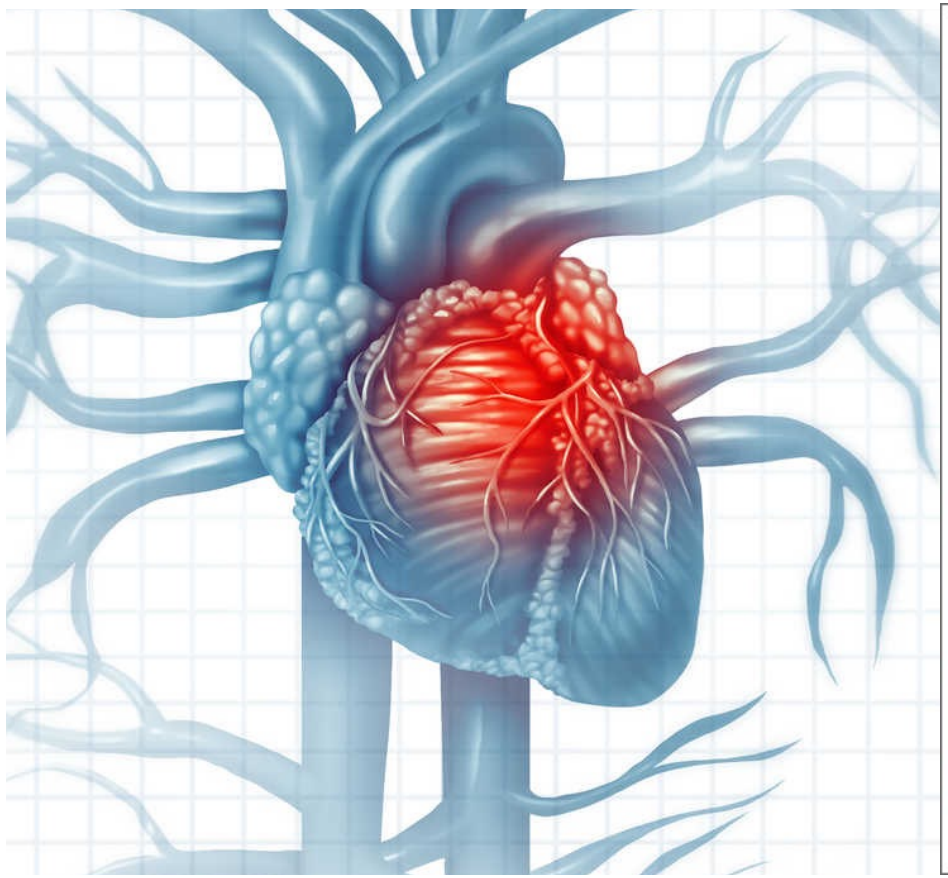
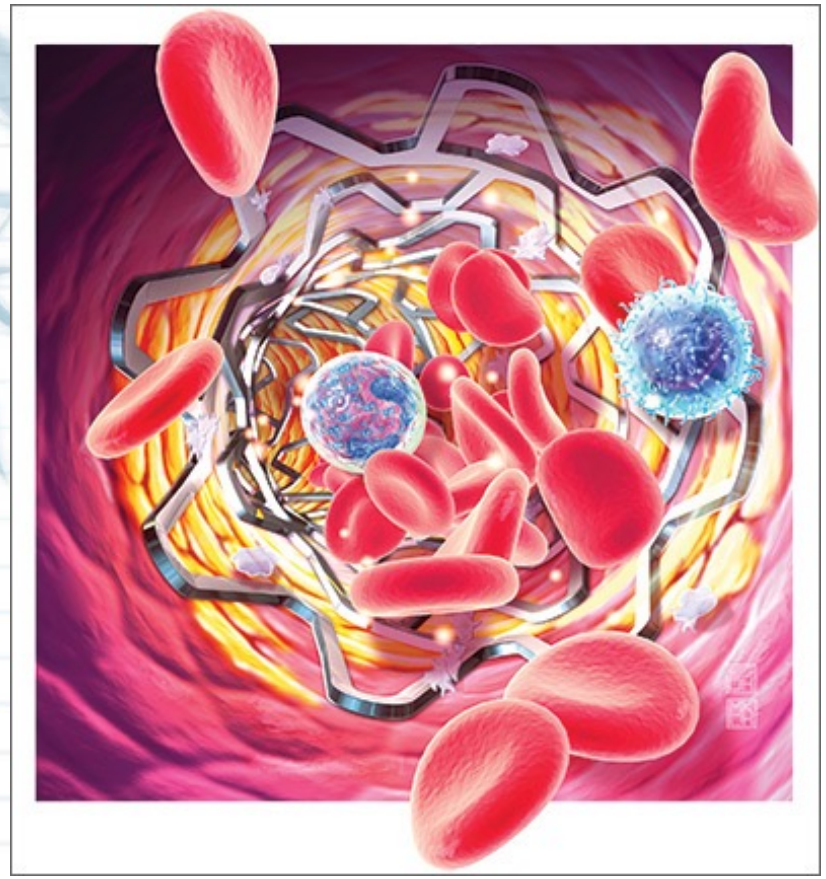
L’uso dei NAO nella cardiopatia ischemica





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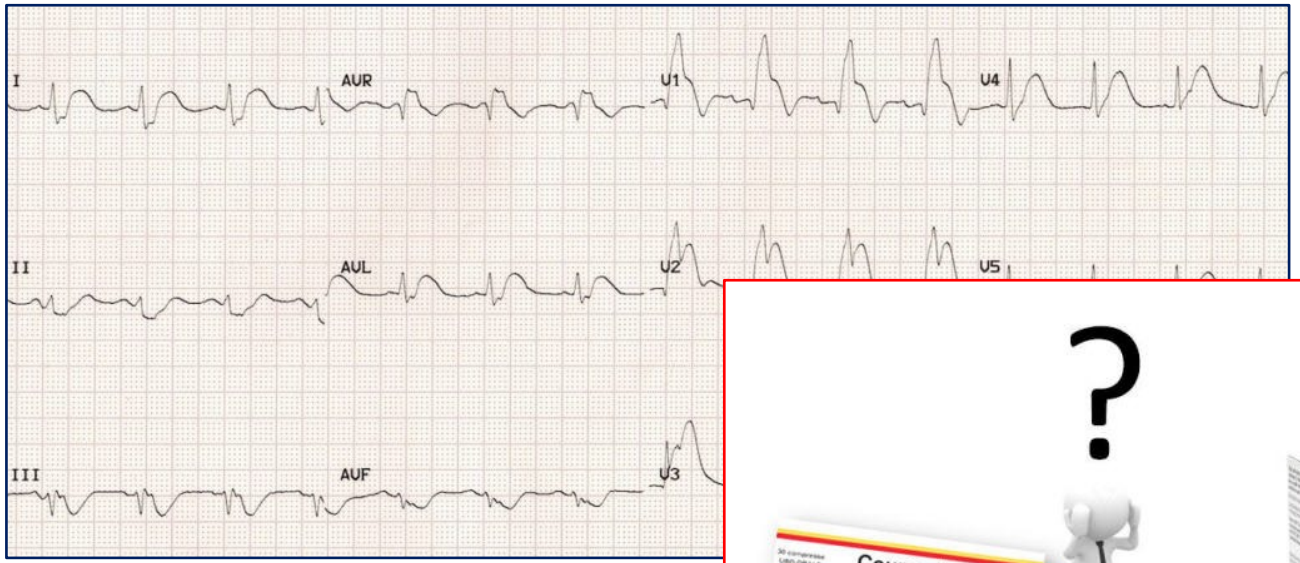
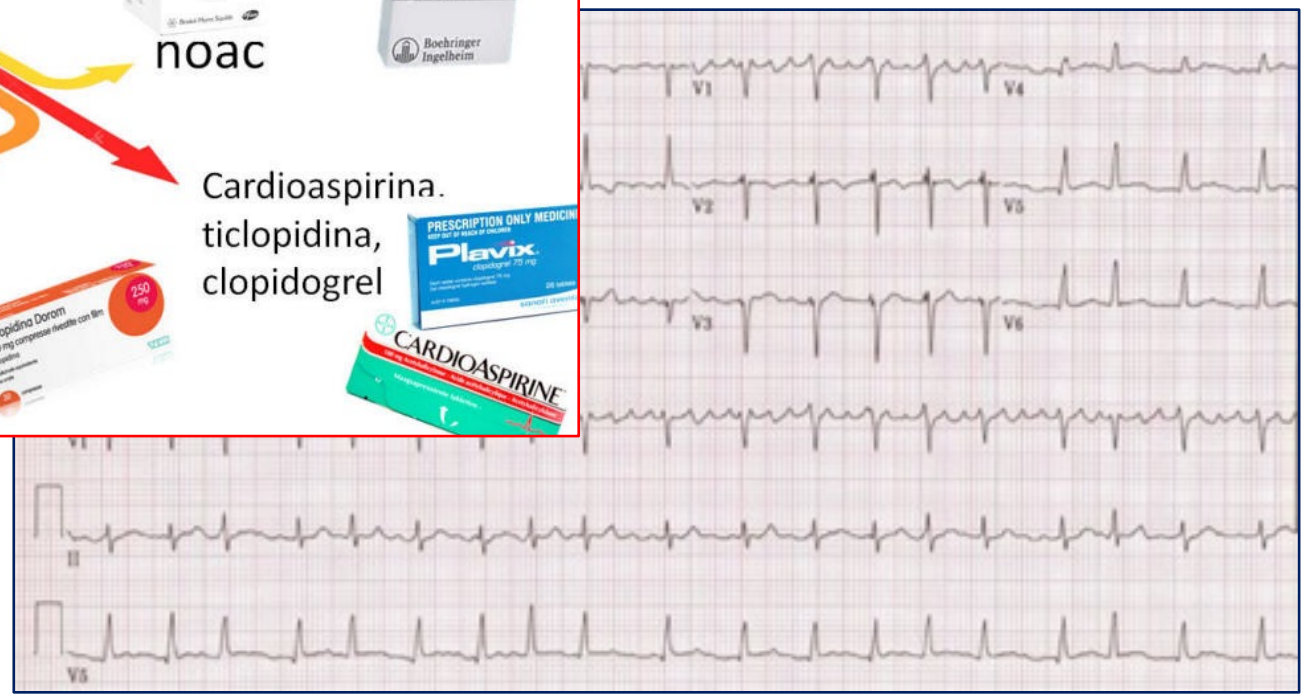
EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Imola

Dott. Mauro Li Calzi
Cardiologia – Azienda USL di IMOLA


European Heart Journal Advance Access published August 27, 2016
ESC GUIDELINES
2016 ESC Guidelines for the management of atrial fibrillation developed in collaboration with EACTS
SPECIAL ARTICLE
The 2018 European Heart Rhythm Association Practical Guide on the use of non-vitamin K
ESC/EACTS GUIDELINES
EHRA CONSENSUS DOCUMENT
2018 Joint European consensus document on
Circulation
WHITE PAPER
Antithrombotic Therapy in Patients With Atrial
Circulation
ACC/AHA/HRS GUIDELINE
2019 AHA/ACC/HRS Foc
ACC/HRS Guideline for
With Atrial Fibrillation
ESC GUIDELINES
2020 ESC Guidelines for the diagnosis and management of atrial fibrillation developed in collaboration with the European Association of Cardio-Thoracic Surgery (EACTS)
The Task Force for the diagnosis and management of atrial fibrillation of the European Society of Cardiology (ESC)
Developed with the special contribution of the European Heart Rhythm Association (EHRA) of the ESC


I
AUR
U1
U4
II
AUL
U2
U5
III
AUF
U3


?
Coumadin 5mg compresse
warfarin sodico
Sintrom 4
NOVARTIS
Xarelto
Rivaroxabán
10mg
Eliquis
apixaban tablets
5 mg
Pradaxa
110 mg
30 hard capsules
Boehringer Ingelheim
noac
tao
Cardioaspirina.
ticlopidina,
clopidogrel
Ticlopidina Dorom
250 mg
PRESCRIPTION ONLY MEDICINE
Plavix
CARDIOASPIRINE


V1
V4
V2
V5
V3
V6
II
V5

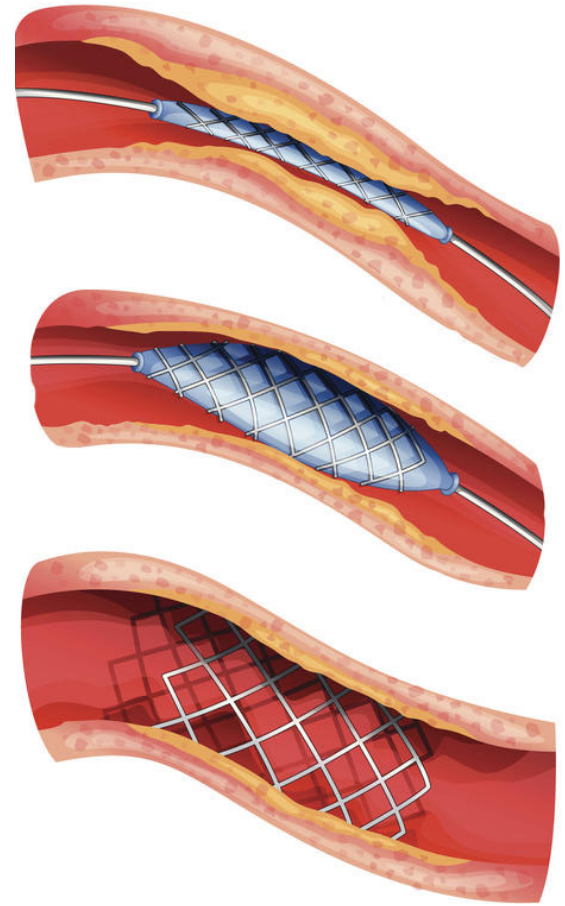
Doppia terapia antiaggregante per pazienti in anticoagulazione orale (triplice terapia)

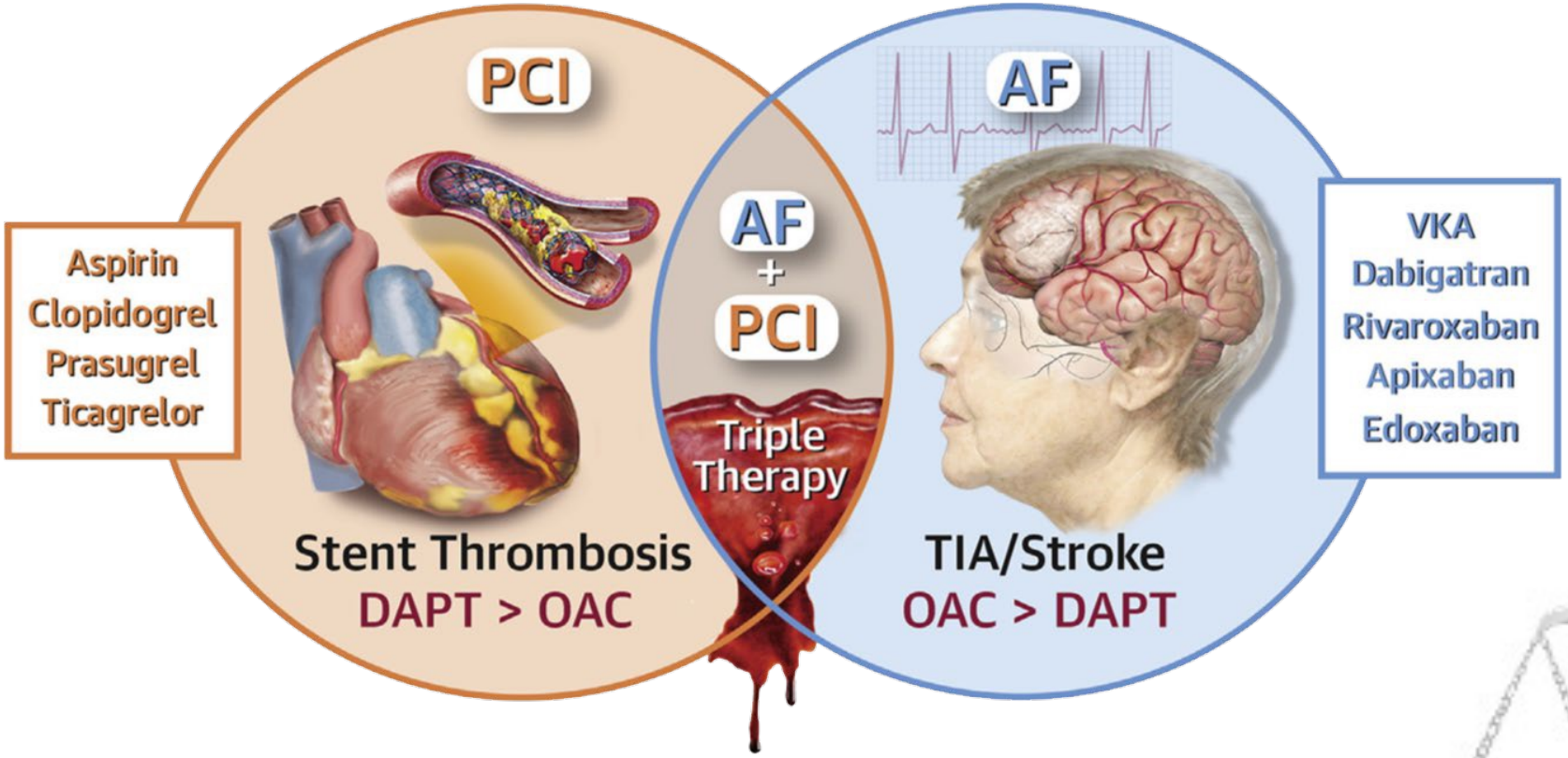
Perché è utile

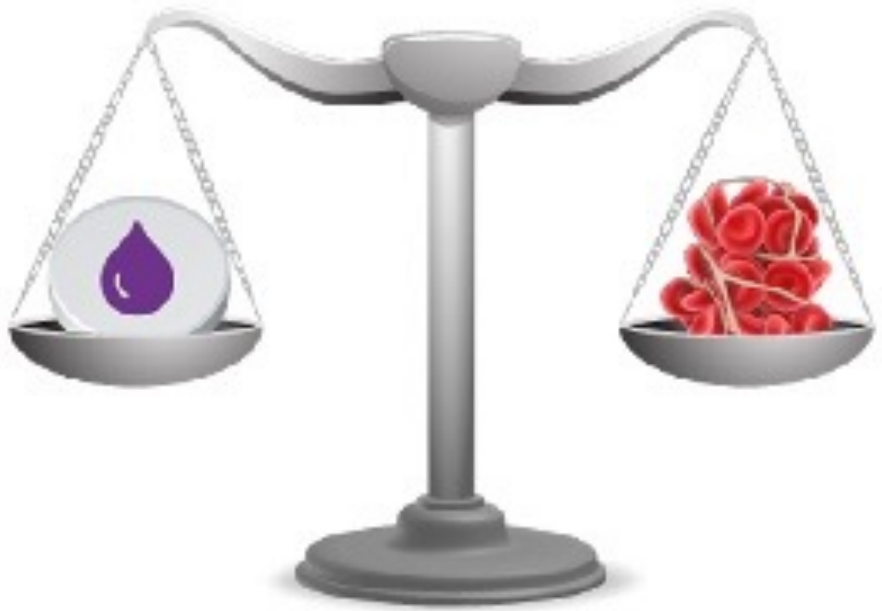
- Circa il 6–8% dei pz sottoposti a PCI hanno indicazione alla terapia anticoagulante a lungo termine per varie patologie quali FA, protesi valvolari meccaniche cardiache, tromboembolismo venoso

- Secondo le conoscenze attuali, in fase acuta la DAPT è necessaria per prevenire la trombosi dello stent ma non è sufficiente a prevenire lo stroke

- Viceversa, la terapia anticoagulante orale è essenziale per la prevenzione dello stroke, ma in fase acuta/subacuta non è idonea a prevenire nuovi eventi coronarici




PCI
AF
AF
+
PCI
Aspirin
Clopidogrel
Prasugrel
Ticagrelor
VKA
Dabigatran
Rivaroxaban
Apixaban
Edoxaban
Triple
Therapy
Stent Thrombosis
DAPT > OAC
TIA/Stroke
OAC > DAPT



Doppia terapia antiaggregante per pazienti in anticoagulazione orale (triplice terapia)

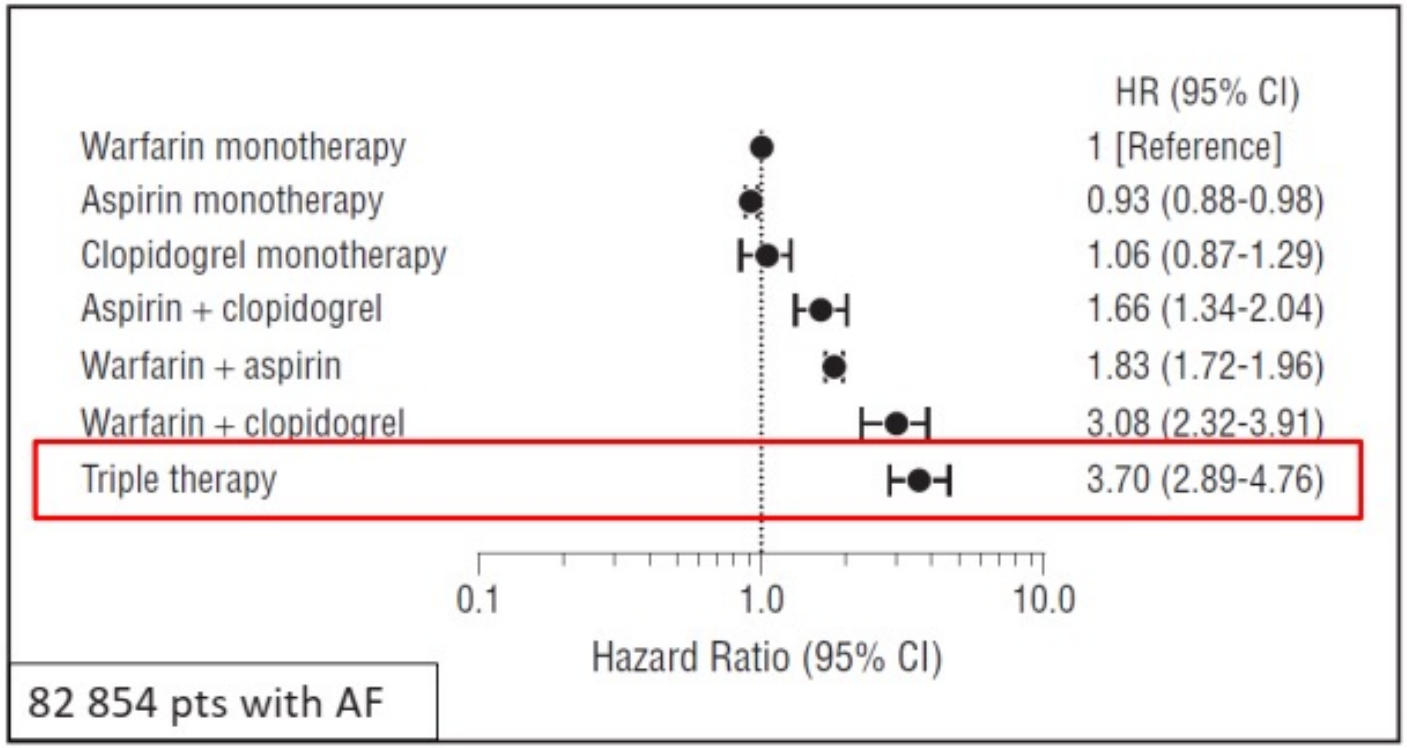
Quali rischi comporta

- Paragonata alla sola terapia anticoagulante orale, l'aggiunta della DAPT a questa **aumenta le complicanze emorragiche di circa 3 volte**
- Pertanto questi pz vanno considerati ad alto rischio di sanguinamento
- Le indicazioni alla terapia anticoagulante orale vanno attentamente rivalutate
- La triplice terapia va continuata solo fino a quando viene valutata assolutamente indispensabile

LESS IS MORE

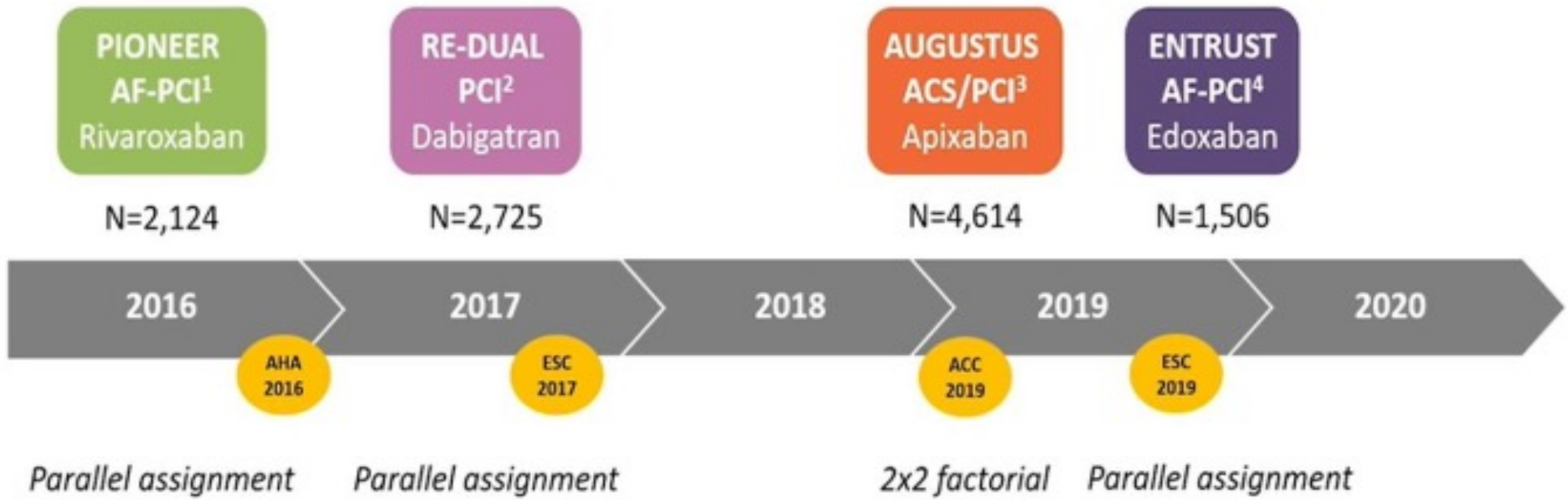
Risk of Bleeding With Single, Dual, or Triple Therapy With Warfarin, Aspirin, and Clopidogrel in Patients With Atrial Fibrillation

Morten L. Hansen, MD, PhD; Rikke Sørensen, MD; Mette T. Clausen, MSc Pharm; Marie Louise Fog-Petersen, MSc Pharm; Jakob Raunsø, MD; Niels Gadsbøll, MD, DMSc; Gunnar H. Gislason, MD, PhD; Fredrik Folke, MD; Søren S. Andersen, MD; Tina K. Schramm, MD; Steen Z. Abildstrøm, MD, PhD; Henrik E. Poulsen, MD, DMSc; Lars Køber, MD, DMSc; Christian Torp-Pedersen, MD, DMSc



Arch Intern Med. 2010;170(16):1433-1441

NOACs nella FA + ACS/PCI



All 4 trials are powered for safety (bleeding) and underpowered for efficacy (ischaemic endpoints)

Sospensione della terapia antiaggregante

- I dati al riguardo non sono univoci
- Nei pz stabili e liberi da eventi, viene in genere consigliata la sospensione dei farmaci antiaggreganti a 1 anno dopo la procedura di stent
- Studi dimostrano che dopo tale periodo la terapia anticoagulante da sola è superiore all'aspirina, e che la TAO + aspirina non dà maggiore protezione ma è associata con un maggiore rischio emorragico

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What is new in the 2020 Guidelines? New recommendations (12)

Recommendations	Class
Recommendations for patients with AF and an ACS, PCI, or CCS	
Recommendations for AF patients with ACS	**ACUTI**
In AF patients with ACS undergoing an uncomplicated PCI, early cessation (≤1 week) of aspirin and continuation of dual therapy with an OAC and a $P2Y_{12}$ inhibitor (preferably clopidogrel) for up to 12 months is recommended if the risk of stent thrombosis is low or if concerns about bleeding risk prevail over concerns about risk of stent thrombosis, irrespective of the type of stent used.	I
Recommendations in AF patients with a CCS undergoing PCI	**CRONICI**
After uncomplicated PCI, early cessation (≤1 week) of aspirin and continuation of dual therapy with OAC for up to 6 months and clopidogrel is recommended if the risk of stent thrombosis is low or if concerns about bleeding risk prevail over concerns about risk of stent thrombosis, irrespective of the type of stent used.	I

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(European Heart Journal 2020-doi/10.1093/eurheartj/ehaa612)

Figure 20 (1) Post-procedural management of patients with AF and ACS/PCI (full-outlined arrows represent a default strategy; graded/dashed arrows show treatment modifications depending on individual patient's ischaemic and bleeding risks)

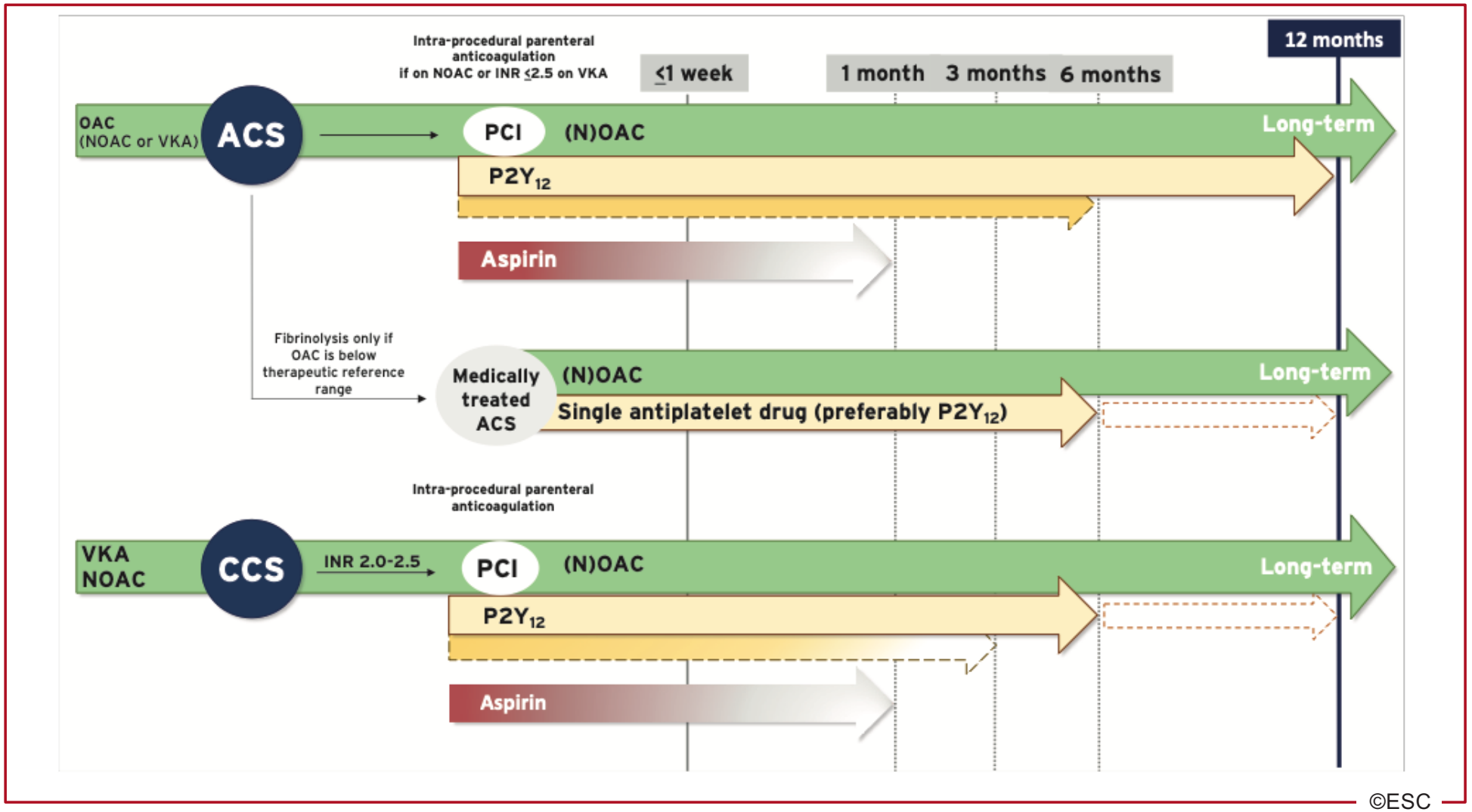

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Figure 20 (2) Post-procedural management of patients with AF and ACS/PCI (full-outlined arrows represent a default strategy; graded/dashed arrows show treatment modifications depending on individual patient's ischaemic and bleeding risks)

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THROMBOTIC RISK FACTORS

- Diabetes mellitus requiring therapy
- Prior ACS/recurrent myocardial infarction
- Multivessel CAD
- Concomitant PAD
- Premature CAD (occurring at age of <45 y) or accelerated CAD (new lesion within 2 years)
- CKD (eGFR <60 mL/min)
- Clinical presentation (ACS)
- Multivessel stenting
- Complex revascularisation (left main stenting, bifurcation lesion stenting, chronic total occlusion intervention, last patent vessel stenting)
- Prior stent thrombosis on antiplatelet treatment
- Procedural factors (stent expansion, residual dissection, stent length, etc.)

BLEEDING RISK FACTORS

- Hypertension
- Abnormal renal or liver function
- Stroke or ICH history
- Bleeding history or bleeding diathesis (e.g., anaemia with haemoglobin <110 g/L)
- Labile INR (if on VKA)
- Elderly (>65 years)
- Drugs (concomitant OAC and antiplatelet therapy, NSAIDs), excessive alcohol consumption

STRATEGIES TO REDUCE BLEEDING ASSOCIATED WITH PCI

- Radial artery access
- PPIs in patients taking DAPT who are at increased risk of bleeding (e.g., the elderly, dyspepsia, gastro-oesophageal reflux disease, Helicobacter pylori infection, chronic alcohol use)
- Non–administration of unfractionated heparin in patients on VKA with INR >2.5
- Pre-treatment with aspirin only, add a $P2Y_{12}$ inhibitor when coronary anatomy is known or if STEMI
- GP IIb/IIIa inhibitors only for bailout or periprocedural complications
- Shorter duration of combined antithrombotic therapy

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Recommendations for patients with AF and an ACS, PCI, or CCS (1)

Recommendations	Class	Level
General recommendations for patients with AF and an indication for concomitant antiplatelet therapy		
In AF patients eligible for NOACs, it is recommended to use a NOAC[a] in preference to a VKA in combination with antiplatelet therapy.	I	A
In patients at high bleeding risk (HAS-BLED ≥3), rivaroxaban 15 mg o.d. should be considered in preference to rivaroxaban 20 mg o.d. for the duration of concomitant single or DAPT, to mitigate bleeding risk.	IIa	B

[a]See summary of product characteristics for reduced doses or contraindications for each NOAC in patients with CKD, body weight <60 kg, age >75–80 years, and/or drug interactions.

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Recommendations for patients with AF and an ACS, PCI, or CCS (2)

Recommendations	Class	Level
General recommendations for patients with AF and an indication for concomitant antiplatelet therapy (continued)		
In patients at high bleeding risk (HAS-BLED ≥3), dabigatran 110 mg b.i.d. should be considered in preference to dabigatran 150 mg b.i.d. for the duration of concomitant single or DAPT, to mitigate bleeding risk.	**IIa**	**B**
In AF patients with an indication for a VKA in combination with antiplatelet therapy, the VKA dosing should be carefully regulated with a target INR of 2.0–2.5 and TTR >70%.	**IIa**	**B**

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Recommendations for patients with AF and an ACS, PCI, or CCS (3)

Recommendations	Class	Level
Recommendations for AF patients with ACS		
In AF patients with ACS undergoing an uncomplicated PCI, early cessation (≤1 week) of aspirin and continuation of dual therapy with an OAC and a $P2Y_{12}$ inhibitor (preferably clopidogrel) for up to 12 months is recommended if the risk of stent thrombosis[b] is low or if concerns about bleeding risk[c] prevail over concerns about risk of stent thrombosis[b], irrespective of the type of stent used.	I	A
Triple therapy with aspirin, clopidogrel, and an OAC[d] for longer than 1 week after an ACS should be considered when risk of stent thrombosis[b] outweighs the bleeding risk,[c] with the total duration (≤1 month) decided according to assessment of these risks, and the treatment plan should be clearly specified at hospital discharge.	IIa	C

[b]Risk of stent thrombosis encompasses: (i) risk of thrombosis occurring and (ii) risk of death should stent thrombosis occur, both of which relate to anatomical, procedural, and clinical characteristics. Risk factors for CCS patients include stenting of left main stem or last remaining patent artery; suboptimal stent deployment; stent length >60 mm; diabetes mellitus; CKD; bifurcation with two stents implanted; treatment of chronic total occlusion; and previous stent thrombosis on adequate antithrombotic therapy. [c]Bleeding risk in AF patients may be assessed using the HAS-BLED score, which draws attention to modifiable bleeding risk factors; those at high risk (score ≥3) can have more frequent or early review and follow-up. Bleeding risk is highly dynamic and does not remain static, and relying on modifiable bleeding risk factors alone is an inferior strategy to evaluate bleeding risk. [d]When dabigatran is used in triple therapy, dabigatran 110 mg b.i.d may be used instead of 150 mg b.i.d, but the evidence is insufficient.

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Azienda Unità Sanitaria Locale di Imola

Azienda Usl Di Imola
Viale Amendola, 2 - 40026 Imola (BO)

U.O.C. Cardiologia
ORTOLANI PAOLO

Imola, il 29/03/2023

Egregio dott.ssa
Medico Curante di anni 76 ,
Relazione clinica di ricovero dal 21/03/2023 al 29/03/2023

Diagnosi di Dimissione
RECENTE INFARTO MIOCARDICO ACUTO (STEMI) A SEDE INFERIORE SOTTOPOSTO AD ANGIOPLASTICA PRIMARIA SULLA CORONARIA DESTRA. FIBRILLAZIONE ATRIALE PAROSSISTICA RECIDIVANTE. LIEVE DISFUNZIONE VENTRICOLARE SINISTRA.

Da segnalare durante la degenza
- Persistente stabilità emodinamica e buon compenso circolatorio. I valori di troponina risultavano in progressivo calo rispetto alle precedenti misurazioni.

- In relazione agli episodi recidivanti di fibrillazione atriale parossistica ed all'elevato rischio tromboembolico (CHA2-DS2-VASc = 4), è stata impostata terapia anticoagulante orale con apixaban e contestualmente eseguito shit antiaggregante da Ticagrelor a Clopidogrel.

Conclusioni
Paziente affetto da cardiopatia ischemica post-infartuale (recente STEMI inferiore) con lieve disfunzione ventricolare sinistra ed episodi di fibrillazione atriale parossistica. Impostata terapia antitrombotica con Apixaban e Clopidogrel.
Il Clopidogrel andrà proseguito per almeno 6 mesi ed auspicabilmente per 12 mesi, ma tale scelta terapeutica dovrà essere valutata nel follow-up, anche in base ad eventuali eventi emorragici ed all'andamento dei controlli dell'esame emocromocitometrico.

Programma Terapeutico
- CLOPIDOGREL 75 MGR (OS) 1 Cp ore 08:00 (da proseguire per almeno 6 mesi)
- ELIQUIS 5MG (OS) 1 Cpr ore 08:00 + 1 Cpr ore 20:00
- CORDARONE 200 MGR (OS) 1 Cpr ore 13:00 (da Lunedì a Venerdì)
- BISOPROLOLO 2,5MG (OS) 1 Cp ore 08:00 + 1 Cp ore 20:00

Conclusioni

- ✓ Non sono infrequenti pazienti con indicazione a terapia anticoagulante orale e che richiedano una duplice terapia antiaggregante per PCI in elezione o ACS, per ridurre occlusione dello stent e reinfarti
- ✓ L'impiego dei NOACs è preferibile al warfarin per il favorevole profilo di sicurezza ed efficacia
- ✓ Sono stati pubblicati vari lavori che impiegano solo una duplice terapia antitrombotica - NOACs + inibitore recettori piastrinici $P2Y_{12}$ (clopidogrel) - subito dopo la procedura o l'evento ischemico cardiaco
- ✓ Le recentissime LG ESC sulla FA hanno cambiato le indicazioni, riducendo il tempo di triplice terapia a 1 settimana e in certi casi fino al massimo di 1 mese, per continuare poi con la duplice terapia fino a 1 anno
- ✓ Oltre l'anno nella maggioranza dei casi è indicato l'uso del solo anticoagulante orale

Grazie per l’attenzione