SCA sense elevació del ST: aspectes novedosos

16.10.2015

Aleix Fort

Què hi ha de nou?

a. DIAGNÒSTIC: nou algoritme 0-1h “rule in-rule out”

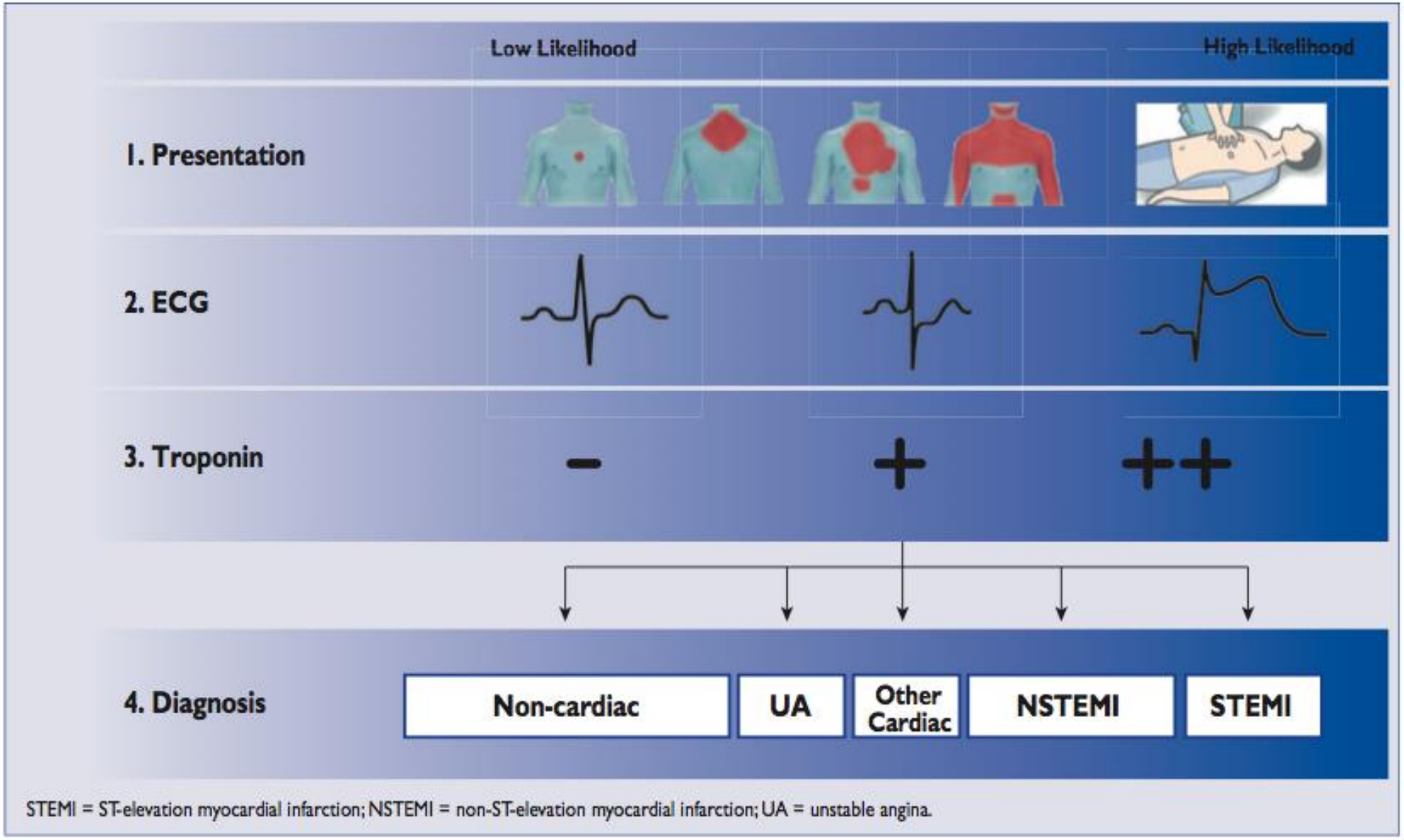
b. MONITORITZACIÓ

c. TRACTAMENT (antitrombòtic)

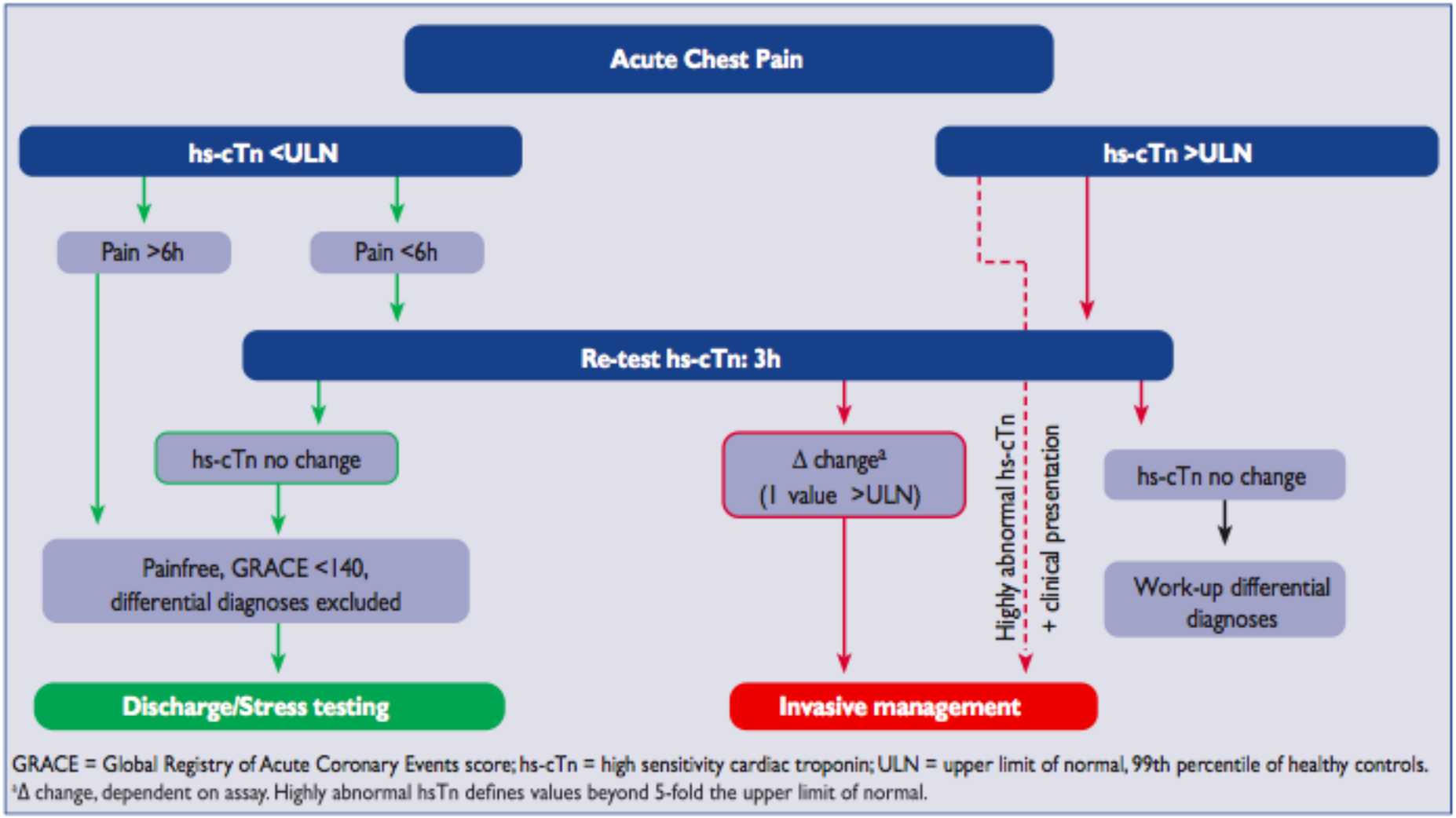
d. REVASCULARITZACIÓ

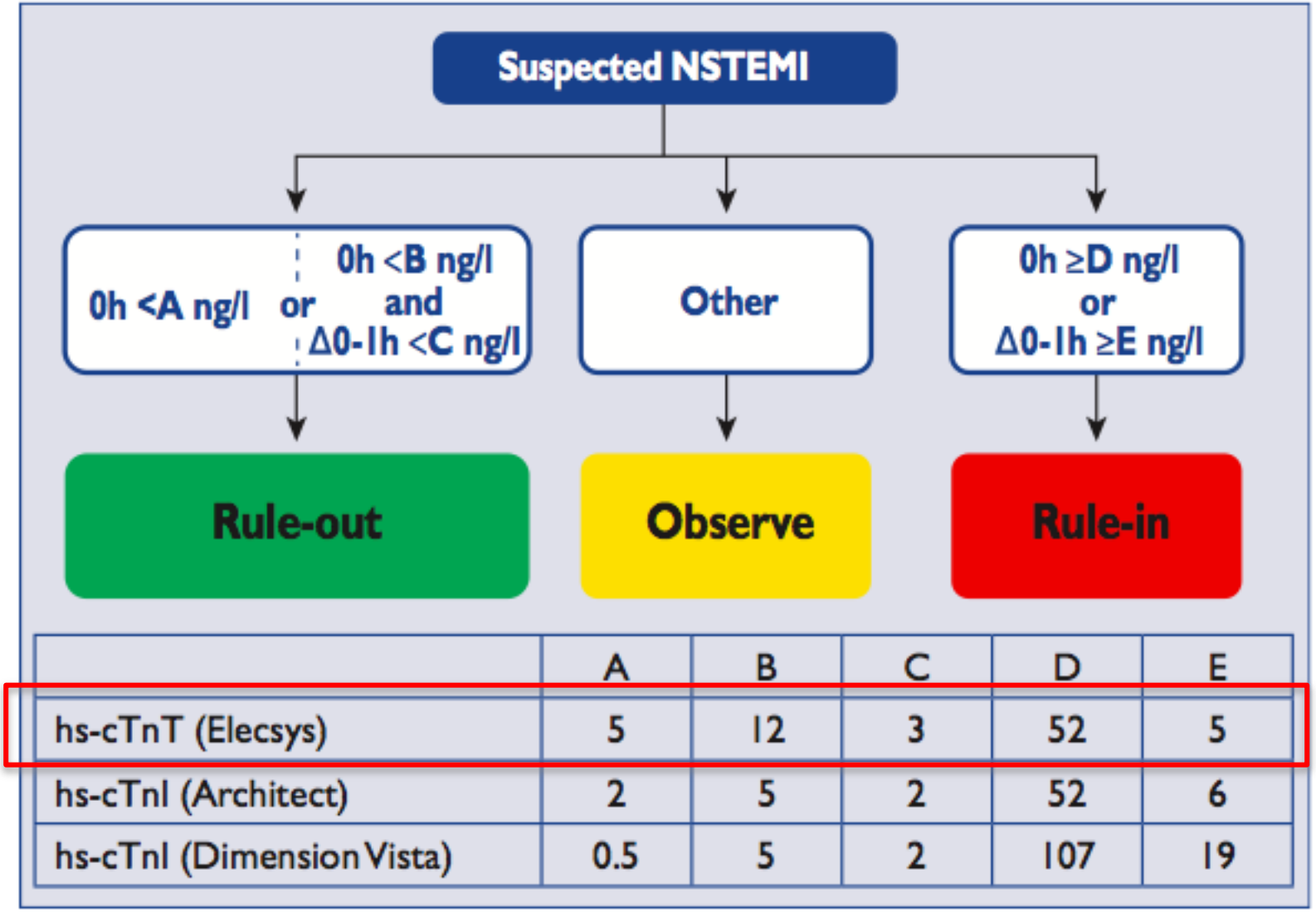
e. PREVENCIÓ SECUNDÀRIA

a) diagnòstic



- nou algoritme 0-1h “rule in-rule out”





	A	B	C	D	E
hs-cTnT (Elecsys)	5	12	3	52	5
hs-cTnI (Architect)	2	5	2	52	6
hs-cTnI (Dimension Vista)	0.5	5	2	107	19

Table 5 Characteristics of the 0 h/3 h and the 0 h/1 h algorithms

	0h/3 h algorithm	0h/1 h algorithm
Negative predictive value for acute MI	98–100%	98–100%
Positive predictive value for acute MI	Unknown, depending on delta change and assay	75–80%
Effectiveness[a]	++	+++
Feasibility	++ requires GRACE score	+++
Challenges	Pain onset cannot be reliably quantified in many patients	Cut-off levels are assay-specific and different from the 99th percentile
Validation in large multicentre studies	+	+++
Additional advantages	Already used clinically	Shorter time to decision

It is recommended to measure cardiac troponins with sensitive or high-sensitivity assays and obtain the results within 60 min.	I	A
A rapid rule-out protocol at 0 h and 3 h is recommended if high-sensitivity cardiac troponin tests are available.	I	B
A rapid rule-out and rule-in protocol at 0 h and 1 h is recommended if a high-sensitivity cardiac troponin test with a validated 0 h/1 h algorithm is available. Additional testing after 3–6 h is indicated if the first two troponin measurements are not conclusive and the clinical condition is still suggestive of ACS.	I	B

Diagnòstic

- DT agut URG
  - 5-10% STEMI
  - 15-20% NSTEMI
  - 10% AI
  - 10% altres entitats cardiològiques
  - **50% causes NO cardíaques**.

Additional ECG leads (V_{3R}, V_{4R}, V_7–V_9) are recommended if ongoing ischaemia is suspected when standard leads are inconclusive.	I	C

Cardiac	Pulmonary	Vascular	Gastro-intestinal	Orthopaedic	Other
Myopericarditis Cardiomyopathies[a]	**Pulmonary embolism**	**Aortic dissection**	**Oesophagitis, reflus or spasm**	**Musculoskeletal disorders**	**Anxiety disorders**
Tachyarrhythmias	**(Tension)-Pneumothorax**	Symptomatic aortic aneurysm	Peptic ulcer, gastritis	Chest trauma	Herpes zoster
Acute heart failure	Bronchitis, pneumonia	Stroke	Pancreatitis	Muscle injury/ inflammation	Anaemia
Hypertensive emergencies	Pleuritis		Cholecystitis	Costochondritis	
Aortic valve stenosis				Cervical spine pathologies	
Tako-Tsubo cardiomyopathy					
Coronary spasm					
Cardiac trauma					

- No cal monitorització seriada TnT identificat condició alternativa (FA, crisi HTA..)

b) Monitorització

Pot semblar poca rellevància. Dia a dia. No constava en documents previs.

Clinical Presentation	Unit	Rhythm monitoring
Unstable angina	Regular ward or discharge	None
NSTEMI at low risk for cardiac arrhythmias[a]	Intermediate care unit or coronary care unit	≤24 h
NSTEMI at intermediate to high risk for cardiac arrhythmias[b]	Intensive/coronary care units or intermediate care unit	>24 h

ALT RISC:

- Hemodinàmicament INESTABLE
- Arítmies majors
- FEVI <40%
- Reperfusió fallida
- Altres estenosis coronaries critiques vasos ppals
- Complicacions post revsc

Monitoring		
Continuous rhythm monitoring is recommended until the diagnosis of NSTEMI is established or ruled out.	I	C
It is recommended to admit NSTEMI patients to a monitored unit.	I	C
Rhythm monitoring up to 24 h or PCI (whichever comes first) should be considered in NSTEMI patients at low risk for cardiac arrhythmias.[e]	IIa	C
Rhythm monitoring for >24 h should be considered in NSTEMI patients at intermediate to high-risk for cardiac arrhythmias.[f]	IIa	C
In the absence of signs or symptoms of ongoing ischaemia, rhythm monitoring in unstable angina may be considered in selected patients (e.g. suspicion of coronary spasm or associated symptoms suggestive of arrhythmic events).	IIb	C

Què hi ha de nou?

a. DIAGNÒSTIC: nou algoritme 0-1h “rule in-rule out”

b. MONITORITZACIÓ

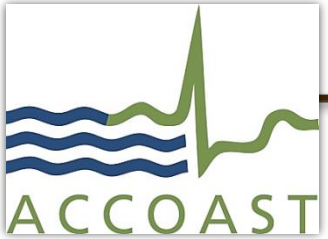
c. TRACTAMENT (antitrombòtic)
   - Pretractament amb prasugrel
   - Duració DAPT
   - Triple teràpia
   - Nous agent: cangrelor

d. REVASCULARITZACIÓ

e. PREVENCIÓ SECUNDÀRIA

It is not recommended to administer prasugrel in patients in whom coronary anatomy is not known.	III

- TRITON TIMI-38 anatomia coronària havia de ser coneguda
- Respondre pregunta, dissenyar ACCOAST.



The NEW ENGLAND JOURNAL of MEDICINE

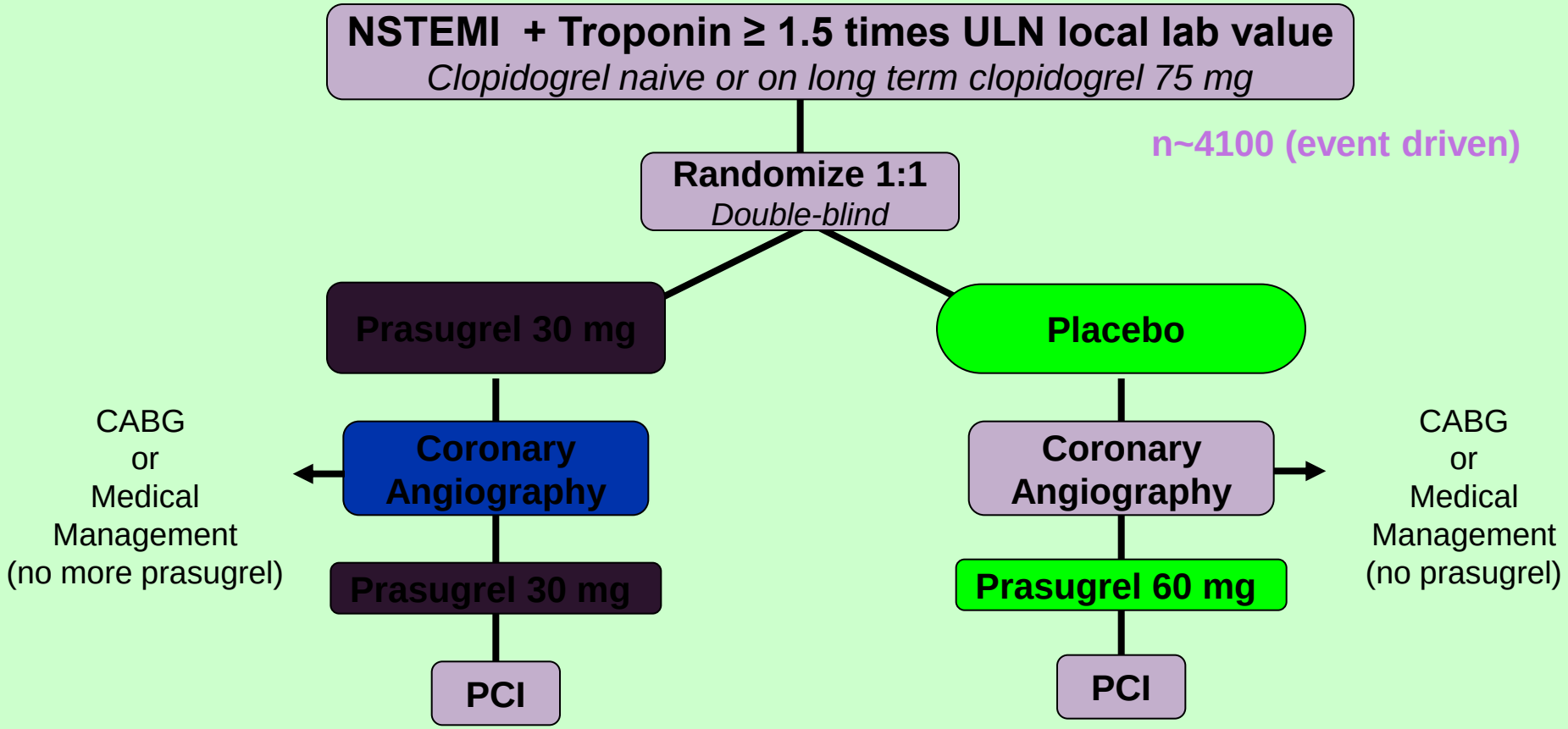
ESTABLISHED IN 1812 SEPTEMBER 12, 2013 VOL. 369 NO. 11

Pretreatment with Prasugrel in Non–ST-Segment Elevation Acute Coronary Syndromes

- Pre-treatment with aspirin and a $P2Y_{12}$ antagonist has been a class I recommendation and common practice for the treatment of NSTE-ACS

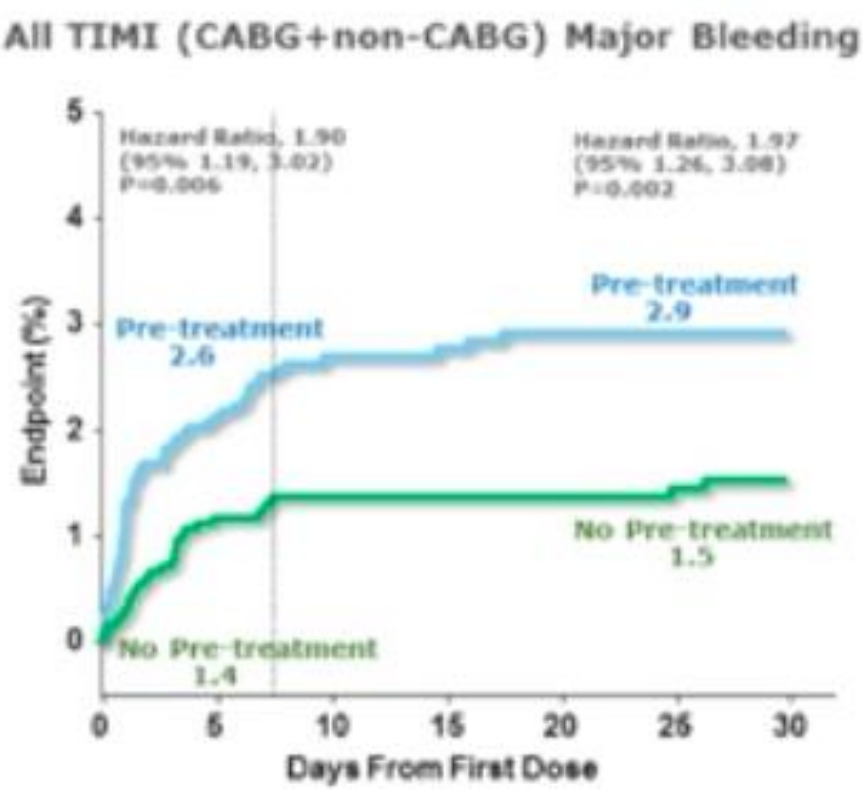
- However, no trial has ever randomized patients presenting with NSTE-ACS, invasively managed, to pre-treatment with clopidogrel, prasugrel or ticagrelor *vs.* no pre-treatment.

ACCOAST design



Montalescot G et al. *Am Heart J* 2011;161:650-656


1° Efficacy End Point @7+30 days
CV Death, MI, Stroke,
UR, GPIIb/IIIa Bailout
Pre-treatment
10.0
Pre-treatment
10.8
No Pre-treatment
10.8
No Pre-treatment
9.8
Hazard Ratio, 1.02
(95% 0.84, 1.25)
P=0.81
Hazard Ratio, 0.997
(95% 0.83, 1.20)
P=0.98
Endpoint (%)
Days From First Dose


All TIMI (CABG+non-CABG) Major Bleeding
Hazard Ratio, 1.90
(95% 1.19, 3.02)
P=0.006
Hazard Ratio, 1.97
(95% 1.26, 3.08)
P=0.002
Pre-treatment
2.9
Pre-treatment
2.6
No Pre-treatment
1.5
No Pre-treatment
1.4
Endpoint (%)
Days From First Dose

Conclusions

- In NSTE-ACS patients managed invasively within 48 hours of admission, pre-treatment with prasugrel does not reduce major ischemic events through 30 days but increases major bleeding complications.
- The results are consistent among patients undergoing PCI supporting treatment with prasugrel once the coronary anatomy has been defined.
- No subgroup appears to have a favorable risk/benefit ratio of pre-treatment.
- Reappraisal of routine pre-treatment strategies in NSTE-ACS is needed.

Baseline Characteristics

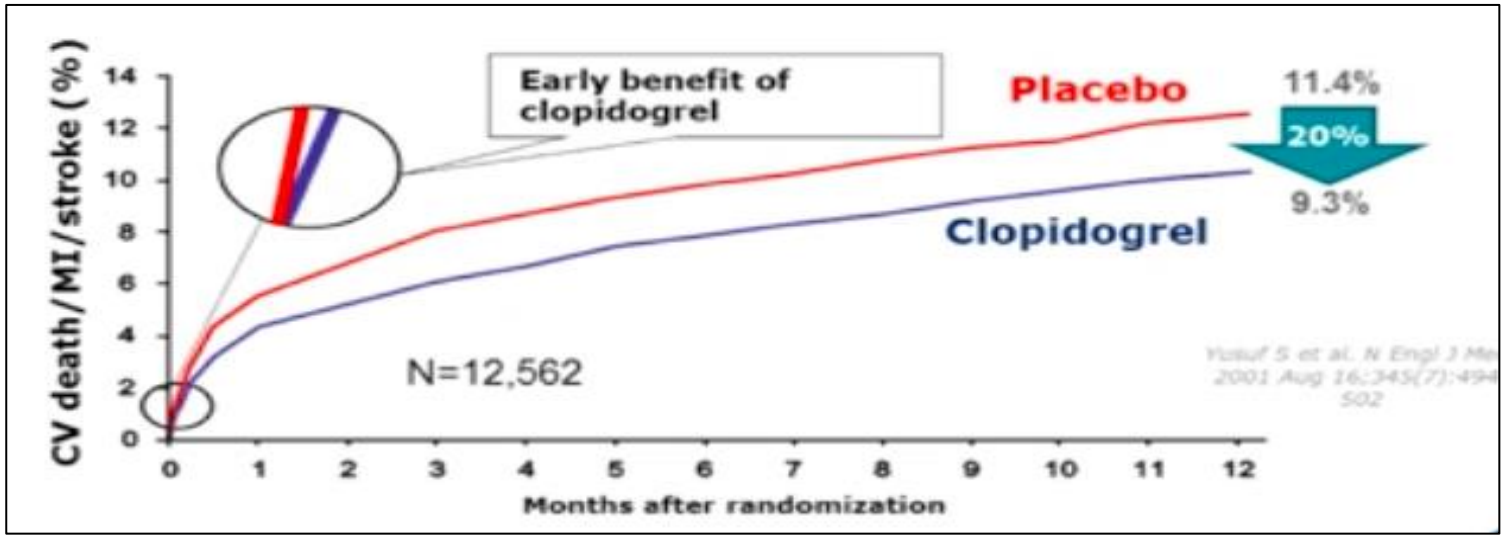
Characteristics	Pre-treatment (N =2037)	No Pre-treatment (N =1996)
GRACE score (%)		
<140	76	78
≥140	24	22
CRUSADE score (median)	34	34
Timing (hr)		
→Symptom onset to 1st LD, median	14.6	15.2
→ 1st LD to coronary angiogram, median	4.4	4.2
Access (%)‖		
Femoral	57	57
Radial	43	43

- Basats en l'estudi ACCOAST, es desaconsella el pretractament amb prasugrel.

- *"as the optimal timing of ticagrelor or clopidogrel administration in NSTE-ACS patients scheduled for an invasive strategy has not been adequately investigated, no recommendation for or against pretreatment with these agents can be formulated"*

Duració DAPT

- Post SCA= 12 mesos DAPT. D'on surt això?
- *Estudi CURE (2001).*



- *Estudi CREDO (2002)*. DAPT 1m vs 1any. n 2116 (50% SCAD, 50% NSTEMI)
  - RRR 27% mort, MI, stroke (8.6% vs 11.8% 95% CI 3.9-44 p<0.02)

- Concepte duració PERSONALITZADA DAPT
  - Recomanació classe I segueix sent 12m
  - Millories tècniques nous stents (retirada precoç)
  - Potència nous AA (pacients ben seleccionats, retirada tardana)

$P2Y_{12}$ inhibitor administration for a shorter duration of 3–6 months after DES implantation may be considered in patients deemed at high bleeding risk.	IIb	A
$P2Y_{12}$ inhibitor administration in addition to aspirin beyond 1 year may be considered after careful assessment of the ischaemic and bleeding risks of the patient.	IIb	A

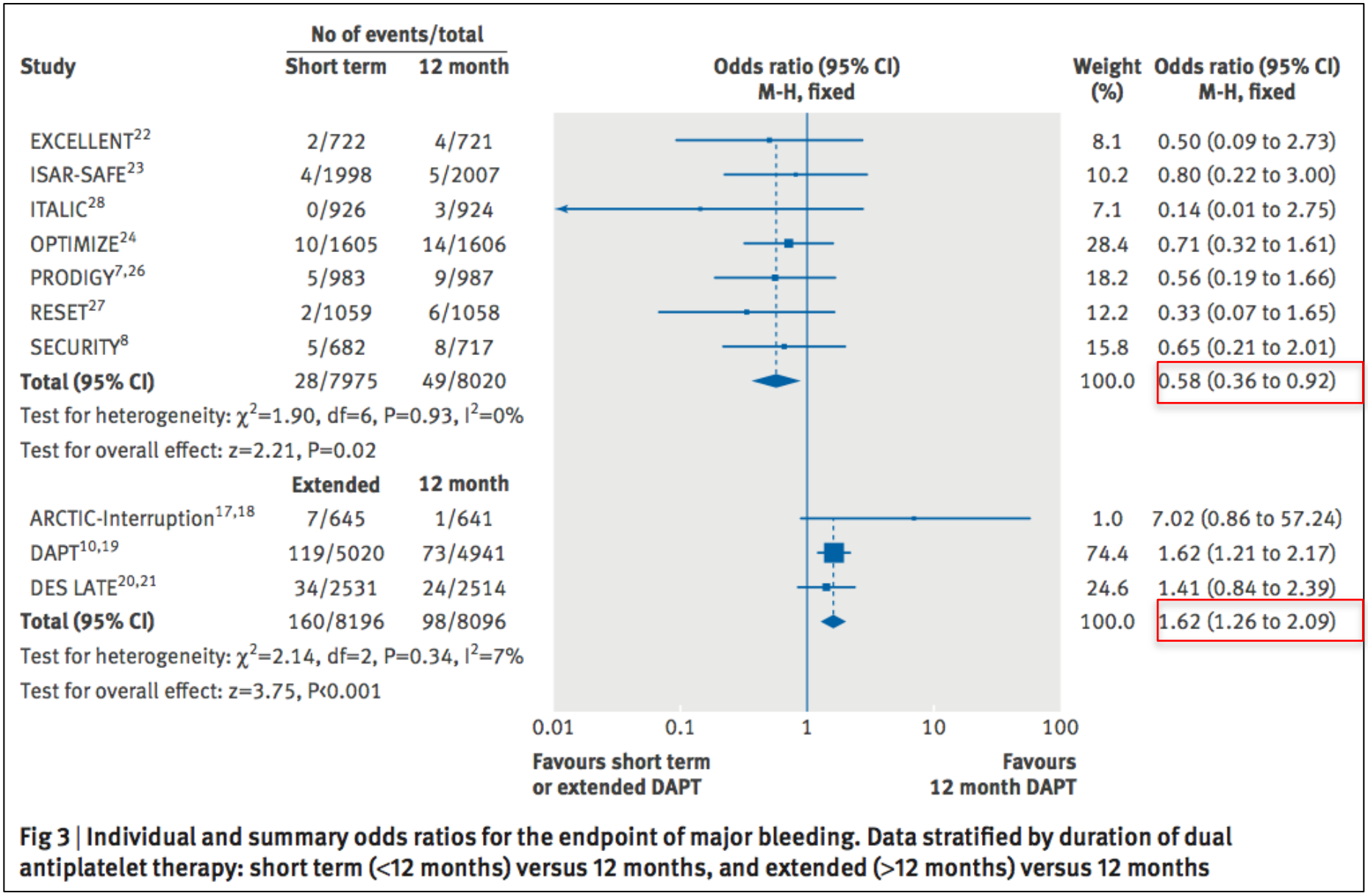
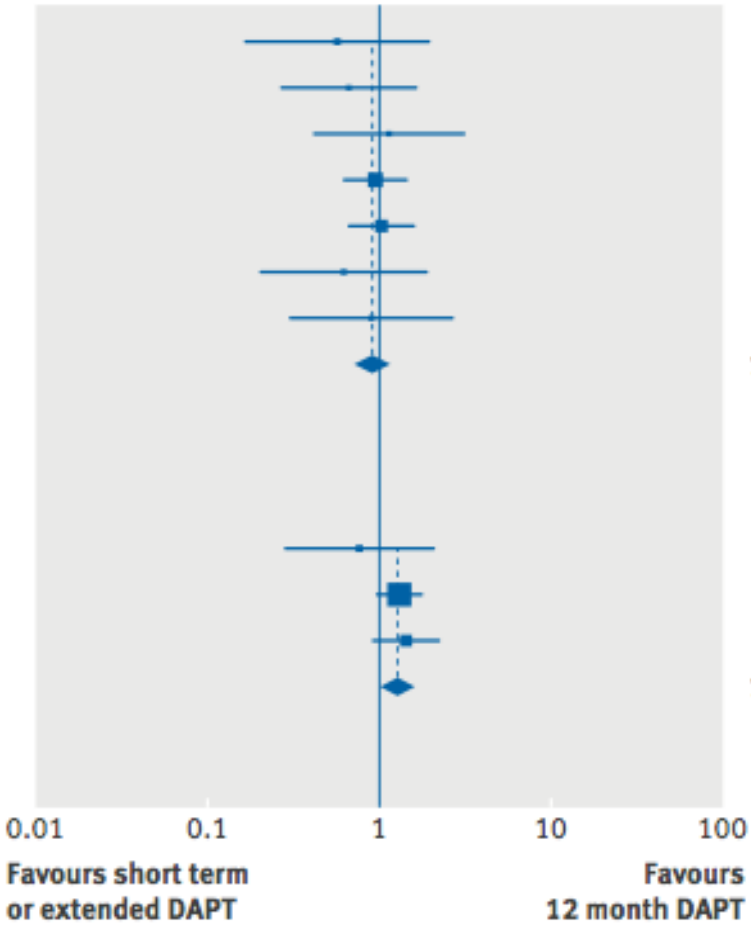


Fig 3 | Individual and summary odds ratios for the endpoint of major bleeding. Data stratified by duration of dual antiplatelet therapy: short term (<12 months) versus 12 months, and extended (>12 months) versus 12 months

Navarese et al, BMJ 2015;350;h1618



Study	No of events/total: Short term	No of events/total: 12 month	Weight (%)	Odds ratio (95% CI) M-H, fixed
EXCELLENT[22]	4/722	7/721	5.7	0.57 (0.17 to 1.95)
ISAR-SAFE[23]	8/1998	12/2007	9.8	0.67 (0.27 to 1.64)
ITALIC[28]	8/926	7/924	5.7	1.14 (0.41 to 3.16)
OPTIMIZE[24]	43/1605	45/1606	36.0	0.95 (0.63 to 1.46)
PRODIGY[7,26]	40/983	39/987	30.7	1.03 (0.66 to 1.62)
RESET[27]	5/1059	8/1058	6.5	0.62 (0.20 to 1.91)
SECURITY[8]	6/682	7/717	5.6	0.90 (0.30 to 2.69)
Total (95% CI)	114/7975	125/8020	100.0	0.91 (0.71 to 1.18)
Test for heterogeneity: χ^2=1.99, df=6, P=0.92, I^2=0%				
Test for overall effect: z=0.69, P=0.49				
	Extended	**12 month**		
ARCTIC-Interruption[17,18]	7/645	9/641	7.9	0.77 (0.29 to 2.08)
DAPT[10,19]	98/5020	74/4941	64.4	1.31 (0.97 to 1.78)
DES LATE[20,21]	46/2531	32/2514	27.8	1.44 (0.91 to 2.26)
Total (95% CI)	151/8196	115/8096	100.0	1.30 (1.02 to 1.66)
Test for heterogeneity: χ^2=1.25, df=2, P=0.54, I^2=0%				
Test for overall effect: z=2.12, P=0.03				

Fig 4 | Individual and summary odds ratios for the endpoint of all cause mortality. Data stratified by duration of dual antiplatelet therapy: short term (<12 months) versus 12 months, and extended (>12 months) versus 12 months

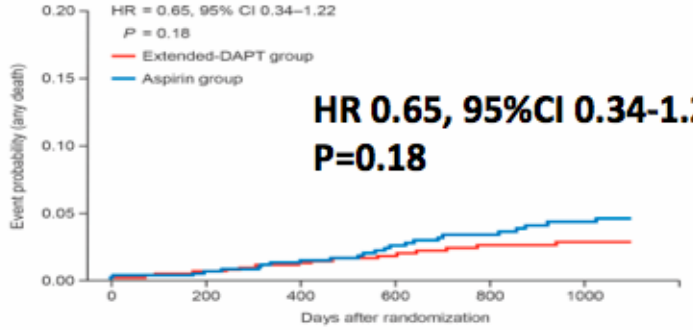
- Risc IAM 0.53 (0.42-0.66) p<0.001(protector)
- Trombosi stent 0.33 (0.21-0.51) p<0.001
- Mortalitat CV 1.09 (0.79-1.50) p<0.001

- Conclusió treuen autors aquests articles (OPTIDUAL publicar recentment ESC)
  - En pacients estables, taxa d'esdeveniments baixa. Benefici DAPT perllongada marginal.
  - DAPT afegeix un important risc hemorràgic
  - Selecció pacients que beneficiaran. Millor estratificació risc (score englobessin anatomia coronaria, marcadors, variables clíniques…)

After DES:

- Supports meta-analyses that L-DAPT reduces the risk of ischaemic events.
- Very low annual rate of death/MI/stroke (0.9%), TIMI major bleed (0.2%), ST (0.1%) regardless L-DAPT.

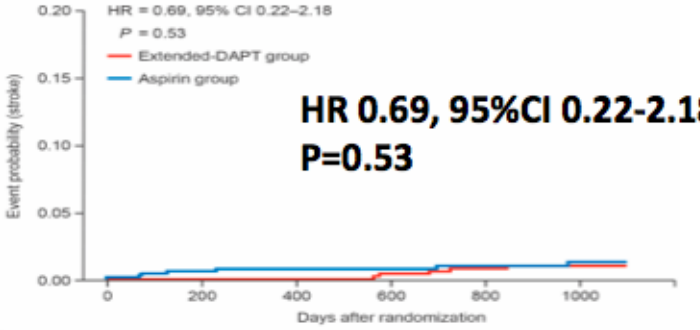
A. Death



Numbers at risk:

Extended-DAPT group	695	651	585	510	456	360
Aspirin group	690	638	573	494	430	343

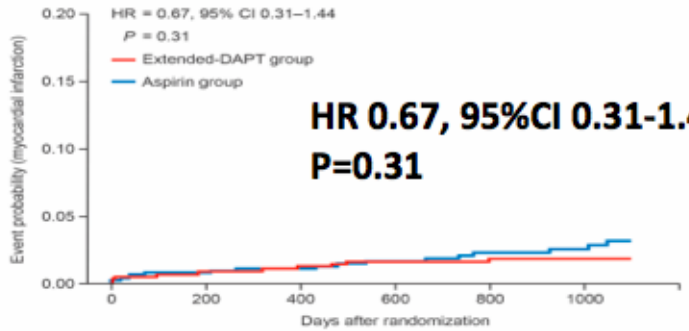
B. Stroke



Numbers at risk:

Extended-DAPT group	695	652	585	509	455	358
Aspirin group	690	635	569	494	428	339

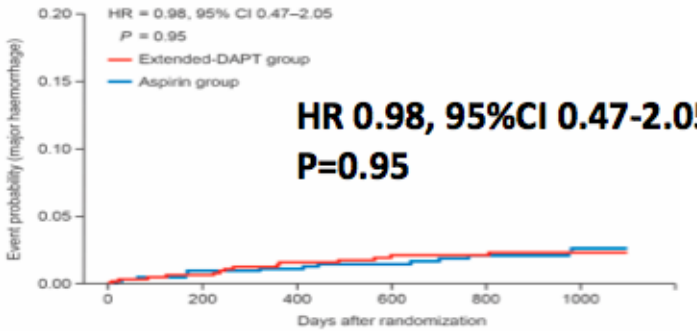
C. MI



Numbers at risk:

Extended-DAPT group	695	652	585	509	455	358
Aspirin group	690	635	569	494	428	339

D. Major bleed



Numbers at risk:

Extended-DAPT group	695	648	576	501	449	354
Aspirin group	690	632	566	491	426	338

+ Cangrelor

	Clopidogrel	Prasugrel	Ticagrelor	Cangrelor
Chemical class	Thienopyridine	Thienopyridine	Cyclopentyl-triazolopyrimidine	Stabilized ATP analogue
Administration	Oral	Oral	Oral	Intravenous
Dose	300–600 mg orally then 75 mg a day	60 mg orally then 10 mg a day	180 mg orally then 90 mg twice a day	30 μg/kg bolus and 4 μg/kg/min infusion
Dosing in CKD				
• Stage 3 (eGFR 30–59 mL/min/1.73m^2)	No dose adjustment	No dose adjustment	No dose adjustment	No dose adjustment
• Stage 4 (eGFR 15–29 mL/min/1.73m^2)	No dose adjustment	No dose adjustment	No dose adjustment	No dose adjustment
• Stage 5 (eGFR <15 mL/min/1.73m^2)	Use only for selected indications (e.g. stent thrombosis prevention)	Not recommended	Not recommended	No dose adjustment
Binding reversibility	Irreversible	Irreversible	Reversible	Reversible
Activation	Prodrug, with variable liver metabolism	Prodrug, with predictable liver metabolism	Active drug, with additional active metabolite	Active drug
Onset of loading dose effect[a]	2–6 hours[b]	30 min[b]	30 min[b]	2 min
Duration of effect	3–10 days	7–10 days	3–5 days	1–2 hours
Withdrawal before surgery	5 days[c]	7 days[c]	5 days[c]	1 hour
Plasma half-life of active $P2Y_{12}$ inhibitor[d]	30–60 min	30–60 min[e]	6–12 hours	5–10 min
Inhibition of adenosine reuptake	No	No	Yes	Yes ('inactive' metabolite only)

Cangrelor may be considered in $P2Y_{12}$ inhibitor–naive patients undergoing PCI.	IIb	A

CHAMPION

- Teràpia pont en pacients inestables CABG (precisen DAPT)

IIb/IIIa

- MAJOR LIMITACIÓ seu ús.

Among patients who are already treated with DAPT, the addition of a GP IIb/IIIa receptor inhibitor for high-risk PCI (elevated troponin, visible thrombus) is recommended if the risk of bleeding is low.	I	B

2011

GPIIb/IIIa inhibitors during PCI should be considered for bailout situations or thrombotic complications.	IIa	C

2015

Anticoagulació

- NOVETAT (poc impacte): apareix guies RIVAROXABAN
- RECORDATORI. FONDAPARINUX. Tornen a fer èmfasi

Fondaparinux (2.5 mg s.c. daily) is recommended as having the most favourable efficacy–safety profile regardless of the management strategy.	I	B
Enoxaparin (1 mg/kg s.c. twice daily) or UFH are recommended when fondaparinux is not available.	I	B
In patients on fondaparinux (2.5 mg s.c. daily) undergoing PCI, a single i.v. bolus of UFH (70–85 IU/kg, or 50–60 IU/kg in the case of concomitant use of GPIIb/IIIa inhibitors) is recommended during the procedure.	I	B

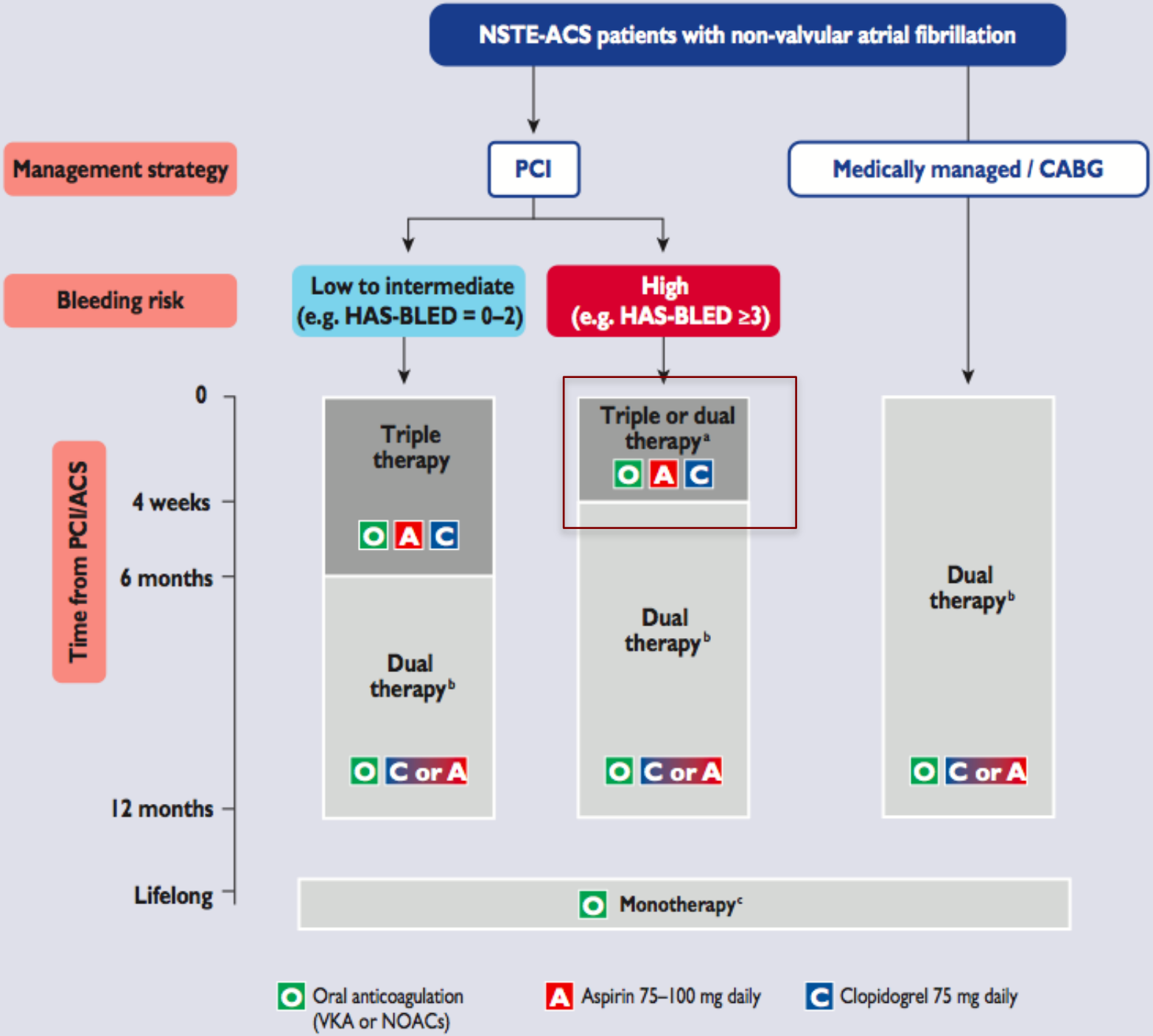
- OASIS 5. FONDAPARINUX i SCASEST
  - n 20.000 pacients
  - Fondaparinux vs enoxaparina
  - Endpoint primari eficàcia 9 dd (no inferioritat): combinat mort, IAM o isq.refract
  - Endopont primari seguretat 9 dd: hemorràgies majors
  - Resultats: NO inferior EFICÀCIA + menys incidència d'hemorràgies majors: reducció mortalitat als 30 dies (no durant fase hospitalització)

- Seguretat: disminuir meitat sagnats majors.
  - HR 0.52 (95% CI 0.44-0.61) p<0.001
- Reducció mortatlitat
  - 30 dies: [2.9% vs. 3.5%; HR 0.83 (95% CI 0.71-0.97)
  - 6m [5.8% vs. 6.5%; HR 0.89 (95% CI 0.80-1.00), P , 0.05]
- Taxa sagnats majors no influenciada pel moment última dosi fondaparinux (< o > 6h)
- Trombosi catèter + freqüent amb fonda (0.9%) que enoxa (0.4%)
  - Desaparèixer bolus HNF al moment PCI.

RIVAROXABAN

- Apixaban provar primer (APPRAISE)
  - Acabar prematurament
  - Augment sagnats (intracraneals) sense aparent benefici events isquèmics. Mateixa dosi que FA

- RIVAROXABAN. ATLAS ACS 2-TIMI 51. Dosi 2.5mg o 5mg
  - Estudi discutit. No sembla que actualment hagi de canviar el maneig (no detalls).
  - Benefici marginal a expenses d'increment notable de complicacions
  - No sembla que vagi en consonància tendència actual reduir mínim triple teràpia


NSTE-ACS patients with non-valvular atrial fibrillation
Management strategy
PCI
Medically managed / CABG
Bleeding risk
Low to intermediate (e.g. HAS-BLED = 0–2)
High (e.g. HAS-BLED ≥3)
Time from PCI/ACS
0
4 weeks
6 months
12 months
Lifelong
Triple therapy
O A C
Dual therapy[b]
O C or A
Triple or dual therapy[a]
O A C
Dual therapy[b]
O C or A
Dual therapy[b]
O C or A
Monotherapy[c]
O
Oral anticoagulation (VKA or NOACs)
A
Aspirin 75–100 mg daily
C
Clopidogrel 75 mg daily

+ 2 opcions:

- triple teràpia 1 mes. Preferència nous DES

If at high bleeding risk (HAS-BLED ≥3), triple therapy with OAC, aspirin (75–100 mg/day) and clopidogrel 75 mg/day should be considered for a duration of 1 month, followed by OAC and aspirin 75–100 mg/day or clopidogrel (75 mg/day) continued up to 12 months irrespective of the stent type (BMS or new-generation DES).	IIa	C

The use of new-generation DES over BMS should be considered among patients requiring OAC.	IIa	B

- Doble teràpia. Estudi WOEST

Dual therapy with OAC and clopidogrel 75 mg/day may be considered as an alternative to triple antithrombotic therapy in selected patients (HAS-BLED ≥3 and low risk of stent thrombosis).	IIb	B

	Doble terapia (n-279)	Triple terapia (n=284)	Hazard ratio (IC95%)	p
Cualquier sangrado	54 (19·4%)	126 (44·4%)	0·36 (0·26–0·50)	<0·0001
TIMI				
Mayor	9 (3·2%)	16 (5·6%)	0·56 (0·25–1·27)	0·159
Mayor y menor	39 (14·0%)	89 (31·3%)	0·40 (0·27–0·58)	<0·0001
GUSTO				
Severo	4 (1·4)	10 (3·5%)	0·40 (0·12–1·27)	0·119
Moderado y severo	15 (5·4%)	35 (12·3%)	0·42 (0·23–0·76)	0·003
BARC				
3	18 (6·5%)	36 (12·7%)	0·49 (0·28–0·86)	0·011
2	23 (8·2%)	59 (20·8%)	0·36 (0·23–0·59)	<0·0001
1	18 (6·5%)	45 (15·8%)	0·38 (0·22–0·66)	0·0004
Cualquier transfusión	11 (3·9%)	27 (9·5%)	0·39 (0·17–0·84)	0·011

sagnats

	Doble terapia (n-279)	Triple terapia (n=284)	Hazard ratio (95% CI)	p
Endpoint secundario	31 (11·1%)	50 (17·6%)	0·60 (0·38–0·94)	0·025
Muerte	7 (2·5%)	18 (6·3%)	0·39 (0·16–0·93)	0·027
IAM	9 (3·2%)	13 (4·6%)	0·69 (0·29–1·60)	0·382
ICP o CABG	20 (7·2%)	19 (6·7%)	1·05 (0·56–1·97)	0·876
Ictus	3 (1·1%)	8 (2·8%)	0·37 (0·10–1·40)	0·128
Trombosis stent	4 (1·4%)	9 (3·2%)	0·44 (0·14–1·44)	0·165

eficàcia

- Nous antiagregants desaconsellats. Recomanació classe III
- Accés radial
- ACO límit baix.
  - AVK. INR 2-2.5 (EXC prot mitrals)
  - NACO's: DBG 110, Rivaroxaban 15, Apixaban 2.5

Què hi ha de nou?

a. DIAGNÒSTIC: nou algoritme 0-1h “rule in-rule out”

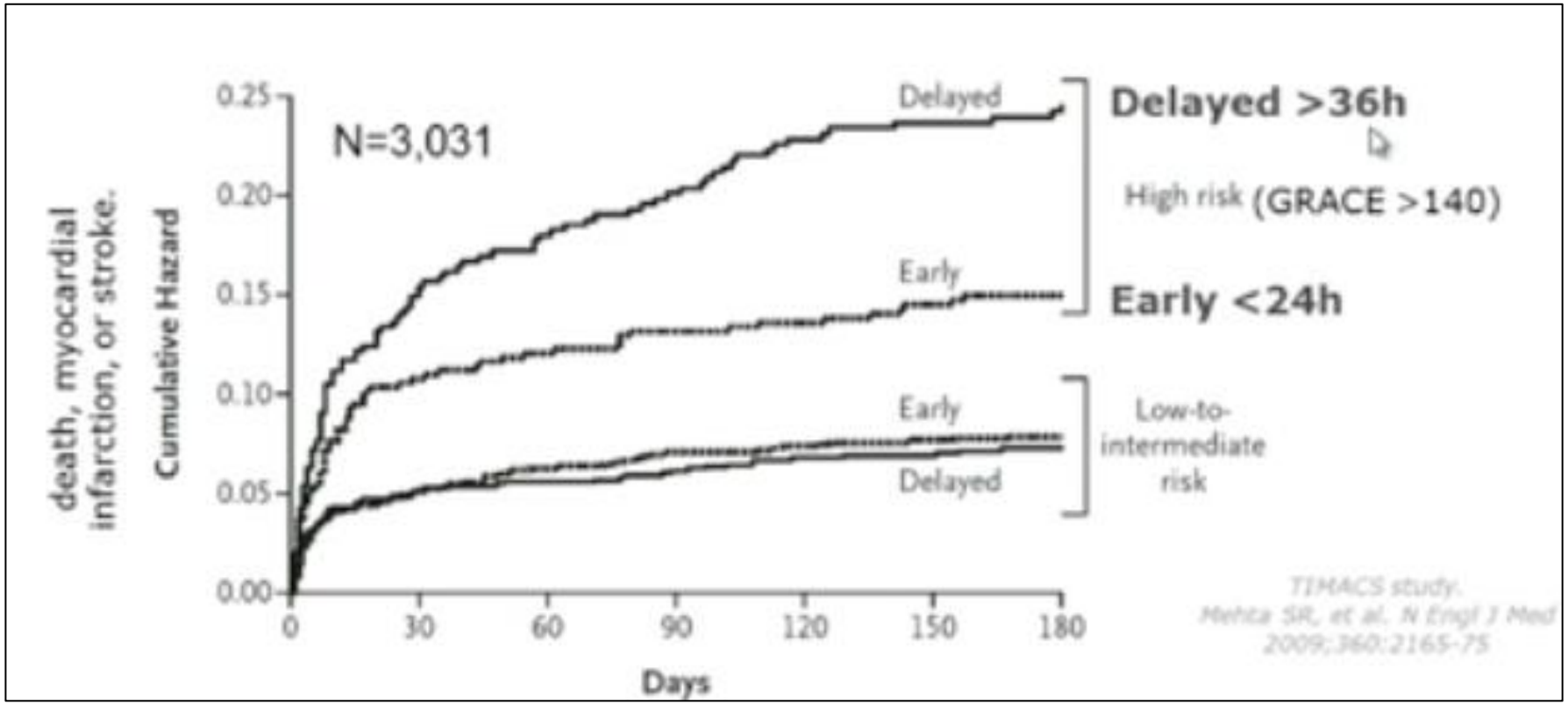
b. MONITORITZACIÓ

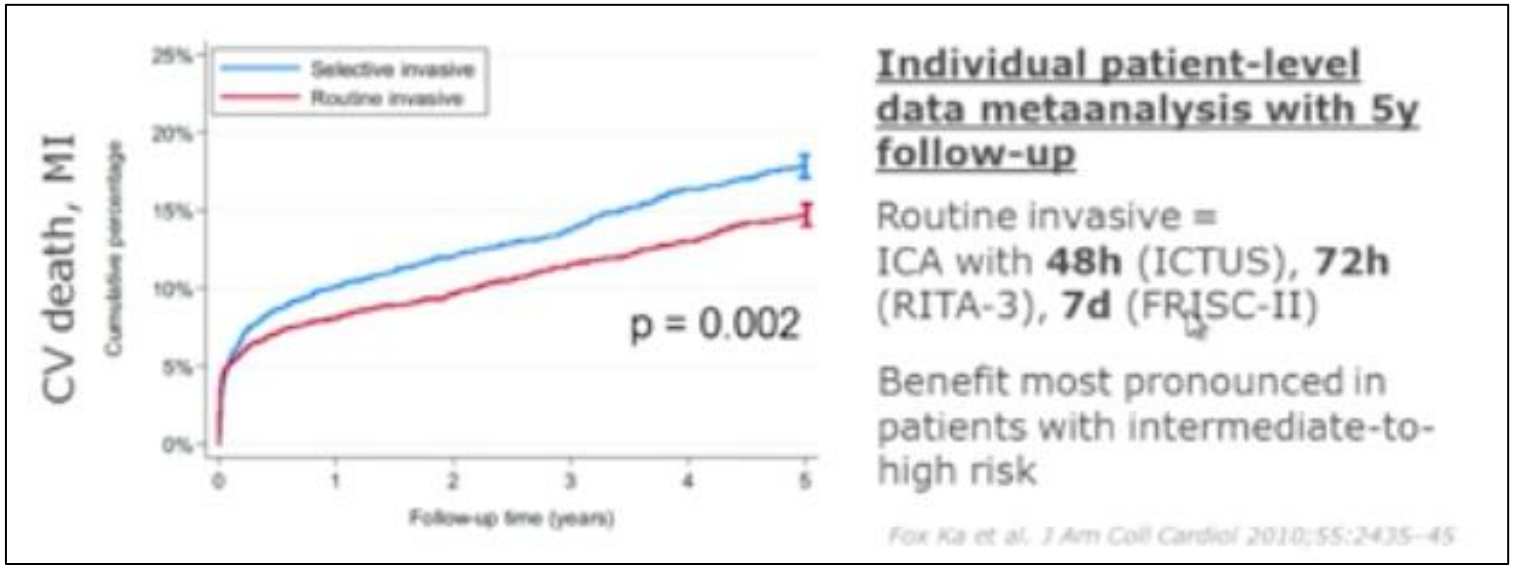
c. TRACTAMENT (antitrombòtic)

d. REVASCULARITZACIÓ
   - Estratificació de risc
   - Via abordatge
   - DES segona generació

e. PREVENCIÓ SECUNDÀRIA

Very-high-risk criteria	<2h
• Haemodynamic instability or cardiogenic shock	
• Recurrent or ongoing chest pain refractory to medical treatment	
• Life-threatening arrhythmias or cardiac arrest	
• Mechanical complications of MI	
• Acute heart failure	
• Recurrent dynamic ST-T wave changes, particularly with intermittent ST-elevation	
High-risk criteria	<24h
• Rise or fall in cardiac troponin compatible with MI	
• Dynamic ST- or T-wave changes (symptomatic or silent)	
• GRACE score >140	
Intermediate-risk criteria	<72h
• Diabetes mellitus	
• Renal insufficiency (eGFR <60 mL/min/1.73 m^2)	
• LVEF <40% or congestive heart failure	
• Early post-infarction angina	
• Prior PCI	
• Prior CABG	
• GRACE risk score >109 and <140	
Low-risk criteria	Non invasive testing
• Any characteristics not mentioned above	


death, myocardial infarction, or stroke.
Cumulative Hazard
0.25
0.20
0.15
0.10
0.05
0.00
N=3,031
Delayed
Early
Early
Delayed
0
30
60
90
120
150
180
Days
Delayed >36h
High risk (GRACE >140)
Early <24h
Low-to-intermediate risk
TIMACS study.
Mehta SR, et al. N Engl J Med 2009;360:2165-75

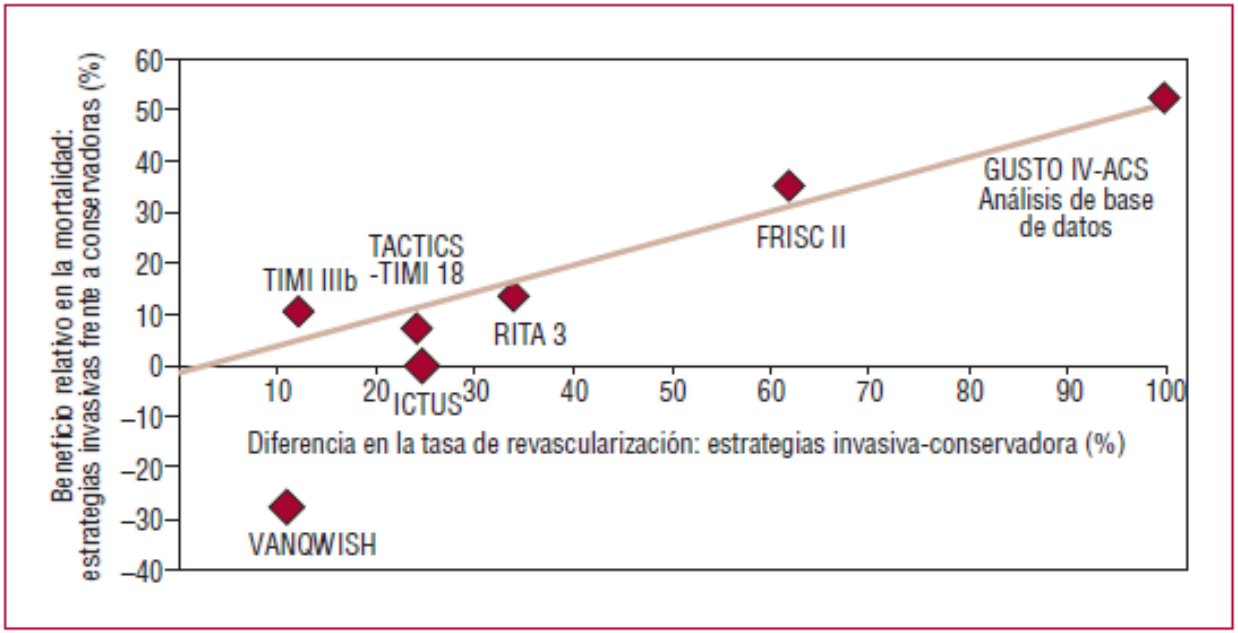


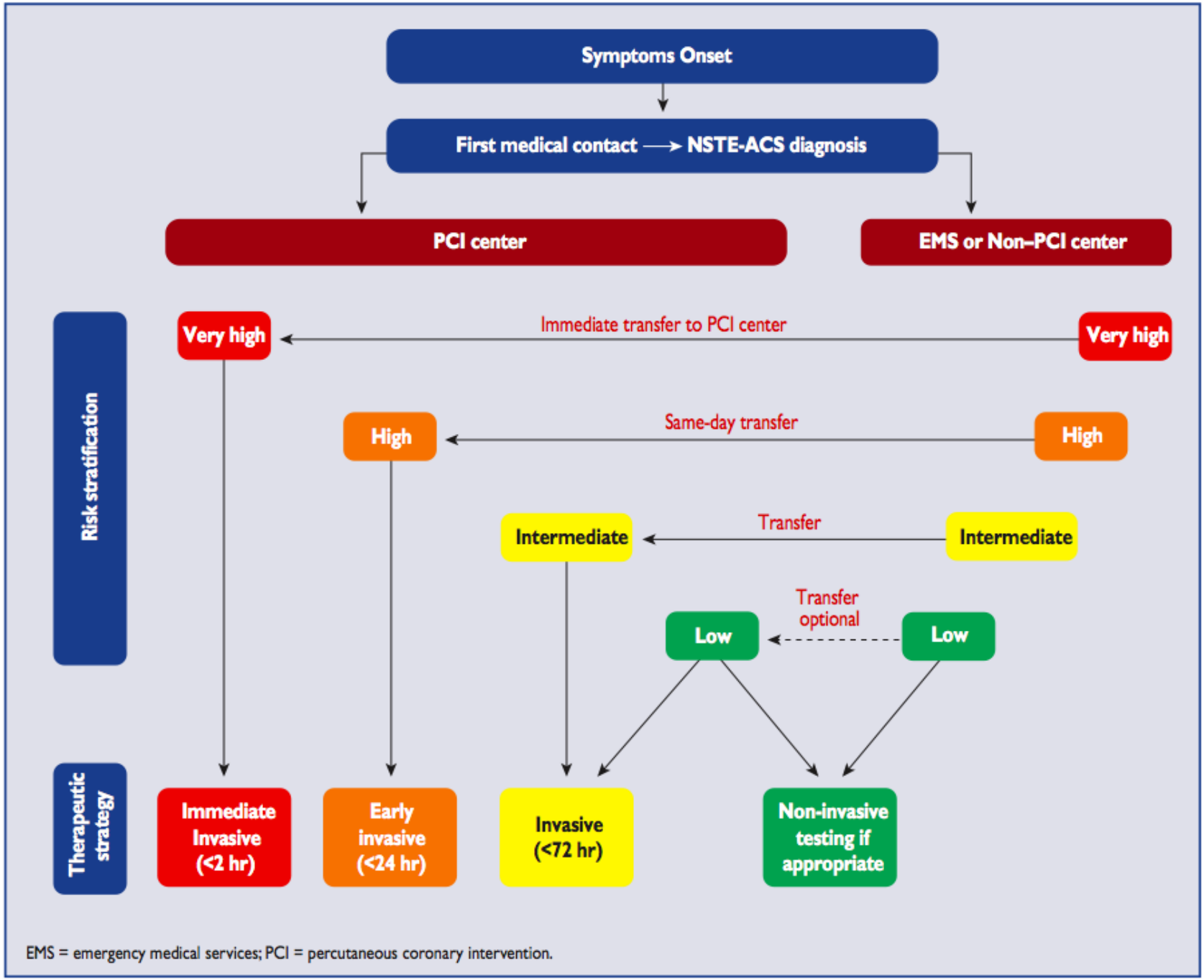
Individual patient-level data metaanalysis with 5y follow-up

Routine invasive = ICA with **48h** (ICTUS), **72h** (RITA-3), **7d** (FRISC-II)

Benefit most pronounced in patients with intermediate-to-high risk

Fox Ka et al. J Am Coll Cardiol 2010;55:2435–45

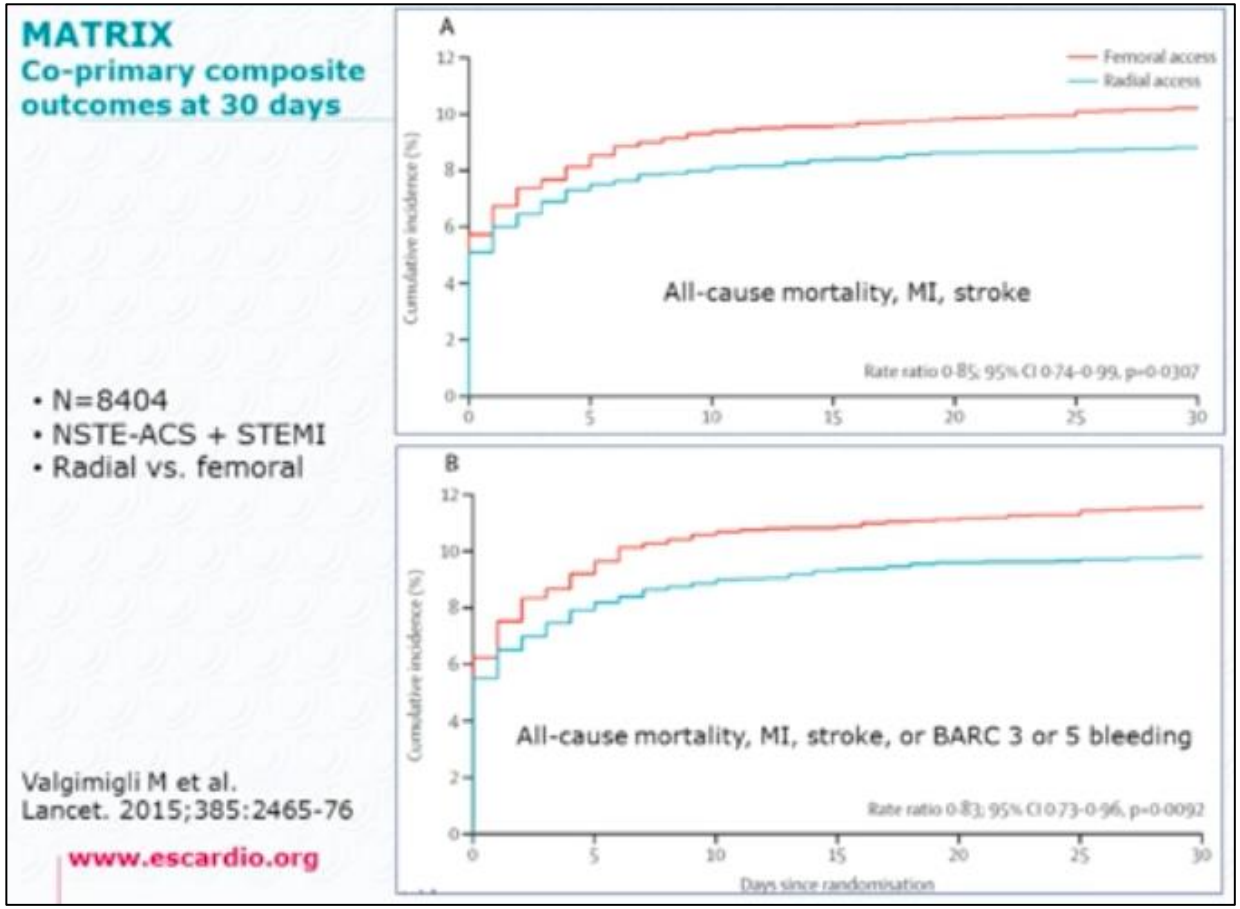


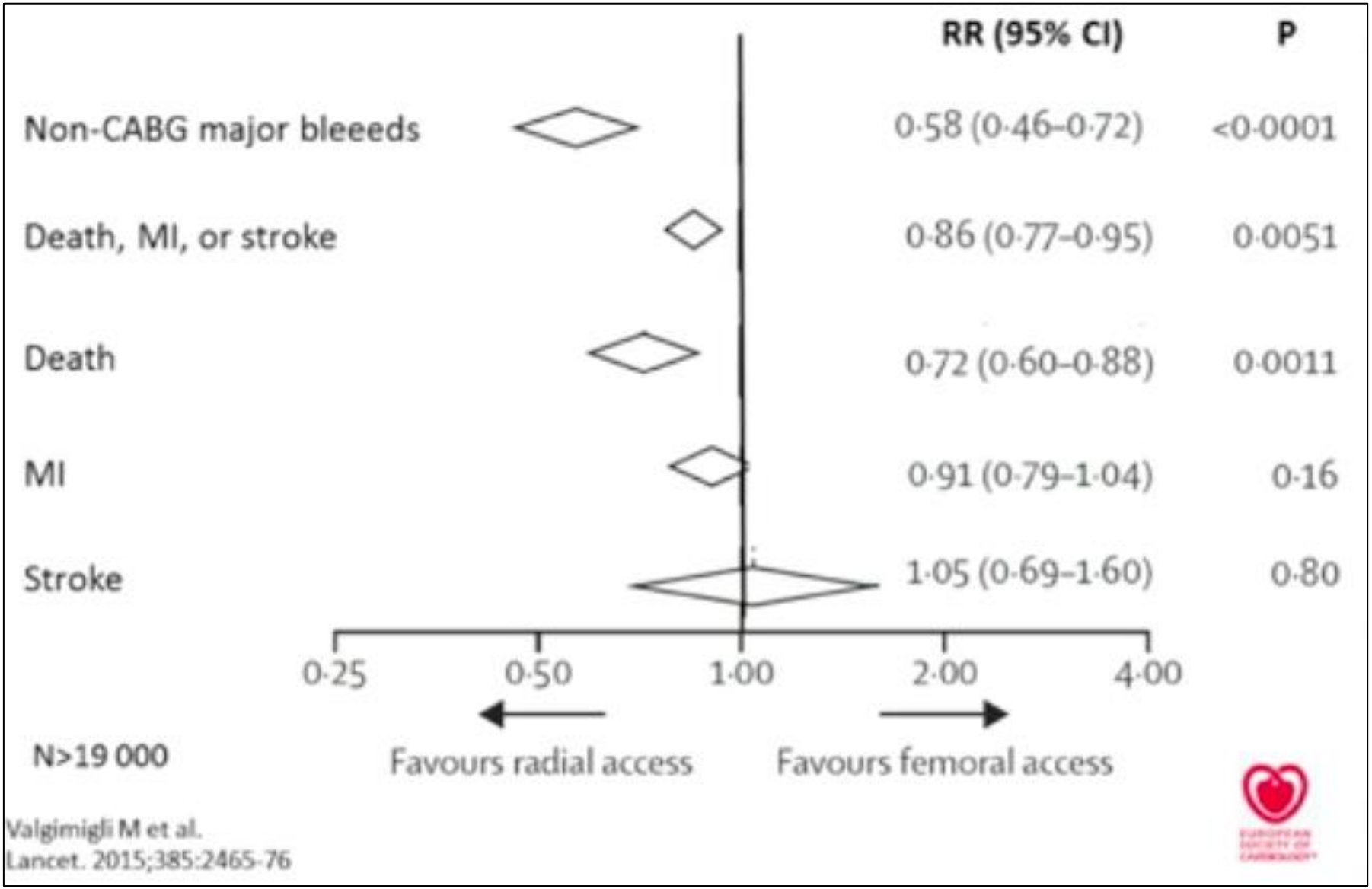


EMS = emergency medical services; PCI = percutaneous coronary intervention.

Revascularització. Abordatge

In centres experienced with radial access, a radial approach is recommended for coronary angiography and PCI.	I	A





Valgimigli M et al.
Lancet. 2015;385:2465-76

Revascularització. Stents

Recommendations	Class[a]	Level[b]	
In patients undergoing PCI, new-generation DESs are recommended.	I	A	
In patients in whom a short DAPT duration (30 days) is planned because of an increased bleeding risk, a new-generation DES may be considered over a BMS.	IIb	B	ZEUS*

Revasc. Tipus de revascularització

In patients with multivessel CAD, it is recommended to base the revascularization strategy (e.g. ad hoc culprit-lesion PCI, multivessel PCI, CABG) on the clinical status and comorbidities as well as the disease severity (including distribution, angiographic lesion characteristics, SYNTAX score), according to the local Heart Team protocol.	I	C

- Tipus revsc no específicament estudiada en SCASEST. Estratègies infereixen estudis altres contextes:
  - STEMI (PRAMI, CvLPRIT
  - SCAD (SYNTAX, FREEDOM)
- Fàcil quan culprit evident o malaltia 1V
- 20% SCASEST no lesions /no obstructives
- 40-80% malaltia multivàs.
- Imatge intracoronaria : vàries plaques vulnerables que podrien complir criteris lesio culprit, pel que KT (luminograma) pot ser complicat identificar-les.
- FFR no provat NSTEMI (disfuncio microvasc associada). Ajuda poc.
- Decisió com si es tractes de SCAD (excepte aquells pacients molt alt risc)

Què hi ha de nou?

a. DIAGNÒSTIC: nou algoritme 0-1h “rule in-rule out”

b. MONITORITZACIÓ

c. TRACTAMENT (antitrombòtic)

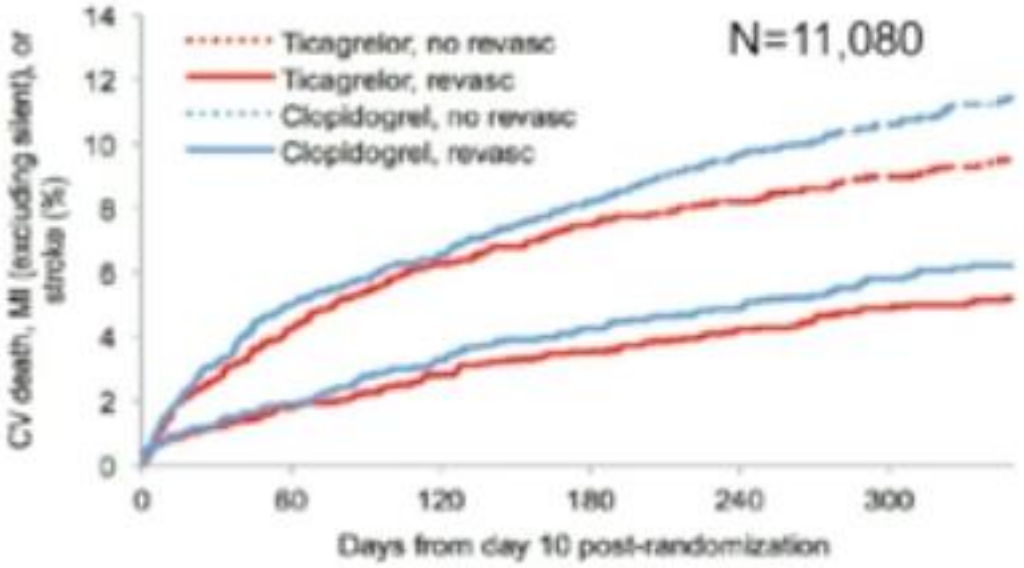
d. REVASCULARITZACIÓ

e. PREVENCIÓ SECUNDÀRIA

Tractament llarg termini

It is recommended to advise all patients on lifestyle changes (including smoking cessation, regular physical activity and a healthy diet).	I	A
It is recommended to start high-intensity statin therapy as early as possible, unless contraindicated, and maintain it long term.	I	A

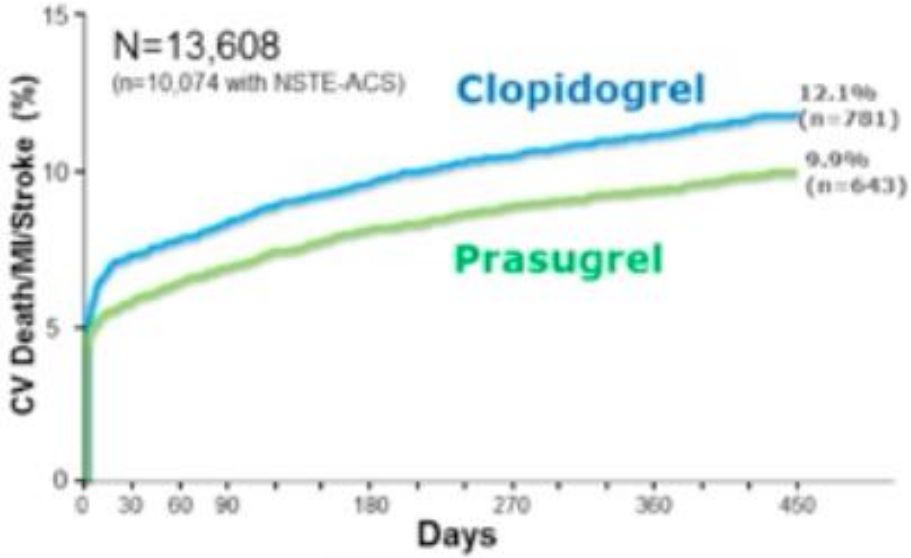
In patients with LDL cholesterol ≥70 mg/dL (≥1.8 mmol/L) despite a maximally tolerated statin dose, further reduction in LDL cholesterol with a non-statin agent[e] should be considered.	IIa	B



PLATO NSTE-ACS subgroup

- **17% RRR** in primary endpoint (p=0.0013)
- **24% RRR** in all-cause mortality (p=0.002)
- **28%** increase in non-CABG-related major bleeds (p=0.014). (No diff in life-threatening and fatal bleeds)

Lindholm D, et al. EHJ 2014;35:2083-2093



TRITON-TIMI 38 (NSTEMI subgroup)

- **18% RRR** in primary endpoint (p=0.002)
- **24% RRR** of recurrent MI (p<0.001)
- **40%** increase in TIMI non-CABG major bleeds (p=0.02).
- 4-fourfold higher risk for fatal bleeds (p=0.002)

Wiviott SD et al. N Engl J Med 2007;357:2001-15.

Gaps in evidence

- Paper genètica individualitzar tractament i millorar resultats està per definir
- Protocol 1h rule out no s'ha estudiat en RCT.
- Maneig dels pacients estan zona gris o d'observació ha de quedar més ben definit.

- Paper BB FEVI normal o DV lleu s'hauria d'inverstigar
- Timig òptim ticagrelor pre-coronariografia s'hauria de definir
- Manquen estudis comparatius entre CABG I PCI en multivàs. S'extrapola SCAD
- Valor FFR context NSTEMI s'hauria d'investigar

TAKE HOME MESSAGES

- TnT ultrasensible actual, si correctament validada, permet una estratègia “rule out” SEGURA encara més curta.
- Pretractament PRASUGREL contradindicat. Només quan anatomia coronària coneguda.
- Nous DES permeten escurçar DAPT fins a 3m (zotarolimus)
- Es pot considerar prolongar la DAPT >1a després d’una estreta valoració del risc isquèmic i hemorràgic del pacient
- Fondaparinux ACO d’elecció en maneig SCASEST
- Cal ajustar-se als temps a l’hora de fer la coronariografia en el context del SCASEST.


“Cuanto más entreno,
más suerte tengo”
Gary Player
dilo.confrases.com