Traitement anticoagulant chez le coronarien

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Paris, France

Traitement anti coagulant chez le coronarien

De quoi parle-t-on?

Le coronarien est redevable d'1 AAG à vie!
(sauf exception)

Complication hémorragique menaçant le Pic vital

Chirurgie impossible sans arrêt du dernier AAG

Nécessité d'un traitement anticoagulant oral

Nécessité de **2** AAG

Discuter la durée

HBR PCI (one factor or more)

OAC planned after PCI

M

- risque ≥ 4% de saignement important (BARC 3 ou 5)
  ou
- risque ≥ 1% de saignement intracrânien

Risk of ICH (patient)

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

Avant et au Cath Lab

Décisions

01 Radiale

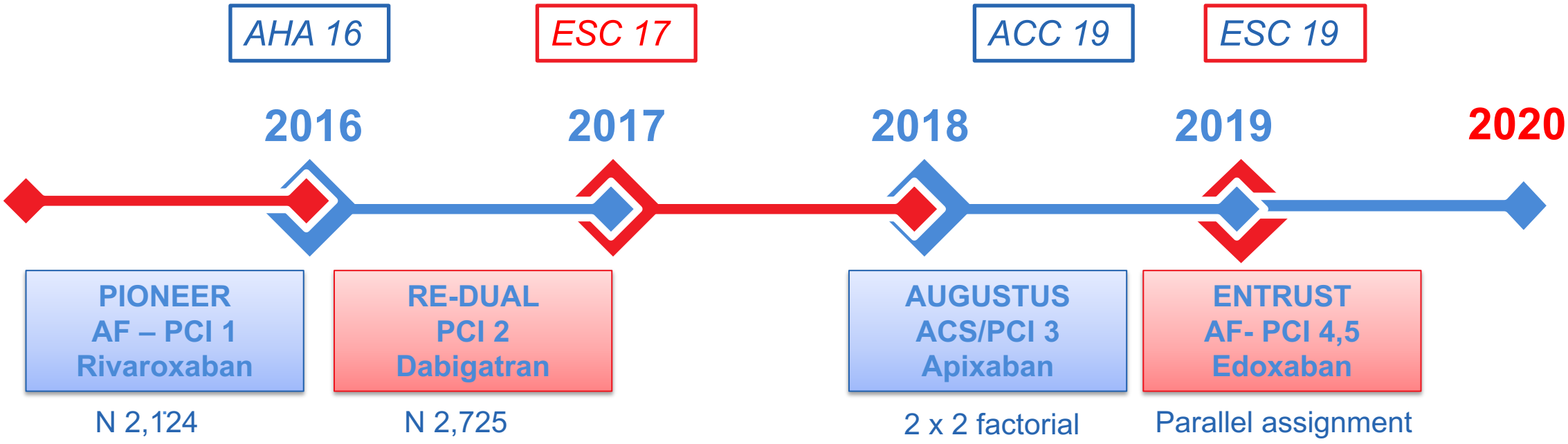
- Low HBR ou urgence
  - Sous A/C
  - Peu d'héparine
  - Pas d'antiplaq IV
- High HBR programmé
  - Sous A/C
  - Peu ou pas d'héparine
  - Pas de pré-traitement

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

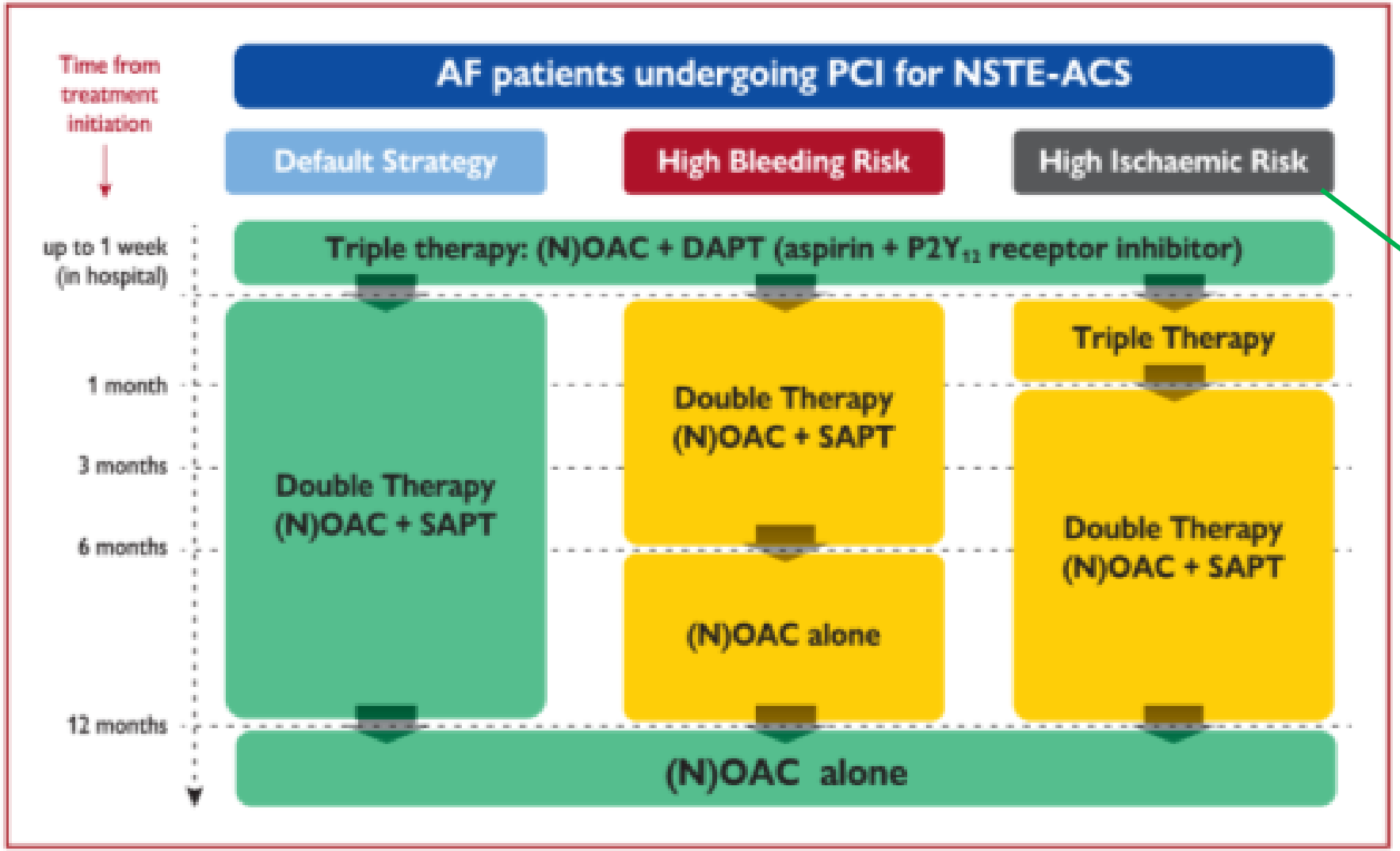
Après le Cath Lab

Le modèle FA et stent

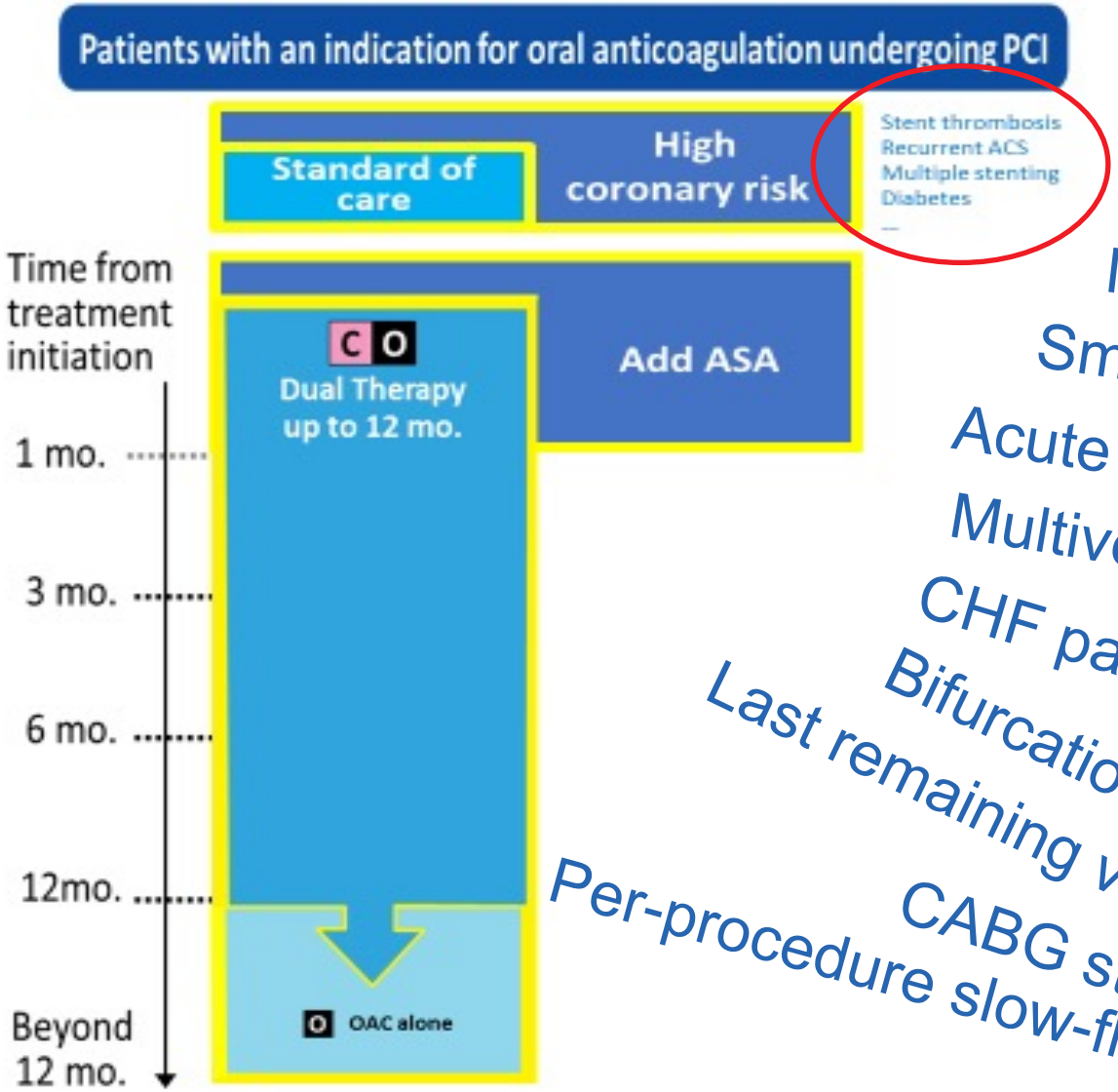


None of these trials were powered for efficacy

ESC Guidelines 2017 → 2020



High ischemic risk...lots of patients



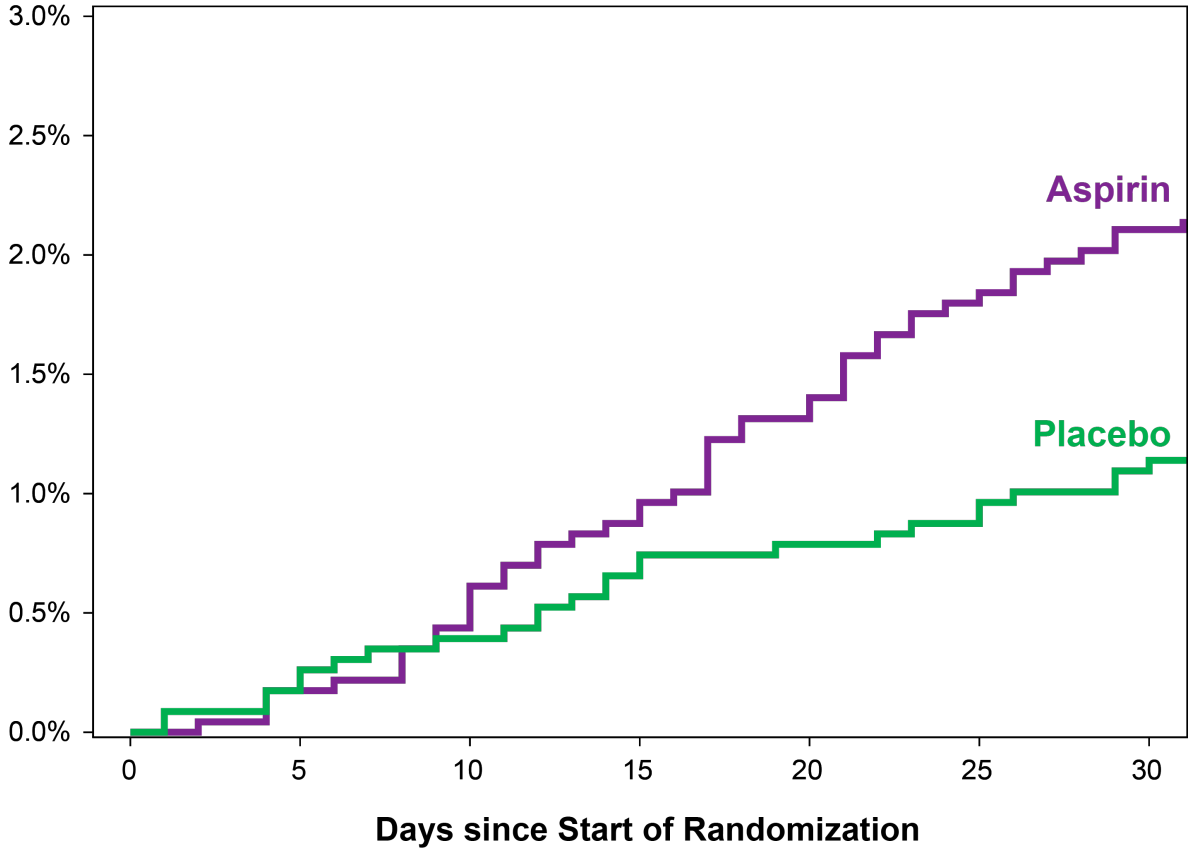
Prior Stent thrombosis
Recurrent ACS
Multiple/long stents
Small arteries
Acute STEMI
Multivessel diabetic disease
CHF patients
Bifurcations, LM
Last remaining vessel
CABG stent
Per-procedure slow-flow

Hammoudi N, Montalescot G. Eur Heart J 2018

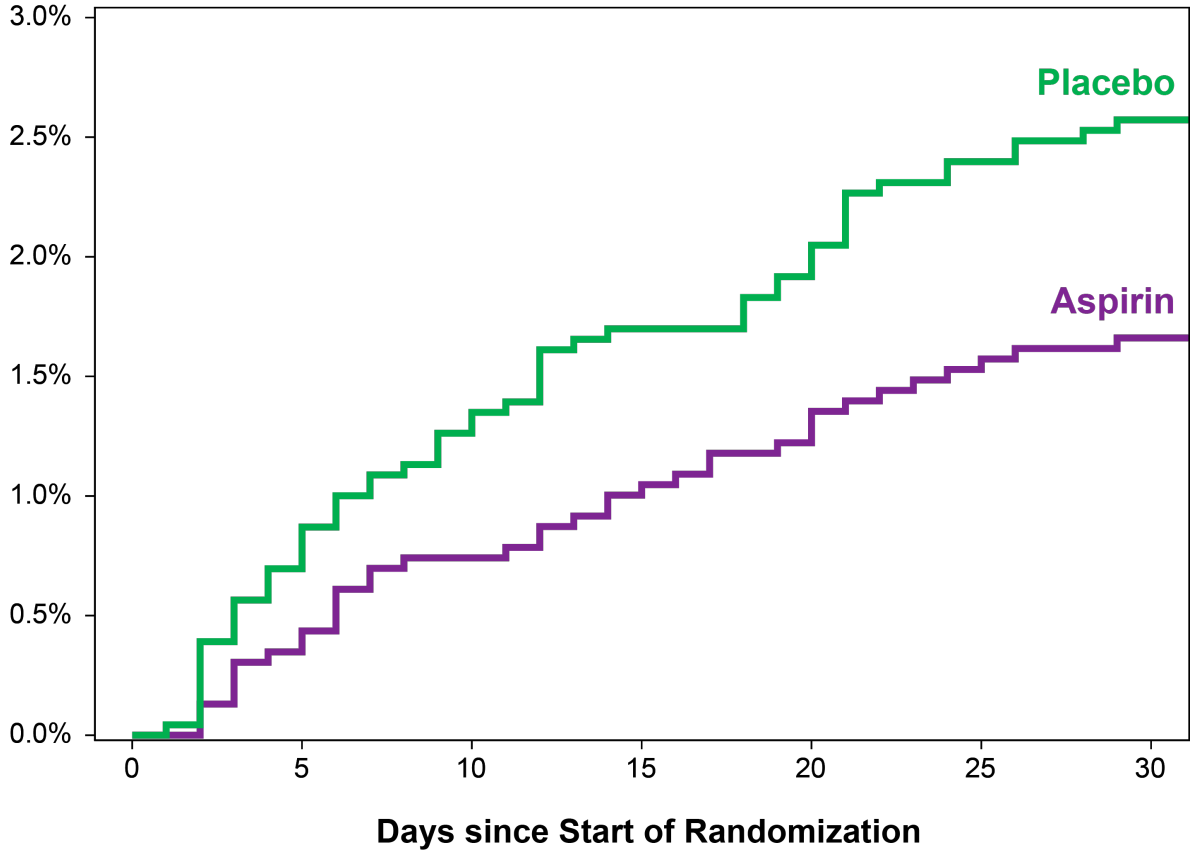
Severe Bleeding and Ischemic Outcomes in AUGUSTUS

Randomization to 30 Days

Fatal, ICH, Major Bleeding



CV Death, Stroke, MI, Stent Thrombosis



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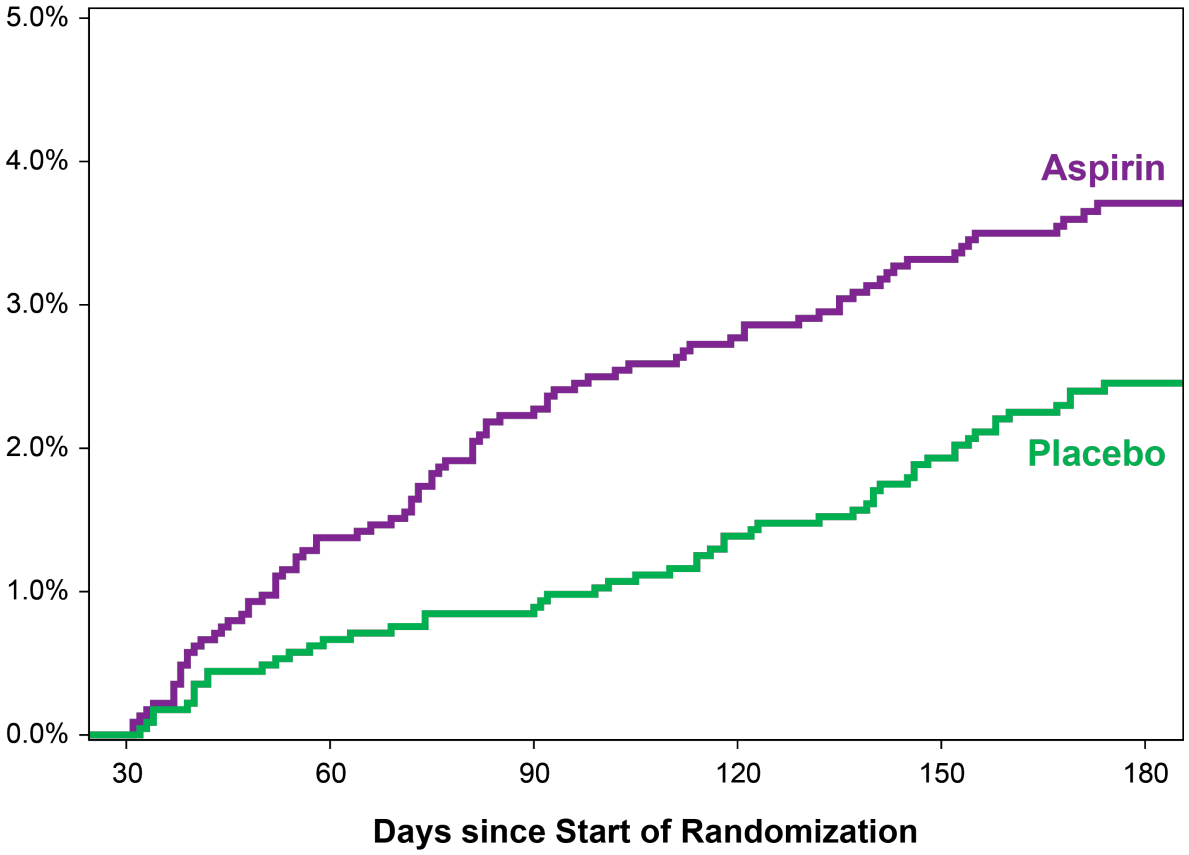
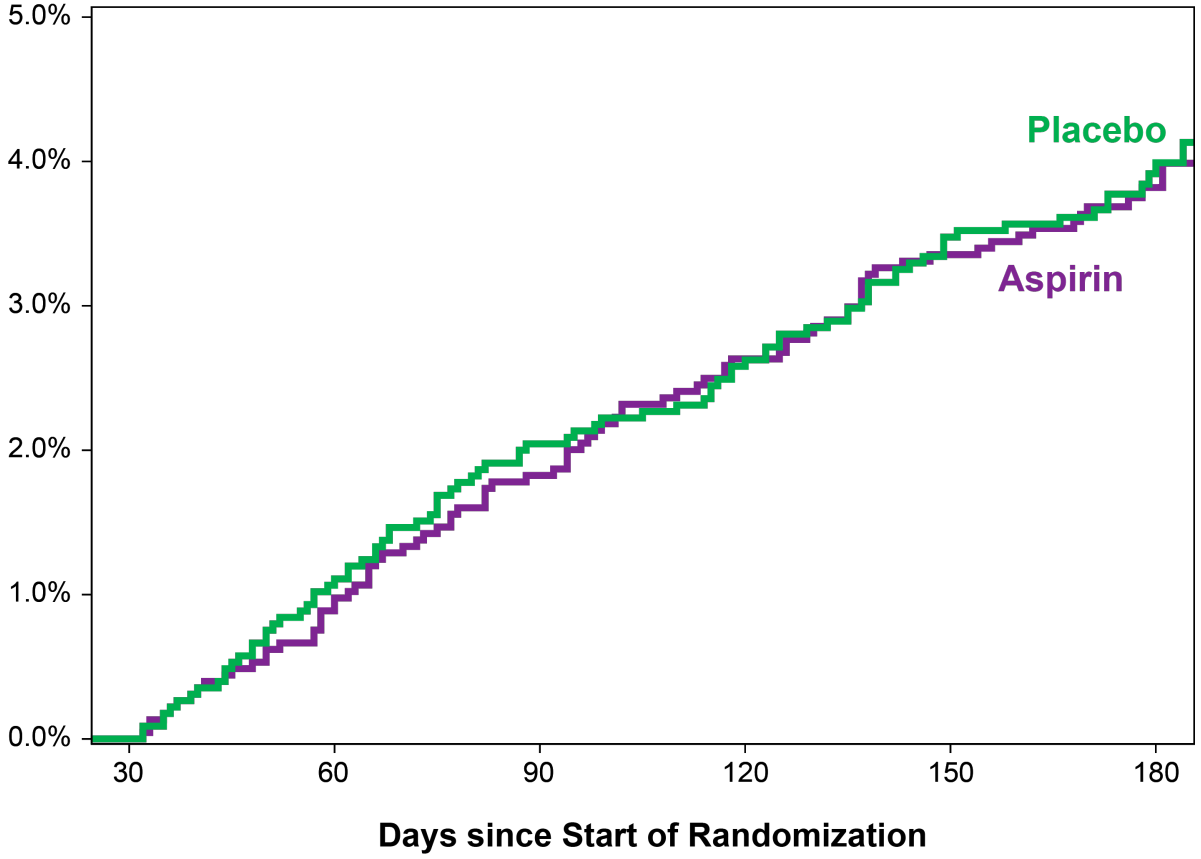
Severe Bleeding and Ischemic Outcomes in AUGUSTUS

30 Days to 6 Months

Fatal, ICH, Major Bleeding



CV Death, Stroke, MI, Stent Thrombosis



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Journal of Clinical Medicine

MDPI

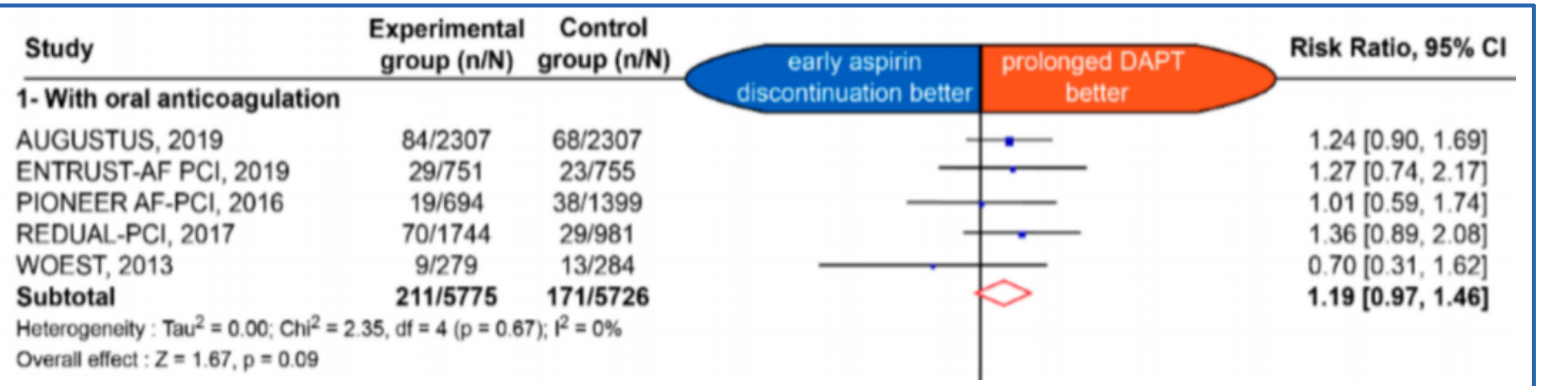
Review

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

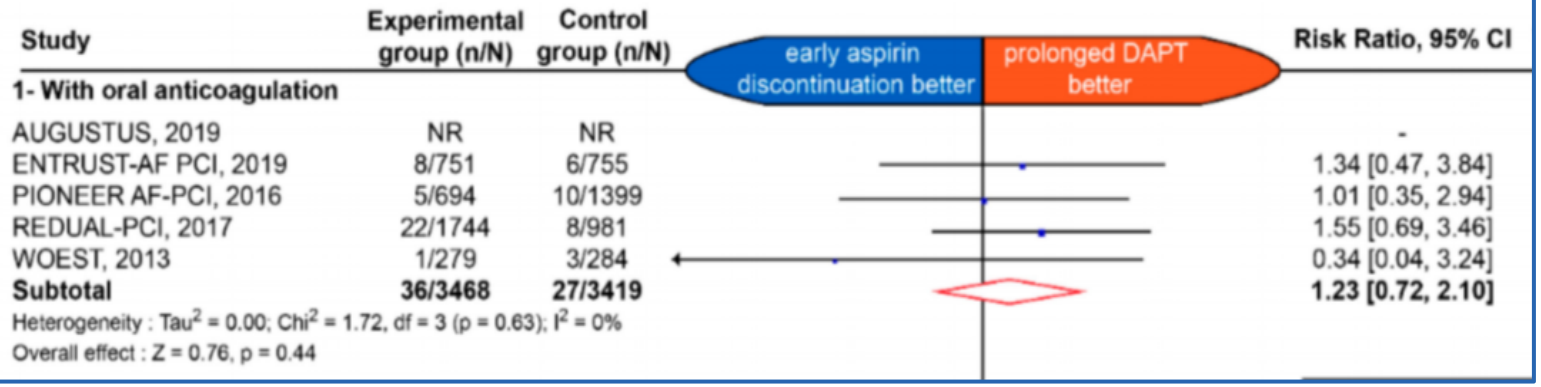
Paul Guedeney [1], Jules Mesnier [1], Sabato Sorrentino [2], Farouk Abcha [1], Michel Zeitouni [1], Benoit Lattuca [1], Johanne Silvain [1], Salvatore De Rosa [2], Ciro Indolfi [2], Jean-Philippe Collet [1], Mathieu Kerneis [1] and Gilles Montalescot [1,*]

ACTION GROUP

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)

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

Durée de l'aspirine

2200 patients with AF ($CHADS_2 \geq 1$) 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

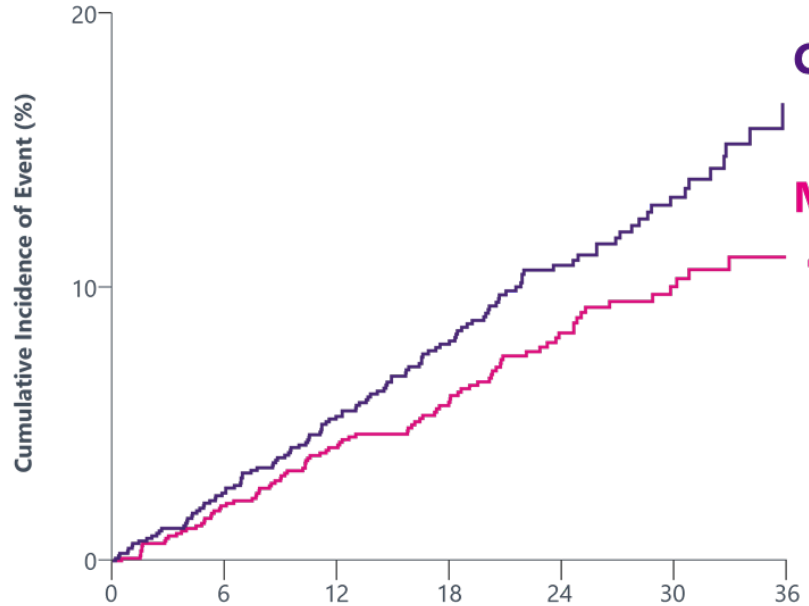
Key exclusion criteria
- A history of stent thrombosis
- Coexisting active tumor
- Poorly controlled hypertension

RANDOMIZE

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



Combination therapy
5.75% per patient-year

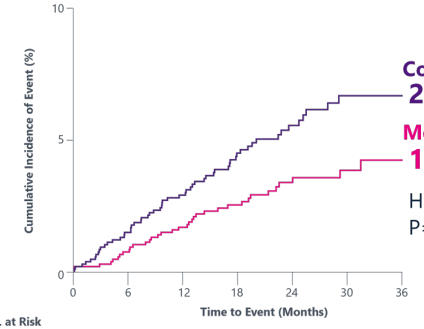
Monotherapy
4.14% per patient-year

HR, **0.72** (**0.55** to **0.95**)
P<0.001 (noninf.)

*In the assessment for **superiority for the primary efficacy end point** (that was not prespecified), the **P value was 0.02.**

No. at Risk							
Rivaroxaban monotherapy	1107	1071	984	774	518	309	89
Combination therapy	1108	1057	962	754	499	292	80

Kaplan-Meier Estimates of First Occurrence of Primary Safety Events



Combination therapy
2.76% per patient-year

Monotherapy
1.62% per patient-year

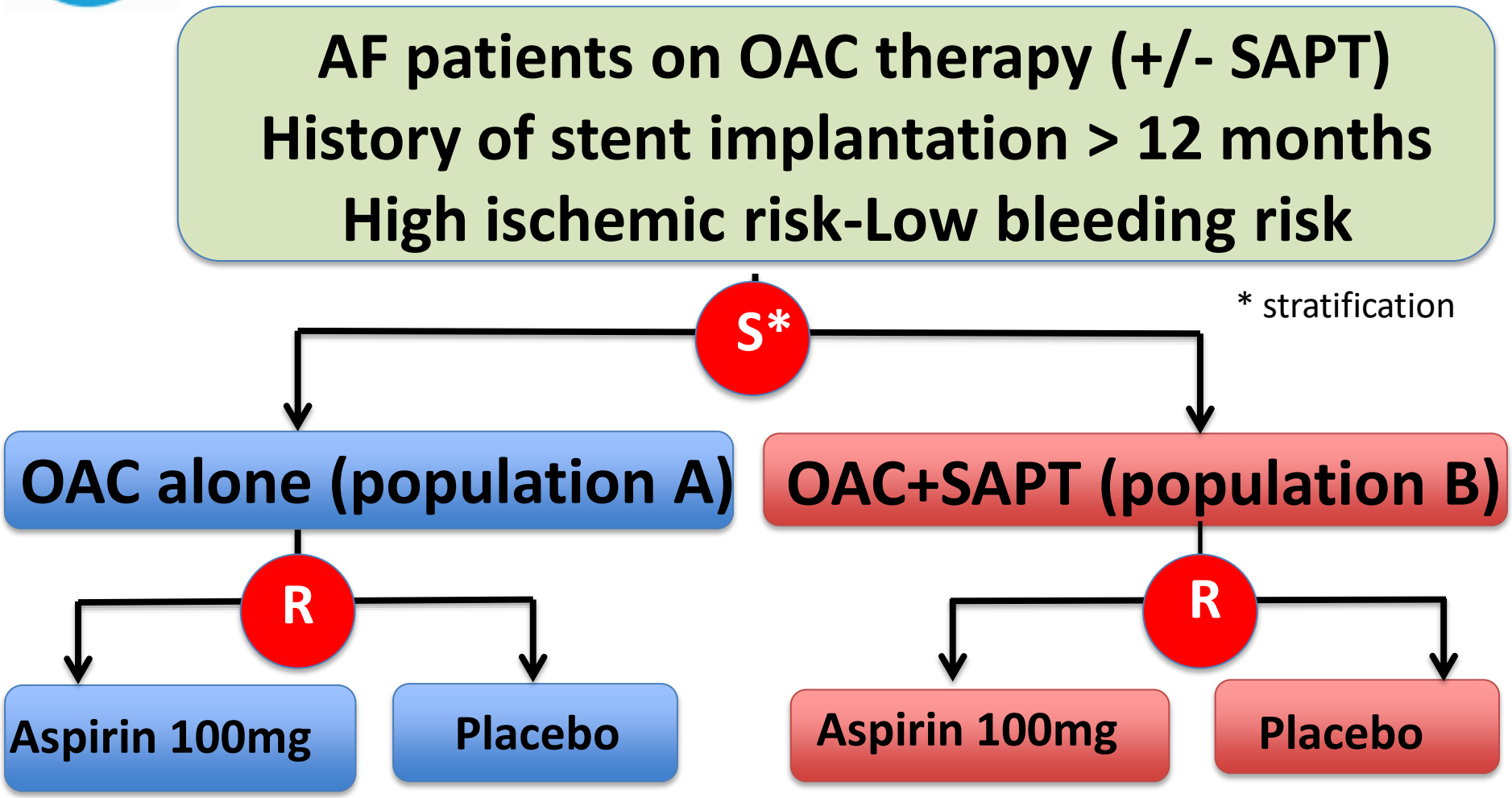
HR, **0.59** (**0.39** to **0.89**)
P=0.01 (sup.)

No. at Risk							
Rivaroxaban monotherapy	1099	1074	994	786	526	312	89
Combination therapy	1099	1055	962	750	506	294	80

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

Yasuda et al. AFIRE - NEJM 2019

AQUATIC study



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 Reconnaitre le haut risque hémorragique

03 Dans l'urgence ischémique: garder le bénéfice attendu en tête

04 Apres le KT: arrêt rapide de l'aspirine

05 Stratégies individuelles possibles au cas par cas

06 Arrêt du dernier antiplaquettaire → randomiser