Conférence scientifique SSMG

Charleroi

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Gestion du traitement antiagrégant après un syndrome coronaire aigu

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les questions à aborder

Quelles molécules doit-on prescrire ? « Consensus CHU-GHDC »

Pour quelle durée ?

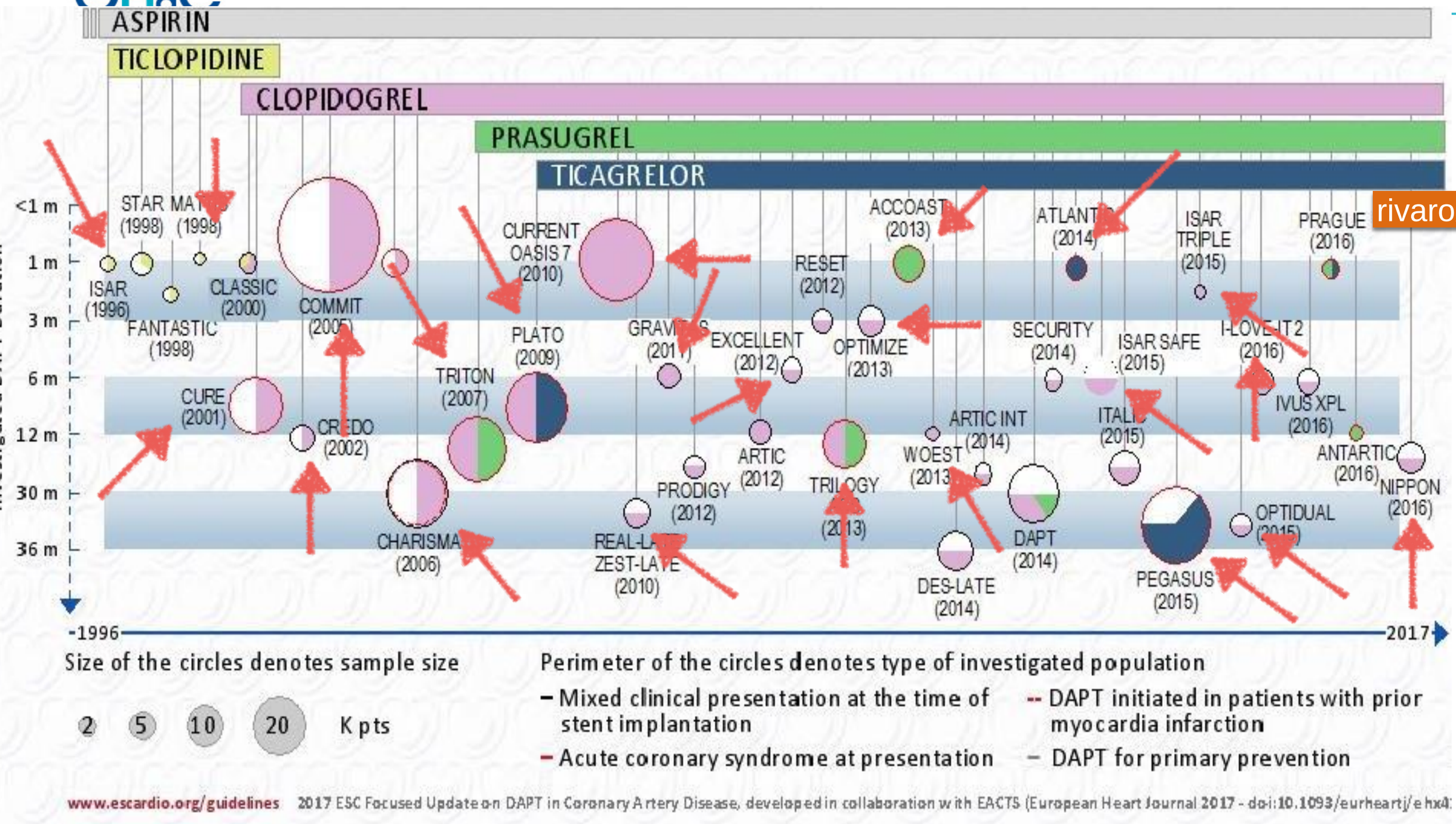
Comment adapter le traitement en cas de:

- saignement ?

- d’intervention ?

- patients à haut risque cardiovasculaire ?

« Une brève histoire du SCA a travers les âges »



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les molécules en question

l'évolution récente

Les nouvelles molécules $P2Y_{12}$ inhibiteurs (Ticagrelor) sont:

- plus puissantes:
  - ↘ - risque ischémique
  - ↗ - risque hémorragique
- moins de résistances à la molécule (>< Clopidogrel)
- effet antiagrégant transitoire

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les molécules

Recommendations	Class	Level
In patients with ACS, ticagrelor (180 mg loading dose, 90 mg twice daily) on top of aspirin is recommended, regardless of initial treatment strategy, including patients pre-treated with clopidogrel (which should be discontinued when ticagrelor is commenced) unless there are contra-indications.	I	B
In patients with ACS undergoing PCI, prasugrel (60 mg loading dose, 10 mg daily dose) on top of aspirin is recommended for $P2Y_{12}$ inhibitor-naïve patients with NSTE-ACS or initially conservatively managed STEMI if indication for PCI is established, or in STEMI patients undergoing immediate coronary catheterization unless there is a high-risk of life-threatening bleeding or other contra-indications.	I	B

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les molécules

Recommendations	Class	Level
Clopidogrel (600 mg loading dose, 75 mg daily dose) on top of aspirin is recommended in stable CAD patients undergoing coronary stent implantation and in ACS patients who cannot receive ticagrelor or prasugrel, including those with prior intracranial bleeding or indication for OAC.	I	A
Clopidogrel (300 mg loading dose in patients ≤75, 75 mg daily dose) is recommended on top of aspirin in STEMI patients receiving thrombolysis.	I	A

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triple anti-agrégation/coagulation

- 2 grands groupes de patients:
  - SCA + arythmie emboligène (FA, Flutter)
  - SCA + risque élevé de récidive

- Facteur Xa et thrombine restent élevés après SCA

- ? OAC doses réduites + $P2Y_{12}$inh ?
  - ATLAS TIMI 51
  - COMPASS

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les molécules après CABG

Recommendations	Class	Level
In patients with ACS (NSTE-ACS or STEMI) treated with DAPT and undergoing CABG and not requiring long-term OAC therapy, resumption of $P2Y_{12}$ inhibitor therapy as soon as deemed safe after surgery and continuation up to 12 months is recommended.	I	C
In patients on $P2Y_{12}$ inhibitors who need to undergo non-emergent cardiac surgery, postponing surgery for at least 3 days after discontinuation of ticagrelor, at least 5 days after clopidogrel, and at least 7 days after prasugrel should be considered.	IIa	B
In CABG patients with prior MI who are at high-risk of severe bleeding (e.g. PRECISE-DAPT ≥25), discontinuation of $P2Y_{12}$ inhibitor therapy after 6 months should be considered.	IIa	C

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les molécules

- **Aspirine:**
  - indispensable sauf si antico
  - toujours à faible dose
- **Ticagrelor:**
  - NStemi - Stemi
  - jamais avec NOAC sauf si cas particulier:
    - thrombose de stent
    - réduction dose OAC
- **NOAC** <u>à petites doses:</u> indication débatue (2019)
  - réduction de mortalité
  - augmentation des saignements

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durée du traitement

- La règle des «12 mois de DAPT » reste valable

- La majorité des stents utilisés sont des **DES** avec risque thombotique très bas

- Patients plus fragiles, polypathologiques et multi-traités

→ La prudence s'impose

Réduction DAPT à 6 mois / 3 mois / 1 mois selon la situation clinique

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durée du traitement

12 ou 6 mois ?

Recommendations	Class	Level
In patients with ACS treated with coronary stent implantation, DAPT with a $P2Y_{12}$ inhibitor on top of aspirin is recommended for 12 months unless there are contra-indications such as excessive risk of bleeding (e.g. PRECISE-DAPT ≥25).	I	A
In patients with ACS and stent implantation who are at high-risk of bleeding (e.g. PRECISE-DAPT ≥25), discontinuation of $P2Y_{12}$ inhibitor therapy after 6 months should be considered.	IIa	B
In patients with ACS treated with bioresorbable vascular scaffolds, DAPT for at least 12 months should be considered.	IIa	C

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durée du traitement

> 12 mois ?

Recommendations	Class	Level
In patients with ACS who have tolerated DAPT without a bleeding complication, continuation of DAPT for longer than 12 months may be considered.	IIb	A
In patients with MI and high ischaemic risk who have tolerated DAPT without a bleeding complication, ticagrelor 60 mg *b.i.d.* for longer than 12 months on top of aspirin may be preferred over clopidogrel or prasugrel.	IIb	B

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durée du traitement

Traitement médical sans angioplastie jusqu'à 12 mois

Recommendations	Class	Level
In patients with ACS who are managed with medical therapy alone and treated with DAPT, it is recommended to continue $P2Y_{12}$ inhibitor therapy (either ticagrelor or clopidogrel) for 12 months.	I	A
Ticagrelor is recommended over clopidogrel, unless the bleeding risk outweighs the potential ischaemic benefit.	I	B
In patients with medically managed ACS who are at high-risk of bleeding (e.g. PRECISE-DAPT ≥25), DAPT for at least 1 month should be considered.	IIa	C

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durée du traitement

Traitement médical sans angioplastie > 12 mois

Recommendations	Class	Level
In patients with prior MI at high ischaemic risk who are managed with medical therapy alone and have tolerated DAPT without a bleeding complication, treatment with DAPT in the form of ticagrelor 60 mg *b.i.d.* on top of aspirin for longer than 12 months and up to 36 months may be considered.	IIb	B
In patients with prior MI not treated with coronary stent implantation who have tolerated DAPT without a bleeding complication and who are not eligible for treatment with ticagrelor, continuation of clopidogrel on top of aspirin for longer than 12 months may be considered.	IIb	C
Prasugrel is not recommended in medically managed ACS patients.	III	B

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durée du traitement

- **DAPT 12 mois** à maintenir si bien tolérée
- DAPT à raccourcir à 6 mois si complications
- Si indication d'anticoagulation:

  - pas de guidelines définitifs en 2019
  - TAPT (AAS + P2Yinh + OAC) ~ 1 mois
  - ensuite: Clopi + Noac **ou** Tica + sintrom

syndrome coronaire aigu

minimiser les risques

syndrome coronaire aigu

minimiser les risques

Recommendations	Class	Level
Radial over femoral access is recommended for coronary angiography and PCI if performed by an expert radial operator.	I	A
In patients treated with DAPT, a daily aspirin dose of 75–100 mg is recommended.	I	A
A PPI in combination with DAPT is recommended.	I	B
Routine platelet function testing to adjust antiplatelet therapy before or after elective stenting is not recommended.	III	A

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minimiser les risques

Faire du « sur-mesure »

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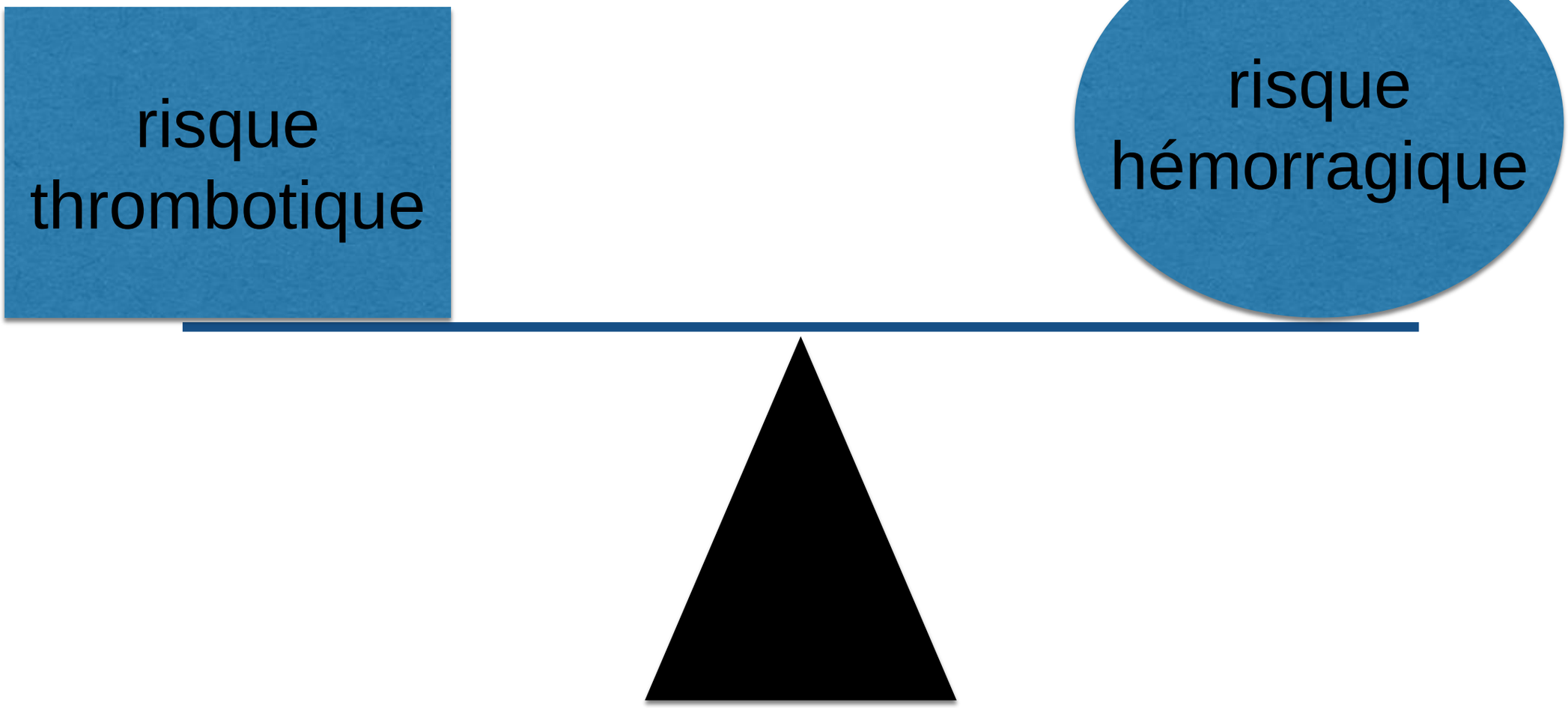
minimiser les risques

Faire du « sur-mesure »



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minimiser les risques

Faire du « sur-mesure »

risque thrombotique

• Prior stent thrombosis on adequate antiplatelet therapy.
• Stenting of the last remaining patent coronary artery.
• Diffuse multivessel disease especially in diabetic patients.
• Chronic kidney disease (i.e. creatinine clearance <60 mL/min).
• At least three stents implanted.
• At least three lesions treated.
• Bifurcation with two stents implanted.
• Total stent length >60 mm.
• Treatment of a chronic total occlusion.

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minimiser les risques

Faire du « sur-mesure »

- Short life expectancy.
- Ongoing malignancy.
- Poor expected adherence.
- Poor mental status.
- End stage renal failure.
- Advanced age.
- Prior major bleeding/prior haemorrhagic stroke.
- Chronic alcohol abuse.
- Anaemia.
- Clinically significant bleeding on dual antithrombotic therapy.

risque hémorragique

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gérer l'anticoagulation

• Assess ischaemic and bleeding risks using validated risk predictors (e.g. CHA_2DS_2-VASc, ABC, HAS-BLED) with a focus on modifiable risk factors.
• Keep triple therapy duration as short as possible; dual therapy after PCI (oral anticoagulant and clopidogrel) to be considered instead of triple therapy.
• Consider the use of NOACs instead of VKA when NOACs are not contra-indicated.
• Consider a target INR in the lower part of the recommended target range and maximize time in therapeutic range (i.e. >65–70%) when VKA is used.
• Consider the lower NOAC regimen tested in approval studies and apply other NOAC regimens based on drug-specific criteria for drug accumulation.
• Clopidogrel is the $P2Y_{12}$ inhibitor of choice.
• Use low-dose (≤100 mg daily) aspirin.
• Routine use of PPIs.

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gérer l'anticoagulation

Recommendations	Class	Level
It is recommended to administer periprocedurally aspirin and clopidogrel in patients undergoing coronary stent implantation.	I	C
In patients treated with coronary stent implantation, triple therapy with aspirin, clopidogrel and OAC should be considered for 1 month, irrespective of the type of stent used.	IIa	B
Triple therapy with aspirin, clopidogrel and OAC for longer than 1 month and up to 6 months should be considered in patients with high ischaemic risk due to ACS or other anatomical/procedural characteristics, which outweigh the bleeding risk.	IIa	B
Dual therapy with clopidogrel 75 mg/day and OAC should be considered as an alternative to 1-month triple antithrombotic therapy in patients in whom the bleeding risk outweighs the ischaemic risk.	IIa	A

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gérer l'anticoagulation

Recommendations	Class	Level
Discontinuation of antiplatelet treatment in patients treated with OAC should be considered at 12 months.	IIa	B
In patients with an indication for VKA in combination with aspirin and/or clopidogrel, the dose intensity of VKA should be carefully regulated with a target INR in the lower part of the recommended target range and a time in the therapeutic range >65–70%.	IIa	B
When a NOAC is used in combination with aspirin and/or clopidogrel, the lowest approved dose effective for stroke prevention tested in AFib trials should be considered.	IIa	C
When rivaroxaban is used in combination with aspirin and/ or clopidogrel, rivaroxaban 15 mg *q.d.* may be used instead of rivaroxaban 20 mg *q.d.*	IIb	B
The use of ticagrelor or prasugrel is not recommended as part of triple antithrombotic therapy with aspirin and OAC.	III	C

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gérer le quotidien

Quid si complications hémorragiques légères ?

Quid si intervention prévue ?

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gérer le quotidien

MILD BLEEDING

Any bleeding that requires medical attention without requiring hospitalization

e.g. not self resolving epistaxis, moderate conjunctival bleeding, genitourinary or upper/lower gastrointestinal bleeding without significant blood loss, mild haemoptysis

- Continue DAPT.
- Consider shortening DAPT duration or switching to less potent $P2Y_{12}$ inhibitor (i.e.from ticagrelor/ prasugrel to clopidogrel), especially if recurrent bleeding occurs.

- In case of triple therapy consider downgrading to dual therapy, preferably with clopidogrel and OAC.

- Identify and possibly treat concomitant conditions associated with bleeding (e.g. peptic ulcer, haemorrhoidal plexus, neoplasm).
- Add PPI if not previously implemented.
- Counsel patient on the importance of drug-adherence.

Legend

DAPT management

OAC management

General recommendations

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gérer le quotidien

arrêt DAPT prématurément

↓

risque de thrombose de stent

↓

récidive infarctus aigu du myocarde
ou

entraîner la mort subite

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gestion avant intervention

arrêt DAPT prématurément = risque de thrombose de stent

? postposer toute intervention non urgente

? évaluer risque hémorragique de la procédure vs risque thrombotique du stent : délais depuis implantation, taille, localisation et nombres de stents, type d'angioplastie (recanalisation, bifurcation, tronc commun,…)

? relais par HBPM: peut-être envisagé mais n'est plus recommandé en raison du risque hémorragique (switch)

? concertation avec le cardiologue interventionnel

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gestion avant intervention

PAS D'ARRET
ASPIRINE

sauf si:

- neurochirurgie intracrânienne
- chirurgie rachidienne (canal médullaire)
- prostatectomie transuréthrale
- chirurgie du segment postérieur de l'oeil

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gestion avant intervention

Chirurgie à bas risque de saignement	Chirurgie à haut risque de saignement
• Intervention dentaire • Chirurgie de la cataracte • Exérèse de lésions cutanées • Endoscopie digestive diagnostique • Ponction biopsie de moelle osseuse • Ponction articulaire, sauf articulation coxo-fémorale, épaule et sacro-iliaques • Biopsie des glandes salivaires accessoires	• Chirurgie cardiovasculaire • Chirurgie et biopsies d'organes fortement vascularisés (foie, rate, reins) • Chirurgie urologique (REP, REV, néphrectomie, biopsie rénale) • Exérèse de polypes à base large (> 1-2 cm), résection d'intestin grêle • Chirurgie étendue (arthroplastie, chirurgie plastique reconstructive étendue, chirurgie oncologique) • Neurochirurgie (dû à la localisation du saignement)

REP: résection arthoscopique de la prostate; REV: résection endoscopique vésicale.

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gestion avant intervention

Intervention ne nécessitant pas l'arrêt de l'anticoagulant

- Intervention dentaire
  - Extraction d'1 à 3 dents
  - Chirurgie parodontale
  - Incision d'abcès
  - Implantation d'implant
- Ophtalmologie
  - Intervention de la cataracte ou du glaucome
- Endoscopie sans chirurgie
- Chirurgie superficielle (incision d'abcès, petite incision dermatologique…)

Intervention avec faible risque d'hémorragie

- Endoscopie avec biopsie
- Biopsie de la prostate ou de la vessie
- Etude électrophysiologique ou ablation par radiofréquence pour tachycardie supraventriculaire (incluant ablation gauche par simple ponction transseptale)
- Angiographie
- Placement d'un pacemaker ou d'un défibrillateur (excepté difficultés anatomiques, telle la cardiopathie congénitale)

Intervention avec haut risque hémorragique

- Ablation gauche difficile (isolation de la veine pulmonaire gauche, ablation de tachycardie ventriculaire)
- Anesthésie épidurale ou rachis, ponction lombaire diagnostique
- Chirurgie thoracique
- Chirurgie abdominale
- Chirurgie orthopédique majeure
- Biopsie hépatique
- Résection transuréthrale de la prostate
- Biopsie rénale

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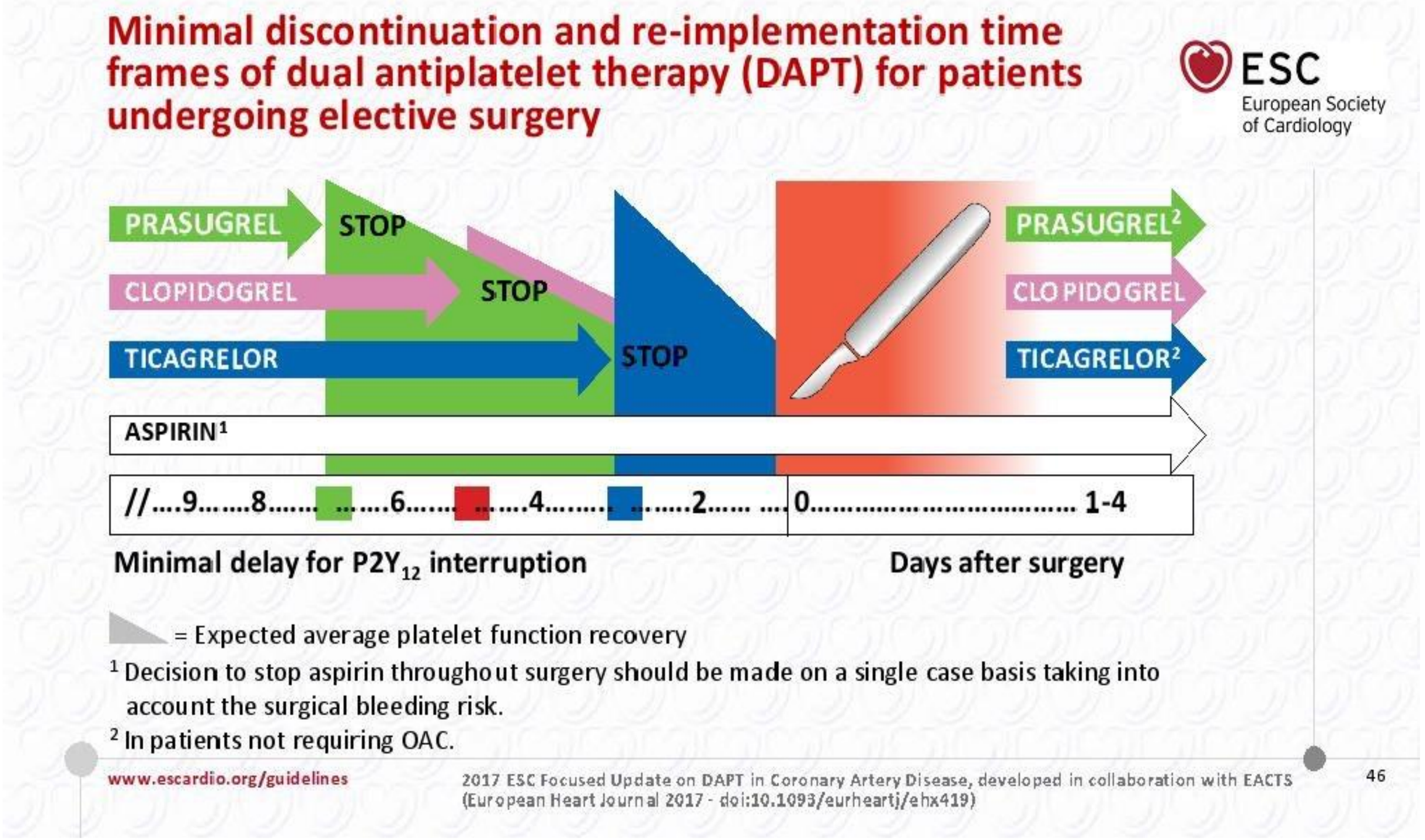
gestion avant intervention



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Dans les grandes lignes

En raison de l'amélioration des stents actifs:

- stents plus fins et délais d'endothélisation plus courts

- en pratique:

  - traitement par **P2Y Inhibiteurs** (clopi/tica):

- 1 mois minimum absolu (cas d'urgence chirurgicale)
- > 3 mois - 6 mois: interruption possible **à discuter avec cardiologue interventionel.**
- > 12 mois: prolongation possible si patient à haut risque CV.
- NOAc combiné ? : indication encore en discussion

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