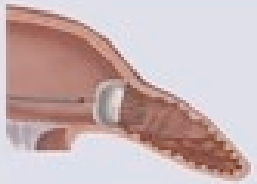
SCAI and HR societies recommendations (2023)

1. Transcatheter LAAC is appropriate for patients with nonvalvular atrial fibrillation with high thromboembolic risk but for whom long-term oral anticoagulation may be contraindicated and who have at least 1 year's life expectancy.
2. Operators should have performed at least 50 prior left-sided ablations or structural procedures and at least 25 transseptal punctures (TSPs). Interventional-imaging physicians should have experience in guiding 25 or more TSPs before supporting LAAC procedures independently.
3. To maintain skills, operators should do 25 or more TSPs and at least 12 LAACs over each 2-year period.
4. On-site cardiovascular surgery backup should be available for new programs and for operators early in their learning curve.
5. Baseline imaging with transesophageal echocardiography (TEE) or cardiac computed tomography should be performed before LAAC.
6. Intraprocedural imaging guidance with TEE or intracardiac echocardiography.
7. Follow labeling of each specific LAAC device for technical aspects of the procedure.
8. Familiarity with avoiding, recognizing, and managing LAAC complications.
9. Predischarge 2-dimensional TTE to rule out pericardial effusion and device embolization.
10. Anticoagulation for device-related thrombus.
11. Make all efforts to minimize peridevice leaks during implantation because their clinical impact and management isn't well understood.
12. Antithrombotic therapy with warfarin, DOAC, or dual-antiplatelet therapy after LAAC based on the studied regimen and instructions for each specific device, tailored to the bleeding risks for each patient.
13. TEE or cardiac computed tomography at 45-90 days after LAAC for device surveillance to assess for peridevice leak and device-related thrombus.

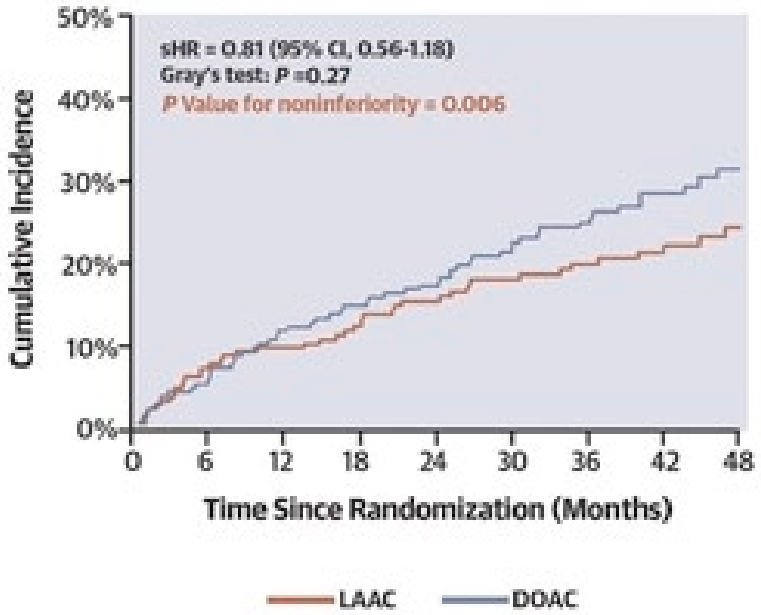
FAG vs. AOD (RCT)

PRAGUE-17 Trial: Long-Term (4-Year) Follow-Up

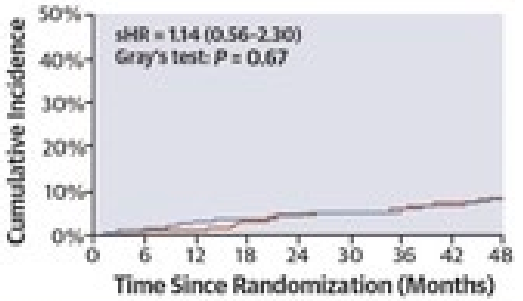
- 402 High-risk AF pts ➡ Randomized
  - CHA_2DS_2-VASc = 4.7 ± 1.5
  - HAS-BLED = 3.1 ± 0.9
- Median Follow-up: 3.5 years (IQR 2.6-4.3), 1,354 pt-year



Primary Endpoint
Stroke, TIA, SE, CV Death, Bleeding or Complications



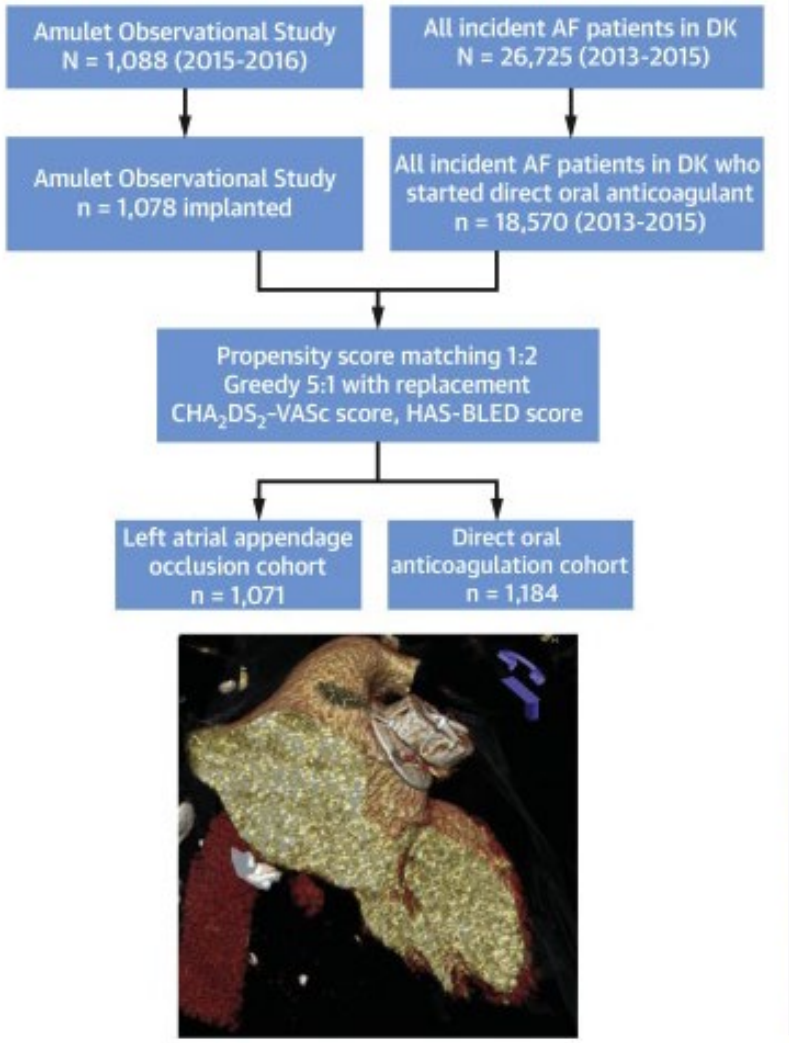
Stroke or TIA

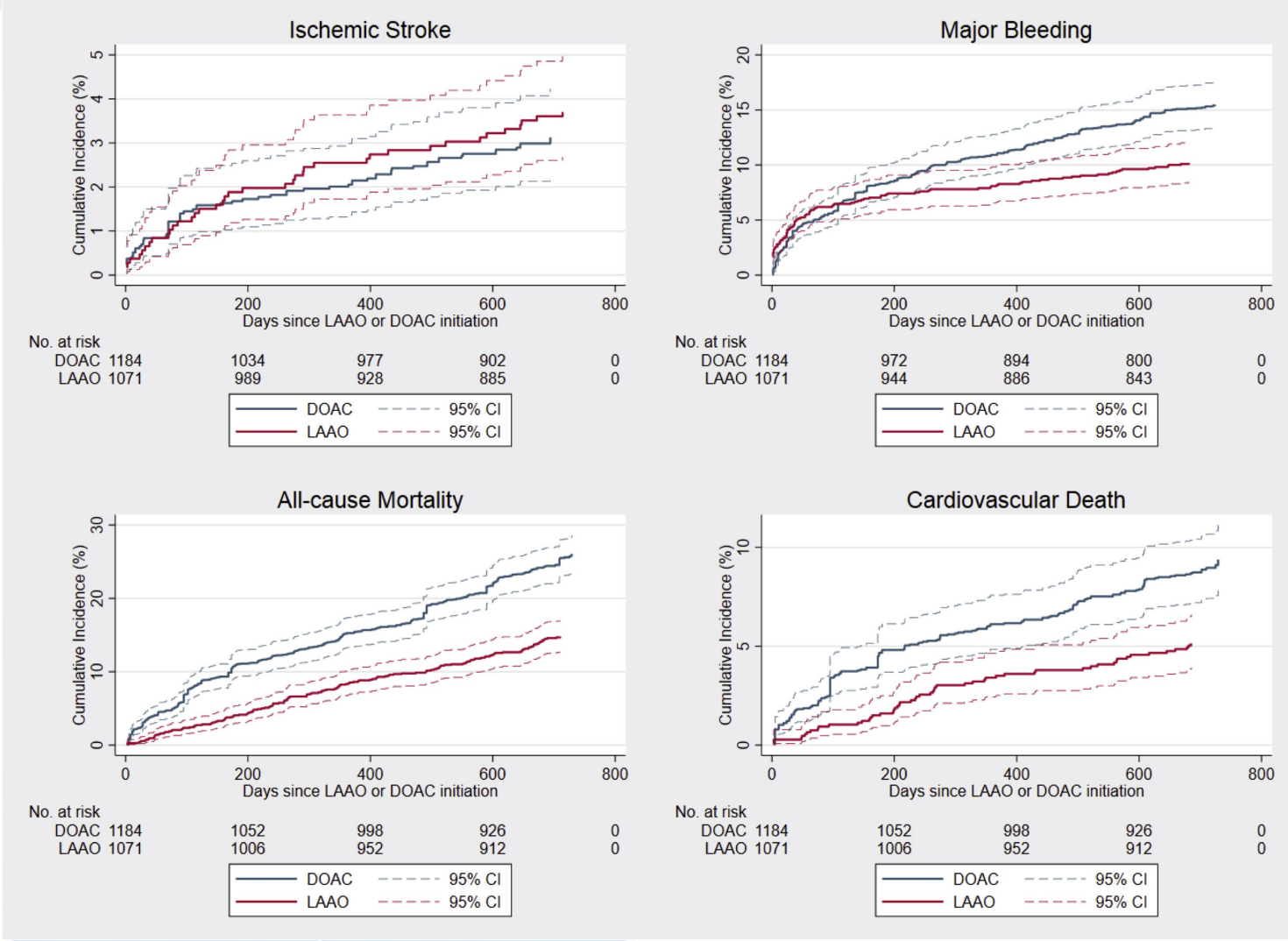


Non-Procedural Clinically Relevant Bleeding

Osmancik, P. et al. J Am Coll Cardiol. 2022;79(1):1-14.

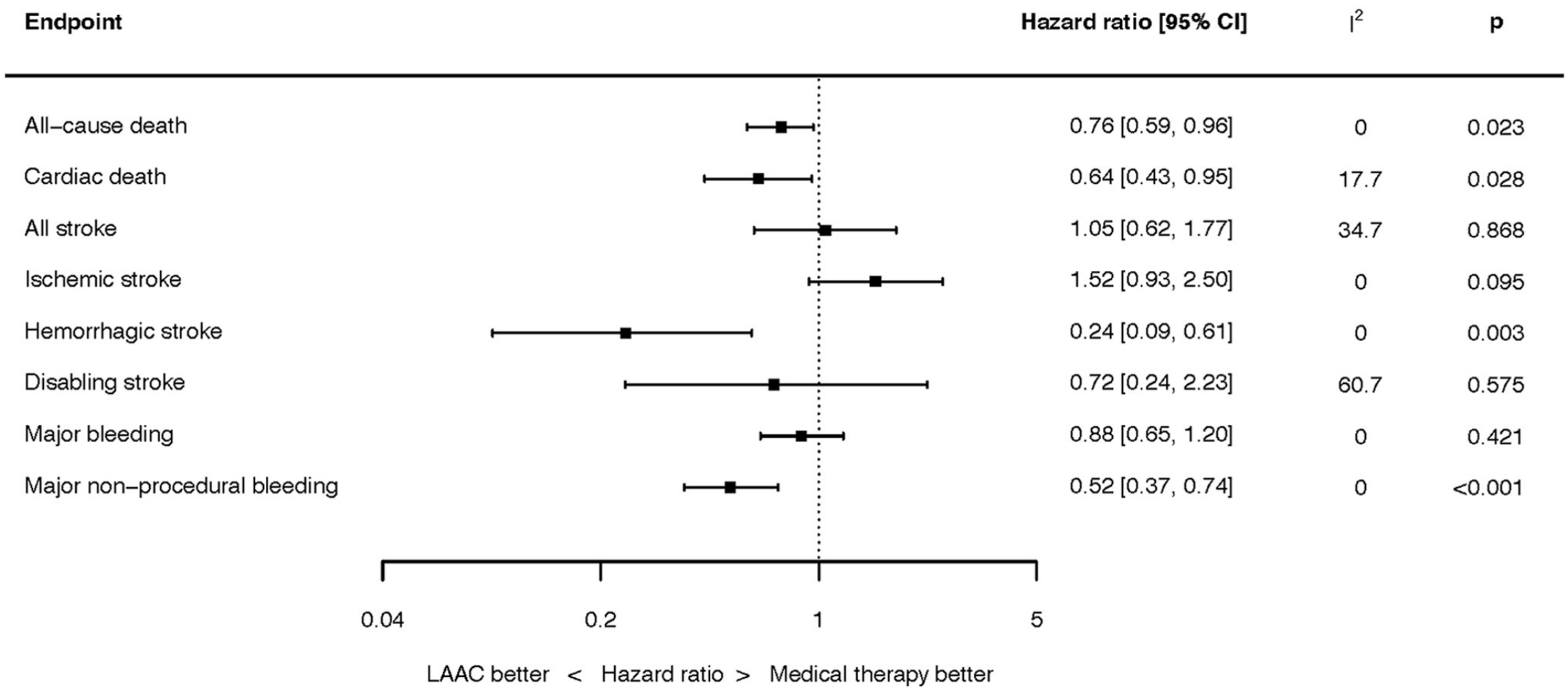
FAG vs. AOD (propensity score matching)





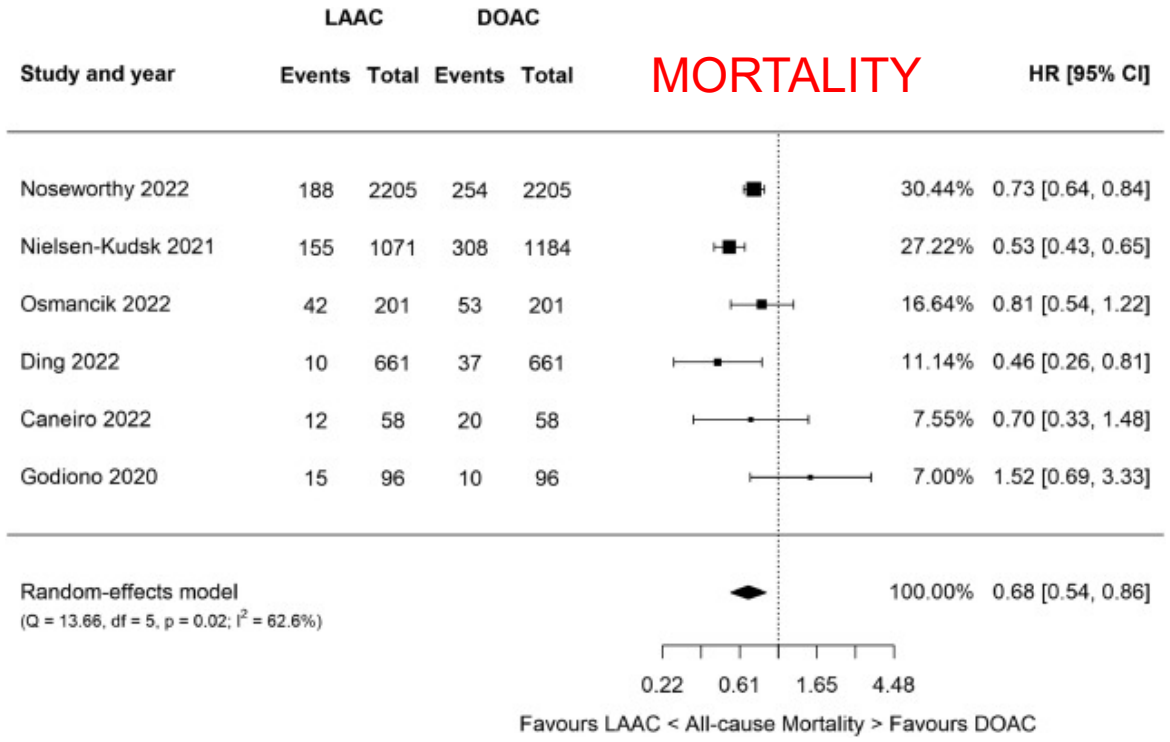
Nielsen-Kudsk, J.E. et al. J Am Coll Cardiol Intv. 2021;14(1):69-78.

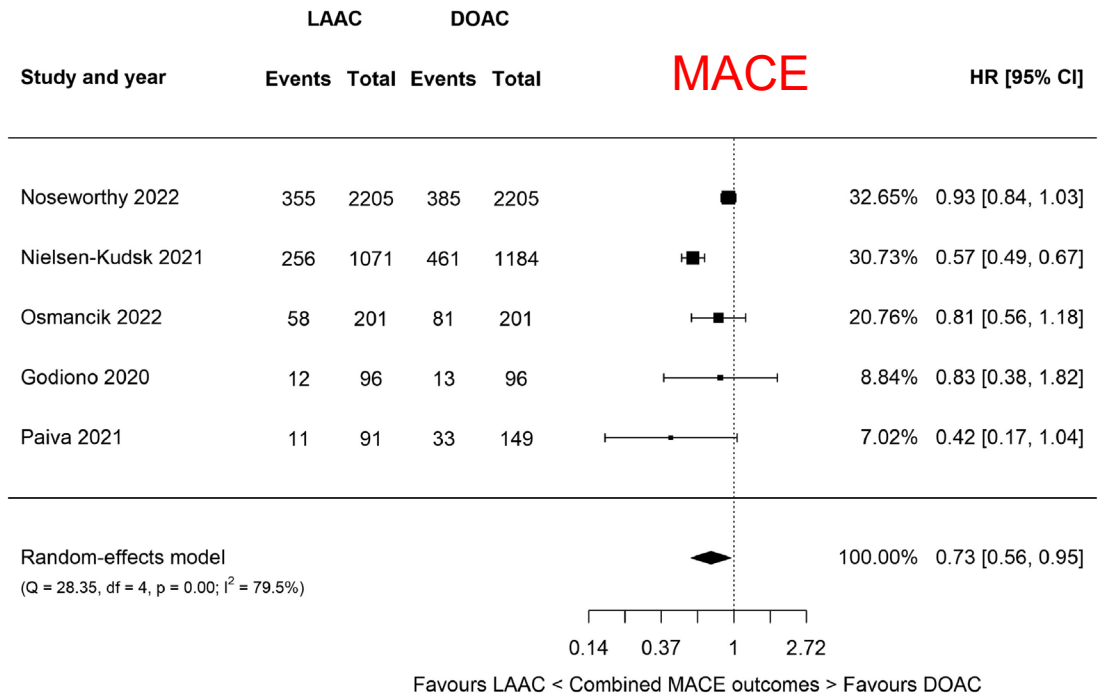
FAG vs AOD (metaanalysis of 3 RCTs)

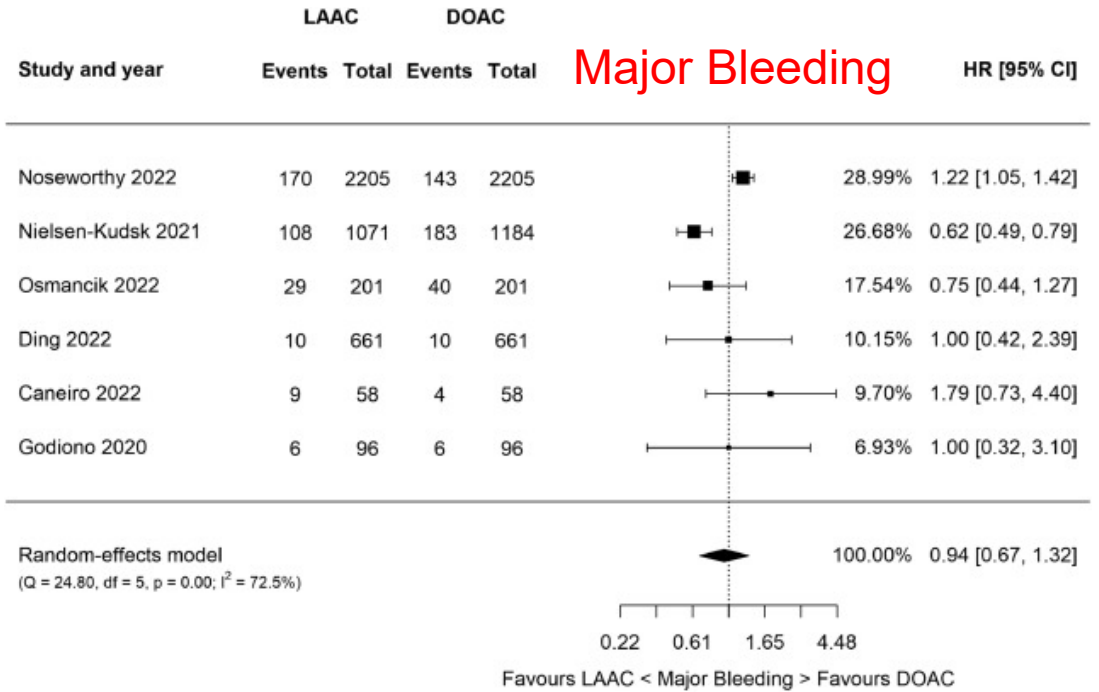


Madhavan MV et al. Structural Heart 7 (2023)

FAG vs AOD (metaanalysis of 7 comparative studies)

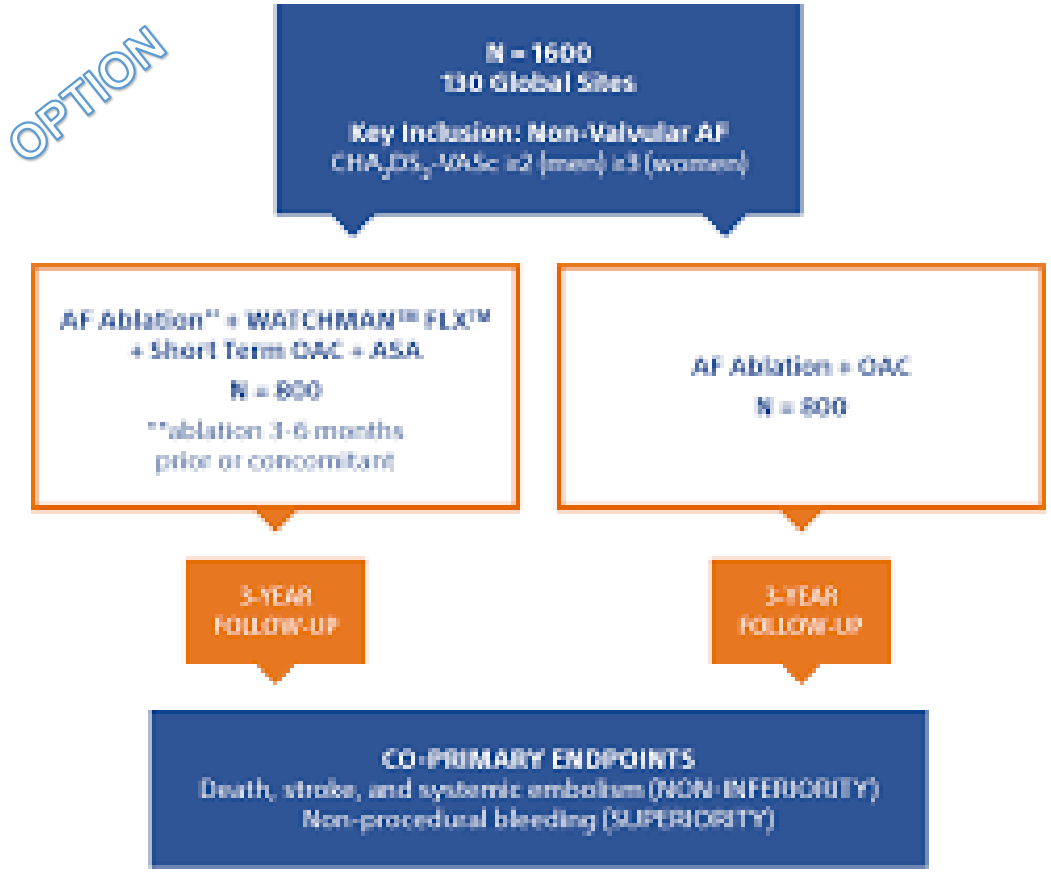


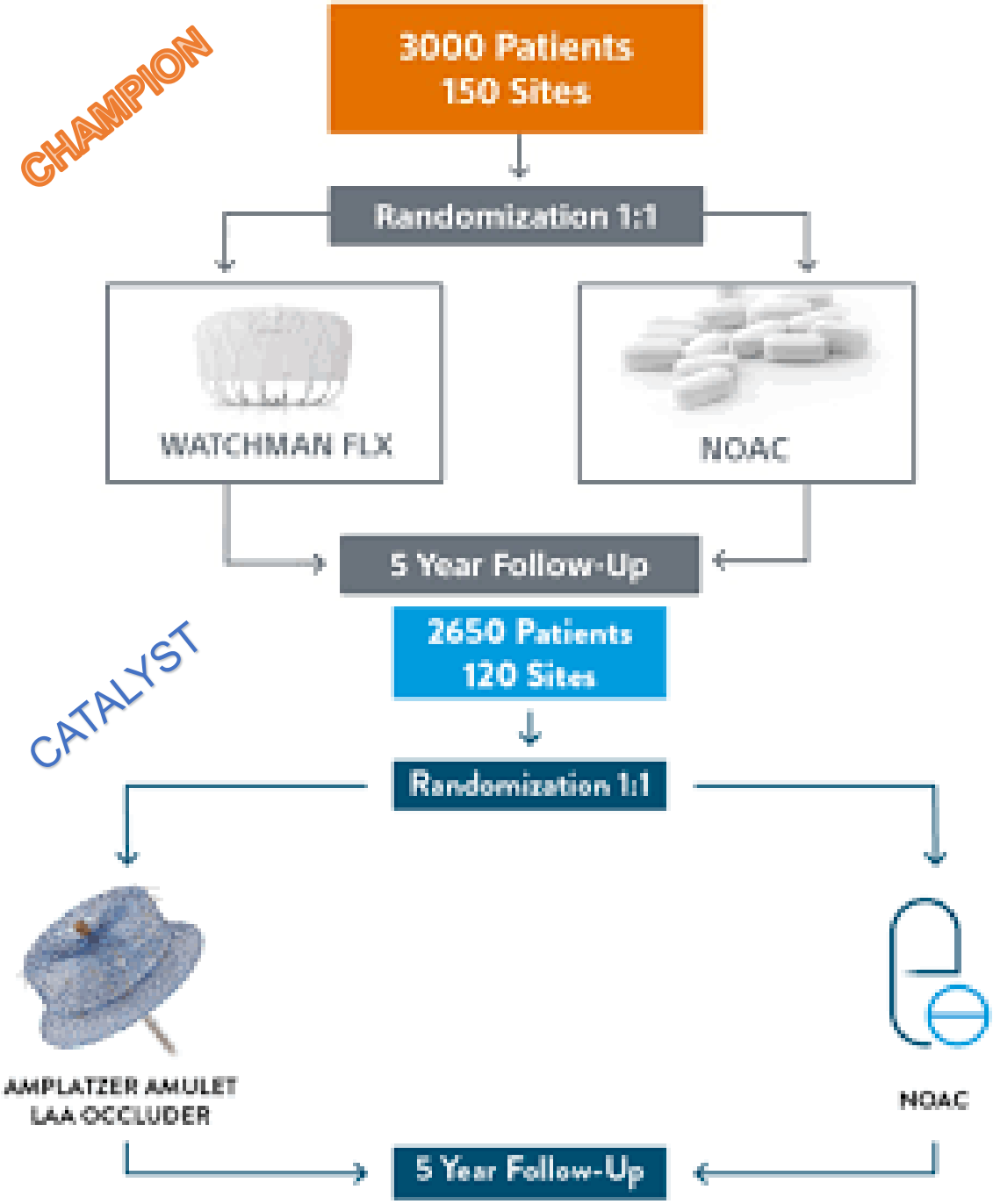




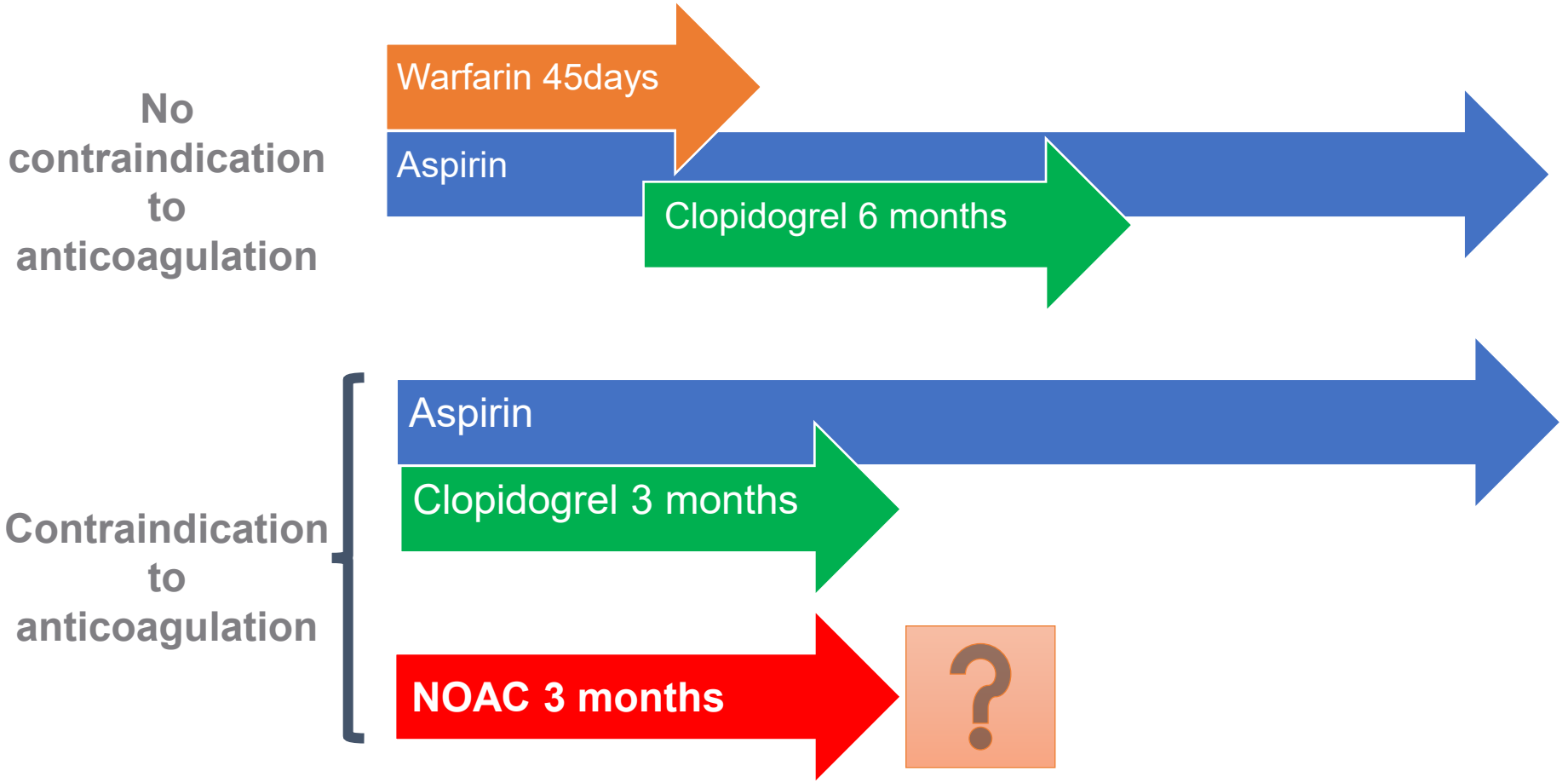
Jiang H et al. Am J Cardiol 2023;200:135−143

FAG vs. AOD (ongoing RCTs)





Post-LAAC antithrombotic treatment



Holmes et al . JACC 2014;64:1-12

ADRIFT

105 patients with successful LAAC

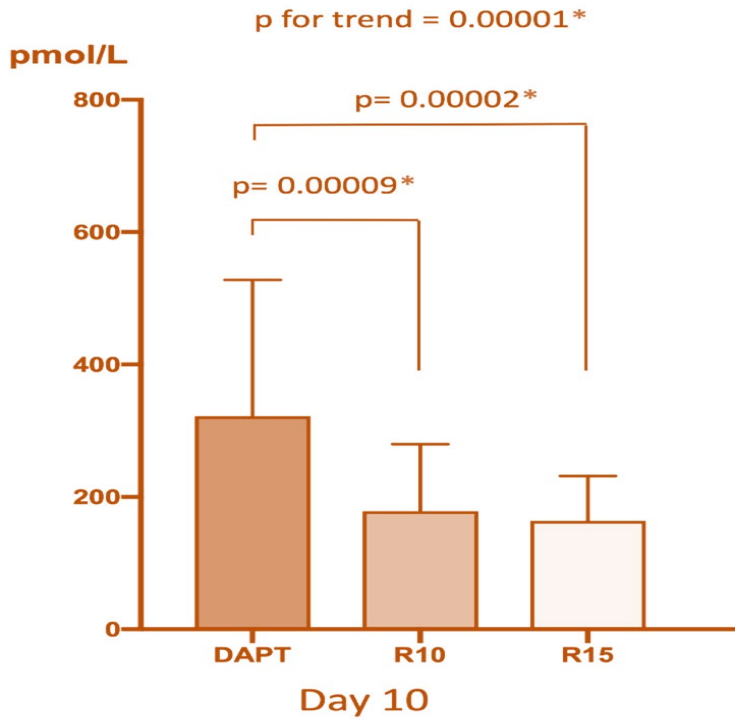
Randomisation 1:1:1

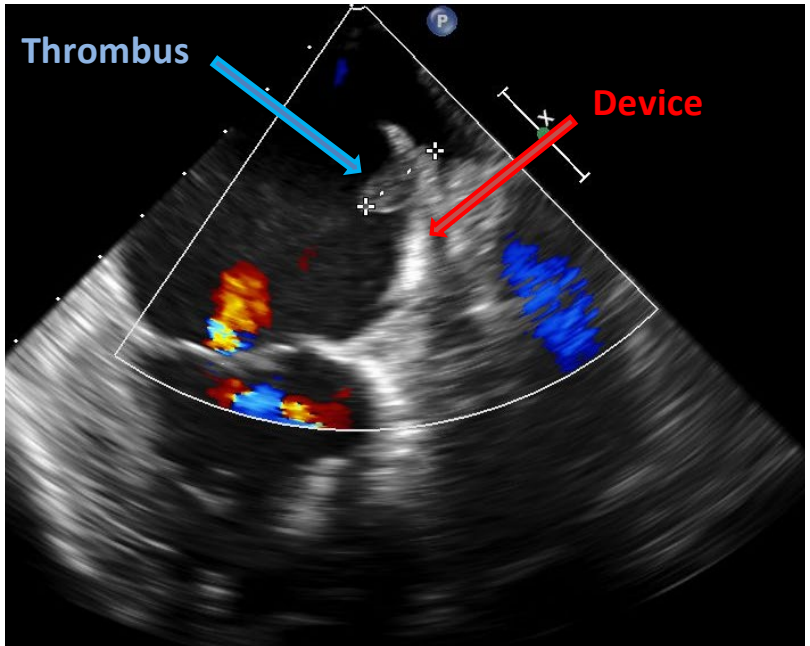
- Rivaroxaban 10 mg OD
- Rivaroxaban 15 mg OD
- DAPT

1° endpoint, D10: Thrombin generation (F1+2)

2° endpoint, D90: F1+2, TAT, D-Dimers and clinical events

Duthoit G. et al. Circ,Cardiovasc. Interv. 2020

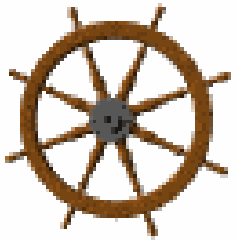




Indications

- Intra-cranial bleeding on anticoagulation
  - 1/3 of ischemic stroke develop hemorrhagic transformation on anticoagulation (Mudd P et al. 2010)
- Extra-cranial bleeding on anticoagulation
  - GI bleeding (e.g. angiodysplasia)
- Contra-indication to anticoagulation
  - Cerebral microbleeds or amyloid angiopathy
  - Low platelet count
- Intolerance to NOAC
  - Renal insufficiency; Liver dysfunction
  - GI intolerance
- Stroke on anticoagulation
- No compliance to anticoagulation
- No prescription of anticoagulation (alternative?)

Merci!



action-groupe.org